Department of Health & Human Services
DHHS
NEBRASKA

Division of Children and Family Services

State of Nebraska
Pete Ricketts, Governor

Division of Children and Family Services Protection and Safety Procedure Update #34-2016	
Regarding:	Ongoing Case Management
Rescinds:	#22-2016– Ongoing Case Management
Date Effective:	9/23/16
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Issued by:	Douglas J. Weinberg, Director, Division of Children and Family Services

Philosophy

The Division of Children and Family Services (DCFS) believes that families should be respected and valued. The family should lead and be an active part of the team that works toward ensuring their child's safety, permanency, educational, mental health, physical and well-being needs are met.
The overarching responsibility for the CFS Specialist is management of safety and risk factors of children and families involved with DCFS because of abuse, neglect, or dependency; the well-being of children in the custody of the agency and their siblings; and permanency for children for whom DCFS is responsible. This includes:

1. Providing for child safety and reducing risk of harm;
2. Establishing goals that address the reason for DCFS involvement, identifying the unmet needs that keep the family from achieving the goals, and developing strength based strategies to address the unmet needs;
3. Assisting families in identifying and accessing informal and formal supports and resources;
4. Increasing family self-sufficiency;
5. Empowering the family;
6. Promoting timely reunification when appropriate; and
7. Providing permanency for children for whom reunification or family preservation is not possible.

Procedure:

I. ONGOING CASE MANAGEMENT OVERVIEW

A. At the conclusion of the initial assessment, the CFS Specialist determines if ongoing services should be offered to the family based on the safety and risk assessments. If courts are involved, ongoing case management will be provided. If courts are not involved, case opening for ongoing case management will be based on the results of the safety and risk or prevention assessment. A CFS Specialist will be assigned an ongoing case and assume case management activities.

B. The CFS Specialist will work with the family and the Family Team to maintain the child in the home whenever it is safe to do so. It may be determined that a child can remain in the home with safety services. If it is determined that the child is not safe in the home, Law Enforcement may remove the child in an emergency or a court of competent jurisdiction can order a removal from the home. If the child is removed, the CFS

Specialist will make all efforts to reunify the child as soon as it is determined that the child can be safe in the home. In abuse, neglect, dependency cases and cases adjudicated as 3(c) Mentally Ill and Dangerous, the CFS Specialist will utilize the Structured Decision Making (SDM®) Reunification Assessment to determine if reunification should be recommended. A court of competent jurisdiction can also order that reunification occur.

C. The decision on recommending case closure in abuse, neglect, dependency cases and cases where the youth is adjudicated as Mentally Ill and Dangerous is based on information gathered for the SDM® Risk Reassessment and the assessment of child safety. Family progress will be evaluated at Family Team meetings.

II. ONGOING SERVICES

A. Families served through ongoing services: Ongoing services will be offered to all families where the children are determined to be:
   1. Unsafe;
   2. Conditionally safe;
   3. At high or very high risk for future maltreatment of their children; or
   4. In need of services and a court of competent jurisdiction has placed the child in the custody of the Department. This includes youth adjudicated as a 3(c) Mentally Ill and Dangerous.

B. **Review available information:** The CFS Specialist assigned to the case will thoroughly review information gathered during the Initial Assessment and during ongoing case management. The review of the history will be conducted by the CFS Specialist on all new cases and whenever a case is reassigned or transferred to a new case manager. It is critical that all previous reports and information be analyzed and taken into consideration. The history of the family is important because it provides critical information on the pattern of behaviors and provides indicators of past trauma that may impact eh parent's ability to safely parent their child.

C. **Court Involved or Non-Court Involved:** Families may work with DHHS without the involvement of the court or DHHS's involvement may be mandated by the court. All cases will remain open until the safety threats have been mitigated. Cases will remain open until the risk level has reduced to the point that the likelihood of future maltreatment is low to moderate or based on supervisory consultation. No case will be closed if the child is determined to be unsafe.

D. **Court Involved Cases:**
   1. Families whose children are placed in the care and custody of the Department are considered court involved with DCFS. A court involved case cannot be closed as long as the child is in the legal care and custody of DHHS pursuant to a court order.
      a) If the risk level is high or very high **and** the family is working with the Department **and** the CFS Specialist no longer sees a need for on-going court involvement, the CFS Specialist may ask the court to dismiss the court case and continue working with the family on a non-court involved basis. The Court must approve this request and issue an order discharging the child from the legal care and custody of DHHS.
      b) If the child is safe and risk is low or moderate the CFS Specialist will ask the court to dismiss the case.

E. **Non-Court Involved Cases**
   1. Non-court involved cases require that the family voluntarily agrees to work with

DCFS on the identified safety and risk issues.

2. Non-court involved cases must be provided the same access to services as court involved cases.
3. Non-court involved cases may move to be court involved if the family's situation changes to such a degree that child safety cannot be maintained in the home or the family is not making sufficient progress in remedying child safety concerns and risk of harm. The CFS Specialist will consult with his/her supervisor to determine if law enforcement should be asked to consider immediate removal and/or the county attorney should be contacted to request court intervention. This is a mandatory consultation point.
4. In cases where there is no identified safety threats but there is high or very high risk and the family refuses to work with DCFS, the CFS Specialist will consult with his/her supervisor to determine if DCFS should make a referral for a Child Abuse and Neglect Investigative or Treatment Team to review or if law enforcement should be asked to consider immediate removal and/or the county attorney should be contacted to request court intervention. This is a mandatory consultation point.

III. ENGAGING FAMILIES WITH SERVICES:

A. The CFS Specialist will make efforts to engage the family and offer interventions prior to requesting the County Attorney to file a petition.

B. When a CFS Specialist has made efforts to engage a family in services and the family refuses to actively participate or their participation is such that child safety or risk cannot be managed the CFS Specialist will consult with his or her supervisor to determine if a request to file should be prepared and forwarded to the County Attorney's office.

C. Despite the parent's engagement with services, a request to file must be sent to the county attorney when the CFS Specialist has information the parent/custodian has been using methamphetamine.

D. If a safety threat is identified during an assessment or the family's risk level is high or very high and the evidence leading to those decisions is based on one of the situations listed below. A request to file should be based on:

1. The presence of any safety threat(s) and the family is unwilling to engage in interventions.
2. There are no safety threat(s), but the family's risk level is high or very high and the evidence leading to those decisions is based on one of the situations listed below. A mandatory staffing with a supervisor is required to determine whether a request to file should be forwarded to the County Attorney's office. These include:
   a) Domestic Violence;
   b) Previous Termination of Parental Rights;
   c) Serious Physical Abuse (e.g. head trauma, broken bones, multiple injuries); or
   d) Sexual Abuse by a Parent.

E. There are no safety threat(s), but the family's risk level is high or very high and the family is unwilling to engage in interventions the CFS Specialist will consult with his or her supervisor to determine next steps.

F. The CFS Specialist is encouraged to involve the Investigative and/or Ongoing (LB1184) Team in discussion of all cases in which the family's risk level is high or very high and the family is unwilling to engage in interventions.

IV. ONGOING RESPONSIBILITIES OF THE CFS SPECIALIST:

A. The CFS Specialist will work collaboratively with the family, the Family Team, supervisors and other relevant persons involved with the family in order to:
   1. Ensure safety of the child;
   2. Establish and implement safety plans;
   3. Assist the family in identifying and accessing informal and formal supports and resources;
   4. Establish and implement the case plan;
   5. Work toward timely permanency for the child;
   6. Ensure child well-being (education and physical/mental health); and
   7. Plan for transition and discharge from CFS intervention.

V. ONGOING ASSESSMENTS-

A. Ongoing assessment of the family will be conducted regularly to provide information as to the progress the family is making toward goal achievement. Assessments include:
   1. SDM® Family Strengths and Needs Assessment (FSNA)(all court and non-court cases: abuse/neglect; dependency; 3(c)). (Conducted at least every 6 months)
   2. SDM® Risk Reassessment of In-Home Cases (Conducted at least every 90 days); and
   3. SDM® Reunification Assessment for families with children placed out of the home. (Conducted at least every 90 days.)

VI. SDM® SAFETY ASSESSMENTS AND SAFETY PLANNING.

A. The ongoing CFS Specialist is always be assessing for safety. The on-going CFS Specialist is responsible to assess for child safety and update the safety plan as often as needed based on the family's circumstances.

B. If a subsequent report of abuse or neglect is reported to the Hotline, the Initial Assessment process will be implemented as described in the Initial Assessment Section. A new safety and risk assessment will be completed.

VII. SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT

A. The CFS Specialist will complete the FSNA with the family. The purpose of the FSNA is to add to information gathered during the initial safety and risk or prevention assessments in order to identify safety related needs and strength based strategies so that a case plan can be developed. Using information gathered for the FSNA, case plan goals, strategies and services can be designed to effectively address the areas that directly impact child safety and risk of future harm for each family. The FSNA also addresses the well-being of every child in the family.

B. The CFS Specialist will conduct a FSNA on every open case and closed cases in the aftercare system.
   1. Each parent in a two parent household is assessed and scored separately.
   2. The child assessment portion is completed for each child who will be included in the case plan.
      a) For non-court involved cases this includes all children in the household. For court involved cases, this includes siblings of wards.
      b) If caregivers are no longer involved in the case plan, only the child assessment is required.

C. Timeframe:
   1. In order to complete the case plan within 60 days from case opening or initial placement in out-of-home care (whichever is earliest), the Family Strengths and Needs Assessment should begin within 7 calendar days of assignment or the completion of the initial assessment if the case is not transferred to a second CFS Specialist. Multiple contacts with the family may be necessary to gather sufficient information.
   2. The CFS Specialist will complete the initial FSNA prior to initial case plan development. The FSNA must be completed within 30 days after completion of the Risk or Prevention Assessment. (This includes cases transferred to another CFS Specialist for ongoing case management.)
   3. For all Child Abuse/Neglect, Dependency or 3(c) cases the initial FSNA and Case Plan will be completed within 60 days of the Intake being Accepted for Assessment.
D. The CFS Specialist should review the caregiver and child domains and definitions of the FSNA. The CFS Specialist will notice that there are item areas they are already assessing. Once the CFS Specialist is familiar with the items that must be assessed to completed the FSNA, the CFS Specialist will complete the FSNA using good social work practice to collect information from the child, caregiver, and/or collateral sources.
E. Reassessment of the FSNA occurs a minimum of every 6 months. The strengths and needs can be reassessed more frequently if necessary to coordinate with the dispositional review.
F. Documentation: The FSNA will be documented on N-FOCUS within 30 days of case assignment to ongoing, but no later than 60 calendar days of the initial custody date. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the questions in the reunification assessment regardless of the final determination. The CFS Specialist will utilize the narrative sections within the SDM assessment to document all supporting information regarding decisions on each of the items.

VIII. COMPLETION OF THE FSNA

A. For each category, there are four possible responses:
   1. "a" This is a strength response. A caregiver/child with a response of "a" has exceptional skills or resources in this area. This is an enhanced capacity.
   2. "b" This is an "average" or adequate functioning response. This response is also used to score children who are too young to assess in some categories. A caregiver/child with a response of "b" has not achieved the exceptional skills or resources reflected by a response of "a" and may experience a degree of stress or struggle common to daily functioning, but is generally functioning well in the area. These responses are considered potential strengths, with the exception of children who are scored "b" in some categories because they are too young to assess. For example, an infant may be scored a "b" for delinquency because he or she is too young to be assessed in this area, but it should not be selected as a strength for case-planning purposes. This is a neutral capacity.
   3. "c" A caregiver/child is experiencing increased need in this domain. This is a diminished capacity.
   4. "d" A caregiver/child is experiencing extraordinary need in this domain. This is a diminished capacity.
B. Completion of the FSNA requires gathering information from all family members,

collaterals, and a review of records. It may be completed or modified during the course of family meetings. The CFS Specialist must be aware of culturally specific interpretation of appearances and must engage the family in culturally appropriate ways to make an accurate assessment. When it is difficult to distinguish between responses, additional assessments may be helpful (e.g., psychological, developmental, substance use assessment), particularly if the difference between one rating and another is likely to impact the identification and selection of priority needs.

When scoring, consider the entire scope of available information, including the family's perspective, information from collateral sources, existing records and documents, and worker observations. Often, different sources will suggest different responses (e.g., father states he has no problem with alcohol, but has two DUIs in the last year; mother states she believes he is an alcoholic; a court-ordered chemical dependency evaluation suggests alcohol dependency; father's brother states father has no problem with alcohol). The worker must make a determination based on social work assessment skills, taking into account the merits of each perspective. The household is assessed by completing all the items. If there are two caregivers, each is assessed and scored separately.

C. Section 1: "Caregiver" Each of the domains below represents a significant area of family functioning that may support or impede a family's ability to maintain the safety and well-being of children. There may be some overlap or interactions between domains (e.g., a need in the domain of substance abuse may impact parenting skills, resource management, and/or several other areas of functioning). Keeping this in mind, the CFS Specialist needs to assess the caregiver's functioning in each domain as it relates to his/her ability to effectively parent and protect the child.

D. The FSNA domains should be considered for each family/household member. The CFS Specialist will base the score on his/her assessment for each item, taking into account the family's perspective, child's perspective where appropriate, the CFS Specialist observations, collateral contacts, and available records. The definitions will be used to determine the most appropriate response.

E. In most cases, a finding of average functioning ("b") will be consistent with functioning in the domain that allows for minimally adequate parenting.

F. Minimally Adequate Parenting: Considering ethnic and cultural differences, an action whereby a caregiver ensures that the child is adequately fed; clothed appropriately for weather conditions; provided with adequate shelter; protected from severe physical, mental, and emotional harm; and provided with necessary medical care as required by law. A parent/parent substitute or caregiver may have personal and situational problems but meet minimum parenting standards.

G. **SN1. Substance Abuse/Use** (Substances: alcohol, illegal drugs, inhalants, prescription/over-the-counter drugs)

1. Teaches and demonstrates a healthy understanding of alcohol and drugs. The caregiver teaches and demonstrates an understanding of the choices made about use or abstinence and the effects of alcohol and drugs on behavior and society. Children are able to describe ways parents have conveyed messages about the effects of drugs and alcohol and/or consequences. The caregiver may be abstinent, or may drink alcohol or appropriately take prescribed drugs, but only in ways that do not negatively affect parenting skills and functioning.
2. Alcohol or prescribed drug use/no use. Caregiver's choices about legal use or abstinence do not negatively affect parenting skills and functioning. The caregiver may have a history of substance abuse, may currently use alcohol or prescribed

drugs, or may be abstinent.

3. Alcohol or drug abuse. The caregiver continues to use despite negative consequences in some areas such as family, social, health, legal, or financial. The caregiver needs help to achieve and/or maintain abstinence from alcohol or drugs.
4. Chronic alcohol or drug abuse. The caregiver's use of alcohol or drugs results in behaviors that impede ability to meet his/her own and/or his/her child's basic needs. He/she experiences some degree of impairment in most areas including family, social, health, legal, and financial. He/she needs intensive structure and support to achieve abstinence from alcohol or drugs.

H. **SN2. Household Relationships/Domestic Violence**

1. Supportive. Internal or external stressors (e.g., illness, financial problems, divorce, and special needs) may be present, but the household maintains positive interactions (e.g., mutual affection, respect, open communication, empathy) and shares responsibilities mutually agreed upon by the household members. Household members mediate disputes and promote nonviolence in the home. Individuals are safe from threats, intimidation, or assaults by other household members. The caregiver demonstrates an effective or adequate coping ability regarding past abuse, if any.
2. Minor or occasional discord. Internal or external stressors are present, but the household is coping despite some disruption of positive interactions. Conflicts may be resolved through less adaptive strategies such as avoidance; however, household members do not control each other or threaten physical or sexual assault, and there is no current domestic violence.
3. Frequent discord or some domestic violence. Internal or external stressors are present, and the household is experiencing increased disruption of positive interactions coupled with lack of cooperation and/or emotional or verbal abuse. This may be evidenced by the following:
   a) A violent/controlling relationship has recently ended (i.e., within review period). One or both partners have decided to end the relationship, but the separation is recent and of uncertain finality.
   b) Custody and visitation issues are characterized by frequent conflicts.
   c) The caregiver's pattern of adult relationships creates significant stress for the child.
   d) Adult relationships are characterized by occasional physical outbursts that may result in minor injuries, and/or controlling behavior that results in isolation or restriction of activities.
4. Chronic discord or severe domestic violence. Internal or external stressors are present and the household experiences minimal positive interactions. This may be evidenced by the following:
   a) Custody and visitation issues are characterized by harassment and/or severe conflict, such as multiple reports to law enforcement and/or DHHS.
   b) The caregiver's pattern of adult relationships places the child at risk for maltreatment and/or contributes to severe emotional distress.
   c) One or more household members use regular or severe physical violence. Individuals engage in physically assaultive behaviors toward other household members. Violent or controlling behavior has resulted in or may result in injury.
   d) Neither caregiver or only one caregiver is willing to seek help in reducing threats of violence, **or** previous treatment efforts have not been successful in

reducing domestic violence incidents.

I. **SN3. Coping Skills/Mental Health/Developmental Disability**

1. Strong coping skills. The caregiver demonstrates the ability to deal with adversity, crises, and long-term problems in a constructive manner. The caregiver demonstrates realistic and logical judgment. The caregiver displays resiliency and has a positive, hopeful attitude. The caregiver has taken action to address current concerns, and is able to actively contribute to the development of safety strategies.
2. Adequate coping skills. The caregiver demonstrates emotional responses that are consistent with circumstances and displays no apparent inability to cope with adversity, crises, or long-term problems. For example, a caregiver may be experiencing stress, sadness, or anger related to the current case, but is able to manage these feelings to the extent that he/she can participate in case and safety planning. The caregiver is not currently experiencing any symptoms that impair his/her ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.
3. Mild to moderate symptoms. Caregiver has difficulty coping with periodic stresses in his/her life. This may be related to a cognitive disability or demonstrated by periodic mental health symptoms such as depression, low self-esteem, or apathy, or the consistent use of a coping mechanism that exacerbates the situation. These symptoms periodically impair the caregiver's ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.
4. Chronic/severe symptoms. Caregiver has severe and chronic difficulty recognizing or coping with routine stress and daily challenges. The caregiver may have a cognitive disability or display chronic, severe mental health symptoms such as depression, apathy, severe low self-esteem, or unfounded mistrust of professionals and others who want to help. The caregiver is debilitated by these symptoms to the extent that he/she is consistently unable to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter. The caregiver may require hospitalization or intensive psychiatric care to control symptoms.

J. **SN4. Social Support System**

1. Strong support system. The family regularly engages with a strong, constructive, mutual support system. Individuals interact with extended family, friends, cultural, religious, and/or community support or services that provide a wide range of positive and available resources.
2. Adequate support system. As needs arise, the family uses extended family, friends, cultural, religious, and community resources to provide support and/or services such as child care, transportation, supervision, role modeling for caregiver(s) and child, parenting and emotional support, guidance, etc.
3. Limited support system. The family has limited support system, is isolated, or is reluctant to use available or identified support; **or** the family's social support system is neutral regarding caregiver choices that place the child(ren) at threat of harm.
4. No support system or support system is harmful. The family has no support system and does not utilize extended family and community resources; **or** the family's social support system enables or encourages the caregiver to make choices that place the child(ren) at threat of harm.
   a) Background check information alone does not indicate a harmful support

system member. When identifying a harmful support system, consider the behavior encouraged by the individuals and its impact on child safety.

K. **SN5. Parenting Skills:** If the current referral involves concerns regarding an only child who is a newborn at the time of referral, consider the caregiver's preparation for parenthood when making an initial assessment of this item. Subsequent reassessments should be based on caregiver behavior in the assessment period.

1. Strong skills. The caregiver displays good knowledge and understanding of age-appropriate parenting skills and integrates use on a daily basis. The caregiver expresses hope for and recognizes the child's abilities and strengths and encourages participation in family, school, and community. The caregiver actively participates with the child, for example, monitoring homework completion, participating in school meetings, etc. The caregiver is able to protect the child and plan ahead to ensure the child's safety. The caregiver advocates for family and responds to changing needs.
2. Adequately parents and protects child. The caregiver displays adequate parenting patterns that are age-appropriate for the child in areas of expectations, discipline, communication, protection, education, and nurturing. The caregiver is able to protect the child, but may have some difficulties with advance planning. Encourages and supports all children's social and emotional well-being, for example, participation in family, school, and community.
3. Inadequately parents and protects child. Improvement of basic parenting skills is needed by the caregiver, or child has exceptional needs for which parent requires specialized training. The caregiver has some unrealistic expectations and gaps in parenting skills; demonstrates limited knowledge of age-appropriate disciplinary methods or need for supervision; and/or lacks knowledge of child development, which interferes with effective parenting. The caregiver may have difficulty placing the child's needs ahead of his/her own or be unable to plan for child protection. Caregiver demonstrates an inability to support children's social and emotional well-being, for example, participation in family, school, and community; parent may model illegal behavior.
4. Destructive/abusive parenting. The caregiver displays destructive/abusive parenting patterns that result in significant harm to the child. The caregiver has unrealistic expectations and significant gaps in parenting skills; demonstrates poor knowledge of age-appropriate disciplinary methods or need for supervision; and/or lacks knowledge of child development, which interferes with effective parenting. The caregiver often does not place the child's needs ahead of his/her own and rarely or never plans for the child's safety. Caregiver discourages or prohibits participation in family, school, and community; caregiver may involve child in illegal behavior.

L. **SN6. Resource Management/Basic Needs**

1. Resources are sufficient to meet basic needs and are adequately managed. The caregiver has a history of consistently providing safe, healthy, and stable housing; nutritious food; and clothing. The caregiver successfully manages available resources to meet basic care needs related to health and safety.
2. Resources may be limited but are adequately managed. The caregiver provides housing, food, and clothing that meet minimal standards. The caregiver adequately manages available resources to meet basic care needs related to health and safety. This includes adhering to any assistance program requirements.
3. Resources are insufficient or not well-managed. The caregiver provides housing, but it does not meet the basic needs of the child due to conditions such as inadequate

plumbing, heating, wiring, or housekeeping. Food and/or clothing do not meet basic needs of the child. The caregiver does not adequately manage available resources, or does not adhere to assistance program requirements, which results in difficulty providing for basic care needs related to health and safety.

4. No resources, or resources are severely limited and/or mismanaged. In at least one of the following areas, household resources are limited or mismanaged to the extent that harm to household members has occurred. Conditions exist in the household that have caused illness or injury to family members, such as inadequate plumbing, heating, wiring, or housekeeping; there is no food, food is spoiled, or family members are malnourished. The child chronically presents with clothing that is unclean, not appropriate for weather conditions, or is in poor repair. The family is homeless. The caregiver severely mismanages available resources, which results in unmet basic care needs related to health and safety.

M. **SN7. Cultural Identity** For this item, cultural identity may refer to an ethnic, religious, or social identity (community norms); sexual orientation; or gender identification that reflects the unique characteristics of the caregiver. Cultural identity is not limited to identification with a minority culture and may refer to the prominent culture. Note that the reference to cultural conflict within the family includes inter-generational cultural conflict and/or generational norms. Consider norms to be patterns of behavior that are accepted as appropriate within family or community.

