

# POLICY AND PROCEDURES MANUAL



**Delaware Department  
of Services for  
Children, Youth and  
Their Families Division  
of Family Services**

October 2022

This manual has been developed for use in the state of Delaware. It may not be implemented in any other jurisdiction without consultation with Evident Change. For more information about the SDM<sup>®</sup> system for child protection, contact [SDMSystems@evidentchange.org](mailto:SDMSystems@evidentchange.org).

Structured Decision Making<sup>®</sup> and SDM<sup>®</sup> are registered in the US Patent and Trademark Office.



## ABOUT EVIDENT CHANGE

Evident Change promotes just and equitable social systems for individuals, families, and communities through research, public policy, and practice. For more information, call (800) 306-6223 or visit us online at [EvidentChange.org](https://EvidentChange.org) and [@Evident\\_Change](https://twitter.com/Evident_Change) on Twitter.

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# CONTENTS

- General Instructions ..... 1
  
- SDM® Screening Assessment.....4
  - Definitions.....7
  - Policy..... 32
  - Procedures..... 33
  
- SDM® Response Priority Assessment ..... 36
  - Definitions..... 40
  - Policy..... 46
  - Procedures..... 47
  
- SDM® Safety Assessment..... 50
  - Definitions..... 53
  - Policy..... 66
  - Procedures..... 68
  
- SDM® Provider Safety Assessment..... 74
  - Definitions..... 77
  - Policy..... 89
  - Procedures..... 91
  
- SDM® Family Risk Assessment ..... 95
  - Definitions..... 98
  - Policy..... 110
  - Procedures..... 112
  
- Family Strengths and Needs Guide..... 118
  - Definitions..... 134
  - Physical and Cognitive Developmental Milestones ..... 155
  - Policy..... 164
  - Procedures..... 166
  
- SDM® Family Risk Reassessment for In-Home Cases..... 170
  - Definitions..... 173
  - Policy..... 179
  - Procedures..... 180

SDM® Reunification Reassessment.....	183
Definitions.....	191
Policy.....	199
Procedures.....	201

## VERSION HISTORY

#	DATE	UPDATES
1	3/19	<ul style="list-style-type: none"><li>• Updates to screening to incorporate CARA and HB181</li><li>• General instructions replace general definitions</li></ul>
2	9/19	<ul style="list-style-type: none"><li>• Minor clarifications on several items or definitions in screening and response priority.</li></ul>
3	11/20	<ul style="list-style-type: none"><li>• Minor revisions to a few definitions and safety interventions in the safety assessment and provider safety assessment, plus replacement of full safety assessment in reunification assessment with abridged version.</li></ul>
4	12/21	<ul style="list-style-type: none"><li>• Revisions to screening tool to better identify third-party perpetrators of exploitation and trafficking; minor changes to other screening categories.</li></ul>
5	10/22	<ul style="list-style-type: none"><li>• Provided updates to support reunification sections and automation.</li></ul>

## GENERAL INSTRUCTIONS

- The Delaware Division of Family Services (DFS) is responsible to investigate intrafamilial and institutional child abuse and neglect. DFS also investigates sexual abuse by a relative and human trafficking by any person.
- The Structured Decision Making® (SDM) screening assessment is used for all reports. Section 2 of the SDM® screening assessment is only completed for intrafamilial child abuse and neglect; sexual abuse by a relative; sexual abuse by non-relative while exercising care, custody, and control; and human trafficking by any person.
- The remaining SDM assessments are not used for institutional child abuse and neglect investigations. Investigations in foster homes use the SDM provider safety assessment only.
- SDM assessments are completed for a household. The household assessed is a household where there is concern of harm to a child. More than one household may require assessment. Each household will have its own set of SDM assessments.

### WHICH HOUSEHOLD?

#### Intrafamilial Child Abuse and Neglect

LIVING ARRANGEMENT	HOUSEHOLD ASSESSED
Child's parents live together	The parent's household
Child's parents live apart	ONLY the parent reported to be causing harm IF the other parent is protective.
	If the other parent is NOT protective, each household is assessed on separate SDM tools.
Child lives with relative or kin and report of harm is with relative or kin  (arrangement made by family)	If the parent is protective, has given consent for the child to live with relative or kin, and this is more than a temporary arrangement, ONLY the household of relative or kin
	If the parent is NOT protective, assess the relative or kin household AND the parent's household on separate SDM assessments.
	If the arrangement is temporary or parent has not given consent, it may be a police matter. If the parent was NOT protective, assess the parent's household. Do NOT assess the relative or kin household unless other children living there are also reported for harm or risk of harm.
Child lives in foster care or kinship care (placed by DFS)	Use the provider safety assessment for the foster or kinship home. No other SDM assessments are required.

## Trafficking and Sexual Abuse by Non-Household Member

HOUSEHOLD ASSESSED		
DOES THE PERSON CAUSING HARM TO A CHILD HAVE A HOUSEHOLD WITH CHILDREN IN IT?	ARE CAREGIVERS IN CHILD'S HOUSEHOLD PROTECTIVE?	
	NO	YES
Yes	Child's household AND person causing harm's household	Person causing harm's household
No	Child's household	

The following are included in a household.

- The child.
- Siblings.
- Parent or other person with care, custody, and control.
- Other adults or children who live in the same residence and who interact as a household. For example, they share meals, resources, and spend time with each other. Do not include other individuals who may share a dwelling but have little or no interaction.