1. Cultural component is supportive and no conflict is present. The caregiver identifies with a culture and its connected community, and that cultural identification is a resource. He/she experiences no conflict related to cultural identity.
2. No cultural component that supports or causes conflict.
   a) The caregiver identifies with a culture and its community; however, that cultural identity is not serving as a resource to him/her. He/she experiences no conflict related to cultural identity; **or**
   b) The caregiver identifies with a culture and its community, and that identification causes some conflict, which affects the child. However, the caregiver is making appropriate and reasonable efforts to support the child and minimize negative effects; **or**
   c) The caregiver has no particular identification with a culture, and the absence of cultural identity is not resulting in conflict with family or community.
3. Cultural component that causes some conflict.
   a) The caregiver identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences some conflict related to cultural identity; **or**
   b) The caregiver has no particular identification with a culture, the absence of cultural identity is resulting in some conflict with family or community; this is having or may have an adverse impact on the child; and the caregiver is unable to unwilling to work to resolve the conflict.
4. Cultural component that causes significant conflict.
   a) The caregiver identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences significant conflict related to cultural identity; **or**
   b) The caregiver has no particular identification with a culture; the absence of cultural identity is resulting in significant conflict with family or community; and this is having or may have an adverse impact on the child.

N. **SN8. Physical Health**

1. Consider the physical health of the caregiver as it relates to his/her ability to care for the child(ren) and/or to direct care for the children and him/herself.
2. Preventative health care is practiced. The caregiver teaches and promotes good health. The caregiver makes efforts to pursue resources and incorporate behaviors that promote health, such as modeling healthy eating habits, physical exercise, and personal hygiene for children in the household. The caregiver additionally displays the behaviors described in response "b".
3. Health issues do not affect family functioning. The caregiver has no current health concerns that affect family functioning. The caregiver accesses regular health services (traditional or effective non-traditional) for him/herself (e.g., medical/dental). The caregiver may have serious or chronic health problems, but is able to address these concerns and access resources to ensure that these concerns do not affect the care and protection of the child(ren).
4. Health concerns/disabilities affect family functioning. The caregiver has health concerns or conditions that affect family functioning and/or family resources.
5. Serious health concerns/disabilities result in inability to care for the child. The caregiver has serious/chronic health problem(s) or condition(s) that affects his/her ability to care for and/or protect the child.

O. **SN9. Identified Caregiver Strength/Need (not covered in SN1-SN8)**

1. Significant strength. A caregiver has identified an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas.
2. Not applicable. The caregiver has no area of strength or need relevant for case planning that is not included in SN1-SN8.
3. Minor need. A caregiver has a need that has a moderate impact on family functioning. The family perceives that they would benefit from services and support that address the need.
4. Significant need. A caregiver has a serious need that has a significant impact on family functioning. The family perceives they would benefit from services and support that address the need.

P. **Section 2: Child** The CFS Specialist will rate each child according to the current level of functioning. For each item, if not applicable to the child's age, score as "b".

Q. **CSN1. Emotional/Behavioral**

1. Strong emotional adjustment. The child displays strong coping skills in dealing with crises and trauma, disappointment, and daily challenges. The child is able to develop and maintain trusting relationships. The child understands and accepts limits. The child is able to identify the need for, seek and accept guidance related to school, family, or community functioning.
2. Adequate emotional adjustment. The child displays developmentally appropriate emotional/coping responses that do not interfere with school, family, or community functioning. The child may demonstrate some depression, anxiety, or withdrawal symptoms that are situation related. The child maintains situationally appropriate emotional control. Developmentally appropriate acting out occurs. Child is able to understand and accept developmentally appropriate consequences.
3. Limited emotional adjustment. The child has a pattern of difficulty in dealing with situational stress, crises, or problems, which impairs functioning. The child displays periodic mental health symptoms including but not limited to depression, running

away, somatic complaints, hostile behavior, or apathy. Child has episodes of extreme acting out, which may include an inability to accept limits on or consequences for behavior.

4. Severely limited emotional adjustment. The child's ability to perform in one or more areas of functioning is severely impaired due to chronic/severe mental health symptoms, such as but not limited to fire-setting, suicidal behavior, or violent behavior toward people and/or animals. Child has a pattern of dysfunctional behavior that limits child or family activities (such as ability to play on a ball team, go to movies, eat at restaurants) or there is evidence that behavior is rapidly deteriorating.

R. **CSN2. Sexualize Behavior**

1. No sexualized behavior; child displays age-appropriate sexuality. The child does not display sexualized behaviors and his/her behavior is consistent with healthy sexual development.
2. Sexualized behavior is appropriately managed. The child may have experienced sexual abuse, but his/her responses do not interfere with his/her ability to interact appropriately with peers or adults. The child has no history of sexual acting out towards other children or towards adults. The child's behavior is consistent with healthy development, but may be inconsistent with the child's current setting (e.g., relationship with a foster sibling).
3. Concerning sexualized behavior. The child has occasional difficulty in maintaining appropriate behaviors and sexual boundaries. The child may engage in sexual attention-seeking behaviors with peers or adults.
4. Severely sexualized behavior. The child is unable to maintain appropriate boundaries to the extent that the child has created concern for his/her own safety or the safety of other children in the home and/or community.

S. **CSN3. Physical Health/Disability.** If the child is a state ward all required medical/dental/vision appointments and other requirements must be met regardless of item scoring. When scoring this item, the CFS Specialist will consider the child's needs independent of these regulations.

1. Good health. The child demonstrates good health and hygiene care involving awareness of nutrition and exercise. The child receives routine preventative and medical/dental/vision care and immunization. The child has no known health care needs, or has medical needs and demonstrates a strong understanding of and ability to monitor and meet these needs.
2. Adequate health. The child has no health care needs or has minor health problems, hygiene concerns, or a disability that can be addressed with minimal intervention that typically requires no formal training (e.g. oral medications). Child may not be current on immunizations or routine medical appointments, but this has not impacted the child's health.
3. Minor health/disability needs. The child has health care or disability needs and the child is at an age or developmental level that requires routine interventions to be provided by someone else; or the child is at an age or developmental level at which he/she could take responsibility for his/her own care, but has not yet demonstrated a willingness to do so.
4. Serious health/disability needs. The child has serious health problems or a disability that requires interventions that are typically provided by professionals or caregivers who have received substantial instruction (e.g., central line feeding,

paraplegic care, or wound dressing changes); or child has a medical condition and child's own behavior causes condition to worsen or health to deteriorate (child refuses to participate in medical care, monitoring of health care, taking medication, and/or altering behavior as prescribed).

T. **CSN4. Education**

1. Does child have a specialized educational plan? (Specialized educational plan includes individualized educational program [IEP], study team, 504 plan, etc.)
2. Outstanding academic achievement. The child is working above grade level and/or is exceeding the expectations of the specific educational plan.
3. Satisfactory academic achievement or child not of school age. The child is working at grade level and/or is meeting the expectations of the specific educational plan, or the child is not of school age. The child is meeting and following the expectations of an alternative educational program (e.g., GED).
4. Academic difficulty. The child is working below grade level in at least one but not more than half of academic subject areas, and/or child is struggling to meet the goals of the existing educational plan. The existing educational plan may need modification or the child may need to be assessed for an educational plan.
5. Severe academic difficulty. The child is working below grade level in more than half of academic subject areas and/or child is not meeting the goals of the existing educational plan. The existing educational plan needs modification. Also score "d" for a child who is required by law to attend school but is not attending.
6. If the child has a need in this domain, the CFS Specialist will indicate if truancy is a significant contributing factor by indicating 1) Yes; 2) No or 3) Not Applicable.

U. **CSN5. Family Relationships**

1. For children in out-of-home placement, the CFS Specialist will score the child's family, not his/her placement family.
2. Nurturing/supportive relationships. The child experiences positive interactions with family members. The child has a sense of belonging within the family. The family defines roles, has clear boundaries, and supports the child's growth and development.
3. Adequate relationships. The child experiences positive interactions with family members and feels safe and secure in the family, despite some minor family conflicts. The family may struggle to define roles and clarify boundaries, but the child's growth and development are supported.
4. Strained relationships. Stress/discord within the family interferes with the child's sense of safety and security. The family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own. The family may have ill-defined roles or lack of boundaries; as a result, the child's development is not well-supported.
5. Harmful relationships. Chronic family stress, conflict, or violence severely impedes the child's sense of safety and security. The family is unable to resolve stress, conflict, or violence on their own and is not able or willing to obtain outside assistance. The family may not define roles or boundaries within the household, or may define roles in ways that are harmful to household members.

V. **CSN6. Child Physical and Cognitive Development**

1. For this item, the CFS Specialist will base the assessment on developmental milestones. These milestones are further described in References section of this document. [1]

2. Advanced development. The child's physical and cognitive skills are above his/her chronological age level.
3. Age-appropriate development. The child's physical and cognitive skills are consistent with his/her chronological age level.
4. Limited development. The child does not exhibit most physical and cognitive skills expected for his/her chronological age level.
5. Severely limited development. Most of the child's physical and cognitive skills are two or more age levels behind chronological age expectations.

W. **CSN7. Substance Abuse**

1. Chooses drug-free lifestyle. The child does not use alcohol or other drugs and is aware of consequences of use. The child avoids peer relations/social activities involving alcohol and other drugs, and/or chooses not to use substances despite peer pressure/opportunities to do so.
2. No use/experimentation. The child does not use alcohol or other drugs. The child may have experimented with alcohol or other drugs, but there is no indication of sustained use. When considering indicators of sustained use, evaluate the impact of use on the child's functioning in school, family, and community (e.g., increase in conflict with parents or care providers, decline in school performance). If impact is not apparent, consider use to be experimentation.
3. Alcohol or other drug use. The child's alcohol or other drug use results in disruptive behavior and discord in school/community/family/work relationships. Negative impacts or alcohol/drug use have not progressed to the point that relationships with individuals or institutions (school, employment) have broken down. Use may have broadened to include multiple drugs.
4. Chronic alcohol or other drug use. The child's chronic alcohol or other drug use results in severe disruption of functioning, such as loss of relationships, job, school suspensions/expulsion/drop-out, problems with the law, and/or physical harm to self or others. The child may require intensive structure and support or medical intervention to achieve and maintain sobriety.

X. **CSN8. Cultural Identity**

1. For this item, cultural identity may refer to an **ethnic, religious, or social identity (community norms); sexual orientation; or gender identification** that reflects the unique characteristics of the caregiver. Cultural identity is not limited to identification with a minority culture and may refer to the prominent culture. Note that the reference to cultural conflict within the family includes inter-generational cultural conflict and/or generational norms. Consider norms to be patterns of behavior that are accepted as appropriate within family or community.
2. Cultural component is supportive and no conflict is present. The child identifies with a culture and its connected community, and that cultural identification is a resource. He/she experiences no conflict related to cultural identity.
3. No cultural component that supports or causes conflict. The child identifies with a culture and its community; however, that cultural identity is not serving as a resource to him/her. He/she experiences no conflict related to cultural identity; **or** the child has no particular identification with a culture, and the absence of cultural identity is not resulting in conflict with family or community.
4. Cultural component that causes some conflict. The child identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences *some* conflict related to cultural identity; **or** the child

has no particular identification with a culture and the absence of cultural identity is resulting in *some* conflict with family or community.

5. Cultural component that causes significant conflict. The child identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences *significant* conflict related to cultural identity; **or** the child has no particular identification with a culture and the absence of cultural identity is resulting in *significant* conflict with family or community.

Y. **CSN9. Peer/Adult Social Relationships**

1. Strong social relationships. The child enjoys and participates in a variety of constructive, age-appropriate social activities. The child enjoys reciprocal, positive relationships with others.
2. Adequate social relationships. The child demonstrates adequate social skills. The child maintains stable relationships with others; occasional conflicts are minor and easily resolved.
3. Limited social relationships. The child demonstrates inconsistent social skills; the child has limited positive interactions with others. Conflicts are more frequent and serious, and the child may be unable to resolve them.
4. Poor social relationships. The child has poor social skills, as demonstrated by frequent conflictual relationships or exclusive interactions with negative or exploitive peers, or the child is isolated and lacks a support system.

Z. **CSN10. Delinquent Behavior**

1. Delinquent behavior includes any action that, if committed by an adult, would constitute a crime. Also include crimes that are youth-specific (e.g., consuming alcohol).
2. Preventive activities. The child is involved in community service, other prosocial community activities, and/or crime prevention programs and takes a stance against crime. The child has no arrest history and there is no other indication of criminal behavior.
3. No current delinquent behavior. The child has no current indication of criminal behavior, **or** the child has successfully completed probation, OJS, or diversion, and there has been no criminal behavior in the past two years.
4. Occasional delinquent behavior. The child is engaging or has engaged in occasional, nonviolent delinquent behavior and may have been arrested or placed on probation or OJS. Also include children who have completed diversion within the past two years or are currently involved in a diversion program. Examples include but are not limited to children who have purchased or had possession of illegal drugs but have not yet been arrested.
5. Significant delinquent behavior. The child is involved or has been involved in any violent or repeated nonviolent delinquent behavior that has or may have resulted in consequences such as arrests, incarcerations, probation, diversion or OJS. Include children who have failed to complete probation or diversion.

AA. **CSN11. Life Skills.** Life Skills are assessed using the Ansell-Casey Life Skills Assessment. The Ansell-Casey Assessment has eight topic areas. Each topic has a score maximum of 5 points. To determine the child's needs using the Ansell-Casey assessment, add the scores of all eight topic areas. The total score of all eight topics provides the rating for this item.

1. No needs. The Ansell-Casey Life Skills Assessment Mastery score is between 30 and 40 for this child.

2. Low Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 20 and 29 for this child.
3. Moderate Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 12 and 19 for this child.
4. Significant Needs. The Ansell-Casey Life Skills Assessment Mastery score is between 0 and 11 for this child.

BB. **CSN12. Identified Caregiver Strength/Need (not covered in CSN1-CSN11)**

1. Significant strength. A child has an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas.
2. Not applicable. A child has no area of strength or need relevant for case planning that is not included in CSN1-CSN11.
3. Minor need. A child has a need that has a moderate impact on family functioning. The family perceives that they would benefit from services and support that address the need.
4. Significant need. A child has a serious need that has a significant impact on family functioning. The family perceives they would benefit from services and support that address the need.

CC. As part of the FSNA the CFS Specialist will:

1. Continue to verify the sufficiency of the Safety Plan;
2. Continue to elicit parent/caregiver perceptions regarding identified safety threats;
3. Reinforce the reduction and elimination of the safety threats;
4. Engage the parents/caregiver in a collaborative partnership for change;
5. Facilitate communication and interaction with parents/caregivers;
6. Recognize parent/caregiver readiness for change related to acknowledging safety threats and need to improve ability to protect their child;
7. Identify safety related needs;
8. Identify family/parent/caregiver strengths around which the case plan can be built; and
9. Identify potential Family Team members and informal resources.

IX. SDM® RISK REASSESSMENT OF IN-HOME CASES:

A. The Risk Reassessment combines items from the original risk assessment with additional items that evaluate a family's progress toward case plan goals.

B. Research has demonstrated that for the reassessment, a single index best categorizes risk for future maltreatment. Unlike the initial risk assessment, which contains separate indices for risk of neglect and risk of abuse, the risk reassessment is composed of a single index.

C. All in-home services cases, including child abuse/neglect, dependency and 3 (c) cases will be assessed by the CFS Specialist using the Risk Reassessment tool.

1. Cases in which any child remains in out-of-home placement with a goal of reunification should be assessed using the Reunification Assessment.

D. These cases will be assessed minimally every 90 days from the initial case plan OR every 90 days from the reunification of all the children to the family home. The reassessment should be completed sooner if there are new circumstances or new information that would affect risk or if a recommendation for case closure is being considered.

E. The Risk Reassessment guides the decision to keep a family preservation case (children

placed at home) open or to recommend case closure.

F. The Risk Reassessment will be documented on N-FOCUS within 7 calendar days of completion. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the answers in the risk reassessment regardless of the risk level. The CFS Specialist will utilize the narrative sections within the SDM assessment.

X. COMPLETION OF THE RISK REASSESSMENT:

A. **Items R1-R5:**

1. The CFS Specialist will use the definitions to determine the appropriate response for each item and enter the corresponding score.
2. Items R1 and R2 refer to the time period prior to the current referral. Scores for these items should be identical to corresponding items on the initial risk assessment unless additional information has become available.

B. **R1 – Number of prior neglect or abuse investigations of any household adult.** The CFS Specialist will score the item based on the count of all investigations, substantiated or not, that were assigned for DHHS investigation for any type of abuse or neglect prior to the investigation resulting in the current case. Where possible, history from other county or state jurisdictions should be included. Exclude dependency intakes and investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

C. **R2 - Household previously had an open ongoing service case (voluntary or court-ordered) due to child abuse or neglect.** The CFS Specialist will mark "yes" if this household previously had an open family preservation or foster care case as a result of a prior investigation prior to the current referral. Include voluntary or court-ordered family services or foster care services; do not include delinquency services or dependency cases (e.g., 3B cases).

D. **R3 - Primary caregiver has a history of abuse or neglect as a child.**

1. The CFS Specialist will mark "yes" if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. Include disclosure of incidents that would be screened in now.
2. R3 and R5 may change if new information is available or if there has been a change in the identified primary caregiver.

E. **R4 - Characteristics of children in the household.** The CFS Specialist will score this item based on credible statements by caregiver that a child has been diagnosed, statements from a physician or mental health professional, or review of records. The CFS Specialist will mark each characteristic that is present and score 1 if any characteristic is present.

1. Score 0 if no child in the household exhibits characteristics listed below.
2. Score 1 if any child has any of the characteristics below.
   a) **Developmental disability,** as evidenced by intellectual disability or other developmental problem, including ADHD that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
   b) **Learning disability.** Child has an IEP to address a learning problem such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for an IEP but does not

have one, who is in preschool, or who is not enrolled in school.

c) **Physical disability** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include only credible information about disabilities of long duration).

d) **Medically fragile or diagnosed with failure to thrive:** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention (include also infants under six months of age with physical conditions requiring medical intervention if the condition is likely to persist for six months or more), or has a diagnosis of failure to thrive by a physician.

3. R4 may change if a child's condition has changed, or if a child with a described condition is no longer part of the household (children in out-of-home placement with a plan to return home are considered part of the household, and the family should be reassessed using the reunification reassessment).

F. **R5 - Primary caregiver has a past or current mental health problem. The CFS Specialist will score the following based on the definitions below.**

1. Score 0 if the primary caregiver does not have a current or past mental health problem.
2. Score 1 if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:
   a) Diagnosis of a DSM condition resulting from formal assessment by a mental health clinician;
   b) Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; or
   c) Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.
3. Indicate if the problem existed within the previous 12 months and/or prior to the previous 12 months. Also indicate if the primary caregiver is currently receiving treatment and what that treatment entails. Do not include diagnoses of ADHD or learning disabilities (e.g. dyslexia).
4. R3 and R5 may change if new information is available or if there has been a change in the identified primary caregiver.

G. **Items R6-R8:** These items are scored based only on observations, since the most recent assessment or reassessment. Using the definitions determine the appropriate response for each item and enter the corresponding score. Both the primary and secondary caregivers are assessed in these items.

H. **Item R6 – In the period since the last assessment, the caregiver has addressed an alcohol or drug problem.**

1. The CFS Specialist will assess each caregiver separately; the item is scored based on the caregiver demonstrating the more severe behavior. The CFS Specialist will indicate whether or not the caregiver has a current alcohol/drug abuse problem that interferes with the caregiver's or the family's functioning and he/she is not addressing the problem. Not addressing the problem may be evidenced by the following:
   a) Substance use that currently affects the caregiver's employment; criminal involvement; marital or family relationships; or his/her ability to provide

protection, supervision and care for the child.

b) An arrest or citation since the last assessment/reassessment for driving under the influence or refusing breathalyzer testing; possession charges for drugs or drug paraphernalia;

c) Self-report of a current problem;

d) Positive toxicology screen during assessment period, or refusal to comply with toxicology screens; or

e) Health/medical problems resulting from current substance use.

2. The CFS Specialist will score the following:

a) Score 0 if there is no history of an alcohol or drug abuse problem or is there is no current alcohol or drug abuse problem that requires intervention.

b) Score 0 if there is an alcohol or drug abuse problem and the caregiver has addressed the problem.

c) Score 1 if there is an alcohol or drug abuse problem and the caregiver has not addressed the problem.

3. Legal, non-abusive prescription drug use and responsible, non-abusive use of alcohol should be scored as an "a".

I. **Item R7 – Problems with relationships among adults within the household.**

1. The CFS Specialist will score this item based on current status of adult relationships in the household.

a) Score 0 if not applicable or there are no relationship problems observed.

b) Score 1 if there are harmful/tumultuous adult relationships or domestic violence.

(1) Adult relationships that are significantly conflictual or harmful to domestic functioning or to the care the child receives (but not at the level of domestic violence). Consider adult relationships in which basic household decisions (e.g., regarding chores, division of child care responsibilities) cannot be settled without conflict.

(2) The household has had, since the most recent assessment, physical assault(s) or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult.

J. **Item R8 – Primary caregiver provides physical care consistent with each child's needs.**

1. The CFS Specialist will mark "yes" if the caregiver is providing age-appropriate physical care for all children in the household. Examples may include the following:

a) Obtaining standard immunizations (do not consider children who have not been immunized due to religious or philosophical objection);

b) Obtaining medical care for severe, chronic, or recurrent illness;

c) Providing the child with adequate food;

d) Providing the child with adequately clean, weather-appropriate clothing;

e) Preventing or addressing rodent or insect infestations;

f) Providing adequate housing with operative plumbing and electricity (heating and cooling);

g) Ensuring that poisonous substances or dangerous objects are not within reach of a small child; or

h) Supporting or providing age/developmentally appropriate hygiene (bathing,

brushing teeth, changing diapers).

K. **Item R9 - Caregiver's progress with case plan outcomes and addressing critical needs.**

1. The CFS Specialist will score this item on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with case plan outcomes. If there are two caregivers, rate progress for each. If progress differs between caregivers, score based on the caregiver demonstrating the least amount of participation/progress.
   a) Demonstrates new skills consistent with case plan outcomes and addressing critical needs OR is actively engaged in services and activities to gain new skills consistent with case plan outcomes. The caregiver is demonstrating behavioral change consistent with the outcomes in the case plan (e.g., is able to manage substance use/abuse to provide for ongoing safety of children; is able to resolve conflict constructively and respectfully; uses age-appropriate, non-physical discipline in conjunction with appropriate boundary-setting; develops a mutually supportive relationship with partner to provide a safe home for children; provides emotional support for the child, etc.). This may include participation in activities identified on the case plan toward achievement of new skills and caregivers who successfully achieve desired behavior change through activities not specifically identified on the plan. Engagement in services and activities means that the caregiver's participation suggests acquisition and application of new skills, not just compliance with attendance. Compliance with services and activities without demonstration of acquisition of new skills consistent with case plan outcomes is not sufficient for scoring.
   b) Does not demonstrate new skills consistent with case plan outcomes or addressing critical needs **and/or** participation is minimal and insufficient to contribute to achieving case plan outcomes or addressing critical needs. This may include complete refusal to participate in services or activities, or participation that has failed to result in behavior change. Caregivers who are demonstrating some progress toward case plan objectives but insufficient progress overall should be scored here.
2. The most difficult part of reassessing risk is completing the case plan progress item (R9). The CFS Specialist can make this easier for yourself and the family by
   a) Using concrete, behavior-based goals.
   b) Using the Family Strengths and Needs Assessment (FSNA) to see if there has been a reduction in, or elimination of needs.
   c) Using the safety assessment to determine if safety threats been resolved
   d) Documenting each contact with the family quickly, focusing on recording observations that directly relate to case plan goals

L. **Scored Risk Level.** After entering the score for each individual item, enter the total score and indicate the corresponding risk level.

Score	Risk Level
0-1	☐ Low
2-4	☐ Moderate
5-7	☐ High
8+	☐ Very High

M. **Policy Overrides:**

1. There are certain conditions that are so serious that a risk level of very high should be assigned regardless of the risk reassessment score. The policy overrides refer to

incidents or conditions that occurred since the risk assessment or last reassessment. If one or more policy override conditions exist, mark "yes" for each reason for the override and mark "very high" for the final risk level.

2. Policy overrides require supervisory review.
   a) Sexual abuse case and perpetrator is likely to have access to the child. One or more of the children in this household are to have been victims of sexual abuse and actions or inaction by the caregivers indicate that there is a safety threat to the child because the perpetrator is likely to have unsupervised access.
   b) Non-accidental injury to a child under 2 years old. Any child under 2 years of age in the household has any physical injury resulting from the actions or inactions of a caregiver.
   c) Severe non-accidental injury. Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; and the child requires medical treatment.
   d) Caregiver action or inaction resulted in death of a child due to abuse or neglect. Any child in the household has died as a result of actions or inactions by the caregiver.

N. **Discretionary Override:**

1. A discretionary override is used whenever the CFS Specialist believes that the risk score does not accurately portray the family's actual risk level. The risk reassessment permits the CFS Specialist to increase or *decrease* the risk level by one step. The reason a CFS Specialist may now decrease the risk level is that after working with the family for a period of time, the CFS Specialist has acquired significant knowledge of the family.
2. If a discretionary override applies, mark yes, indicate the reason, and mark the override risk level. Discretionary overrides require CFS Supervisory approval. The CFS Specialist then indicates the final risk level.

O. **Recommended Decision**

Risk Reassessment Case Status Recommendation	
Risk Level	**Recommendation**
Low	**Recommended Closure***
Moderate	**Recommended Closure***
High	**Recommend the case remain open**
Very High	**Recommend the case remain open**
***Low and moderate risk cases must be recommended for closure only if the case closure SDM® safety assessment finding is safe.** **For cases that remain open following Risk Reassessment, the new risk level guides minimum contact standards that will be in effect until the next Risk Reassessment is completed.**	

XI. SDM® REUNIFICATION ASSESSMENT:

A. The Reunification Assessment consists of four parts where the results are used to reach a permanency plan goal and to guide decisions about whether or not to return a child home.
   1. Risk Reassessment
   2. Parenting Time Evaluation
   3. Safety Reassessment and
   4. Permanency Plan Recommendation.

B. The CFS Specialist will conduct the Reunification Assessment on any ongoing case in which at least one child is in out-of-home placement with a goal of reunification. [Does not apply for OJS cases].

C. The CFS Specialist will not complete this assessment if a court determination has been made that reasonable efforts to reunify the child and parent are not required or for a child with a goal other than reunification. The CFS Specialist will proceed with updating the FSNA.

D. The CFS Specialist will conduct the Reunification Assessment at a minimum, every 90 days from the initial case plan. When possible (e.g., at 6 months, 12 months, etc.), the CFS Specialist will coordinate the reunification assessment with the FSNA and the new case plan.

E. If a Reunification Assessment is completed for purposes outside of the case planning time frame (e.g., court hearing), and the next case plan is due within 30 days, a new Reunification Assessment is not required with the new case plan. After the new case plan, the reunification assessment schedule should resume every 90 days from the case plan.

F. If critical incidents have occurred in the 30 days between the completion of a Reunification Assessment and a recommendation regarding reunification, the CFS Specialist will revise the previous Reunification Assessment if the assessment is not final; a new assessment is not required. If the Reunification Assessment is final, a new assessment is required.

G. The Reunification Assessment results inform the decision of whether a child is recommended for reunification or if a change to the permanency plan goal should be recommended. If families have effectively reduced risk, have achieved at least acceptable parenting time, and the home is safe or conditionally safe, reunification can be recommended by the CFS Specialist. The permanency plan guidelines and recommendation sections guide recommendations to return a child home, continue reunification efforts with this household, or recommend a change to the permanency goal.

H. The Reunification Assessment will be documented on N-FOCUS within 7 calendar days of completion. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the questions in the Reunification Assessment regardless of the final determination. The CFS Specialist will utilize the narrative sections within the SDM assessment to document all supporting information regarding decisions on each of the items.

XII. COMPLETION OF THE REUNIFICATION ASSESSMENT:

A. **Section 1: Reunification Risk Reassessment:** The CFS Specialist will complete the reunification risk reassessment and indicate the final risk level. The final risk level from Section 1 of the reunification assessment also determines the contact guidelines that will apply to the assessed household for the next review period.

B. **R1. Initial risk level or prevention level (after overrides) –** The initial risk level or prevention level for the referral is used to score this item. If there is no initial risk assessment or prevention assessment (for 3B cases) for this family, mark "e" and score as 4.

1. Low – 0
2. Moderate –
3. High – 4
4. Very high – 5 or
5. No initial risk level – 4

C. **R2. Has there been a new substantiation (in this household) since the last assessment/reassessment?** The CFS Specialist will rate this item based on whether new allegations of maltreatment have been received (for this household) since the last assessment (if completed at case opening) or reassessment.

1. Score 0 if no new allegation of maltreatment was substantiated by DHHS, or if DHHS made the agency aware of a concern in the household but did not investigate that concern.
2. Score 6 if a new allegation of maltreatment was received and substantiated by DHHS.

D. **R3. Caregiver(s) progress with case plan.** The CFS Specialist will rate both caregivers based on whether each has mastered or is mastering skills learned from participation in programs and/or services. Indicate the progress for each caregiver in the home, but enter the score based on the caregiver with the least progress. The CFS Specialist will indicate if there is no secondary caregiver.

1. Score minus 2 (-2) if the caregiver: Demonstrates new skills consistent with case plan outcomes and has successfully addressed identified critical needs. Has successfully changed behavior to improve ability to protect and care for children.
   a) Is demonstrating behavioral change consistent with case plan outcomes and addressing critical needs (e.g., is able to manage substance use/abuse to provide for ongoing safety of children; is able to resolve conflict constructively and respectfully; uses age-appropriate, non-physical discipline in conjunction with appropriate boundary-setting; develops a mutually supportive relationship with partner to provide a safe home for children); and
   b) Has successfully completed all recommended services, is actively participating in services, OR is pursuing objectives detailed in case plan.
2. The caregiver's compliance with services and activities without demonstration of acquisition of new skills consistent with case plan objectives and addressing critical needs is not sufficient for scoring.
3. Demonstrates few new skills consistent with case plan outcomes and addressing critical needs. Minimal participation in pursuing outcomes. The CFS Specialist will score 0 if the caregiver has demonstrated some behavioral change consistent with case plan outcomes <u>and</u> addressing critical needs. The caregiver is minimally participating in services <u>or</u> has made progress but is not fully complying with activities in the plan.
4. Does not demonstrate new skills consistent with case plan outcomes <u>or</u> addressing critical needs. May have participated in activities but is not meeting objectives; refuses involvement in services or failed to comply/participate as required. The CFS Specialist will score 4 if the caregiver has demonstrated minimal or no behavioral change consistent with case plan outcomes or addressing critical needs. The

caregiver refuses services, sporadically follows the case plan, or has not demonstrated the necessary skills due to a failure or inability to participate.

E. **Scored Risk Level. The CFS Specialist will assign the family's risk level based on the following chart:**

Score	Risk Level
☐ -2 to 1	☐ Low
☐ 2 to 3	☐ Moderate
☐ 4 to 5	☐ High
☐ 6 and above	☐ Very High

F. **Policy Overrides:** There are certain conditions so serious that a risk level of very high should be assigned regardless of the risk reassessment score. The policy overrides refer to incidents or conditions that occurred only during the current review period (i.e., since the initial risk assessment or last reassessment). If one or more policy override conditions exist, the CFS Specialist will select "yes" for each reason for the override and select "very high" for the final risk level. Policy overrides require supervisory review.

1. Sexual abuse case and perpetrator is likely to have access to the child. One or more of the children in this household are to have been victims of sexual abuse AND actions or inaction by the caregivers indicate that there is a safety threat to the child because the perpetrator is likely to have unsupervised access.
2. Non-accidental injury to a child under 2 years old. Any child under 2 years of age in the household has any physical injury resulting from the actions or inactions of a caregiver.
3. Severe non-accidental injury. Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; AND the child requires medical treatment.
4. Caregiver action or inaction resulted in death of a child due to abuse or neglect. Any child in the household has died as a result of actions or inactions by the caregiver.

G. **Discretionary Override:** The CFS Specialist may request a discretionary override that would move the final score up or down one risk level. This request must be approved by a supervisor.

1. When a judge orders a child to be placed in out-of-home care, an override should be considered but should not be the reason sole reason to override the CFS Specialists assessment.

H. **Section 2: Parenting Time Evaluation:**

1. For each child, the CFS Specialist will indicate the level at which the caregiver demonstrating the least progress has participated in the parenting time plan.
2. Only combinations of frequency and quality that fall into the shaded section of the grid may be considered acceptable.
3. The parenting time evaluation considers the caregivers parenting time separately for each child. When assessing parenting time, the CFS Specialist will consider the

caregiver making the least progress.

Parenting Time Frequency	Quality of Face-to Face Visit			
	Strong	Adequate	Limited	Destructive
Totally				
Routinely				
Sporadically				
Rarely or never				

Note: Shaded cells indicate acceptable parenting time. Unshaded cells indicate unacceptable parenting time.

4. The CFS Specialist will utilize the following guidelines to determine the quality and frequency of parenting time visits.
5. Parenting time frequency will be evaluated by looking at the following:
   a) Visits that are appreciably shortened by late arrival/early departure are considered missed.
   b) Do not consider as missed visits those that were missed due to child unavailability.
   c) Do not consider as missed visits missed due to illness of a child living with the caregiver, or severe weather.
   d) When a legitimate reason to miss a visit (e.g., caregiver illness or caregiver work schedule) is used with unusual frequency, consider asking the caregiver to provide documentation.
6. To calculate the parenting time percentage, divide the number of visits the caregiver successfully attended by the number of visits scheduled in the review period.
   a) Totally: Caregiver regularly attends visits or calls in advance to reschedule (90-100% compliance).
   b) Routinely: Caregiver may miss visits occasionally and rarely requests to reschedule visits in advance (65-89% compliance)
   c) Sporadically: Caregiver misses or cancels visits, or reschedules many scheduled visits at the last minute (i.e. less than 24 hours prior to visit: 26-64% compliance).
   d) Rarely or never: Caregiver does not visit or attends 25% or fewer of the allowed visits (0-25% compliance). Also select "rarely or never" if any of the following conditions are present:
      (1) Caregiver has failed to visit, or visits have been suspended due to parental behavior. The caregiver has attended none of the scheduled visits during the review period and has not provided a reasonable explanation or attempted to reschedule; or there were no scheduled visits during the review period or visits were cancelled by the agency due to the parent's behavior (e.g., repeated problems with substance abuse during parenting time, therapist's recommendation that parenting time be discontinued, parents threatening to abscond with the children).
      (2) Visitation is not required. The court has ordered that no visits occur, due to safety concerns for the child; or parental rights are no longer intact.
      (3) Caregiver has been unable to visit child. The caregiver has not visited the child during the review period because he/she is unable due to physical

incapacity (e.g., hospitalization), incarceration, or because the caregiver could not be located.

7. The quality of the visit is based on the CFS Specialist's direct observation whenever possible, supplemented by observation of the child, reports from foster parents, etc. When parenting time is not supervised, the CFS Specialist may rely on other information, such as child or therapist reports, the physical condition of children when they return from parenting time, observation of caregiver preparation for parenting time (e.g., purchase of snacks or diapers, provision of age-appropriate toys), reports of caregiver timeliness in picking up or returning children, and contact by caregivers subsequent to unforeseen events (e.g., caregiver contacting worker promptly if a child is accidentally injured during a visit or to report unintended contact with a person who is not permitted access to the child).

Quality of Caregiver Child Interaction	
Strong	• Consistently demonstrates protective and supportive behaviors toward the child that are consistent with case plan outcomes throughout the entire review period. • Responds in an engaging and nurturing manner to the child's cues and behaviors. • Identifies and responds appropriately to the child's emotional and physical care needs. • Demonstrates effective behavior management strategies. • Puts child's needs ahead of his/her own needs. • Demonstrates a focus on the child during visits; shows empathy to child. • Engages the child in age-appropriate activities at own initiative. • Conducts himself/herself appropriately during visits. • Initiates participation in school, other child activities, and medical appointments. • Visitation has progressed to include extended visits.
Adequate	• Consistently demonstrates protective and supportive behaviors toward the child that are consistent with case plan outcomes. • Demonstrates an ability to recognize child's behaviors and cues; generally responds appropriately to behavior and cues. • Identifies the child's physical and emotional needs; responds adequately to these needs. • Demonstrates effective behavior management strategies. • Generally puts child's needs ahead of his/her own. • Demonstrates a focus on the child during visits; shows empathy to child. • Conducts himself/herself appropriately during visits. • Participates in school, other child activities, and medical appointments.
Limited	• Demonstrates an ability to recognize child's cues and behaviors, but needs guidance in establishing an appropriate response to these cues and behaviors. • Recognizes a need to set limits with child, but enforces limits or behavior management in an inconsistent or detrimental manner. • Demonstrates an ability to identify child's physical and/or emotional needs, but may need assistance in consistently responding to the child in an appropriate manner. • Occasionally puts the child's needs ahead of his/her own. • Conducts him/herself appropriately during visits.
Destructive	• Demonstrates lack of understanding for child's cues and behaviors or an inability to respond appropriately to the child's cues and behaviors. • Demonstrates limited or no ability to establish effective behavior management

	strategies. • Has not demonstrated an ability to identify or respond to the child's physical or emotional care needs. • Rarely puts child's needs ahead of his/her own. • May have persisted in maltreatment during visitation. • May not be focused on child during parenting time and/or conducts himself/herself inappropriately during visit (examples of inappropriate conduct include but are not limited to arriving for parenting time while substance-affected, or cursing at/violently arguing with worker in presence of child).

I. **Parenting Time Overrides:** The CFS Specialist will indicate if any condition exists that should override the parenting time evaluation to **unacceptable**.
   1. Policy: Parenting time is supervised for safety. This override must always be selected by the CFS Specialist whenever parenting time is supervised, regardless of whether or not it is court ordered. This includes all instances even when the CFS Specialist may disagree with the court order or determines that there is no safety issue requiring supervision. The court has ordered supervised visitation and the policy override would be marked as unacceptable. Drop-In monitoring of parent/child contact is not considered for an override.
   2. Policy: No visits have occurred in the family home.
   3. Policy: Visitation has not progressed to include extended visits.
   4. Discretionary: The CFS Specialist must document a reason for this override and must have supervisory approval.

J. **Section 3: Reunification Safety Reassessment:**
   1. **Section A. Safety Threat Assessment:** The CFS Specialist will begin by identifying and describing the safety threats that were present at the time the children were taken into protective placement.
      a) If the household currently being considered for reunification was not the removal household, indicate that this is a non-removal household when explaining why safety threats that brought the child into care no longer apply.
      b) For non-removal households, there may not be any past safety threats to document in the first part of Section A.
   2. In the second part of Section A, the CFS Specialist will identify any safety threats that are currently present in the household being considered for reunification. During the safety assessment the CFS Specialist must consider the characteristics and behaviors of all adults who will have access to the children if they are reunified into the household, as well as the physical safety of the home itself.
   3. It is important that the CFS Specialist carefully considers and assesses for each safety threat and works with the family to identify strategies to immediately contain each threat. In some situations, it may not be possible to contain identified safety threats. If it is not possible to mitigate the safety threat through a safety plan, the CFS Specialist should consider adding efforts to resolve the threat to the case plan.

K. **Safety Threats:** The following threats are behaviors or conditions that may place a child in immediate danger of serious harm if returned home. The CFS Specialist will identify the presence of each threat by endorsing the item.
   1. Caregiver made a plausible threat to cause serious physical harm, as indicated by any of the following:
      a) Caregiver fears he/she will maltreat the child and/or requests that placement

continue.

b) Current threat to cause serious harm or retaliate against the child. Threat of action that would result in serious harm, or household member plans to retaliate against the child for DHHS investigation or intervention. This threat may be verbal or may be indicated by physical behavior towards the child. Include credible reports of caregiver statements by others.

2. Caregiver does not protect/is unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.

   a) Caregiver does not protect or is unable to protect the child from serious harm or threatened harm by other family members, other household members, or others having access to the child. Caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age, emotional or physical disability, or developmental stage.

   b) An individual with known violent criminal behavior/history resided in the home or caregiver allows access to the child. Caregiver may or may not know about individual's history. Include homes where gang activity occurs or where there is violent illegal activity in the home.
   Examples include but are not limited to the following:

      (1) Mother and grandfather both reside in the household. Grandfather has a history of using inappropriate physical discipline. Mother believes that grandfather will not change his behavior and does not think that she can stop him.

      (2) Father is aware that a cousin has sexually abused one of the children being considered for reunification, but will not restrict cousin's access to the home.

3. Caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care. Needs may be basic or exceptional.

   a) Caregiver does not or cannot provide appropriate supervision for the child, considering the child's age and developmental level, e.g., allowing a toddler to play unsupervised in front of a busy street.

   b) Caregiver does not or cannot make appropriate child care arrangements, e.g., leaving children with a babysitter who has significant substance abuse problems.

   c) Caregiver does not have the ability to provide or the capacity to keep (refrigerate or heat) food or drink for the child.

   d) Caregiver does not or cannot provide the child with clothing that would protect him/her from severe weather.

   e) Caregiver does not have the resources necessary to safely transport child to necessary medical or mental health appointments due to lack of transportation (public or private vehicle) or lack of nearby facilities.

   f) Child has significant medical or mental health needs, and credible concerns exist regarding caregiver's ability to maintain child's safety or the safety of other vulnerable children in the home.

   g) Caregiver has no housing or is currently residing in a temporary or short-term emergency shelter. If the child were returned to the caregiver, the child's needs for minimally safe conditions (water, structurally safe environment, protection

from severe weather elements) would not be met.

h) Caregiver does not or cannot ensure safe sleeping arrangements for children, taking into consideration age and vulnerabilities of children, e.g., infant sleeping arrangements that include soft surfaces that present suffocation risk.

4. **The physical conditions are hazardous and immediately threatening to the health and/or safety of the child.** Based on the child's age, emotional or physical disability, and developmental status, the child's physical living conditions (including but not limited to the following) are hazardous and immediately threatening:
   a) Leaking gas from stove or heating unit;
   b) Substance or objects accessible to the child that may endanger his/her health and/or safety (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities; unsecured weapons);
   c) Lack of water or utilities (heat, plumbing, electricity), and no alternate, safe provisions are made;
   d) Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows;
   e) Exposed electrical wires;
   f) Excessive garbage or rotted or spoiled food that threatens health;
   g) Serious illness or significant injury is likely to occur due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites, severe infestations);
   h) Evidence of human or animal waste throughout living quarters;
   i) Housing that does not meet minimal community safety standards, e.g., buildings that have been condemned or determined to be unsound by housing authority or other professional inspection.

5. **The severity of previous maltreatment <u>and</u> current circumstances suggest that the child's safety may be of immediate concern.** To endorse this item, there must be either a previous incident or pattern of incidents **<u>and</u>** concern about current circumstances.

Previous maltreatment includes any of the following:	**AND** Previous maltreatment includes any of the following:
• Prior death of a child as a result of maltreatment. • Prior serious injury to the child other than accidental: Caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impaired the health or well-being of the child *and required medical treatment.* Include any sexual abuse that required medical treatment.	• Caregiver has limited resources for parenting support. • Caregiver has had limited opportunity to demonstrate improved parenting for more than 48 hours at a time and/or under significant stress. • Caregiver continues to show no remorse or responsibility for previous behavior that resulted in harm to a child. • Case manager and/or others involved in the case have credible concerns regarding the child's safety if he/she returned home.

• Drug-exposed infant. Prior to the current case, a child was born drug-exposed, meaning having a positive toxicology screen at birth for mother or child, and a current caregiver considered for reunification was the birth parent. • Prior termination of parental rights or permanent placement of another child: The caregiver had parental rights terminated as a result of CA/N, or has had a child permanently placed outside his/her custody (i.e., guardianship or other planned permanent placement). • Prior removal of a child or failed reunification: Removal/placement of a child by DHHS or other responsible agency or concerned party was necessary for the child's safety, or child has reentered foster care after prior reunification attempts.	

6. **Child behaviors place or would place the child at imminent threat of serious harm, in spite of appropriate response by caregiver.** To mark this threat, **three** conditions **must** be present:

The child is currently engaging in or habitually engages in behaviors that place him/her at imminent risk of serious harm. Examples include but are not limited to children who run away from home and place themselves in unsafe living/sleeping situations, children who engage in prostitution, children who engage in self-harming behaviors if returned to the home (e.g., prior reunifications have failed due to child behaviors or child has stated an intent to	**AND** The child's caregiver(s) have responded or are currently responding appropriately and making reasonable efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child and increasing direct supervision and monitoring of the child.	**AND** The caregiver's current or prior efforts, although appropriate, are/were insufficient to prevent the child from engaging in the behavior in the future.

return to such behaviors).		

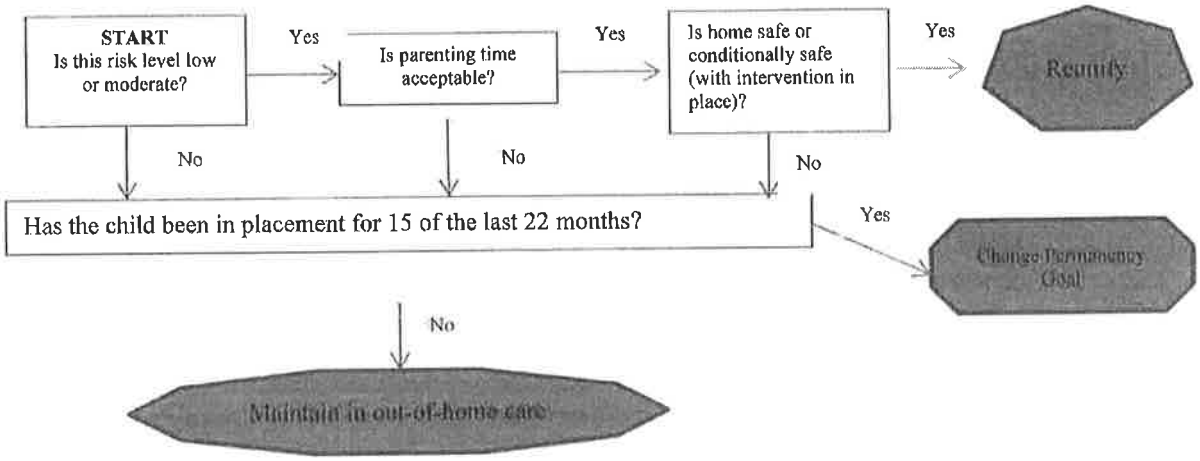
7. **Other (specify).** The CFS Specialist will select this safety threat if no other threat applies and the CFS Specialist can describe the situation and the threat.