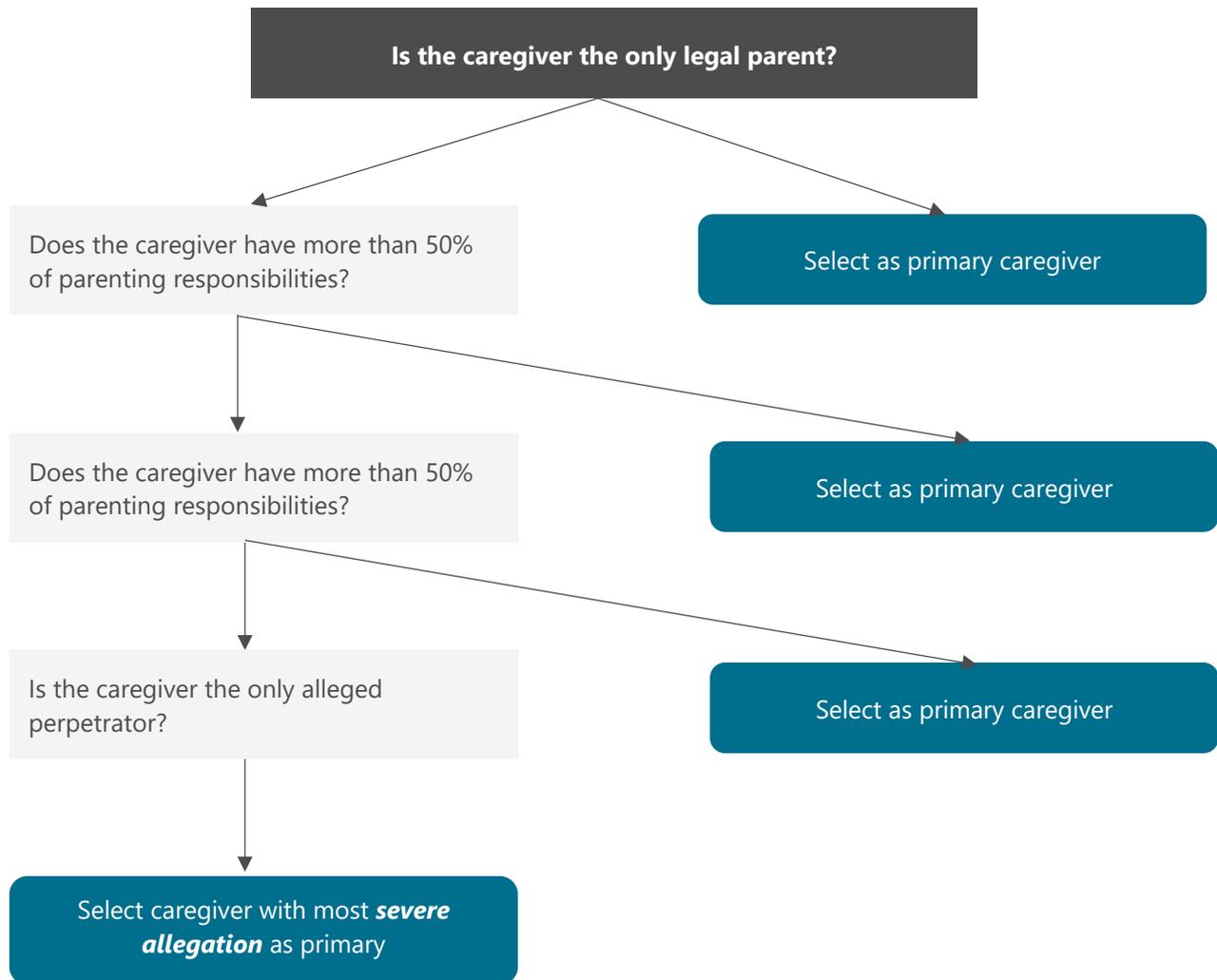
### CAREGIVER IDENTIFICATION

Use to identify primary and secondary caregivers for all SDM tools.

For each household of which a child is a member, distinguish between primary and secondary caregivers according to the following criteria.

**For the safety assessment:** Assess all household members who have access to the child.

**For all other assessments:** When answering risk items, answer with careful attention to whether the question refers to the primary or secondary caregiver.



If both have equally severe allegations, select one to be primary and the other to be secondary. The risk level will likely be the same for both options anyway.

**DSCYF:**

Department of Services for Children, Youth and their Families.

**DFS:**

Division of Family Services, which falls under DSCYF. Throughout this manual, DFS is used to refer to the Division of Family Services in Delaware specifically, rather than to any child protective services agency.

**CPS:**

Child protective services. This refers to DFS in Delaware and similar agencies in other states.

**SECTION 1: CHILD ABUSE/NEGLECT REPORT TYPE**

- Reports that require SDM screening (*Complete SDM screening assessment*)
  - Intrafamilial
  - Human trafficking
  - Sexual abuse by relative of child or by a person while exercising care, custody, and control
- Reports that do not require further SDM screening (*Document report and take further action if required*)
  - Extrafamilial not listed above (*Refer to law enforcement*)
  - Institutional abuse
  - Out-of-state allegation
  - Adult victim
  - Child victim now an adult

**SECTION 2: MALTREATMENT TYPES** (*Select only if definitional threshold is met. Select all that apply. Person causing harm must be a caregiver or household member having care, custody, and control except where noted.*)