L. **Safety Decision:** After the CFS Specialist has identified the past and current safety threats, the CFS Specialist will base the safety decision on whether or not the family has made **sustainable change** to resolve the safety threats identified at the time of removal and/or whether or not safety interventions are available to develop a safety plan to **contain or mitigate** current safety threats.

1. The CFS Specialist will determine the following:
   a) The child is **SAFE.** No safety concerns are present. **Safety threats that resulted in the child's removal** (as documented on the initial safety assessment) **are no longer present,** and no current safety threats were identified. The CFS Specialist will **document how initial safety issues were resolved.**
   b) The child is **CONDITIONALLY SAFE.** One or more safety threats are present. The CFS Specialist will **briefly describe the specific safety plan** that has been written with the family **to immediately** address the safety threats(s).
   c) The child is **UNSAFE.** One or more safety threats are present. **The only intervention to ensure safety is continued out-of-home placement.** The CFS Specialist will document why other interventions could not be implemented to reunify the child at the present time.
2. The CFS Specialist will also document in the Reunification Safety Assessment the following:
   a) Evidence and observations of caregiver behaviors used to answer safety assessment items; and
   b) The supports provided by the CFS Specialist to the family during the review period to help address safety threats.

M. **Section 4: Permanency Plan Recommendation Summary:**

1. The CFS Specialist will complete the decision tree for each child being considered for reunification and document the results.
2. Reunification is recommended when:
   a) Risk is low or moderate, parenting time for the child is acceptable, and the home is safe or conditionally safe, reunification is recommended. If any of these three conditions is not met, the CFS Specialist should indicate if the child has been in care for 15 of the previous 22 months. If so, a new permanency goal should be recommended. If not, efforts toward reunification should be continued.
   b) The recommendation of the assessment will be evaluated by the CFS Specialist. The CFS Specialist will determine if the outcome of the permanency plan recommendations summary decision tree is the appropriate action for this case. If there are unique circumstances in this family that justify a different recommendation, the CFS Specialist may exercise a discretionary override. If the CFS Specialist chooses to override the tool recommendation, he or she should indicate a reason for this override and seek supervisor approval.
      (1) The CFS Specialist, may, for example, override a tool recommendation to change the permanency goals if the family has made good progress on case plan goals and the CFS Specialist believes reunification may be achieved in the next review period. The CFS Specialist should carefully document the evidence that supports this view.



The CFS Specialist will utilize the Reunification Assessment tool in N-FOCUS to document the following recommendations for each child.

3. The CFS Specialist will utilize the Reunification Assessment tool in N-FOCUS to document the following recommendations for each child.

Child Name	Parenting Time	In care for 15 of 22 months?	Permanency Plan Recommendation Summary Outcome	Discretionary Override	New Goal Recommendation
	☐ Acceptable ☐ Unacceptable	☐ Yes ☐ No	☐ Reunify ☐ Maintain in care ☐ Change permanency goal	☐ No override ☐ Reunify ☐ Maintain in care ☐ Change permanency goal	☐ Reunification ☐ Adoption ☐ Permanent Guardianship ☐ I.L. ☐ Self-sufficiency with support

4. The CFS Specialist will summarize in N-FOCUS Narrative the following:
   a) Briefly describe the permanency plan recommendation for each child and why this recommendation was selected for the child; and
   b) Explain why a discretionary override was needed for the child (if applicable).
5. The Reunification Assessment can be completed at any time the situation changes. **NOTE:** Reports of concern of abuse or neglect or other care concerns regarding a licensed or approved foster or relative foster care provider will be assessed using the Assessment for Safety and Suitability.

XIII. CASE PLANNING: *Refer to Program Guidance Memo "Permanency and Case Planning.*

A. Case Plans for Wards who are 16 Years of Age or Older: *Refer to Program Guidance Memo #30-2015 – Transitional Living Planning.*

XIV. **GENOGRAMS AND ECO-MAPS:** All CFS Specialists are required to develop a genogram and eco-map with each family receiving ongoing services, whether court or non-court involved. The genogram and eco-map will be started at the assessment stage for any family whose child has been determined to be conditionally safe or unsafe, or for whom the risk of future maltreatment is high or very high. Documentation will be completed using the standardized format.[11] Genograms and eco-maps are reviewed and updated by the CFS Specialist throughout the family's involvement with DHHS. Genograms and eco-maps will be documented and placed in the most current volume of the case file. The genogram and ecomap should be a part of every team meeting and updated as new information is obtained.

XV. **SDM CASE REVIEWS:** At a minimum, the CFS Supervisor will conduct the following reviews of SDM Assessments. The CFS Supervisor will utilize discretion and the work performance of individual CFS Specialists to determine the frequency of additional SDM Reviews.

A. The CFS Supervisor will review every SDM Assessment in which an Override is utilized;
B. The CFS Supervisor will review every SDM Assessment for CFS Trainees for the first 6 months or until the CFS Trainee has been promoted to CFS Specialist;
C. The CFS Supervisor will conduct a random sample of SDM Assessments. One SDM Assessment will be selected each month for each CFS Specialist. The CFS Supervisor will conduct an in-depth review of one SDM Assessment for each CFS Specialist.

XVI. **CASE CLOSURE**

A. The decision on recommending case closure in abuse, neglect, dependency, and 3 (c) cases is based on information gathered for the SDM® Risk Reassessment and the Safety Assessment.
B. The child, parent/caregiver (when parental rights are intact), family, and family team members are all involved when considering making a recommendation to the court to close a case. In all court involved cases, in addition to the family team members, all legal parties including the Guardian ad Litem, CASA and county attorney will provide input in the decision to recommend case closure.
C. Building Support Systems. Stabilizing the changes which have been made by the family is important. The CFS Specialist and the Family Team must identify changes and develop a plan that will enable the family to be successful without DHHS involvement. This process may be completed with case plans prior to requesting discharge. The use of informal supports is a key to stabilizing and maintaining change after DCFS involvement.
D. If referrals for services have not been made for children and families prior to discharge, the CFS Specialist will assist the ward and family by making referrals to DHHS programs such as AABD, medical assistance, Developmental Disabilities or other programs such as Social Security.
E. The CFS Specialist will inform the parent, guardian, or young adult to apply for a change in payee with the Social Security Administration, Veterans Administration or Railroad Retirement Board, as appropriate.
F. Safety Plan in Place: The CFS Specialist cannot close a case with a safety plan in place. If a safety plan is still needed, the child is not safe and the case cannot be closed. If the safety plan depends on the case monitoring or resources of agencies DCFS contracts with, the case cannot be closed. The CFS Specialist must ensure the family has developed and/or implemented strategies to keep the child safe over the long term.
G. In order to recommend discharge one of the following must be in place:

1. Non-Court Involved Cases: The CFS Specialist will take action to close a case when:
   a) All children in the family are determined to be safe **and** the determination of risk is low or moderate;
   b) All children in the family are determined to be safe **and** a high or very high risk family refused services **and** the supervisor have determined that the county attorney should not be contacted **or** the County Attorney has determined that there will be no court intervention; or
   c) The child, parent/caregiver, or family in a non-court case cannot be located after all reasonable efforts have been made.
2. Court Cases: The CFS Specialist will take action to close a court case when:
   a) A Court of competent jurisdiction has dismissed the involvement of the Department in the case;
   b) Reunification has occurred and the child is determined to be safe;
   c) The child's adoption is finalized;
   d) The child's guardianship is finalized (court appoints a guardian and terminated Department custody);
   e) The sending state through the Interstate Compact for the Protection of Children closes the case;
   f) The child has reached the age of majority. See guidance on the Transitional Living Plan Program;
   g) The child enlists in the armed services and completes basic training;
   h) The child marries;
   i) The child has been a runaway for 12 consecutive months and cannot be located;
   j) The child dies; or
   k) The child is convicted and sentenced as an adult.

XVII. **CLOSED CASE FILES:** Files that are closed must contain the following information, as applicable. All information except for the following, will be in N-FOCUS:

A. Original certified documents containing a raised seal or certified documents;
B. Signed relinquishment of Parental Rights;
C. Original documents necessary for an adoption or evidence in the court room;
D. Any document that is not readily and easily readable once imaged;
E. Photographs, cards or other keepsakes that may be valuable to the family should be given to the appropriate person when appropriate to do so, or if not appropriate, they should be maintained in the hard file.

XVIII. **CLOSED CASE RETENTION:** For information on maintenance of closed child welfare files, see the Children and Family Services retention and disposal schedule which can be accessed at www.sos.state.ne.us/records-management.

XIX. **PERSONAL PROPERTY AND INFORMATION AT CASE CLOSURE:** The following information and documents will be provided to the legal custodian of the child at the time of case closure or the child if they have reached the age of majority upon discharge and case closure for children who were in out of home care.

A. The original birth certificate: a copy must be retained in the case record;
B. The original Social Security card: a copy must be retained in the case file;
C. A written summary of medical history or a copy of medical records to include:
   1. Immunizations; and
   2. Names, addresses, and phone numbers of primary medical providers;
D. Copies of report cards or transcript of grades;
E. A written summary of the family background including
   1. Relatives and Kin;
   2. Birthdates; and
   3. Medical history
F. A written summary of the child's out-of-home placement history;
G. Photo(s) of the child and family;
H. Any personal records such as baptism or confirmation certificate;
I. Information regarding trust accounts and amounts; and
J. Any records of tribal affiliations, including tribal identification cards or Certificates of Degree of Indian Blood. (Copies must be maintained in the case record.)

XX. **DISPOSITION OF GUARDIANSHIP FUNDS AT DISCHARGE:** When a ward is discharged from the Department, all of the funds that are held by the Department in a guardianship "trust fund" account must be transferred immediately to the most appropriate individual or agency. The CFS Specialist will complete a "Request and Authorization for use of State Ward Guardianship Funds" on N-FOCUS. Finance and Accounting will ensure correct distribution of funds. The CFS Specialist should contact their local Income Maintenance Foster Care Worker if they have specific questions.

GLOSSARY

Abandonment means a parent's intentionally withholding from a child, without just cause or excuse, the parent's presence, care, love, protection and maintenance and the opportunity for the display of parental affection for the child.

Abandoned Child means a child who is without an appropriate caregiver due to the intentional act and conscious decision of the parent not to care for the child.

Active efforts means and includes and includes, but is not limited to:

1. A concerted level of casework, both prior to and after the removal of an Indian child, exceeding the level that is required under reasonable efforts to preserve and reunify the family described in section 43-283.01 in a manner consistent with the prevailing social and cultural conditions and way of life of the Indian child's tribe or tribes to the extent possible under the circumstances;
2. A request to the Indian child's tribe or tribes and extended family known to the department or the state to convene traditional and customary support and services;
3. Actively engaging, assisting, and monitoring the family's access to and progress in culturally appropriate and available resources of the Indian child's extended family members, tribal service area, Indian tribe or tribes, and individual Indian caregivers;
4. Identification of and provision of information to the Indian child's extended family members known to the department or the state concerning appropriate community, state, and federal resources that may be able to offer housing, financial, and transportation assistance and actively assisting the family in accessing such community, state, and federal resources;
5. Identification of and attempts to engage tribally designated Nebraska Indian Child Welfare Act representatives;
6. Consultation with extended family members known to the department or the state, or a tribally designated Nebraska Indian Child Welfare Act representative if an extended family member cannot be located, to identify family or tribal support services that could be provided by extended family members or other tribal members if extended family members cannot be located; and
7. Exhaustion of all available tribally appropriate family preservation alternatives.

Adjudication means the process of rendering a judicial decision as to whether the facts alleged in a petition or other pleadings are true.

Administrative Hearing is a due process hearing held to appeal a decision made by a state agency.

Adoption means the method provided by law to establish the legal relationship of parent and child with the same mutual rights and obligations that exist between children and their birth parents.

Adoption Disruption means termination of an adoptive placement prior to finalization of the adoption.

Adoption Dissolution means legal termination of an adoption that has been finalized, including legal termination of the adoptive parent(s)' rights.

Adoption Exchange means a listing of children with special needs for whom an adoptive family is being sought, and of families approved for adoption of special needs for children. Some exchanges also list children needing a legal risk placement.

Adoption Registry means a central repository of profiles for all families approved for adoption or fos-adopt by the Department and available for such a placement.

Adoptive Placement means a type of placement that has not been finalized by a Decree of Adoption issued by a county or juvenile court.

Adult means an individual 19 years or older.

Affidavit is a written statement of facts signed under penalty of perjury, often before a court clerk or notary public who administers the oath to the signing party, who is called the affiant or declarant. Affidavits are routinely required for the procurement of warrants and are used in some jurisdictions to initiate juvenile court proceedings. They may be admitted into evidence.

Aftercare means the control, supervision, and care exercised over youth who have been paroled. It also means the outpatient treatment program for persons who have completed inpatient substance abuse treatment.

Age of Majority means the age at which, by statute, an individual is considered an adult and responsible for his/her own care, support and actions.

Agency Substantiated means that the Department's determination of child abuse or neglect against the subject of the report of child abuse or neglect was supported by a preponderance of the evidence and based upon an investigation pursuant to Neb. Rev. Stat. 28-713.

Allegation means a charge or claim of fact in a petition or other pleading which must be proven if the petition or other pleading is to be found true.

Approval study means a process which includes results of a home visit, a Child Protective Services check, a law enforcement check, and responses from references completed by the Department of a relative or person known to a child prior to placement occurring.

Beginning of foster care means the first 60 days after a placement in out-of-home care is made.

Beyond a reasonable doubt means the highest standard of proof, most often used in criminal cases. The evidence must, by virtue of their probative force, prove guilt. This standard of proof is applied when a court terminates the parental rights of Indian and non-Indian parents to an Indian child.

Caregiver means a parent or guardian, or in some cases, other adult in the household who provides care and supervision for the child. The primary caregiver provides the most child care. The primary caregiver is considered to provide at least 51% of care. The secondary caregiver is the other legal parent or another adult in the household who cares for the children.

Case Closure
Case closure means the 1) safety and risk does not rise to the need for court intervention; or the children are safe and the risk is low to moderate; or the family is unable to be located or 2) decision and process on the successful achievement of goals and outcomes of a child/family that eliminate the need for services and supervision.

Case Plan means a written agreement developed by the CFS Specialist with input from the family

members and other team members that identifies the agreed upon goals and objectives. Case Plans are developed for both court involved and non-court involved families.

Case Planning means the family-centered strengths-based process of engaging family members to ensure services are tailored to best address the family's strengths and needs. For Indian children/youth, case planning includes contacting and involving the tribe at the earliest opportunity.

Central Registry means the list of records maintained by the Department containing records of all reports of child abuse or neglect opened for investigation which have been classified as Court Substantiated or Agency Substantiated.

Child means an individual who by reason of minority, is legally subject to parental, guardianship, or similar control. In the state of Nebraska child means an individual less than 19 years of age.

Child and Families Services Specialist means the case manager, initial assessment or ongoing case manager assigned to work with a child or their family who is employed by the Department of Health and Human Services.

Child Caring Agency means an agency incorporated to provide care for children in residential settings maintained by the organization for that purpose.

Child custody proceeding for an Indian child means and includes:

1. "Foster care placement" means any action removing an Indian child from its parent or Indian custodian for temporary or emergency placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian custodian cannot have the child returned upon demand, but where parental rights have not been terminated;
2. "Termination of parental rights" means any action resulting in the termination of the parent-child relationship;
3. "Preadoptive placement" means the temporary placement of an Indian child in a foster home or institution after the termination of parental rights, but prior to or in lieu of adoptive placement;
4. "Adoptive placement" means the permanent placement of an Indian child for adoption, including any action resulting in a final decree of adoption; and
5. "Voluntary foster care placement" means a non-court-involved proceeding in which the department or the state is facilitating a voluntary foster care placement or in-home services to families at risk of entering the foster care system. **This includes cases that are identified as non-court involved and Alternative Response.** An Indian child, parent, or tribe involved in a voluntary foster care placement shall only be provided protections as provided in Neb. Rev. Statute 43-1505(4) and sections 43-1506 and 43-1508

Child Placing Agency means an organization authorized by its articles of incorporation to place children with a foster family or in adoptive homes.

Child Pornography means any visual depiction (live performance or photographic representation) and includes undeveloped film or video tape or data stored on a computer disk or by other electronic means which is capable of conversion into a visual image and also includes any photograph, film, video, picture, digital image or computer-displayed image, video or picture, whether made or produced by electronic, mechanical, or other means of an individual under 18 years of age of sexually

explicit conduct.

Clear and convincing evidence means the amount of evidence needed to convince ordinarily prudent minded people that the evidence is strongly in favor of one of the parties. It is more than a preponderance of evidence. Clear and convincing evidence is the standard of proof needed to place an Indian child in foster care.

Closed Adoption means an adoptive situation in which there is no contact or exchange of information between birth relatives(s) and adoptive parent(s) after a decree of adoption.

Commitment means an order by the court committing a child to the care and custody of the Department of Health and Human Services.

Commitment Date means the date that a child is made a Department ward via court order or voluntary relinquishment.

Concurrent Planning means the process of developing and implementing plans simultaneously to reach the primary permanency objective and an alternative objective. Concurrent planning may occur at any time in a case regardless of adjudication, including status offense and delinquency.

Conditionally Safe means that one or more safety threats are present, and protective safety interventions have been identified and agreed to by caregiver(s). An in-home safety plan is required.

Continuance means the postponement of a hearing, trial or other scheduled court proceeding, at the request of one or both parties, or by the judge without consulting them.

Conviction means the finding that an individual is guilty beyond a reasonable doubt of committing a crime.

Court Appointed Special Advocate (CASA) means a lay volunteer appointed by the court to assist in representing the child's interest in a juvenile court proceeding.

Court Involved Case means a case in which the County Attorney has filed a petition in the interest of the child and the court has assigned responsibility of the child to DHHS or the court has taken jurisdiction of the child and family to address identified safety threats, risk of harm to the child or community safety.

Court Pending means that a criminal complaint, indictment, or information or a juvenile petition under Neb. Rev. Stat. § 43-247(3)(a) has been filed in District Court, County Court, or separate Juvenile Court, and that the allegations of the complaint, indictment, information, or juvenile petition relate or pertain to the same subject matter as the report of abuse or neglect.

Court Report means a written document that contains information about the child and the family and the progress towards achieving the goals in the case plan.

Court–Substantiated means that a district court, county court, or separate juvenile court has entered a judgment of guilty on a criminal complaint, indictment, or information, or an adjudication of jurisdiction on a juvenile petition pursuant to Neb. Rev. Stat. § 43-247(3) (a), and the judgment or adjudication relates or pertains to the same subject matter as the report of abuse or neglect.

Courtesy Assessment means an assessment completed at the request of another state jurisdiction without continuing involvement of DHHS.

Courtesy Supervision means a cooperative arrangement between two or more counties, states or tribes to provide, or continue to provide, services to children and their families who are the subject of a dispositional order.

Criminal History means a county, state, or federal criminal history of conviction or pending indictment of a misdemeanor or felony.

Cruel Punishment means any type of discipline that results in injury, cuts, extreme bruising; withholding food, water, or required care, or requiring child to consume non-food items or inappropriate amounts of food, water or non-food items; a parent/caregivers' use of sadistic measures or weapons.

Cultural Plan means a written plan to ensure a life-long process of encouraging and fostering the Indian child's awareness and understanding of their Native American and tribal heritage and the development of a positive cultural identity. Key components of this plan include, but are not limited to, educating the child about his/her tribal history; initiating and maintaining connections and contact with extended family and other tribal members; exposing the child to positive Native American role models, literature, music, and art; recognizing and addressing racism at the child's current age and in the future, planning for the child to be a part of tribal events and ceremonies, etc.

Custody means the right to or responsibility for a child's care and control, carrying with it the duty of providing food, shelter, medical care, education and discipline.

Dependent Child means a child whose parent is or will be unable to care for the child through no fault of the parent, when no maltreatment has been identified. The parent may be incapacitated or absent due to illness, death, incarceration, or otherwise unavoidably unable to provide care, the child has extraordinary mental health, emotional, or physical needs which the parent does not have the ability or capacity to meet.

Discharge means the termination of Department guardianship or custody of the child.

Disposition means the court's determination of a case in which there is an issuance of a final order or opinion.

Dispositional Hearing means the hearing used for the purpose of determining what will occur with or by a child and/or parents who have been adjudicated within the juvenile court's jurisdiction. A dispositional hearing is when the juvenile court judge will order implementation of a treatment plan.

Domestic Violence means the establishment of control and fear in a relationship through the use of violence and other forms of abuse between spouses, persons living as spouses or adult members of the same household. The offender may use physical abuse, emotional abuse, sexual abuse, economic oppression, isolation, threats, intimidation, and maltreatment of the children to control the other person. Relationships involving domestic violence may differ in terms of the severity of the abuse, but control is the primary goal of all offenders.

Emotional Abuse means the parent/caregiver demonstrates a pattern of criticizing, rejecting,

insulting, isolating, terrorizing, or humiliating the child, resulting in serious emotional or behavioral issues.

Emotional Neglect means a parent/caregiver's pattern of failure to seek ongoing or emergency mental health services for a child who has suicidal, homicidal, or severe self- harming behaviors. Severe self-harming behaviors include cutting, burning, or other self- mutilation that requires medical treatment OR risk-taking behaviors likely to result in serious physical harm.

Escapee means a youth who has made an unauthorized flight from a facility to which he/she has been committed by the court or placed by lawful authority.

Evidence means any sort of proof submitted to the court for the purpose of influencing the court's decision on a case.

Expungement Review means the process for an individual, whose name has been entered on the Child and/or Adult Abuse Central Registry, to request that their name be removed.

Failure to Thrive means a serious medical condition in which a child's weight and motor development are significantly below average for his/her age. Usually, though, not always, found in children less than one year old, the syndrome may have an organic cause or it may be caused by severe emotional or physical neglect.

Family means a biological, adoptive or self-created unit of people residing together consisting of adult(s) and child(ren) with the adults(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, cultural practices and a significant relationship. Biological parents, siblings, and others with significant attachments to a child living outside of the home are included in the definition of a family.

Family/Person Centered Practice means a process that is based on a core set of values, beliefs, and principles that recognize that families can and should contribute to all aspects of services through their active participation.

Family Preservation means the efforts being made to safely keep the family together. Family Preservation is also the permanency objective whenever a decision is made that indicates the child can be safely maintained in the home

Family Strength means areas of a family's life where they exhibit power and decision making that is an asset to the family. Identified family strengths are used when developing safety interventions and strategies to achieve case plan goals.

Family Team means a group comprised of individuals selected by the family (including children), including, but not limited to family, friends, relatives, peers, providers, teachers, etc. who come together both formally and informally to form a circle of support around a person and/or family. . Children must be involved in all family team meetings unless they are younger than age 9 or not developmentally appropriate to participate.

Family Team Meeting: A meeting that is convened for the purpose of creating, implementing, evaluating, and updating a Safety Plan and/or Case Plan that furthers an individual's/family's achievement of their goals and the child safety concerns. The team meeting must include the family (unless reunification is not the permanency goal), the Case Manager, and may include other formal

and informal supports selected by the family (or others if the family is no longer involved).

Formal Resource People/Participants/Supports means individuals who participate as members of the Family Team due to their paid relationship with the child and family. Examples of this include foster parents, teachers, therapists, community treatment aides, family organization advocates (mentors paid to provide support who are not chosen by the family), and agency staff.