<b>Death of Child</b>	<input type="checkbox"/> Death due to abuse <input type="checkbox"/> Death due to neglect <input type="checkbox"/> Sudden, unexpected, AND unexplained death of child age 3 or younger										
<b>Physical Abuse</b>	<input type="checkbox"/> Child injury <ul style="list-style-type: none"> <li><input type="checkbox"/> Serious non-accidental injury</li> <li><input type="checkbox"/> Other non-accidental injury</li> </ul> <input type="checkbox"/> Excessive discipline/bizarre treatment <input type="checkbox"/> Dangerous behaviors involving child <input type="checkbox"/> Risk of physical abuse										
<b>Neglect</b>	<input type="checkbox"/> Injury/illness resulting from medical neglect <input type="checkbox"/> Injury/illness due to other neglect <input type="checkbox"/> Neglect (without injury/illness) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Basic needs (food/clothing/shelter)</td> <td style="width: 50%;"><input type="checkbox"/> Reckless behavior involving child</td> </tr> <tr> <td><input type="checkbox"/> Mental health care neglect</td> <td><input type="checkbox"/> Failure to protect</td> </tr> <tr> <td><input type="checkbox"/> Inadequate supervision</td> <td><input type="checkbox"/> Failure to protect from trafficking</td> </tr> <tr> <td><input type="checkbox"/> Abandonment/no caregiver available/lockout</td> <td><input type="checkbox"/> Exploitation</td> </tr> <tr> <td><input type="checkbox"/> Educational neglect</td> <td><input type="checkbox"/> Labor exploitation</td> </tr> </table> <input type="checkbox"/> Risk of neglect <input type="checkbox"/> Risk of trafficking	<input type="checkbox"/> Basic needs (food/clothing/shelter)	<input type="checkbox"/> Reckless behavior involving child	<input type="checkbox"/> Mental health care neglect	<input type="checkbox"/> Failure to protect	<input type="checkbox"/> Inadequate supervision	<input type="checkbox"/> Failure to protect from trafficking	<input type="checkbox"/> Abandonment/no caregiver available/lockout	<input type="checkbox"/> Exploitation	<input type="checkbox"/> Educational neglect	<input type="checkbox"/> Labor exploitation
<input type="checkbox"/> Basic needs (food/clothing/shelter)	<input type="checkbox"/> Reckless behavior involving child										
<input type="checkbox"/> Mental health care neglect	<input type="checkbox"/> Failure to protect										
<input type="checkbox"/> Inadequate supervision	<input type="checkbox"/> Failure to protect from trafficking										
<input type="checkbox"/> Abandonment/no caregiver available/lockout	<input type="checkbox"/> Exploitation										
<input type="checkbox"/> Educational neglect	<input type="checkbox"/> Labor exploitation										
<b>Infant With Prenatal Substance Exposure</b>	<input type="checkbox"/> Infant or mother with positive toxicology at birth <input type="checkbox"/> Infant is substance affected <input type="checkbox"/> Mother with positive toxicology within 60 days prior to birth <input type="checkbox"/> Mother discloses using substances within 60 days prior to birth										
<b>Emotional Abuse/Neglect</b>	<input type="checkbox"/> Child emotionally harmed <input type="checkbox"/> Suspected emotional harm <input type="checkbox"/> Risk of emotional harm										
<b>Parental Risk Factors</b>	<input type="checkbox"/> Chronic and severe substance abuse <input type="checkbox"/> Domestic violence <input type="checkbox"/> History of serious child abuse and neglect or prior child fatality <input type="checkbox"/> Caregiver mental health problem <input type="checkbox"/> Caregiver cognitive or physical disability										

<b>Dependency</b>	<input type="checkbox"/> Dependent child <input type="checkbox"/> Child living in non-related home without DCYF approval <input type="checkbox"/> Inability to complete adoption plan <input type="checkbox"/> Out-of-state runaway <input type="checkbox"/> Abandoned infant (Safe Arms)
<b>Sexual Abuse/ Exploitation</b> Person causing harm may also be any adult relative who is not a household member or any other person exercising care, custody, and control.	<input type="checkbox"/> Sexual abuse <input type="checkbox"/> Sexual exploitation <input type="checkbox"/> Risk of sexual abuse
<b>Human Trafficking</b> Person causing harm is not a caregiver.	<input type="checkbox"/> Sexual trafficking <input type="checkbox"/> Labor trafficking

### SECTION 3: INITIAL CHILD ABUSE AND NEGLECT SCREENING DECISION

- Screen report in: One or more maltreatment types are checked.
- Screen report out: Does not meet SDM maltreatment type definition; no maltreatment types are checked.

### SECTION 4: OVERRIDES

#### Override to Screen In Report

- Court order to investigate.
- Discretionary override (*specify*): \_\_\_\_\_

#### Override to Screen Out Report

- The report is in relation to an active treatment case and the treatment unit is addressing the issue. Complete treatment response event in treatment case.
- Insufficient information to locate family.
- The information is identical to another accepted report (same alleged victim(s), same alleged perpetrator, same incident or behaviors).
- The alleged incident occurred more than one year ago. (Exception: Allegations of sexual abuse.)
- Infant prenatally exposed to medication as prescribed or MAT AND there are no other risk factors AND the provider is completing a plan of safe care.
- Discretionary override (*specify*): \_\_\_\_\_

- No overrides apply.**

## SECTION 5: FINAL SCREENING DECISION

### ○ **Screen in child abuse and neglect report for:**

- New investigation
  - No associations
  - Link to an open investigation
  
- Family Assessment and Intervention Response (FAIR)
  - DFS FAIR
  - Link to an open DFS FAIR
  - Contracted FAIR
    - Adolescent
    - Domestic violence
    - Substance abuse
  - Link to an open contracted FAIR
  
- Plan of Safe Care (POSC)
  - Contracted POSC
  - Link to an open contracted POSC
  
- Promoting Safe and Stable Families (PSSF)
  - PSSF
  - Link to an open contracted PSSF

### ○ **Screen out**

- No DFS response
- Treatment response

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH AND THEIR FAMILIES  
SDM® SCREENING ASSESSMENT  
DEFINITIONS**

**SECTION 1: CHILD ABUSE/NEGLECT REPORT TYPE**

**Reports that require SDM® screening**

- Intrafamilial: The person causing harm is a caregiver or adult member of the child's household.
- Human trafficking: The concern relates to sexual or labor trafficking.
- Sexual abuse by relative of child or by a person while exercising care, custody, and control: The person causing sexual harm is not a member of child's household but IS:
  - » A relative of the child; OR
  - » A non-relative who sexually abused the child while exercising care, custody, and control (e.g., babysitter).