Foster Care means engaged in the service of exercising 24-hour daily care, supervision, custody, or control over children, for compensations or hire, in lieu of the care of supervision normally exercised by parents in their own home. Foster care will not include casual care at irregular intervals or programs as defined in Neb. Rev. Stat. §71-1910. The Indian Child Welfare Act expands the definition of foster care to include guardianships and placements in which the parent or Indian custodian cannot have the child returned upon demand.

Foster Care Placement means (a) all types of placements of juveniles described in Neb. Rev. Stat. 43-245 and 43-247, (b) all types of placements of neglected, dependent, or delinquent children, including those made by the Department of Health and Human Services, by the court, by parents, or by third parties, (c) all types of placements of children who have been voluntarily relinquished pursuant to Neb. Rev. Stat. 43-106.01 to the department or any child-placing agency as defined in Neb. Rev. Stat. 71-1926 licensed by the department, and (d) all types of placements that are considered to be a trial home visit, including those made directly by the department or office.

Foster family means the placement in which a child is residing other than with their biological parent(s) or legal guardians.

Foster Home means a private single-family living unit, under one roof, housing no more than nine children/youth under the age of 19 including foster children and children of the provider that provides 24-hour parenting to all of the children. No more than six children can be under the age of 12.

Group Home means a home operated under the auspices of an organization that is responsible for providing social services, administration, direction, and control for the home and that is designed to provide 24-hour care for twelve or fewer foster children in a residential setting.

Guardian means an individual appointed by a court who has the powers and responsibilities of a parent. The guardian is empowered to facilitate education, authorize medical care, consent to marriage or adoption of the ward. Under Nebraska law a guardian is not legally required to provide financial support for the ward and is not liable for acts of the ward.

Guardian ad Litem means an attorney appointed by the court to act in the minor's or an incompetent adult's behalf in a lawsuit and protect the minor's or adult's best interests in court.

Guardianship means that the court has appointed an individual to become a child's guardian. Guardianship is one of the permanency objectives available to children if reunification or adoption cannot occur.

Household means all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. A person considered as a member of the household if he/she spends 50% or more of his/her time in the home OR if the home is his/her only permanent residence (e.g., deployed members of the military, temporarily

incarcerated individuals).

Household Violence means violence within the household which can include child to child; child and parent; parent to parent; or other caretakers or relatives in the home.

Independent Living means the establishment of a residence for a foster youth to reside outside of a foster placement or his/her family. The youth would reside in an apartment, house, dorm or other type of living arrangement and is responsible for taking care of their needs i.e., paying rent, buying and preparing food, managing a budget). It is also a term used as a permanency objective or concurrent plan for a youth 16 years of age or older when it appears reunification may not occur and adoption or legal guardianship are not appropriate and the youth's best interest is served by self-sufficiency.

Indian Child Welfare Act means the federal and state law that provides direction in working with Indian Children and their families. Refer to the Indian Child Welfare Act Operations Manual for specific direction in working with children and families that may be Indian.

Informal Living Arrangement means that the parent has made arrangements prior to or after DCFS involvement for a temporary and alternative place for their child to reside until child safety can be managed in the parental home.

Informal Resource People/Participants/Supports means individuals who participate as members of the Family Team and do not receive payment for their responsibility with respect to the family. Examples of this may be relatives, neighbors, spiritual leaders, volunteer mentors, friends, etc.

Initial Assessment means the process the Department utilizes to assess for child safety, risk and to determine if maltreatment occurred.

Injury means tissue damage such as welts, bruises, or lacerations that last more than 24 hours, resulting from trauma.

Intake means the stage of the CPS case process where the CPS caseworker screens and accepts reports of child maltreatment.

Interstate Compact on Juveniles (ICJ) means the law which provides (1) for the return from one state to another of delinquent juveniles who have absconded; (2) for the return of non-delinquent juveniles who have run away from home; (3) for the cooperative supervision of delinquent juveniles on probation or parole; and, (4) for additional cooperative measures to the protection of juveniles and of the public.

ICJ Compact Administrator means the individual in each compacting state appointed by the appropriate state authority for the administration and management of the state's supervision and transfer of juvenile delinquents.

Interstate Compact on the Placement of Children (ICPC) means the law which controls the movement of children from one state to another for the purposes of placement.

ICPC Administrator or designee means a person designated by the executive head of each jurisdiction that is party to this compact who shall be general coordinator of activities under this compact in his/her jurisdiction and who, acting jointly with like persons of other party

jurisdictions, shall have the power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact. In Nebraska this person is located in the Policy Unit of the Division of Children and Family Services. Interstate Compact on ICPC and ICPC Administrator designee definitions are out of alphabetical order and should be moved to where Interstate Compact on Juveniles definition is located.

Juvenile Offender means (1) any juvenile who has committed an act other than a traffic offense which would constitute a misdemeanor or an infraction under the laws of the state or violation of a city or village ordinance; or (2) any juvenile who has committed an act which would constitute a felony under the laws of this state; or (3) any juvenile who has committed an act which would constitute a traffic offense as defined in Neb. Rev. Stat section 43-245.

Kinship Home means a home where a child or children receive foster care and at least one of the primary caretakers has previously lived with or is a trusted adult that has a pre-existing, significant relationship with the child or children or is a sibling of such child or children pursuant to Neb. Rev. Stat. 43-1311.02.

Law Enforcement means the police department or town marshal in incorporated municipalities, the office of the sheriff in unincorporated areas, the Nebraska State Patrol, or tribal law enforcement.

Law Enforcement Check means a review of computer information or contact with a law enforcement agency to determine all felony or misdemeanor filings, including any charges filed, the dates filed, the level of charges, disposition date and final disposition.

Least restrictive means a child in a placed in a setting that is most comparable to his/her home.

Legal custody means a legal relationship that is established by court order, in which one individual, referred to as the Custodian, if given legal authority over, and the corresponding legal responsibility for, another individual. Physical custody may or may not be simultaneous with legal custody.

Maltreatment means parenting behavior that is harmful or destructive to a child's (age birth through age seventeen (17)) cognitive, social, emotional, and/or physical development.

Medical Neglect means the parent/caregiver's pattern of refusing or failing to seek/obtain medical treatment or rehabilitative care for the child's conditions that have potential life-threatening or long-term health effects, including failure to thrive. This includes appropriate medication, medical or dental care, or speech or physical therapy when there is potential for lifelong negative impact.

Medical Neglect of Handicapped Infant means the withholding of medically indicated treatment (including appropriate nutrition, hydration, and medication) from disabled infants with life-threatening conditions. Exceptions include those situations in which:

1. The infant is chronically and irreversibly comatose;
2. The provision of this treatment would merely prolong dying or not be effective in improving or correcting all the life-threatening conditions; or
3. The treatment would be virtually futile in terms of the survival of the infant and the treatment itself in such a situation be inhumane. Food and water must always be provided regardless of the extent of disabilities, and "quality of life" cannot be used as a criterion for deciding upon appropriate medical treatment.

Missing Child/Family Alert means the process whereby CFS agencies can attempt to locate families

who have left their jurisdiction by notifying other parts of the state or other state CFS agencies that the children are under the jurisdiction of the court or may be in danger.

Near Fatality means a case in which an examining physician determines that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment (Neb. Rev. Stat. 81-3126).

Non-Court Involved Case means a case in which the family agrees to work with DHHS without involving the juvenile court system, to address the identified safety threats and/or reduce the potential for risk of future maltreatment to children. Non-court involved cases are also described as Voluntary Cases.

Non-custodial Parent means any individual recognized as the parent legally through marriage, adoption, or biology; a man named by the mother or other relative as the father, who agrees he is the father; or in some cases, an individual who has acted in the role of parent for a significant period of time who does not have placement of the child the majority of the time.

Parenting Time means the quality and quantity of time a parent spends with their child who is in out of home care.

Permanency is both a process and a result that includes involvement of the child as a participant or leader in finding a permanent connection with at least one committed adult who provides a safe, stable and secure parenting relationship, love, unconditional commitment and lifelong support in the context of reunification, a legal adoption, or guardianship, where possible, and in which the child/youth has the opportunity to maintain contacts with important persons including brothers and sisters.

Permanency Plan means the systematic process of carrying out (within a brief, time-limited period) a set of goal-directed activities designed to help children live in permanent families. This process has the goal of providing the child continuity of relationships with nurturing parents or caretakers and the opportunity to establish lifetime family relationships.

Permanency Objective means an anticipated result of all efforts and services, which will result in permanency for the child or his/her discharge from Department custody.

Petition means a document filed by a county attorney in a juvenile court at the beginning of a maltreatment, status offense, and/or delinquency case. The petition states the allegations that, if true, form the basis for court intervention.

Physical Abuse means the non-accidental infliction of injury or an act the poses substantial likelihood of inflicting bodily injury.

Physical Custody means the individual with whom the agency places a child for provision of physical care, or in the case of children who are not wards of DHHS, or the individual(s) physically caring for the child.

Physical Neglect means the failure of the caregiver to provide basic needs, for example food, clothing, shelter, medical care, supervision and a safe and sanitary living environment for the child.

Placement means the arrangement for the care of a child in a licensed or approved foster family or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic or any institution primarily education in character, and any hospital or other medical facility. For purposes of the Indian Child Welfare Act, the definition of placement can include an institution caring for the mentally ill, mentally defective or epileptic or any institution primarily educational in character, and any hospital or other medical facility.

Prevention Assessment means a process to evaluate the probability (likelihood, chance, potential, prospect) that a family involved with DHHS for Dependency or Status Offense will experience maltreatment in the next 12 to 18 months.

Primary Caregiver means the person in the household who provides the most child care. The primary caregiver is considered to provide at least 51% of the care.

Preponderance of Evidence means that an event is more likely to have occurred than not by a greater weight of the evidence. As the term "preponderance of the evidence" suggests, there must be credible evidence of maltreatment documented in the case record to support a finding of agency substantiated.

Protective Placement means that safety threats are identified and no interventions are possible, the child is unsafe and must be taken into protective placement. Protective placement is defined as: 1) the family voluntarily placing their child out of the home in a residence approved by the Department; or 2) the Department initiating court action.

Putative Father: A person alleged to be the biological father with no legal establishment of paternity. Also referred to as the alleged parent.

Reasonable efforts mean those supports and services both informal and formal that may allow the child to remain in his/her home safely or to be returned home.

Relative means a person connected to the child by blood, marriage, adoption or tribal law or custom. A person related through legal guardianship will be deemed to be a relative for the purpose of these regulations. For Native American children, relative will be defined either by the law or custom of the tribe, or, in the absence of tribal law or custom, as defined by the Indian Child Welfare Act.

Reunification means a permanent plan for the child that involves the return of the child to any individual who retains parental or legal rights to the child after removal for child abuse, neglect, or both, regardless of the custody arrangement prior to the child entering out-of-home care.

Reunification Assessment means a process to assess whether a child(ren) can be safely returned to the family home based on an evaluation of safety, risk and parenting time.

Risk means the probability (likelihood, chance, potential, prospect) that any harm will occur in the next year to two years.

Risk Assessment means an objective appraisal of the likelihood that children in a household will experience abuse or neglect in the future.

Risk Re-assessment means the process of reassessing for risk to determine if change has been made

in the family that has reduced or increased the probability of future harm.

Runaway means there is reasonable evidence to suggest that the child has runaway or has been absent from home for at least 12-14 hours without parent/caregiver consent, and the parent/caregiver does not know where to locate the child.

Safe child means no safety threats were identified at the present time. Based on currently available information, there are no children likely to be in imminent danger of serious harm.

Safety means actions of protection, demonstrated by a caregiver, that mitigate the danger, demonstrated over time.

Safety Assessment means an immediate (here and now) observation and investigation of whether there are serious and imminent threats to a child. Safety is about the short term.

Safety Intervention means involvement to mitigate safety threats which utilizes family strengths whenever possible through the use of family, kin, neighbors or other individuals in the community as safety resources. It may also include direct services by the case manager and community and agency resources. Action to remove a child from the home may be necessary to ensure child safety through court action, a Voluntary Placement Agreement or the family and DHHS agreement to an informal out-of-home placement with relatives.

Safety Plan means there is a written agreement created with the family that describes the safety threats and how those safety threats will be managed to ensure child safety. The plan may remain in effect as long as needed and must be continuously evaluated and modified as long as it is in effect.

Safety Threat means there are circumstances in the family situation that could result in serious harm to the child. "Serious" means that the harm would require medical or mental health attention or emergency services, and that if DHHS staff do not think they could contain the threat, staff could not leave the child in the home. Imminent means that there is a reasonable expectation that the harm will occur in the next week or month.

Secondary Caregiver is a person residing in the household and provides care for children. They are usually a legal parent or another adult that provides less than 50% of care to the child.

Sexual Abuse means any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, the child, or other person.

Sexual Exploitation means, but is not limited to, causing, allowing, permitting, inflicting or encouraging, or forcing a minor child to solicit for or engage in voyeurism, exhibitionism, or prostitution, or in the production, distribution or acquisition of pornographic photography, films or depictions of the child when the child is unable to give consent due to the child's age or incapacity.

Status Offender means any juvenile who, by reason of being wayward, or habitually disobedient, is uncontrolled by his or her parent, guardian, or custodian; who deports himself or herself so as to injure or endanger seriously the morals or health of himself, or others; or who is habitually truant from home or school.

Torture means the infliction of intense pain to punish, coerce, or afford sadistic pleasure.

Trial Home Visit means a placement of a court-involved juvenile who goes from a foster care placement back to his or her legal parent or parents or guardian but remains as a ward of the state.

Transitional Living Proposal means there is a Transitional Living Proposal/Plan developed by identifying knowledge and skills of a youth related to their ability to live on their own with limited supports and providing them with education, support and training to develop and improve those skills and knowledge. This term has also been referred to as an Independent Living Plan

Unable to Locate means the subjects of the maltreatment report have not been located after a good faith effort on the part of the Department.

Unfounded means all reports not classified as court substantiated, court pending, agency substantiated, or unable to locate.

Unreasonable use of Confinement/Restraints means the use of restraints without a physician's order; the parent/caregiver using confinement to a chair, bed, corner or similar environment for unreasonable periods of time is considered physical abuse.

Unsafe child means a child for whom one or more safety threats are present and placement is the only protective intervention possible. Without placement, the children will likely be in imminent danger of serious harm.

Violence means the exertion of physical force so as to injure, abuse, or control.

Vulnerable Child means a child/youth that does not have sufficient capacity for self-protection.

References:

[i] See attached. Physical and Cognitive Developmental Milestones – Adapted from "Developmental Milestones Summary," Institute for Human Services, (1990); "Developmental Charts" provided by Jeffery Lusko, Orchards Children's Services, Southfield, MI; "Early Childhood Development from two to six years of age," Cassie Landers, UNICEF HOUSE, New York.

ACTIVE EFFORTS

DHHS.PSPolicyandGuid@nebraska.gov

The CFS Specialist must follow Active Efforts in any case as soon as the CFS Specialist knows or has reason to believe ICWA could apply.

I. ACTIVE EFFORTS.

1. The Indian Child Welfare Act (ICWA) establishes a minimum standard for preventing the breakup of the family, removal of an Indian child from their home and guidelines for placement in foster or adoptive homes. Active efforts must be made to keep the Indian family together. Active efforts means that ***everything possible*** must be performed to help the family resolve the problems that led to neglect or abuse, including referral to services that are sensitive to the family's culture. The CFS Specialist must involve and use the available resources of the extended family, the tribe, Indian social service agencies and individual Indian caregivers.
2. The CFS Specialist will provide active efforts to provide remedial services and rehabilitative programs to prevent the breakup of the Indian family. The CFS Specialist must consider services available through tribal social services, Native American service providers, and service providers with appropriate cultural components, experience or knowledge as well as individual Indian caregivers (traditional healers, spiritual leaders, etc.) and extended family members.
3. The CFS Specialist will provide Active efforts as described below. This list is not exhaustive and the CFS Specialist can and should take any action necessary to prevent removal and to help the family resolve the problems that led to the alleged abuse or neglect.
    1. Collaborative casework that includes the family and the tribe(s), both prior to and after the removal of an Indian child, exceeding the level that is required under reasonable efforts to preserve and reunify the family that is consistent with the current social and cultural conditions and way of life of the Indian child's tribe or tribes to the extent possible under the circumstances;
    2. A request to the Indian child's tribe or tribes and extended family known to DCFS to convene traditional and customary support and services;
    3. Actively engaging, assisting, and monitoring the family's access to and progress in culturally appropriate and available resources of the Indian child's extended family members, tribal service area, Indian tribe or tribes, and individual Indian caregivers;
    4. Identification of and provision of information to the Indian child's extended family members concerning appropriate community, state, and federal resources that may be able to offer housing, financial, and transportation assistance and actively assisting the family in accessing such community, state, and federal resources;
    5. Identification of and attempts to engage tribally designated Nebraska Indian Child Welfare Act representatives;
    6. Exhaustion of all available tribally appropriate family preservation alternatives.

4. At every court hearing involving an ICWA child, the CFS Specialist will provide a written report of DCFS attempts to provide or provision of active efforts based on Neb. Rev. Stat. 43-1503. This report will be sent to the Indian child's tribe or tribes within three (3) days after being filed with the court regardless of the decision of the tribe to intervene or efforts made to be involved in the case. The CFS Specialist may contact the DCFS ICWA Program Specialist to consult on the provision of Active Efforts.
   When the Court or Court Order does not find that active efforts have been made, the CFS Specialist and CFS Supervisor will contact the DCFS ICWA Program Specialist for consultation.

References:

Program Guidance on ICWA.
ICWA Case Management Desk Aid

SUMMARY OF REVISIONS	
DATE	REVISION
11/08/2017	Effective

OUT OF HOME ASSESSMENT

DHHS.PSPolicyandGuid@nebraska.gov

I. CONDUCTING THE OUT-OF-HOME ASSESSMENT.

A. To obtain the most accurate information it is the procedure of the Department to proceed in the following order. The CFS Specialist will:

1. Review relevant Department and law enforcement records.
2. Notify all CFS Specialists of children in care to discuss relevant case information and coordinate decision-making about the child(ren).
3. In cases involving a licensed child caring agency, the investigating CFS Specialist request incident reports from the agency and documentation from the licensed facility that describes the action the facility has taken to ensure child safety. In cases involving foster homes, the licensing agent in consultation with his/her supervisor will determine when a Safety Plan is developed. The Out-of-Home Assessment is only conducted on foster homes when the foster family has no current placements and the allegations involve foster children previously placed in the foster home.
4. Coordinate contact and consultation, as appropriate, with law enforcement, licensing, contracting, and resource development regarding placement and safety status.
5. Conduct interviews in the following order:
   a. Reporting party to confirm details;
   b. Identified child victims;
   c. Other children in care who might have knowledge related to allegations;
   d. Anyone identified as present during incidents or who have knowledge of incidents;
   e. In the case of foster parents, the non-maltreating foster parent; and
   f. Alleged perpetrator
6. If law enforcement is conducting a criminal investigation, the involved law enforcement officer will be responsible to determine how and when the interviews with the alleged perpetrator will occur. The Department will not interview the alleged perpetrator until approved by law enforcement.

B. **Notification of Parents of Children.**

1. When conducting an assessment of alleged neglect, physical abuse or sexual abuse of a child in a child care home or facility, the CFS Specialist will make every effort to contact the parent or legal guardian of any suspected victims before interviewing the child.
   a. If attempts to contact the parent or legal guardian are unsuccessful and there is reason to believe that interviewing the child is necessary to protect the child or other children, the CFS Specialist will interview the child without parental consent. Contact with the parent or legal guardian will occur as soon as possible following the interview with the child.
   b. The following information will be provided to the parents or legal guardians of children alleged to have been abused or neglected in a child care home or facility:
      (1) Notice that a report alleging neglect, physical abuse or sexual abuse has been received and information on the nature of the maltreatment;
      (2) Notice that the DCFS is conducting an assessment of the allegations;
      (3) The safety/protective or corrective measures taken; and
      (4) The conclusions of the assessment along with any recommendations that will help protect the child from future maltreatment in the facility.

C. **Case Status Determination in a facility.**

1. The CFS Specialist will follow the Program Guidance on Central Registry Entries to determine whether there is preponderance of evidence that child abuse, neglect or sexual abuse occurred.
2. The CFS Specialist will determine if there is risk to other children in care will determine if child abuse and neglect occurred and whether there is preponderance of the evidence.
3. The CFS Specialist may determine that risk of maltreatment to children exists without a substantiated finding that actual incidents of child abuse, neglect or sexual abuse has actually occurred. Recommendations about changes in practice or conditions that will reduce the likelihood of maltreatment will be made. Once these determinations have been made the following will occur:
   a. The case status determination will be entered into the Child Abuse and Neglect Central Registry utilizing the Program Guidance on Central Registry Entries.
   b. A summary of the assessment, findings and recommendations for action will be sent to the appropriate licensing staff, resource development staff, CFS Specialists with children in placement and the county attorney.
   c. The case findings will be shared with the alleged perpetrator and facility director.
4. Recommendations about changes in practice and conditions that would reduce the likelihood of maltreatment will be provided to the child care provider, the parents involved and the child care director in cases of a child care facility.

D. **Substantiated Reports.**

1. When reports of child maltreatment are substantiated, the Department will:
   a. Assess present risk to the child(ren) involved and assure steps are taken to protect the child(ren).
   b. Inform the child's parent or legal guardian as soon as possible.
   c. Notify the agency responsible for the child's placement when an incident involves a child placed by another child caring agency.
   d. Immediately notify the appropriate licensing and contracting authorities of the substantiated abuse or neglect.
2. When neglect or abuse is substantiated the parents of the victim(s) and subject of the report in that home or child care facility will be notified.
3. Information on the status of the investigation cannot be shared with the parent/caretakers of children who are not identified victims or witness of abuse/neglect in the facility.
4. Requests for information from others who are not subjects in the report will be referred to Law Enforcement to make a request for information.

When Licensing determines that children are not safe in the care of home or facility, licensing staff will make recommendations to the parent or legal guardian to make alternative child care arrangements.

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-17	Effective

SDM ASSESSMENT OF PLACEMENT SAFETY AND SUITABILITY

DHHS.PSPolicyandGuid@nebraska.gov

SDM Assessment of Placement Safety and Suitability (APSS) is the tool that is used to assess safety and care concerns in a foster home placement. Foster home placements include agency based, traditional, relative, ~~DD Family homes~~kinship, or adoptive homes.

The process for completion of the APSS will be consistent across the state. Individual Service Areas may assign ~~staff~~ CFS Specialists or Resource Development to complete the APSS process ~~differently~~, based on Service Area needs and resources. The APSS will be completed by ~~staff~~ CFS Specialist or Res~~u~~ource Development in the service area in which the home is located, even though there may be children placed in a foster home from other Service Areas. CFS Specialists for the child will share any information they may have about the child and the home with the worker completing the assessment.

An Initial Assessment CFS Specialist will assess the foster home related to allegations of abuse or neglect using the APSS.

The APSS **will not** be used for congregate care placements (i.e., group homes and institutions) or for foster homes with no current placement. If a report of abuse/neglect is made on a licensed/approved foster home with no placements the CFS Specialist will investigate the alleged maltreatment and document all information in the Organization Related Investigation narrative. The Organization Related Investigation on N-FOCUS will be used to assess and document complaints on these types of homes and facilities. This is also known as the Out-of-Home Care Assessment. The assigned worker will coordinate with the Licensure Unit, Medicaid, Managed Care Association(s), Behavioral Health, and Developmental Disabilities divisions as appropriate. The Out of Home Assessment will be documented using the Organization Related Investigation icon on N-FOCUS.

The APSS is to be used at the following times:

- When an Intake report is ~~received accpeted~~ accepted on a licensed or approved foster home where foster children are placed;
- When there are placement concerns related to child safety regarding behaviors among children in a foster home; or
- When there are significant changes in a placement that impacts child safety.

SDM ASSESSMENT OF PLACEMENT SAFETY AND SUITABILITY

Completion of the assessment is done in two parts. Information gathered must be comprehensive so that both parts of the assessment can be completed accurately.

1. The investigation component must be done to determine if there was maltreatment, which is important in assessing safety and risk, and so the appropriate case status determination or finding can be made.
2. The second part is completion of the APSS and consideration of the placement decision.

   The APSS looks at possible safety threats to the child and care concerns for the child in placement. Placement resources are held to a higher standard of care than a parental home. A situation in the foster home does not have to rise to the level of a safety threat before an intervention is put in place. The APSS placement decision guides the worker(s) to the final decision of assuring safety and suitability of the placement for the child. If a safety or care concern is identified, the worker assigned will assess if an intervention can be put in place to improve safety and care. The placement decision is based on identified concerns and available interventions.

While completing assessments based on intakes with allegations and intakes with only care concerns, workers involved will assess the suitability of the placement resource for future placements. Any and all concerns will be documented.

The APSS will be documented on N-FOCUS on the Organization in Home Details by completing the SDM Assessment for Placement Safety and Suitability. Family Functioning Narratives are available for documentation for Intakes with allegations, but can also be used for documentation by other CFS Specialist and RD staff cooperating with the assigned worker while the case is in draft status. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the questions in the APSS. The CFS Specialist will utilize the narrative sections within the SDM assessment to document all supporting information regarding the decisions on each of the items. Although the CFS Specialist completing the initial assessment will take the lead in completing the investigation of abuse/neglect allegations, the CFS Specialist will collaborate with the ongoing worker(s), RD staff and agency staff supporting the placement.

It is expected that not all facts about a case can be known immediately. Some information is inaccessible, and some can be deliberately hidden from the CFS Specialist. Based on reasonable efforts to obtain information necessary to

respond to each item, the CFS Specialist will review each of the concerns and accompanying definitions

I. COMPLETING THE APSS.

A. **Section 1A: Safety Concerns** – Safety concerns are circumstances in the placement that make a child less safe. They may or may not rise to the level of being a safety threat, but, because the child is in state custody, would represent a reason to consider changing the placement if the concern cannot be contained through a plan to increase safety.

1. **Care provider caused physical harm to the child or made a plausible threat to cause physical harm in the current incident, as indicated by any of the following:**
   a. Any non-accidental injury or abuse to any child in the household.
   b. Care provider fears he/she will physically harm the child and/or requests removal.
   c. Threat to cause harm or retaliate against the child: Threat of action that could result in harm, or plans to retaliate against the child for CPS investigation.
   d. Excessive discipline: Care provider has acted in a way that bears no resemblance to appropriate discipline, considering the previous experiences of child. Consider any discipline that is not in compliance with DHHS or agency policy.
   e. Use of physical force or corporal punishment.

2. **Current circumstances, combined with prior allegations of abuse/neglect and/or incident reports, suggest that the child's safety may be of immediate concern.** There must be both current concerns **and** related previous allegations/incidents that represent an emerging or unresolved pattern.

Current circumstances include any behaviors or conditions that diminish child safety without rising to the level of concern as defined here. Examples include but are not limited to the following: • Child sometimes does not have sufficient nutrition, but malnourishment is not yet a concern.	**AND** Previous incidents may include any of the following: • Prior incident reports, including any licensing complaints or citations. • Prior referrals of abuse/neglect to the child. • Evidence of prior unreported injuries or incidents.

• Child sometimes has imperfect hygiene that does not rise to the level of a concern.	

3. **Child sexual abuse is suspected <u>and</u> circumstances suggest that the child's safety may be of immediate concern.** To select this threat, two conditions must be present: suspicion and circumstances.

Suspicion of sexual abuse may be based on indicators such as the following: • The child discloses sexual abuse either verbally or behaviorally (e.g., age-inappropriate, sexualized behavior toward self or others). • Medical findings consistent with sexual abuse. • Care provider or others in household have been convicted, investigated, or accused of sexual misconduct with the child. • Indications of poorly defined or questionable sexual boundaries between household members, and/or care provider engages in or permits other household members to engage in behaviors that infringe upon appropriate sexual boundaries. Based on age, gender, and developmental status of household members, examples of inappropriate and/or poorly defined sexual boundaries may include such things as non-gender-specific sleeping	**AND** • Access to the child by possible or confirmed sexual abuse perpetrator exists.

arrangements or showering/bathing practices, exposure to nudity or sexually explicit materials, etc.	

4. **Care provider does not/is unable to protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, neglect, or emotional abuse.** The CFS Specialist will select this item when there is current harm or an identified current threat of harm to a child **and** the care provider does not take action.

Current harm or an identified threat may be indicated by the following: • An individual(s) with known violent criminal behavior/history resides in the household or frequents the home, and care provider allows access to the child. • The care provider does not or cannot comply with orders to prevent contact between the child and birth parent or other family members. • Include homes where gang activity occurs or where there is criminal activity in the home.	**AND** Care provider does not/is unable to protect the child from harm or threatened harm as a result of physical abuse, neglect, sexual abuse, or emotional abuse by other family members, other household members, or others having regular access to the child. Based on the child's age or developmental stage, care provider does not provide supervision necessary to protect the child from potential harm by others.

5. **Care provider's explanation for the injury to the child is questionable or inconsistent with the type of injury.** Factors to consider include age and vulnerability of the child, location of injury, exceptional needs of the child and chronicity of injuries.
   a. Medical evaluation indicates injury is consistent with abuse; care provider denies, or attributes injury to accidental causes.
   b. Care provider's explanation for the observed injury is inconsistent with the type of injury.
   c. Care provider's description of the injury or cause of the injury minimizes the extent of harm to the child.

6. **Care provider actively impedes assessment by denying access to the child, coercing or coaching the child, or fleeing with the child.** Do not include care providers who are uncooperative or non-compliant with assessment requests and/or court orders or if the care provider is uncooperative with safety planning. In such cases, consider other safety concerns.
   a. Care provider currently hinders or refuses access to the child.
   b. Care provider has removed the child from a hospital against medical advice.
   c. Care provider keeps the child at home, away from peers, school, and other outsiders for extended periods of time.
   d. Care provider intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

7. **Care provider does not, cannot, or will not meet the child's need for supervision, food, clothing, and/or medical or mental health care.**
   Note: If the care provider's limitations in this regard are directly related to substance abuse, select item 8.
   a. Care provider does not attend to the child to the extent that the child's need for care goes unnoticed or unmet (e.g., care provider is present but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).
   b. Care provider leaves the child alone (time period varies with age, developmental state, and vulnerability).
   c. Care provider is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) or incapacitated (e.g., injured, ill).
   d. Care provider makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.
   e. Nutritional needs of the child are not met, resulting in danger to the child's health and/or safety; the child appears malnourished; or there is insufficient food in the home.
   f. The child is without appropriate clothing for the weather.
   g. Care provider does not seek treatment for the child's medical/dental/vision conditions(s) or does not follow prescribed treatment for such conditions.

h. The child has a special need, such as being medically fragile, which care provider does not or cannot meet.
i. The child has serious emotional symptoms, lack of behavioral control, or psychosomatic symptoms (e.g., sleep/appetite disturbance) and care provider will not/cannot seek or provide appropriate interventions.

8. **Care provider's current use of a legal or illegal substance impairs his/her ability to supervise, protect, or care for the child.**
Care provider uses legal or illegal substances, including alcohol, to the extent that control of his or her actions is impaired. As a result, care provider was/is unable to care for the child, has harmed the child, or is likely to harm the child.

9. **The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.**
Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:
a. Leaking gas from stove or heating unit.
b. Substances or objects accessible to the child that may endanger the health and/or safety of the child (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities).
c. Lack of water or utilities (heat, plumbing, electricity) and no alternate, safe provisions have been made.
d. Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows.
e. Exposed electrical wires.
f. Excessive garbage or rotted or spoiled food that threatens health.
g. Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites).
h. Evidence of human or animal waste throughout living quarters.
i. Guns and other weapons are not locked.
j. Unrestricted access to pool or other body of water.
k. Blocked exits or unmarked exit routes.
l. Missing or non-functioning smoke detectors.
m. Un-gated stairways in home with young children, as licensing regulations apply.

n. Unsafe sleeping arrangements (e.g., infants sleeping on their stomachs, sleeping arrangements for infants that include pillow and comforters that may present a SIDS risk).

10. **Child behaviors raise concerns regarding child safety, in spite of appropriate response by care provider(s).**

To mark this threat, the following three conditions MUST be present:		
The child is currently engaging in or habitually engages in behaviors that place him/her at imminent risk of serious harm. Examples include but are not limited to children who run away from placement and place themselves in unsafe living/sleeping situations, children who engage in prostitution, and children who engage in self-harming behaviors, such as cutting, that require medical intervention.	**AND** The care provider(s) have responded appropriately and made reasonable efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child, and increasing direct supervision and monitoring of the child.	**AND** The care provider's current efforts, although appropriate, are insufficient to prevent the child from engaging in the behavior in the future

11. **Other.** If, after careful review of the definitions for the other 10 safety threats, the CFS Specialist feels there is something unique in this care provider that was not captured in any other safety threat, the CFS Specialist should select "other" and document the identified unique safety threat that, if not resolved immediately, would lead to removal of a child in this home.

B. **Section 1B: Care Concerns**

Care concerns are circumstances that do not diminish child safety, but that may indicate that a placement change should be considered if the concern cannot be addressed through a plan.

12) **Care provider's overall functioning impairs his/her current ability to supervise, protect, or care for the child.**

a. Care providers refusal to take prescribed medications impedes his/her ability to care for the child.
b. Care provider's inability to control his/her emotions impedes his/her ability to care for the child.
c. Care provider acts out or exhibits distorted perception that impedes his/her ability to care for the child.
d. Care provider's emotional stability, developmental status, or cognitive deficiency impedes his/her ability to care for the child.
e. Care provider expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to cry, be still for extended periods, be toilet trained, eat neatly, or older children expected to care for younger siblings or stay alone).
f. Care provider lacks the basic knowledge related to parenting skills:
   (1) Does not know that infants need regular feedings;
   (2) Fails to access and obtain basic/emergency medical care;
   (3) Does not understand what constitutes proper diet; or
   (4) Does not understand what constitutes adequate supervision.

13) **Care provider routinely describes the child or family of origin in negative terms or acts toward the child in negative ways.**
   a. Care provider describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
   b. Care provider curses and/or repeatedly puts the child down.
   c. Care provider scapegoats a particular child in the household.
   d. Care provider blames the child for a particular incident or household problems.
   e. Care provider treats the child in markedly different ways that may stigmatize the child.
   f. Care provider interferes with the child's reunification or adoption (e.g., interferes with visitation or communication with birth parent, makes negative comments about the child's birth/adoptive family).
   g. Care provider undermines the child's identity (e.g., mocking the child for his/her background).

14) **Domestic violence currently exists in the household.**
   a. The child is or has been exposed to domestic violence in the household; OR
   b. Domestic violence among adults in the household is ongoing, and the child may or may not be aware of or involved in recent incidents.

C. Section 2. Interventions to improve safety and care

1. This section is completed only if one or more concerns are identified. If one or more concerns are present, it does not automatically follow that a child must be removed from the placement. In many cases, it will be possible to initiate a temporary plan that will mitigate the concern(s) sufficiently so that the child may remain in the home.
2. When there are safety concerns, the CFS Specialist completing the assessment must complete the interventions section.
3. The intervention list contains general categories of interventions rather than specific programs. The CFS Specialist should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the concern(s), and whether there is reason to believe the placement will follow through with a planned intervention. The CFS Specialist may determine that even with an intervention, the child would be unsafe, or the CFS Specialist may determine that an intervention would be satisfactory, but has reason to believe the placement would not follow through. The CFS Specialist must keep in mind that any single intervention may be insufficient to mitigate the concern(s), but a combination of interventions may provide adequate safety and care. Interventions are not intended to solve the household's problems or provide long-term answers. A plan permits a child to remain in the home while further issues are resolved.
4. The process of writing a plan to improve safety and care and selecting interventions should be a collaboration between the CFS Specialist and placement family, starting with consideration of the least intrusive interventions that make use of the family's strengths, and ending with a plan that is both feasible and effective while taking into account the family's view.
5. Interventions marked with an asterisk (*) should be used in combination with monitoring by the CFS Specialist or another person who has passed suitability.
   a. Interventions that utilize the families strengths:
   (1) **Use of family, neighbors or other individuals in the community as safety resources.** Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbors, or other individuals to mitigate safety concerns; agreement by a neighbor or relative to serve as a safety net for the child. An Assessment of Safety Plan Participants is REQUIRED for each person who will be engaged in this safety intervention.

(2) ***The care provider will appropriately protect the victim from the alleged perpetrator.** Care provider has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator.

(3) ***The alleged perpetrator will leave the household, either voluntarily or in response to legal action.** Removal of the allege perpetrator. Examples include arrest of alleged perpetrator, "kicking out" alleged perpetrator who has no legal right to residence, or perpetrator agrees to leave.

b. **Interventions that utilize community or agency resources.**

(1) **Intervention or direct services by CFS Specialist.** Actions taken or planned by the CFS Specialist or other agency/DHHS staff that specifically address one or more safety threats. Examples include providing information about nonviolent disciplinary methods, the child's developmental needs, or parenting practices; providing emergency material aid such as food; planning return visits to the home to check on progress; providing information on obtaining restraining orders; and providing definition of child abuse laws and informing involved parties of consequences of violating these laws. DOES NOT INCLUDE services provided to respond to family needs that do not directly affect safety.

(2) **Use of community agencies or services as safety resources.** Involving community-based organizations, faith-related organization, or other agency in activities to address safety concerns. DOES NOT INCLUDE long-term therapy or treatment or being put on a waiting list for services.

(3) **Other.** The family or CFS Specialist identified a unique intervention for an identified safety concern that does not fit within the items above.

c. **Placement change intervention.**
Removal from current placement is necessary because interventions above do not adequately ensure the child's safety. One or more children are removed from the current placement resource.

D. **Section 3: Placement Decision**

1. The placement decision is the result of careful consideration of the safety concerns and care concerns present and any available interventions taken or immediately planned by the care provider, community partners, or agency to protect the child. The CFS Specialist will collaborate with Resource Development on licensing and

placement and will identify the placement decision based on the CFS Specialist's independent assessment of all safety concerns, care concerns, interventions, and any other information known about the case.

2. The CFS Specialist will determine if the home is:
   a. **Safe and suitable**. Based on currently available information, there are no child concerns in this placement.
   b. **Conditionally safe and suitable.** Based on interventions, the child will remain in the household at this time. An intervention plan is required.
   c. **Unsafe or unsuitable; removal from the household is the only protective intervention possible for one or more children.** Without removal, one or more children will likely be in danger of serious harm or in an unsuitable care arrangement.
3. The CFS Specialist will document their conclusion to include the following in N-FOCUS in the APSS narrative:
   a. **Concerns:** The CFS Specialist will identify the safety and/or care concerns identified and briefly describe the specific individuals, behaviors, conditions, and/or circumstances associated with each particular concern.
   b. **Interventions:** The CFS Specialist will identify all interventions identified and how the intervention(s) will adequately and effectively mitigate all identified concerns.
   c. **Placement Decision:** The CFS Specialist will identify the placement decision made and briefly describe why this decision was selected.

E. **Intervention Plan:**

1. An intervention plan is required whenever the decision is conditionally safe and suitable. The following should be included in any plan which is written in a family friendly manner:
   a. A description of each safety and care concern.
   b. A detailed description for each planned intervention.
   c. A description of how the plan will be monitored (e.g., who is responsible for each intervention action).
   d. The plan should be signed by the family members, the CFS Specialist, and his/her supervisor.

The intervention plan MUST be completed with the care provider and a copy should be left with the family. The Intervention Plan is located on the last page(s) of the APSS, the CFS Specialist must print off the APSS in N-FOCUS in order to provide a copy with the family.

SDM ASSESSMENT OF PLACEMENT SAFETY AND SUITABILITY

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-2017	Effective

SDM HOUSEHOLDS

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SDM Assessments are completed on households. Do not consider employees (babysitter, nanny, etc.) to be household members. When a child's caregivers do not live together, the child may be a member of two households. If both households are involved in the report, both households should be assessed. In a situation in which multiple families share a home, consider the group to be one household if there is shared child care and/or shared access to children. For example, if two families share a house, and adults in both family groups have access to children in both families, assess the group as one household. However, if two families share a house with clear partitions of space and the ability to restrict access to children (e.g., locked doors between living area, separate entrances to the home, etc.), consider the families to comprise two separate households.

The CFS Specialist should keep in mind that during the course of a case, the number and configuration of households may change. For example, a case may begin with both parents living together with the child in the same household. At that point in time, they would be assessed as a single household, and the primary and secondary caregiver would be identified. If the parents separated while the child was in placement, and both parents were considered for reunification, then *two* assessments would become necessary, one for each household, with the legal parent as primary caregiver in each household.

There can be many family units in one household. When considering safety you assess everyone in the household.

Caregivers: The CFS Specialist should use the matrix below to assist in determining the primary and secondary caregivers.

Circumstance	Primary Caregiver	Secondary Caregiver
Two legal parents living together	Provides the most child care. May be 51% of care. • If care is divided precisely 50/50, select the alleged perpetrator. • If both are alleged perpetrators, select the caregiver contributing the most to abuse/neglect.	The other legal parent

	• If there is no alleged perpetrator or both contributed equally, pick either.	
Single legal parent, no other adult in the household	The only parent	None
Single legal parent and any other adult living in the household	The only legal parent	Another adult in the household who contributes the most to care of the child. If none of the other adults contribute to child care, there is no secondary caregiver.
No legal parents Assess only if this household will be engaged in services or is the subject of initial assessment.	The household adult who provides the most child care.	Another adult in the household who contributes the most to care of the child. If there are no other adults, or none contributes to child care, there is no secondary caregiver.

When a **minor parent** is living with his/her parent and the minor parent retains legal care and custody of the child, the minor parent should be considered the primary caregiver of his/her child. The minor parent's parent may be considered a secondary caregiver of the infant/young child.

If both the CP and the NCP have allegations of abuse or neglect the CFS Specialist will open separate households. If there are no allegations against the non-custodial parent there is no reason to open a household to conduct SDM Assessments on the non-custodial parent.

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-2017	Effective

SDM HOUSEHOLDS

SDM PREVENTION ASSESSMENT

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I. COMPLETING THE PREVENTION ASSESSMENT.

A. The prevention assessment is completed based on conditions that exist at the start of the initial assessment or referral to ongoing services. An SDM prevention assessment must be completed on each household that is involved in the referral

B. The CFS Specialist should refer to the policy definitions to determine his/her selection for each item.

C. **Section 1: Neglect/Abuse Index**

1. **P1. Prior investigations of any household adult**
   Assess prior DHHS or other CPS history. Determine if there are any prior intakes, excluding those accepted as dependency, Alternative Response, duplicate/multiple reports, information only, and law enforcement only, involving any adult members of the current household as alleged perpetrators for any type of neglect or abuse, regardless of finding. Keep in mind that one intake may involve multiple allegations and/or multiple children, but will still be counted as one intake. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect. Where possible, history from other jurisdictions should be included.
   Answer both P1a and P1b, indicating the number of prior neglect investigations and the number of prior abuse investigations.
   a. Neglect includes general neglect or abandonment, and if the caregiver is absent or incapacitated.
   b. Abuse includes physical abuse, emotional abuse, and sexual abuse/sexual exploitation.

P1. Prior investigations of any household adult	**Neglect Score**	**Abuse Score**
[ ] a. No	**-1**	**0**
[ ] b. Yes	**0**	**0**
P1a. Prior neglect (select one)		
[ ] a. None	**0**	**0**
[ ] b. One or Two	**2**	**0**
[ ] c. Three or More	**3**	**0**
P1b. Prior Abuse (select one)		
[ ] a. None	**0**	**0**
[ ] b. One	**1**	**1**
[ ] c. Two or More	**1**	**2**

2. **P2. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)**
   The CFS Specialist will mark "Yes" if this household previously had or currently has an open family preservation or foster care case as a result of a prior investigation. Include voluntary or court-ordered family services or foster care services; do not include delinquency, Alternative Response, status offense or dependency cases.

P2. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	3	2

3. **P3. Number of children in the household.**
   Determine the number of children under 19 years of age who live in the home, related or not. Include the following:
   a. An unborn child if the mother is in the last trimester of pregnancy;
   b. Children who have been removed from the home in the current referral;
   c. The legal children of any caregiver, even if that caregiver does not have full custody (e.g., if those children reside in the household less than 50% of the time).

   Do not include children who are not the legal responsibility of a household caregiver if they do not reside in the home full-time (e.g., an unrelated child who frequently stays in the home but has a permanent residence elsewhere).

P3. Number of child children in the Household.	Neglect Score	Abuse Score
[ ] a. One, two, or three	0	0
[ ] b. Four or more	2	0

4. **P4. Prior substantiated physical abuse**
   The CFS Specialist will mark "Yes" if any prior physical abuse investigation was substantiated for any current adult member of the household. The CFS Specialist will mark "No" if there is no history of substantiated physical abuse.

P4. Prior substantiated physical abuse	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	2

5. **P5. Age of youngest child in the home**
   The CFS Specialist will determine the current age of the youngest child presently in the household. If a child was removed as a result of the current referral, count the child as residing in the home.

P5. Age of youngest child in the home	Neglect Score	Abuse Score
[ ] a. 2 or older	0	0
[ ] b. Under 2	1	0

6. **P6. Characteristics of children in the household**
   The CFS Specialist will assess each child in the household and determine the presence of any of the following characteristics:
   a. **Medically fragile/failure to thrive.** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention (include also infants under six months of age with physical conditions requirement medical intervention if the condition is likely to persist for six months or more), or is diagnosed as failure to thrive. Requires medical documentation or credible report of professional diagnosis.

   The following characteristics may be present during the initial assessment, or may have been true for any child in the household at any time in the past.

   b. **Drug or alcohol exposure.** A child was affected by drugs or alcohol in utero or at birth as evidenced by maternal alcohol or drug use during pregnancy, OR any child had a positive toxicology report for alcohol or another drug at birth or at any time in the past.
   c. **Physical disability,** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include any credible information).
   d. **Developmental disability,** as evidenced by intellectual disability, learning disability, or other developmental problem including ADHD, that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
   e. **Delinquency history.** A child has been referred to juvenile court for delinquent or status offense behavior. Status offenses that are not brought to court attention but that create stress within the household should also be scored, such as children who run away or are habitually truant.
   f. **Current or previous mental health/behavior problems.** These are problems not related to a physical or developmental disability. This could be indicated by a current Diagnostic and Statistical Manual (DSM) diagnosis, received or receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking psychotropic medication. Exclude ADHD and use of related medications, which would be included in item “d”.
   g. **None of the above.** No characteristics are exhibited by any child in the household.