**Reports that do not require further SDM® screening**

The following types of reports do not require SDM screening. However, they must be documented and additional actions must be taken as noted.

- Extrafamilial not listed above: The person causing harm is not a caregiver or adult member of the child's household. Excludes institutional abuse. Refer to law enforcement.

NOTE: If the incident falls under the definition of human trafficking or sexual abuse as described above, the report requires screening.

- Institutional abuse: The report involves an allegation of institutional abuse.
- Out-of-state allegation: The report alleges child abuse/neglect occurring in another state. Refer the report to the appropriate agency in the other state.
- Adult victim: The report alleges abuse/neglect of a person who is/was over 18 at the time of the incident. Refer reporter to adult protective services or law enforcement if appropriate.

- Child victim now an adult: Report alleges abuse/neglect of a person who is now an adult while that person was a child **AND** the adult is not currently in foster care or a residential care facility. Consider referring reporter to adult protective services or law enforcement if appropriate.

## **SECTION 2: MALTREATMENT TYPES**

*Select only if definitional threshold is met. Select all that apply. Person causing harm must be a caregiver or household member having care, custody, and control except where noted.*

### **Death of Child**

#### Death due to abuse

A person caused a non-accidental injury that resulted in a child fatality.

#### Death due to neglect

The child suffered an injury or illness that resulted in death, and this injury/illness was a direct result of neglect. Include fatalities resulting from the caregiver's failure to obtain or maintain adequate medical care for serious/chronic conditions and fatalities resulting from other forms of neglect, including inadequate supervision, hazardous conditions in the household, malnutrition, suffocation from co-sleeping while caregiver was impaired from substance use, etc.

#### Sudden, unexpected, AND unexplained death of child age 3 or younger

A child who has not reached their fourth birthday has died AND all of the following are true of the death.

- *Sudden*: The child was physically healthy until the death occurred or shortly before death occurred.
- *Unexpected*: There was no basis to anticipate child's death.
- *Unexplained*: The cause of death is not immediately known at this time. Explained death includes homicide, suicide, drug overdose (accidental or intentional), or terminal illness.

## Physical Abuse

### Child injury

A person recklessly caused physical injury to a child. Include any non-accidental injury or death. An injury is non-accidental if it was inflicted willfully or as a result of punishment. If the reporter does not know how a reported injury was caused, consider the allegation to be a non-accidental injury. If the reporter does not know whether the caregiver's behavior resulted in an injury, do not mark as injury. Include injuries that result from a domestic violence incident or other criminal behavior of the caregiver. Include visible injuries and suspected injuries due to symptoms such as loss of consciousness, altered mental status, inability to use an arm, inability to bear weight, etc. Do not include injuries that result from sexual acts.

- *Serious non-accidental injury*: Examples of serious non-accidental injuries include: blunt force trauma; bone fracture; burns and scalds; head trauma; internal injuries; puncture and stab wounds; injuries consistent with abusive head trauma; suffocation; and bruises, lacerations, dislocations, and sprains where the **injury requires medical intervention**.
- *Other non-accidental injury*: Examples of other, non-serious injuries include bruises, cuts, and lacerations where medical intervention is not necessary.

### Excessive discipline/bizarre treatment

The alleged perpetrator uses physical discipline that bears no resemblance to reasonable discipline **AND** that is likely to cause physical injury. Actions likely to cause injuries include the following.

- Throwing the child.
- Kicking.
- Striking with a closed fist.
- Interfering with breathing.
- Use of, or threatened use of, a deadly weapon.
- Any other act that is likely to cause physical injury or disfigurement.
- Hitting, pinching, pushing, hitting with objects, etc. IF the frequency and force used, or the location on the child's body (e.g., head, neck), were significant enough that an injury was likely.

### Dangerous behaviors involving child

The alleged perpetrator behaves in ways that are not related to discipline but are likely to result in serious injury to the child. Examples may include the following.

- Giving alcohol or drugs to a child.
- Using the child as a shield (e.g., in domestic violence cases).
- Domestic violence incidents that occur while the child is present and in which weapons or objects have been used or the child has attempted to intervene physically. A child is considered to be present if within sight or sound of the incident.

### Risk of physical abuse

Risk of physical abuse refers to circumstances where although the child has not yet experienced significant harm and there have been no clear-cut abusive actions, it can reasonably be concluded that if the circumstances continue without change, significant harm will likely result in the near future due to the abusive actions of a caregiver.

More specifically, risk of physical abuse means that there are alleged perpetrator characteristics or conditions (e.g., substance abuse, mental health issues) that currently frequently result in physically aggressive or violent actions toward others and are likely to result in significant harm to the child in the near future. For example, the caregiver gets belligerent and violent while substance-affected.

*Select only if no other category of physical abuse has been selected.*

## **Neglect**

### Injury/illness resulting from medical neglect

The caregiver has failed to obtain or follow through with appropriate medical care for a child resulting in or potentially resulting in a serious illness, injury, or condition, and/or exacerbating a pre-existing illness/injury/condition. As a result, the child is likely to require hospitalization or surgery, or the condition may worsen to the extent that unnecessary permanent disability, disfigurement, or death results. Include situations in which a family is declining health care for an acute or chronic condition due to religious convictions.

### Injury/illness due to other neglect

The child has suffered an injury or illness that requires medical attention, and this injury or illness was a direct result of neglect (other than medical neglect), including but not limited to the following.

- Failure to provide adequate supervision (e.g., young child hit by car while playing unsupervised in the street; infant falling from a window or balcony).
- Hazardous conditions in the household (e.g., exposed electrical wiring; broken windows or stairs; or access to weapons, chemicals, or harmful drugs).
- Excessive substance use or mental health issues by the person with care, custody, and control.
- Physical, mental, intellectual, or other limitations of the caregiver result in inability to provide safe care (e.g., lack of knowledge about the child’s developmental needs leads to significant underfeeding).
- The child has suffered serious illness or contracted a disease that requires medical attention, and this illness/disease was a direct result of neglect, including but not limited to the following illnesses or conditions.
  - » Diagnosed malnutrition.
  - » Inadequate nutrition causing serious illness.
  - » Diagnosed failure to thrive. The child has significantly failed to reach normal growth and developmental milestones where physical and genetic reasons for the failure have been medically eliminated and a diagnosis of non-organic failure to thrive has been made by a medical professional.
  - » Illness due to hazardous conditions in the household, such as access to chemicals, rat or cockroach infestations, excessive garbage, or decaying food. Medical conditions have arisen (e.g., sores, infection, physical illness, etc.) because the child’s basic needs for clothing and/or hygiene are unmet.

Neglect (without injury/illness)

The caregiver has the ability and financial means to provide necessary care but fails to do so.

- *Basic needs (food/clothing/shelter)*
  - » *Food:* The caregiver does not provide sufficient food to meet minimal requirements for the child to maintain health and growth. The child experiences unmitigated hunger, e.g., lack of food has a negative impact on school performance. Note: Caregiver’s use of food stamps and/or food pantries as sources of food should not be considered failure to provide food.

- » *Clothing*: The child's clothing is insufficient to protect the child from the elements. Whether the clothing is new or name brand is not relevant to the discussion of whether the caregiver is providing proper care. Consideration is given to whether the clothing is sufficient to protect the child from the elements and health hazards.
- » *Shelter*: Shelter is hazardous and jeopardizes physical safety. Structural issues to consider include: exposed electrical wiring; holes in the floor of the home; flaking lead-based paint; plumbing/septic tank issues that affect the living area; leaking gas from stove or heating unit; open, broken, or missing windows; or lack of utilities that provide sanitary sewage, fresh water, and adequate heat (between October 15 and April 15) with no alternative provisions or inappropriate provisions made to provide utilities. Do not include housekeeping/cleanliness issues unless they present a threat of imminent and serious harm to a child. Younger children are generally at greater risk than older ones. Cleanliness issues to consider include: a substantial amount of scattered garbage/trash accessible to a young child; a substantial amount of contained garbage/trash that sits to the point that vermin are present; animal or human waste that is not disposed of properly; cleanliness issues that cause or exacerbate medical conditions for the child.

If reported by a credible source (e.g., police), also include activities of the caregiver that create a hazardous living environment, such as the manufacture or distribution of drugs/alcohol, or allowing activities that involve constant disruption of the home environment and the threat of violence in the home (e.g., gang activity, prostitution). Also include situations in which guns, weapons, and other dangerous objects are or may be accessible to the child and are not secured. Guns that are properly secured (e.g., in a locked case) should be excluded.

- *Mental health care neglect*: A caregiver has a pattern of failing to seek ongoing or emergency mental health services for a child who is suicidal, homicidal, or self-harming.
- *Inadequate supervision*: The caregiver fails to provide necessary supervision for a child who is unable to care for their own basic needs or safety. Consider such factors as the child's age, mental ability, physical condition, the length of the caregiver's absence, and the context of the child's environment (Delaware Code, Title 10, §901). Examples include:
  - » Any child who is or has been left unsupervised for a period of time inappropriate to the child's age or developmental status;

- » Any situation in which the caregiver may be present but does not attend to the child (e.g., the child is playing with dangerous objects, running into the street, etc.);
- » Child is not supervised to the extent that the child has avoided serious injury only due to intervention by a third party; or
- » A child is left in a motor vehicle in circumstances that are unsafe based on child's age, developmental status, or environmental conditions.
- *Abandonment/no caregiver available/lockout:* The caregiver fails or refuses to assume responsibility or to provide basic care (food, shelter, clothing etc.) for a child on a daily basis. Examples include:
  - » The caregiver has left without making reasonable ongoing arrangements for the child's care, and there are indications that the caregiver does not intend to return or assume ongoing responsibility for the child;
  - » The child has been left in the full-time care of another person, but that person is unable or unwilling to provide—or continue to provide—care for the child; or
  - » The caregiver is unwilling to provide ongoing care for the child due to caregiver-child conflict, including situations in which the caregiver locked the child out (current report) or locks the child out of the house on a recurring basis.
- *Educational neglect:* Failure by caregiver to follow through with court-ordered activity for the child after conviction in court for "Failure to Send Child to School."
- *Reckless behavior involving child:* The alleged perpetrator behaves in ways that are likely to result in serious injury to the child. Examples may include the following.
  - » Driving or operating a motorized vehicle or vessel (e.g., car, boat) under the influence of drugs or alcohol while the child is in the vehicle.
  - » Intoxicated/impaired caregiver bed-sharing with an infant (12 months or younger).
  - » Inappropriate confinement. The alleged perpetrator has confined the child in a bedroom, basement, or any other space for a period of time that is inappropriate to the child's age and/or vulnerability. The alleged

perpetrator may have locked the child in or otherwise impeded the child's ability to leave the space.