P6. Characteristics of children in the household	Neglect Score	Abuse Score
[ ] a. Medically fragile/failure to thrive	1	0
[ ] b. Drug or alcohol exposure	1	0
[ ] c. Physical disability	1	0
[ ] d. Developmental disability	0	1
[ ] e. Delinquency history	0	1
[ ] f. Current or previous mental health/behavior problems	0	1
[ ] g. None of the Above	0	0

7. **P7. Primary caregiver provides physical care consistent with each child's needs**
   The CFS Specialist will mark "Yes" if the caregiver is providing age-appropriate physical care that meets minimal standards for all children in the household. Examples may include the following:
   a. Obtaining standard immunizations. Do not mark cases in which the caregiver has made a choice not to immunize due to religious or philosophical convictions.
   b. Obtaining medical care for severe, chronic, or recurrent illness. Mark as "No" missed well-baby/child visits where there are concerns for infant/child health.
   c. Providing the child with adequate food.
   d. Providing the child with adequately clean, weather-appropriate clothing.
   e. Preventing or addressing rodent or insect infestations.
   f. Providing adequate housing with operative plumbing and electricity (heating and cooling).
   g. Ensuring that poisonous substances or dangerous objects are not within reach of a small child.
   h. Supporting or providing age/developmentally appropriate hygiene (bathing, brushing teeth, changing diapers).

P7. Primary caregiver provides physical care consistent with each child's needs service case due to child abuse or neglect (voluntary or court-ordered)	Neglect Score	Abuse Score
[ ] a. No	1	0
[ ] b. Yes	0	0

8. **P8. Primary caregiver characteristics**
   Assess the primary caregiver for each characteristic and mark all that apply.
   a. **Provides insufficient emotional/psychological support** to the child, such as persistently berating/belittling/demeaning the child, not attempting to bond with the child, or depriving the child of affection or emotional support.
   b. **Employs excessive/inappropriate discipline** that caused or threatened harm to the child because the actions were excessively harsh physically or emotionally

and/or inappropriate to the child's age or development. Examples may include the following:
(1) Locking the child in a closet or basement;
(2) Holding the child's hand over fire;
(3) Hitting the child with dangerous instruments; or
(4) Depriving a young child of physical and/or social activity for extended periods.

c. **Domineering parent,** indicated by controlling, abusive, overly restrictive, bullying, or over-reactive rules. This may be characterized by a caregiver seeing his/her own way as the only way or by little two-way communication between the caregiver and child.
d. **None of the above** characteristics are exhibited by the primary caregiver.

P8. Primary caregiver characteristics	**Neglect Score**	**Abuse Score**
[ ] a. One or more apply	**0**	**1**
[ ] Provides insufficient emotional/psychological support		
[ ] Employs excessive/inappropriate discipline		
[ ] Domineering parent		
[ ] b. None of the above	**0**	**0**

9. **P9. Primary caregiver has a past or current mental health problem**
The CFS Specialist will mark "Yes" if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:
a. Current DSM diagnosis by a mental health clinician;
b. Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; or
c. Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.

Do not include diagnoses of ADHD or learning disabilities (e.g., dyslexia).

P9. Primary caregiver has a past or current mental health problem	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes (mark all that apply)	**1**	**0**
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

10. **P10. Primary caregiver has past or current alcohol or drug problem that interferes with family functioning**
The CFS Specialist will assess whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Include abuse of alcohol and/or illegal substances, and abusive use of prescription drugs. Legal, non-abusive prescription drug or alcohol use should not be considered

an alcohol or drug problem. Assess for the following characteristics and mark all that apply:
Interference in function may be evidenced by the following:

a. Substance use that affects or affected the following:
   i. Employment;
   ii. Criminal involvement;
   iii. Marital or family relationships; or
   iv. Ability to provide protection, supervision, and care for the child.
b. An arrest or citation in the past for driving under the influence of drugs and/or alcohol, refusing breathalyzer testing, possession of a controlled substance or paraphernalia;
c. Self-report of a problem;
d. Treatment received currently or in the past;
e. Multiple positive toxicology screens;
f. Health/medical problems resulting from substance use; or
g. The child was diagnosed with fetal alcohol syndrome or exposure (FAS or FAE), or the child had a positive toxicology screen at birth <u>and</u> the primary caregiver was the birthing parent.

The CFS Specialist will select the following based on whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

P10. Primary caregiver has past or current alcohol or drug problem	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes	**2**	**1**
[ ] Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] Drugs (mark all that apply		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

11. **P11. Secondary caregiver has past or current alcohol or drug problem**
Applying the definition in P10 to the secondary caregiver, the CFS Specialist will select the following based on whether the secondary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

P11. Secondary caregiver has past or current alcohol or drug problem	**Neglect Score**	**Abuse Score**
[ ] a. No secondary caregiver	**0**	**0**
[ ] a. No	**0**	**0**

[ ] b. Yes	**0**	**1**
[ ] Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] Drugs (mark all that apply		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

12. **P12. Primary caregiver has a history of abuse or neglect as a child**
The CFS Specialist will mark "Yes" if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. Include disclosure of incidents that would be screened in for assessment now.

P12. Primary caregiver has a history of abuse or neglect as a child	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes	**2**	**1**

13. **P13. Primary caregiver has a criminal arrest history**
The CFS Specialist will indicate whether the primary caregiver has ever been arrested or convicted either as adult or as a juvenile. This includes DUI but exclude all other traffic offenses (e.g., willful-reckless driving, speeding, parking tickets; consider citations for window tint, driving without insurance and other non-moving violations as traffic offenses).

P13. Primary caregiver has a criminal arrest history	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes	**1**	**1**

14. **P14. Two or more incidents of domestic violence in the household in the past year.**
The CFS Specialist will mark "Yes" if credible statements by caregivers or others indicate that there have been two or more physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult in the past year. Include domestic violence involving minor parents if they are the primary or secondary caregiver. Do not include violence among other household members that does not involve primary and/or secondary caregivers. The CFS Specialist will use collaterals and/or supporting evidence in describing the item.

P14. Two or more incidents of domestic violence in the household in the past year.	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**

[ ] b. Yes	**0**	**1**

15. **P15. Housing**
The CFS Specialist will assess and determine the presence of any of the characteristics below and mark all that apply. If the agency or DHHS has already provided emergency services to address housing, assess housing as it was prior to the intervention. If the agency or DHHS helps the family move to a DV shelter as part of a Safety Plan, do not mark this item.
    a. **Current housing is physically unsafe,** such that it does not meet the health or safety needs of the child (e.g., exposed wiring; structurally unsafe conditions; unsafe/insufficient heating and cooling, and alternative safe arrangements have not been made; unsanitary plumbing; roach/rat infestations; human/animal waste on floors or other household surfaces; rotting food); **or family is homeless** or has received an eviction notice at the time of the referral. Include families who are living in temporary shelter. If the caregiver is unsure of the family's living situation or family considers themselves homeless, endorse this item.
    b. **Family has housing that is physically safe.**

P15. Housing	**Neglect Score**	**Abuse Score**
[ ] a. Current housing is physically unsafe or family is homeless	**2**	**0**
[ ] b. Family has housing that is physically safe	**0**	**0**

D. Section 2: Scoring and Overrides

- **Scoring Individual Items**:
    a. A score for each assessment item is derived from the CFS Specialist's observation of the characteristics it describes. Some characteristics are objective (such as prior child abuse/neglect history or the age of the child). Others require the CFS Specialist to use discretionary judgment based on his/her assessment of the family.
    b. Sources of information used to determine the CFS Specialist's endorsement of an item may include statements made by the child, caregiver, or collateral persons; CFS Specialist observations; reports; or other reliable sources. The CFS Specialist should refer to the definitions to determine his/her selection for each item.
    c. After all index items are scored, the CFS Specialist totals the scores and indicates the corresponding prevention level of each index. Next, the scored prevention level (whichever is higher of the abuse or neglect index) is entered.

Neglect Score	**Abuse Score**	**Prevention Level**
-1-0	0-1	Low
1-3	2-4	Moderate
4-8	5-8	High

9+	9+	Very High

- **Overrides:**
  a. After completing the prevention assessment, the CFS Specialist determines if any of discretionary overrides exist. The prevention assessment does not have any policy overrides.
  b. A discretionary override is applied by the CFS Specialist to increase the prevention level in any case in which the CFS Specialist believes that the prevention level set by the prevention assessment is too low. This may occur when the CFS Specialist is aware of conditions affecting the likelihood of future harm that are not captured within the items on the prevention assessment. Discretionary overrides may increase the prevention level by one unit (for example, from low to moderate OR moderate to high, but NOT from low to high).
  c. After completing the Override section, the CFS Specialist will indicate the final prevention level, which is the highest of the scored level, or discretionary override level.
  d. The prevention level informs the decision to open an ongoing services case.

Note: Alternative Response policy will be used in Alternative Response Cases regarding recommendations.

Final Prevention Level	Recommendation
Low	Recommend for referral*#
Moderate	Recommend for referral*#
High	Ongoing services needed
Very High	Ongoing services needed
**Low and moderate risk cases must be recommended for ongoing services if the most recent SDM safety assessment finding was conditionally safe or unsafe.*	

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-17	Effective

SDM RISK ASSESSMENT

DHHS.PSPolicyandGuid@nebraska.gov

I. COMPLETING THE RISK ASSESSMENT.

A. The risk assessment is completed based on conditions that exist at the start of the initial assessment.

B. The CFS Specialist will refer to the definitions to determine his/her selection for each item.

C. **Section 1: Neglect/Abuse Index**

1. **R1. Current report is for.**
   The CFS Specialist will determine if the report that led to the current referral or DHHS investigation is for abuse, neglect, or both. Neglect includes general neglect, abandonment, and caregiver absence/incapacity. Abuse includes physical abuse, emotional maltreatment and/or exploitation, or sexual abuse/sexual exploitation. *Neither category includes dependency.*

   Include reported allegations as well as allegations added by DHHS during the course of the initial assessment.

R1. Current report is for	Neglect Score	Abuse Score
[ ] a. Neglect	1	0
[ ] b. Abuse	0	1
[ ] c. Both	1	1

2. **R2. Prior investigations of any household adult**
   Assess prior DHHS or other CPS history. Determine if there are any prior intakes, excluding those accepted as dependency, alternative response, duplicate/multiple reports, information only, and law enforcement only, involving any adult members of the current household as alleged perpetrators for any type of neglect or abuse, regardless of finding. One intake may involve multiple allegations and/or multiple children, but will still be counted as one intake. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect. Where possible, history from other jurisdictions should be included.

   If yes, answer both R2a and R2b, indicating the number of prior neglect investigations and the number of prior abuse investigations.
   a. Neglect includes general neglect or abandonment, and if the caregiver is absent or incapacitated.
   b. Abuse includes physical abuse, emotional abuse, and sexual abuse/sexual exploitation.

R2. Prior investigations of any household adult	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	1	0

R2a. Prior Neglect		
[ ] a. None	**0**	**0**
[ ] b. One	**1**	**0**
[ ] c. Two	**1**	**0**
[ ] d. Three or more	**2**	**0**
R2b. Prior Abuse		
[ ] a. None	**0**	**0**
[ ] b. One	**0**	**1**
[ ] c. Two or more	**0**	**2**

3. **R3. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)**
   The CFS Specialist will mark "Yes" if this household previously had or currently has an open family preservation or foster care case as a result of a prior investigation. Include voluntary or court-ordered family services or foster care services; do not include delinquency, status offense, alternative response or dependency cases.

R3. Household previously had an open ongoing service case due to child abuse or neglect (non-court (voluntary) or court-ordered)	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes	**1**	**1**

4. **R4. Number of child victims involved in the current child abuse or neglect incident**
   Determine the number of children under 19 years of age for whom abuse or neglect was alleged or substantiated in the current investigation. Only include the number of children listed on the intake who have allegations. If it is discovered that other children are victims, they would need to be added to the intake and counted.

R4. Number of child victims involved in the current child abuse or neglect incident	**Neglect Score**	**Abuse Score**
[ ] a. One, two, or three	**0**	**0**
[ ] b. Four or more	**1**	**0**

5. **R5. Prior injury to any child in household resulting from child abuse or neglect**
   The CFS Specialist will mark "Yes" if any child sustained an injury resulting from abuse and/or neglect prior to the referral that resulted in the current investigation. Injury sustained as result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn. Prior injury may or may not have been subject to a child protection investigation. Include prior substantiated injuries and credible report of prior injuries, but exclude accidental injuries.

R5. Prior injury to any child in household resulting from child abuse or neglect	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	1

6. **R6. Age of youngest child in the home**
   The CFS Specialist will determine the current age of the youngest child presently in the household where the child abuse or neglect incident reportedly occurred. If a child was removed as a result of the current investigation, count the child as residing in the home.

R6. Age of youngest child in the home	Neglect Score	Abuse Score
[ ] a. 2 or older	0	0
[ ] b. Under 2	1	0

7. **R7. Characteristics of children in the household**
   The CFS Specialist will assess each child in the household and determine the presence of any of the following characteristics. These characteristics are separate and distinct from the child vulnerabilities on the safety assessment. Diagnoses are required where indicated. Diagnoses must be listed as a current Diagnostic and Statistical Manual (DSM) diagnosis.
   1. **Medically fragile/failure to thrive.** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention, or is diagnosed as failure to thrive. Requires medical documentation or credible report of professional diagnosis.

   The following characteristics may be present during the initial assessment, or may have been true for any child in the household at any time in the past.

   b. **Positive toxicology,** any child had a positive toxicology report for alcohol or another drug at birth or at any time in the past. The child need not have been born in the current incident or during the initial assessment.
   c. **Physical disability,** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include any credible information).
   d. **Developmental disability,** as evidenced by intellectual disability, learning disability, or other developmental problem including ADHD, that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
   e. **Delinquency history.** A child has been referred to juvenile court for delinquent or status offense behavior. Status offenses that are not brought to court attention but that create stress within the household should also be scored, such as children who run away or are habitually truant.
   f. **Current or previous mental health/behavior problems.** These are problems not related to a physical or developmental disability. This could be indicated by a current Diagnostic and Statistical Manual (DSM) diagnosis, received or receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking psychotropic medication. Exclude ADHD and use of related medications, which would be included in item “d”.

g. **None of the above.** No characteristics are exhibited by any child in the household.

R7. Characteristics of children in the household	Neglect Score	Abuse Score
[ ] a. Medically fragile/failure to thrive	1	0
[ ] b. Positive toxicology screen at birth	1	0
[ ] c. Physical disability	1	0
[ ] d. Developmental disability	0	1
[ ] e. Delinquency history	0	1
[ ] f. Current or previous mental health/behavior problems	0	1
[ ] g. None of the above	0	0

8. **R8. Primary caregiver's assessment of incident**
   The CFS Specialist will assess for each characteristic and mark all that apply.
   a. **Blames child.** Blaming refers to caregiver's statement that the maltreatment incident occurred because of the child's action or inaction (e.g., claiming that the child seduced him/her, or the child's misbehavior forced caregiver to beat him/her). Exclude situations in which the caregiver claims that one child injured another child or in which the caregiver claims that the child injured him/herself.
   b. **Justifies maltreatment of the child.** Justifying refers to caregiver's statement that his/her action or inaction, which resulted in harm to the child, was appropriate and constitutes good parenting (e.g., claiming that this form of discipline was how the caregiver was raised, so it is all right).
   c. **None of the above** characteristics are applicable.

R8. Primary caregiver's assessment of incident	Neglect Score	Abuse Score
[ ] a. Blames child	0	1
[ ] b. Justifies maltreatment of the child	0	2
[ ] c. None of the above	0	0

9. **R9. Primary caregiver provides physical care consistent with each child's needs**
   The CFS Specialist will mark "Yes" if the caregiver is providing age-appropriate physical care that meets minimal standards for all children in the household. Examples may include the following:
   a. Obtaining standard immunizations. Do not mark cases in which the caregiver has made a choice not to immunize due to religious or philosophical convictions.
   b. Obtaining medical care for severe, chronic, or recurrent illness. Mark as "No" missed well-baby/child visits where there are concerns for infant/child health.
   c. Providing the child with adequate food.
   d. Providing the child with adequately clean, weather-appropriate clothing.
   e. Preventing or addressing rodent or insect infestations.
   f. Providing adequate housing with operative plumbing and electricity (heating and cooling).

g. Ensuring that poisonous substances or dangerous objects are not within reach of a small child.
h. Supporting or providing age/developmentally appropriate hygiene (bathing, brushing teeth, changing diapers).

R9. Primary caregiver provides physical care consistent with each child's needs	**Neglect Score**	**Abuse Score**
[ ] a. No	**1**	**0**
[ ] b. Yes	**0**	**0**

10. **R10. Primary caregiver characteristics**
Assess the primary caregiver for each characteristic and mark all that apply.
a. **Provides insufficient emotional/psychological support** to the child, such as persistently berating/belittling/demeaning the child, not attempting to bond with the child, or depriving the child of affection or emotional support.
b. **Employs excessive/inappropriate discipline** that caused or threatened harm to the child because the actions were excessively harsh physically or emotionally and/or inappropriate to the child's age or development. Examples may include the following:
(1) Locking the child in a closet or basement;
(2) Holding the child's hand over fire;
(3) Hitting the child with dangerous instruments; or
(4) Depriving a young child of physical and/or social activity for extended periods.
c. **Domineering parent,** indicated by controlling, abusive, overly restrictive, bullying, or over-reactive rules. This may be characterized by a caregiver seeing his/her own way as the only way or by little two-way communication between the caregiver and child.
d. **None of the above** characteristics are exhibited by the primary caregiver.

R10. Primary caregiver characteristics	**Neglect Score**	**Abuse Score**
[ ] a. Provides insufficient emotional/psychological support	**0**	**1**
[ ] b. Employs excessive/inappropriate discipline	**0**	**1**
[ ] c. Domineering parent	**0**	**1**
[ ] d. None of the above	**0**	**0**

11. **R11. Primary caregiver has a past or current mental health problem**
The CFS Specialist will mark "Yes" if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:
a. Current DSM diagnosis by a mental health clinician;
b. Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; **or**

c. Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.

Do not include diagnoses of ADHD or learning disabilities (e.g., dyslexia).

If the CFS Specialist selects "Yes", documentation must reflect details as to how the CFS Specialist made their determination (i.e., parent reported specific diagnosis and was able to provide information on the doctor, medications, treatment etc.)

If the CFS Specialist selects "No", documentation must include references to collaterals or supporting evidence (e.g., spouse, parent, children, friends, NDEN) that no one indicated that mental health has been an issue.

R11. Primary caregiver has a past or current mental health problem	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes (mark all that apply)	**1**	**0**
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

12. **R12. Primary caregiver has past or current alcohol or drug problem that interferes with family functioning**

The CFS Specialist will assess whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Include abuse of alcohol and/or illegal substances, and abusive use of prescription drugs. Legal, non-abusive prescription drug or alcohol use should not be considered an alcohol or drug problem. The CFS Specialist will assess for the following characteristics using the definitions and mark all that apply:

Interference in function may be evidenced by the following:

a. Substance use that affects or affected the following:
   i. Employment;
   ii. Criminal involvement;
   iii. Marital or family relationships; or
   iv. to provide protection, supervision, and care for the child.
b. An arrest or citation for driving under the influence of drugs and/or alcohol, refusing breathalyzer testing, possession of a controlled substance or paraphernalia (this includes situations when the individual was not charged or the charge was dismissed);
c. Self-report of a problem;
d. Treatment received currently or in the past;
e. Multiple positive toxicology screens;
f. Health/medical problems resulting from substance use; or
g. The child was diagnosed with fetal alcohol syndrome or exposure (FAS or FAE), or the child had a positive toxicology screen at birth <u>and</u> the primary caregiver was the birthing parent.

The CFS Specialist will select the following based on whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

R12. Primary caregiver has past or current alcohol or drug problem	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Alcohol (mark all that apply)	**1**	**0**
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] c. Drugs (mark all that apply)	**1**	**0**
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

13. **R13. Secondary caregiver has past or current alcohol or drug problem**
    Applying the definition in R12 to the secondary caregiver, assess for the following characteristics and mark all that apply.

R13. Secondary caregiver has past or current alcohol or drug problem	**Neglect Score**	**Abuse Score**
[ ] a. No secondary caregiver	**0**	**0**
[ ] b. No	**0**	**0**
[ ] c. Yes	**0**	**1**
Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
Drugs (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

14. **Primary caregiver has a history of abuse or neglect as a child**
    The CFS Specialist will mark "Yes" if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. The alleged abuse or neglect does not need to have happened by the adult's caregiver/parent. Include disclosure of incidents that would be screened in for assessment now.

R14. Primary caregiver has a history of abuse or neglect as a child	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes	**0**	**1**

15. **R15. Two or more incidents of domestic violence in the household in the past year**
    The CFS Specialist will mark "Yes" if credible statements by caregivers or others indicate that there have been two or more physical assaults and/or periods of intimidation/threats/harassment between caregivers, or between a caregiver and

another adult, in the past year. Instances of domestic violence that occur outside the physical household structure (i.e. bar) or with any of the current household members will be included in the count. The CFS Specialist will use collaterals and/or supporting evidence in describing the item.

R15. Two or more incidents of domestic violence in the household in the past year	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	2

16. **R16. Housing**

The CFS Specialist will assess and determine the presence of any of the characteristics below and mark all that apply. If the agency or DHHS has already provided emergency services to address housing, assess housing as it was prior to the intervention. If the agency or DHHS helps the family move to a DV shelter as part of a Safety Plan, do not mark "a" or "b" in this item.

a. **Current housing is physically unsafe,** such that it does not meet the health or safety needs of the child (e.g., exposed wiring; structurally unsafe conditions; unsafe/insufficient heating and cooling, and alternative safe arrangements have not been made; unsanitary plumbing; roach/rat infestations; human/animal waste on floors or other household surfaces; rotting food).
b. **Homeless at time the investigation began,** or about to be evicted at the time the investigation began. Include families who are living in temporary shelter. If the caregiver is unsure of the family's living situation or family considers themselves homeless, endorse this item.
c. **Family has housing that is physically safe.**

R16. Housing (mark all that apply)	Neglect Score	Abuse Score
[ ] a. Current housing is physically unsafe	1	0
[ ] b. Homeless at time the investigation began	2	0
[ ] c. Family has housing that is physically safe	0	0

D. **Section 2: Scoring and Overrides**

1. **Scoring Individual Items**:
   a. A score for each assessment item is derived from the CFS Specialist's observation of the characteristics it describes. Some characteristics are objective (such as prior child abuse/neglect history or the age of the child). Others require the CFS Specialist to use discretionary judgment based on his/her assessment of the family.
   b. Sources of information used to determine the CFS Specialist's endorsement of an item may include statements made by the child, caregiver, or collateral persons; CFS Specialist observations; reports; or other reliable sources. The CFS Specialist should refer to the definitions to determine his/her selection for each item.

c. After all index items are scored, the CFS Specialist totals the scores and indicates the corresponding risk level of each index. Next, the scored risk level (whichever is higher of the abuse or neglect index) is entered.