- *Failure to protect:* The child has been or is being abused or neglected by another person and, despite this knowledge (or reasonable expectation that the caregiver should have that knowledge), the caregiver has failed to intervene and/or continues to allow that person to have access to the child.
- *Failure to protect from trafficking:* The child has been exploited by a third party, and despite this knowledge (or reasonable expectation that the caregiver should have that knowledge), the person responsible for the child's care has failed to protect or been unable to protect the child from being commercially sexually exploited, sex trafficked and/or labor trafficked. Note: The extent to which a third party is involved in the exploitation is addressed in separate screening criteria under human trafficking/sexual trafficking and human trafficking/labor trafficking.

Children and youth 17 years old and younger are sexually exploited when they have engaged in, been solicited for, or been forced to engage in sexual conduct or performance of sexual acts (e.g., stripping) in return for a benefit—such as money, food, drugs, shelter, clothing, gifts, or other goods—or for financial or some other gain for a third party. The sexual conduct may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed. Commercial sexual exploitation of children and youth may include prostitution, pornography, trafficking for sexual purposes, and other forms. The youth is treated as a sexual object and as a commercial object. The sexual exploitation of the child may profit a much wider range of people than the immediate beneficiary of the transaction.

Labor trafficking means that a child has been recruited, transported, harbored, received, isolated, advertised, solicited, or enticed for the purpose of servitude other than for sexual purposes.

- *Exploitation:* The caregiver teaches, encourages, or instructs a child to engage in illegal behaviors (e.g., shoplifting, burglary, drug dealing, driving without a license).
- *Labor exploitation:* A caregiver has actively involved the child in acts of exploitation or trafficking. Caregiver has involved the child in being recruited, transported, harbored, received, isolated, advertised, solicited, or enticed for the purpose of servitude other than for sexual purposes. This includes a child being exploited and/or labor trafficked by or with knowledge and consent of the caregiver. In this circumstance, an allegation of neglect/labor exploitation should

be applied to the caregiver AND an allegation of trafficking should be applied to any third-party perpetrators.

### Risk of neglect

Risk of neglect means that there are circumstances or conditions (e.g., substance abuse, mental health issues) that are likely to result in failure to meet the child's basic needs in the near future, and this failure can reasonably be expected to produce a substantial and demonstrably adverse impact on the child's safety, welfare, or well-being. Marking this item indicates that there are concerning behaviors by the caregiver that do not constitute neglect, but that indicate a trend or escalating pattern towards inability to meet the child's basic needs.

*Select only if no other category of neglect has been selected.*

For example:

- Caregiver is extremely depressed;
- Caregiver has little interest in taking care of self and/or child;
- One partner's financial control (a form of domestic violence) is preventing the other from purchasing items needed for the basic care of the child; or
- The caregiver's intellectual disability impairs their ability to provide adequate care, supervision, or protection for an infant/child.

### Risk of trafficking

The child is at significant risk of being exploited/trafficked (either sexual or labor) by a third party even though the child has not yet experienced harm and there may not have been any clear-cut exploitative actions, and it reasonably can be concluded that the current circumstances represent a significant threat of trafficking in the near future. The caregiver may or may not be aware of the risk of trafficking.

Note: If information suggests that a referral to law enforcement should be made, this maltreatment type should not be selected. Consider selecting another maltreatment type instead.

Select only if no other category of neglect or trafficking has been selected.

Parental risk factors are NOT required for selection of this maltreatment subtype.

## **Infant With Prenatal Substance Exposure**

*A substance includes alcohol, illegal drug, prescription drug, or MAT drug.*

### Infant or mother with positive toxicology at birth

Laboratory results from tests performed at the birth event confirm the presence of a substance in either the mother or the infant.

### Infant is substance affected

The healthcare provider attending to the birth reports one or more of the following:

- Infant is experiencing symptoms of withdrawal from a substance.
- Infant is experiencing medical complications related to prenatal substance use (e.g. infant is premature).
- Infant's facial features are consistent with fetal alcohol syndrome disorder.

### Mother with positive toxicology within 60 days prior to birth

At any point during the 60 days prior to the actual birth event, or within 60 days prior to the projected due date, a toxicology test for the mother is positive for a substance.

### Mother discloses using substances within 60 days prior to birth

Mother discloses that she used substances within 60 days prior to the birth event. This includes

- Prior to the birth event, mother discloses that she used a substance within 60 days prior to the due date.
- Following the birth event, mother discloses that she used a substance within 60 days prior to the birth.

## **Emotional Abuse/Neglect**

The caregiver has made threats to inflict undue physical or emotional harm, and/or there are chronic or recurring incidents of ridiculing, demeaning, making derogatory remarks, ignoring or isolating, shunning, or rejecting (Delaware Code, Title 10, §901). Include caregiver action or inaction that has led to child's severe anxiety, depression, withdrawal, or aggressive behavior toward self or others or the imminent likelihood thereof.