Neglect Score	**Abuse Score**	**Risk Level**
0-1	0-1	Low
2-4	2-4	Moderate
5-8	5-7	High
9+	8+	Very High

2. **Policy Overrides:** After completing the risk assessment, the CFS Specialist determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns, and have been determined to warrant a risk level designation of very high regardless of the risk level indicated by the assessment. **Note: Mark each policy override that is present:**
   a. Sexual abuse case AND the perpetrator is likely to have access to the child. This override only applies if it happened within the review period.
   b. Non-accidental injury to a child under age 2. This override only applies if it happened within the review period.
   c. Severe non-accidental injury. This override only applies if it happened within the review period.
   d. Caregiver action or inaction resulted in death of a child due to abuse or neglect. This policy override is considered over the lifetime of the case. If the caregiver ever caused a child death either by action or inaction this policy override will be selected.

3. **Discretionary Override:** A discretionary override is applied by the CFS Specialist to increase the risk level in any case in which the CFS Specialist believes that the risk level set by the risk assessment is too low.
   a. This may occur when the CFS Specialist is aware of conditions affecting risk that are not captured within the items on the risk assessment.
   b. Discretionary overrides may increase the risk level by one unit (for example, from low to moderate risk OR moderate to high risk, but NOT from low to high risk).
   c. After completing the Override section, the CFS Specialist will indicate the final risk level, which is the highest of the scored risk level, policy override risk level (which is always very high), or discretionary risk level.
   d. The risk level informs the decision to open an ongoing services case.

Final Risk Level	Recommendation
Low	Close Case*
Moderate	Close Case*
High	Ongoing services needed
Very High	Ongoing services needed

**Low and moderate risk cases must be recommended for ongoing services if the most recent SDM safety assessment finding was conditionally safe or unsafe.*

II. DETERMINING RISK ASSESSMENT RESPONSE.

Following the completion of the safety and risk assessments, the CFS Specialist determines the DCFS response. The response by DCFS must be the least intrusive, most appropriate level of service necessary to meet the identified needs of the family.

A. An on-going case will be opened based on the following:
   1. Families with an unsafe or conditionally safe child; and/or
   2. Families at high or very high risk for future child abuse or neglect of their children; and/or
   3. Families with court ordered DHHS involvement regardless of Safety/Risk Assessment determinations.

Ongoing cases may be court or non-court involved. All ongoing cases will be assessed to determine if a child or family is Native American. If a child is identified or is believed to be Native American, the CFS Specialist will send Non-Court or Court Notice to the Tribe(s) and follow all ICWA procedures described in the Indian Child Welfare Act Operations Manual.

SUMMARY OF REVISIONS	
DATE	REVISION
11-08-2017	Effective

SDM SAFETY ASSESSMENT

DHHS.PSPolicyandGuid@nebraska.gov

I. SDM Safety Assessment Overview.

A. The purpose of the safety assessment is to assess whether a household presents imminent **danger of serious harm** to any child, and if so, to determine what interventions should be initiated or maintained to provide appropriate protection or if protective placement is necessary.

B. **Safety versus risk assessment:** It is important to keep in mind the difference between safety and risk when completing this assessment. The safety assessment focuses on the serious and imminent threat of harm to the child in the household and the interventions currently needed to protect the child. The risk assessment looks at the likelihood of **future** maltreatment in the next year to two years.

C. The CFS Specialist will conduct the safety assessment when a report of child abuse or neglect has been accepted for assessment. If both the Custodial Parent (CP) and the Non-Custodial Parent (NCP) have allegations of abuse or neglect the CFS Specialist will open separate households and complete the safety and risk assessment for each home and provide services as necessary. The first safety assessment is completed by the CFS Specialist assigned to conduct the initial assessment with the family. If subsequent new reports are accepted for assessment the Service Area will develop protocols to determine if an Initial Assessment worker or the CFS Specialist responsible for the case will conduct a safety assessment. Safety reassessments are completed by the CFS Specialist responsible for the case at any time a change in safety status is noted.

D. During an initial assessment and throughout the case, more than one safety assessment may be required, due to changes in family circumstances. The safety assessment *process is required:*

1. At the first face-to-face contact with the family in the initial assessment;
2. When a new allegation of abuse or neglect involving the caregiver's household is received on an open case;
3. Whenever new information becomes available or family conditions change;
4. Prior to recommending case closure when the initial safety finding was unsafe or conditionally safe.

II. Completing the Safety Assessment:

A. **Child Vulnerabilities**. The CFS Specialist will consider the vulnerability of each child throughout the assessment. Young children cannot protect themselves. For older children, the inability to protect themselves could result from diminished mental or physical capacity, or repeated victimization. The following conditions may result in a child's inability to protect self. The CFS Specialist will select all vulnerabilities that apply to any child.

1) Age 6 and under: Any child in the household is under the age of 7 years. Younger children are considered more vulnerable, as they are less verbal and less able to

protect themselves from harm. Younger children also have less capacity to retain memory of events. Infants are particularly vulnerable, as they are nonverbal and completely dependent on others for care and protection.

2) Significant diagnosed medical or mental disorder that significantly impairs ability to protect self: Any child in the household who has a diagnosed medical or mental disorder that significantly impairs their ability to protect self from harm, or diagnosis may not yet be confirmed but preliminary indications are present and testing/evaluation is in process. Examples may include but are not limited to severe asthma, severe depression, severe ADHD, medically fragile (e.g., requires assistive devices to sustain life), etc. For developmental disabilities, mark the item for "diminished developmental/cognitive capacity."
3) Isolated or less visible in the community: Examples of children who are isolated or less visible in the community include but are not limited to any child of school age who is not currently enrolled in school or is enrolled but habitually absent, a child whose family lives in an isolated or remote community, a child who is not routinely involved in other activities within the community, etc.
4) Extreme allegiance to the alleged perpetrator: Any child in the household would be unable to protect him/herself or to assist others in acts of protection due to allegiance to the alleged perpetrator. Examples include children who prioritize protecting the caregiver over protecting themselves.
5) Diminished developmental/cognitive capacity: Any child in the household has diminished developmental/cognitive capacity, which impacts ability to communicate verbally or to care for and protect self from harm. Examples include but are not limited to autism, language disability, fetal alcohol effect, etc.
6) Diminished physical capacity: Any child in the household has a physical condition/disability that impacts ability to protect self from harm (e.g., cannot run away or defend self, cannot get out of the house in an emergency situation if left unattended).
7) Prior history of abuse/neglect as a victim that impacts child's ability to protect self: Any child in the household has previously been the victim of abuse or neglect AND this prior experience negatively affects that child's ability to protect him/herself in the current situation. Include both substantiated prior assessments or credible report.

B. **Section 1: Safety Threats:** The CFS Specialist will use the definitions below to assess the following behaviors or conditions in the household that may place a child in immediate danger of serious harm. **The CFS Specialist will analyze and answer each safety threat as it relates to the most vulnerable child.**

1) **Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm, as indicated by any of the following:**
   a. Current serious injury or abuse to the child other than accidental. Caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health

or well-being of the child (e.g., suffocating, shooting, bruises/welts, bite marks, choke marks) and requires medical treatment. Medical treatment is defined as going to a doctor or hospital. Include serious child injuries that result from domestic violence.
Treatment that can be accomplished by a lay person in the home such as bandaging or icing should not be included as medical treatment. This threat is not met if the parent takes the child to the doctor/hospital but it was not necessary (such as the child has a scratch).

b. Caregiver fears he/she will physically harm the child and/or requests placement.
c. Current threat to cause serious harm or retaliate against the child. Threat of action that would result in serious harm, or household member plans to retaliate against the child for DHHS investigation or intervention.
d. Current excessive discipline or physical force. Caregiver has used torture or physical force, or has acted in a way that bears no resemblance to reasonable discipline; or he/she punished the child beyond the child's endurance. Examples include but are not limited to having the child kneel on rice or hold phone books with extended arms as punishment.
e. Drug-exposed infant. There is evidence that the mother used alcohol or other drugs during pregnancy AND this has created imminent danger to the infant.
   (1) Indicators of drug use during pregnancy include drugs found in the mother's or child's system, mother's self-report, diagnosed high risk pregnancy due to drug use, efforts on mother's part to avoid toxicology testing, withdrawal symptoms in mother or child, and pre-term labor due to drug use.
   (2) Indicators of imminent danger include the level of toxicity and/or type of drug present; the infant is diagnosed as medically fragile as a result of drug exposure; the infant suffers adverse effects from introduction of drugs during pregnancy.
f. Domestic violence likely to physically injure child. Domestic violence involves physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult. Include situations in which a child has already been injured, even if the intended victim of harm was not the child. Threat of physical harm to a child includes child behaviors that increase the risk of injury (e.g., attempting to intervene during violent dispute, participating in a violent dispute, clinging to an adult involved in the violent dispute), and the use of weapons or other instruments in a violent, threatening, and/or intimidating manner.

2) **Child sexual abuse is suspected and circumstances suggest that the child's safety may be of immediate concern.** To mark this safety threat, TWO conditions must be present: 1) suspicion and 2) circumstances. Consider the vulnerability of the alleged child victim, vulnerability of other children in the home, and the relationship of alleged perpetrator to other children in the home.

Suspicion of sexual abuse may be indicated by any of the following: • The child discloses sexual abuse either verbally or behaviorally (e.g., age-inappropriate sexualized behavior toward self or others). • Medical findings are consistent with molestation. • A possible or confirmed sexual perpetrator has access to any child in the household. Include any person (household member or not) who has been convicted, investigated, or accused of any sexual crime, or who has had other sexual contact with any child. • Caregiver or another household member has forced or encouraged any child in the household to engage in or observe sexual performances or activities.	**AND** An immediate concern for child safety may be characterized or indicated by the following: • Non-offending caregiver has expressed disbelief that sexual abuse occurred and appears unable or unwilling to prevent access to child by alleged perpetrator. • Alleged perpetrator refuses to leave the home or limit contact with alleged victim and siblings. • Child expresses fear that maltreatment will recur.

3) **Caregiver does not/is unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.** The CFS Specialist will select this threat when there is current harm or an identified current threat of harm to a child **and** the caregiver does not take action.

Current harm or an identified threat may be indicated by the following: • An alleged perpetrator of abuse who is not the caregiver. • An individual with known violent criminal behavior/history resides in the home, or caregiver allows access to the child. Caregiver may or may not know about the individual's history.	**AND** Caregiver does not or is unable to protect the child from serious harm or threatened harm by other family members, other household members, or others having access to the child. Caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age, emotional or physical disability, or developmental stage.

• Include homes where gang activity occurs or where there is criminal activity in the home.	

4) **Caregiver's explanation for current injury to the child is questionable or inconsistent with the type of injury, <u>and</u> the nature of the injury suggests that the child's safety may be of immediate concern.**

Evidence of questionable or inconsistent explanation includes the following: • Medical evaluation indicates that the injury is a result of abuse; however, caregiver denies, or attributes injury to accidental causes. • Caregiver's explanation for the observed injury is inconsistent with the type of injury. • Caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child. • Caregiver does not or cannot explain injury when there is a reasonable expectation that the caregiver should know (e.g., caregiver is sole person caring for the infant; caregiver states that child has not been out of his/her supervision during time that injury occurred).	**AND** When determining if the nature of the injury suggests that safety is of immediate concern, consider the vulnerability of the child, location and/or severity of injury, physical or emotional disability of the child, and chronicity of injuries.

5) **The family actively impedes assessment by denying access to the child, coercing or coaching the child, or fleeing with the child.** Do not include families who are uncooperative or non-compliant with assessment requests and/or court orders or a caregiver who is uncooperative with safety planning. In such cases, consider other threats to child safety.
   a. Family currently refuses or does not provide access to the child, or cannot or will not provide the child's location.
   b. Family has removed the child from a hospital against medical advice to avoid assessment/investigation.

c. Family has previously fled in response to a CPS investigation, or has previously fled with a child during visitation.
d. Family has a history of keeping the child at home or away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding assessment.
e. Caregiver intentionally coaches or coerces the child or allows others to coach or coerce the child in an effort to hinder the assessment.

If the family will not allow the CFS Specialist to see the child at all or if the family coaches the child to give false information, the threat is present.

The threat is NOT present if:

a. The caregiver denies that maltreatment is occurring (despite evidence to the contrary);
b. The caregiver is reluctant to allow the child to be interviewed but relents during the contact and permits it;
c. The caregiver refuses to allow the CFS Specialist to take a follicle sample for testing;
d. The caregiver refuses to participate in safety planning regarding another safety threat;
e. The caregiver repeatedly delays efforts to contact and/or evaluate the family but the child is seen.

6) **Caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care. Needs may be basic or exceptional.**
   a. Caregiver does not attend to the child to the extent that the need for care goes unnoticed or unmet (e.g., caregiver is present but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).
   b. Caregiver leaves the child alone (time period varies with age, physical or emotional disability, and developmental stage).
   c. Caregiver makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.
   d. Minimal nutritional, clothing, and/or supervisory needs of the child are not met, resulting in danger to the child's health and/or safety.
   e. Child appears malnourished (e.g., child is listless and has difficulty concentrating; child or caregiver discloses inadequate nutritional practices).
   f. The child is without minimally acceptable clothing for the weather and environment.
   g. Caregiver does not seek treatment for the child's immediate, chronic, and/or dangerous medical/mental health condition(s) or does not follow prescribed treatment for such conditions, and lack of treatment presents an imminent and serious threat to child safety.
   h. The child has exceptional needs, such as being medically fragile, which caregiver does not or cannot meet.

i. The child is violent, assaultive, or suicidal and caregiver will not/cannot take protective action.
j. The child shows effects of maltreatment such as serious emotional symptoms, lack of behavioral control, or serious physical symptoms.

Situations of abandonment or desertion are included in safety threat 7 and should not be marked as part of item 6.

7) **Caregiver is not available, is unwilling to provide care, or has deserted the child.** Examples of desertion include but are not limited to the following:
   a. Caregiver is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).
   b. The caregiver left a child unattended, the child is unable to identify him/herself, and there is no evidence with which to identify the child's family.
   c. The caregiver left the child unattended or in the temporary care of an adult caregiver, and it is not known where the caregiver is or if the caregiver will return.
   d. There is evidence that the caregiver will no longer parent and will not assume further responsibility for the child (e.g., does not pick up child who is ready to be discharged from hospital or juvenile detention, the caregiver demands a child removal, child "evicted" from family home). For whatever reason, the parent ceases parental responsibilities.

   This threat does not include educational neglect.

8) **The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.** Based on the child's vulnerability, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:
   a. Leaking gas from stove or heating unit;
   b. Substances or objects accessible to the child that may endanger his/her health and/or safety (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities; unsecured weapons);
   c. Lack of water or utilities (heat, plumbing, electricity), and no alternate, safe provisions are made;
   d. Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows;
   e. Exposed electrical wires;
   f. Excessive garbage or rotted or spoiled food that threatens health;
   g. Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites, severe infestation of pests including cockroaches and bedbugs causing negative medical/health effects);
   h. Evidence of human or animal waste throughout living quarters.

9) **Child shows signs of significant emotional harm that present an imminent threat to child safety and concerning caregiver behaviors are currently present.**
Note: Child behaviors that indicate mental health or disability concerns that are not being addressed should be addressed under safety threat 6.

Indicators of significant emotional harm to the child include the following: • The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations in household. • The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of conditions in the home. • Child is a danger to self or others, is acting out aggressively, is suicidal, or otherwise exhibits severe emotional disturbance.	**AND** Examples of caregiver behaviors include the following (indicate all that apply): • Domestic violence among adults is present in the household. Domestic violence may involve physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult. • Caregiver behavior towards the child. The caregiver may do any of the following: • Describe the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly); • Curse at the child and/or repeatedly put the child down; • Scapegoat a particular child in the family; • Blame the child for a particular incident or for family problems; • Place the child in the middle of a custody battle; or • Choose his/her own relationships with an intimate partner above child's emotional safety.

10) **Child behaviors place the child at imminent threat of serious harm, in spite of appropriate response by caregiver(s).**
To mark this threat, all three of the following conditions **must** be present:

The child is currently engaging in or habitually engages in behaviors that place him/her at	**AND** The child's caregiver(s) have responded appropriately and made reasonable	**AND** The caregiver's current efforts, although appropriate, are insufficient to prevent

imminent risk of serious harm. Examples include but are not limited to children who run away from home and place themselves in unsafe living/sleeping situations, children who engage in prostitution, and children who engage in self-harming behaviors, such as cutting, that require medical intervention.	efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child, and increasing direct supervision and monitoring of the child.	the child from engaging in the behavior in the future.

11) **There is a pattern of prior CPS investigations of household members as alleged perpetrators, protective placements, or caregiver behavior <u>and</u> current circumstances are near the definition for any other safety threat.**

A pattern may be established by any of the following: • Prior death of a child as a result of action or inaction of current household members. • Prior serious harm to a child: Previous maltreatment by caregiver or other household adult that was serious enough to cause severe injury (e.g., fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks, and/or physical findings consistent with sexual abuse based on medical exam). • Termination of parental rights: Caregiver had parental rights terminated as a result of a prior CPS investigation. • Prior removal of the child from caregiver: Removal/placement of the child by DHHS or other responsible party was	**AND** Current circumstances are concerning, but not sufficiently imminent or serious to warrant the marking of another safety threat. Examples include but are not limited to the following: • Child has a physical injury that is not serious or that does not warrant medical attention. • Child sometimes does not have sufficient nutrition, but malnourishment is not yet a concern.

necessary for the safety of the child. • Prior CPS substantiation: Prior CPS investigation involving current household adults substantiated for maltreatment. • A pattern of unsubstantiated CPS investigations for any household adult. • Prior threat of serious harm to child by any household adult: Previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against the child for previous incidents; or prior domestic violence that resulted in serious harm or threatened harm to a child. • Prior service failure: Caregiver previously failed to successfully complete court-ordered or previously recommended services.	

12) Other. If, after careful review of the definitions for the other 11 safety threats, the CFS Specialist feels there is something unique in this family that was not captured in any other safety threat, the CFS Specialist should select “other” and document the identified unique safety threat that, if not resolved immediately, would lead to removal of a child in this home.

The CFS Specialist will utilize “other” when methamphetamine use by the parent or caregiver has been identified. The CFS Specialist will document the supporting evidence for selection of this safety threat.

If the CFS Specialist is unable to identify the perpetrator and there is a severe injury there is an active safety threat. The CFS Specialist should start to rule out people that they know did not cause the injury and then safety plan from there.

Safety Assessment decisions are based on what the CFS Specialist knows at a point in time, so the CFS Specialist will make the best informed decision they can with the

information they have available to them. Safety decisions can/may change as more information becomes available.

C. <u>Section 2: Safety Interventions</u>

1) If no safety threats are present, the CFS Specialist can proceed to Section 3 of the Safety Assessment. The CFS Specialist will complete Section 2 – Safety Interventions whenever one or more safety threats are present. For each safety threat identified, the CFS Specialist will consider the resources available in the family and the community that might help to keep the child safe. This section is intended to assist the family and the CFS Specialist in developing a strategy to allow a child to remain safely in the home.
2) Safety interventions are actions that will be taken by the family to allow the child to remain safely in the home. The interventions, either singly or in combination/sequence, will allow a safety plan to be written that will adequately and effectively mitigate all identified safety threats.
3) The process of writing a Safety Plan and selecting safety interventions should be a collaboration between the CFS Specialist and the family, starting with consideration of the least intrusive interventions that make use of the family's strengths, and ending with a plan that is both feasible and effective while taking into account the family's view. In furtherance of the Child Protection Act, the CFS Specialist may contact the non-custodial parent or the parent with shared custody when it has been determined that there is an active safety threat and the non-custodial or shared custodial parent may be able to provide for the child's safety.
4) The CFS Specialist will identify all types of safety interventions that will be implemented. If there are no available safety interventions that would allow the child to remain in the home, the CFS Specialist will indicate the need for protective placement.

D. Interventions that utilize family strengths:

Interventions marked with an asterisk (*) **must** be combined with frequent monitoring and oversight by the CFS Specialist or a person who has passed suitability.

1) **Use of family, kin, neighbors or other individuals in the community as safety resources.** Applying the family's strengths as resources to mitigate safety concerns, or using extended family members, kin, neighbors, or other individual to mitigate safety concerns. An Assessment of Safety Plan Participants is REQUIRED for each person who will be engaged in this safety intervention.
2) ***The caregiver will appropriately protect the child from the alleged perpetrator.** A non-offending caregiver has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator.
3) ***The non-offending caregiver will move to a safe environment with the child.** A caregiver not suspected of harming the child has taken or plans to take the child to an alternate location where the alleged perpetrator will not have access to the child.
4) ***The alleged perpetrator will leave the home, either voluntarily or in response to legal action.**
   Another caregiver is available and the alleged perpetrator will be temporarily or

permanently removed from the home. Examples include non-perpetrating caregiver "kicking out" alleged perpetrator who has no legal right to residence, or perpetrator agreeing to leave. When there are concerns about the reliability of either caregiver or perpetrator, this intervention should be used in combination with other interventions and increased monitoring of the Safety Plan.

E. Intervention's that utilize community and agency resources:

1) **Intervention or direct services by worker.**
   Actions taken or planned by the CFS Specialist that specifically address one or more safety threats. Examples include providing information about nonviolent disciplinary methods, child development needs, or parenting practices; providing emergency material aid such as food; and advocacy and support in obtaining restraining orders. DOES NOT INCLUDE the assessment itself or services provided to respond to family needs that do not directly affect safety.
2) **Use of community agencies or services as safety resources.**
   Involving a community-based organization, faith-related organization, or other agency in activities to address safety concerns, e.g., using a local food pantry, community mental health crisis intervention.
3) **Legal action planned or initiated; the child may remain in the home.**
   A legal action has already commenced or will commence that effectively mitigates identified safety concerns. This includes family-initiated (e.g., restraining orders, protection orders, mental health commitments, change in custody/visitation/guardianship) and/or DHHS/agency-initiated (file petition and the child remains in the home) actions. When there are concerns about enforcement, this intervention should be combined with another intervention.
4) **Other.** The family and/or CFS Specialist identified a unique intervention for an identified safety concern that does not fit within the items above, and this intervention allows child(ren) to return to the home or remain in the home.

F. Intervention to remove a child from the home is necessary to adequately ensure the child's safety.

Indicate the removal action taken:

1) The parent or legal guardian has chosen to utilize an Informal Living Arrangement;
2) Request emergency protective custody;
3) Other court action.

G. <u>Safety Concerns:</u>

1) At the initial contact and every subsequent contact with the family, CFS Specialists must recognize immediate safety concerns. The CFS Specialist must start with a review of child vulnerabilities. No child is responsible for creating safety, but some children may have limited capacity to ask for help or escape maltreatment.
2) The CFS Specialist will then consider threats to safety. When the CFS Specialist identifies a threat to safety using the definitions on the safety assessment, there is imminent risk of serious harm to a child, the CFS Specialist cannot leave the home without taking action to ensure the child will be safe.

3) When safety threats are identified, the CFS Specialist must assess the parent's ability to protect the child and consider if any safety interventions will keep the child safe in the home. The safety decision is the interaction of threats and interventions. If the family and CFS Specialist can develop and implement a Safety Plan that will keep the child safe from the identified threats, the child is conditionally safe and may remain in the home. The CFS Specialist must follow up and monitor the family to ensure that the Safety Plan is followed.
4) If safety threats are identified and no interventions are possible, the child is unsafe and must be placed in out of home care.

SUMMARY OF REVISIONS	
DATE	REVISION
11/08/2017	Effective