### Child emotionally harmed

The child has/is experiencing significant psychological harm that is related to a persistent pattern of alleged perpetrator behavior **AND** that results in severely impaired functioning at home, in school, or in the community (e.g., social isolation, seriously impaired ability to do schoolwork, frequent disruptive or aggressive behaviors). Significant psychological harm includes the following:

- A diagnosed mental health condition such as anxiety, depression, or PTSD; **OR**

In the absence of a diagnosis, observable behaviors or conditions that signify severe psychological harm, such as ongoing sleep/appetite disturbance, bedwetting/ wetting/soiling, severe withdrawal, extremely and persistently aggressive behavior, starting fires, or cruelty to animals. For infants and toddlers, indicators of significant psychological harm may include delays in physical development (e.g., walking, talking, non-organic failure to thrive) and/or behavioral indicators such as being abnormally and chronically unresponsive or withdrawn (e.g., never responding to cuddling, never smiling or making sounds), exaggerated fears and extreme clinginess, chronic head banging, or regressive and persistent bedwetting/wetting/soiling.

**AND**

- These behaviors or conditions are related to a persistent pattern of alleged perpetrator behavior. Behaviors include credible threats by the caregiver to cause serious physical or emotional harm, or rejection, hostility, blaming, criticizing, scapegoating, ignoring, isolating, manipulating, terrorizing, or domestic violence, **AND** these behaviors are ongoing and repetitive or take place in a single, extremely traumatic incident.
  - » Rejecting behaviors are those that communicate abandonment or a negative sense of identity to the child/young person.
  - » Hostility refers to behaviors that reflect predominant feelings of anger, antagonism, or hatred toward the child.
  - » Blaming refers to the alleged perpetrator repeatedly saying or acting as though the child is at fault for negative things that have happened to the caregiver, child, or family.
  - » Criticizing refers to constant expressions of disappointment, disapproval, dissatisfaction, or fault-finding with the child.
  - » Scapegoating refers to making the child take the blame for the action of others.
  - » Ignoring refers to being emotionally unavailable to the child, and can include the absence/withdrawal of love/affection.
  - » Isolating involves preventing the child from participating in normal opportunities for social or cultural interaction.

- » Manipulating involves enticing, pressuring, or coercing the child to act against their best interests or sense of right and wrong (e.g., alienating the child from the other caregiver or another person, or getting the child to break the law).
- » Terrorizing involves threatening the child with severe or sinister punishment or deliberately developing a climate of fear or threat (e.g., exposing the child to ridicule by others; threatening to harm the other caregiver, siblings, or other significant person; or killing or injuring pets or animals).
- » The child has witnessed or is aware of the caregiver's domestic violence on multiple occasions or has witnessed or is aware of a single severe incident that resulted in a significant injury to an adult (i.e., requiring hospitalization or medical attention) or that involved the use of a weapon such as a firearm or knife.

#### Suspected emotional harm

The child does not have a diagnosed mental health condition, and functioning (e.g., schoolwork, maintaining relationships) is not severely impaired. However, the child expresses or displays symptoms such as persistent and/or profound sadness, fear, worry, confusion, anger, or low self-esteem. For infants and toddlers, symptoms of significant psychological harm may include being unresponsive or withdrawn (e.g., not responding to cuddling, not smiling or making sounds), fearfulness and clinginess, or occasional regressive bedwetting/soiling.

#### **AND**

This is related to a persistent pattern of caregiver behaviors. Behaviors include threats to cause physical or emotional harm, rejection, hostility, blaming, criticizing, scapegoating, ignoring, isolating, manipulating, terrorizing, domestic violence, **AND** these behaviors are sustained and repetitive or a single, traumatic incident (see above for definitions of these behaviors).

#### Risk of emotional harm

Risk of significant emotional harm means that there are circumstances or conditions (e.g., substance abuse, mental health issues, domestic violence) that frequently result in behaviors that may reasonably be expected to produce a substantial and demonstrably adverse impact on the child's emotional well-being. For example:

- The caregiver's substance use or state of mental health renders them emotionally unavailable;
- The child has witnessed or is aware of the caregiver's domestic violence on multiple occasions or has witnessed or is aware of a single severe incident that

resulted in a significant injury to an adult (i.e., requiring hospitalization or medical attention) or that involved the use of a weapon such as a firearm or knife; or

- The child has witnessed or is aware of the caregiver's domestic violence, and during or following the incident(s) the child demonstrated significant emotional distress. Examples include shaking with fear, inconsolable sobbing, cowering, or hiding, OR having a flat affect, showing little or no emotion, especially where the violence has been longstanding.

When considering if a child is aware of the caregiver's domestic violence, determine if the child knows that the caregiver has been injured AND if the child knows or can reasonably be expected to know that the injury was caused by another person (e.g., if there is a history of domestic violence in the home, if the child was within sight or sound during the incident, if the child expresses suspicion of the alleged abuser).

*Select only if no other category of emotional abuse/neglect has been selected.*

## **Parental Risk Factors**

### Chronic and severe substance abuse

The caregiver chronically and/or severely abuses alcohol or a controlled substance, and the abuse threatens the child's ability to receive care necessary for safety and general well-being (see Delaware Code, Title 10, §901).

Do not select for reports of an expecting mother using drugs or alcohol if no other children reside in the home. Refer to prenatal substance exposure items to determine whether any apply.

The alleged perpetrator currently has a significant substance abuse problem that interferes with their daily functioning, **AND** this substance abuse problem negatively impacts the alleged perpetrator's care and supervision of the child to the extent that there is risk of significant abuse or neglect.

Indicators of a significant substance abuse problem that interferes with daily functioning may include:

- Serious family conflict over substance abuse;
- Inability or unwillingness to carry out daily household chores/responsibilities;
- Recent criminal behavior associated with drug use; or
- Domestic violence resulting from substance use.

Examples of a substance abuse problem's negative impact on the alleged perpetrator's care and supervision of the child may include:

- Abuse and/or neglect has already occurred and it is/was associated with substance use;
- Patterns of behavior associated with substance use indicate significant impairment of the caregiver's ability to meet the basic needs of the child, e.g., caregiver spends money on drugs while child has less than adequate food, clothing, or shelter;
- A child has access to drugs or paraphernalia used for drug consumption in the household;
- Caregiver provides inadequate/questionable supervision while intoxicated;
- Caregiver bed-shares with infant (12 months or younger) while under the influence of drugs or alcohol; or
- Caregiver displays aggressive or erratic behavior toward child while under the influence of drugs or alcohol.

The substance abuse may be:

- An ongoing problem (e.g., dependency);
- A one-time incident; or
- Binge use (e.g., blackouts, violent behavior, gone from the home multiple days at a time, or leaving child alone or in inappropriate care while on a binge).

#### Domestic violence

Domestic violence includes physical assaults and/or periods of intimidation/threats/harassment between caregivers, or between a caregiver and another adult household member.

At least one caregiver is a victim or perpetrator of violence that is chronic and/or severe, **AND** one or more of the following thresholds applies.

- A child has witnessed in the last 12 months one or more family violence incidents that are consistent with felony-level charges (e.g., resulted in an injury that required or should have resulted in hospitalization or medical attention; involved the use of a weapon such as a firearm or knife).
- A child has been exposed in the last 12 months to chronic episodes of domestic violence that are consistent with misdemeanor-level charges (e.g., pushing, hitting, kicking, throwing objects) **AND** these episodes are known to the police.

- Though it may not have involved a child directly, chronic domestic violence has occurred in the household during the past 12 months and/or the caregiver has not followed through with treatment referrals made by victim's services or domestic violence professionals. Consider chronic domestic violence to exist when there are multiple assaults and/or an escalation of violence in a 12-month period and/or repeated criminal charges for domestic assault.
- A pattern of power and control exists, such as isolation, financial control, or emotional abuse, which prevents one partner from making choices for the safety of self and/or child/young person.
- Multiple breaches or disregard of a restraining order by either party.

Include situations in which violent behavior occurred more than 12 months ago if the partners have been separated and are now reuniting.

#### History of serious child abuse and neglect or prior child fatality

Examples include:

- The caregiver has previously been convicted for serious injury or death of a child due to child abuse or neglect. Include convictions that have occurred at any time in the past;
- The caregiver has previously had parental rights terminated involuntarily due to child abuse or neglect; or
- A caregiver has previously seriously abused or neglected this or another child, **AND** the severity of the prior incident **OR** the caregiver's response to that incident suggests that this child may be at risk of significant harm.

Examples of serious prior abuse/neglect include the following.

- A current caregiver has previously had a substantiation against them for serious abuse or neglect (i.e., a serious injury or illness occurred).
- There was a previous child death not due to natural causes or that was unexplained/suspicious or is still under investigation, and caregiver contribution to the death was suspected.
- A child was removed from the household as a result of abuse/neglect.
- There is a history of serious injuries to a young child in the family that have been considered suspicious, but for which there was not enough evidence to prove that someone deliberately harmed the child.

- Two or more unduplicated reports in the past year have been received **AND** the nature of the reports is escalating in terms of the severity of the alleged harm or the frequency of the reports.
- Two or more unduplicated reports in the past year have received an investigation.

The nature of the caregiver's response to prior incidents should also be considered. Risk is increased if the caregiver did not assume responsibility (e.g., denied, blamed child, or minimized or dismissed the incident's seriousness); did not cooperate with the investigation; or did not respond to offers of services or participate in planned interventions to reduce risk.

#### Caregiver mental health problem

A caregiver has a mental health problem or diagnosed mental illness that interferes with their daily functioning. Indicators may include the following.

- Serious family conflict due to mental health concerns.
- Inability or unwillingness to carry out daily household chores/responsibilities.
- Frequent mental health hospitalizations.
- Domestic violence associated with emotional instability.

#### **AND/OR**

The mental health issue or diagnosed mental illness negatively impacts their care and supervision of the child to the extent that there is significant risk of serious abuse or neglect. For example:

- Abuse and/or neglect has already occurred and it is/was associated with the caregiver's mental health issues; **OR**
- There are patterns of behavior associated with the mental health problem that indicate significant impairment of the caregiver's ability to meet the basic needs of the child, such as the following:
  - » Caregiver's depression is immobilizing, resulting in the child frequently being unsupervised or unfed;
  - » Aggressive or erratic behavior toward the child;
  - » Inability to protect the child from others due to mental health issues; or
  - » Caregiver's distorted perceptions lead to rejection, hostility, blaming, or threats toward the child.

The problem may be either of the following:

- An ongoing problem (e.g., depression); or
- Single or recurring incidents of significant dysfunction (e.g., psychotic episode, violent behavior).

Caregiver cognitive or physical disability

A caregiver has a diagnosed cognitive disability (e.g., intellectual disability, severe cerebral palsy, delirium, dementia, or other condition that impairs general intellectual functioning) that negatively affects the following areas:

- Caregiver’s ability to manage their own life on an ongoing basis; and/or
- Caregiver’s ability to provide adequate care, supervision, or protection for a child or infant to the extent that it represents a risk of significant abuse/neglect. For example:
  - » Due to cognitive delays, the caregiver has difficulty managing finances (e.g., paying bills, depositing checks, prioritizing spending) or managing a household (e.g., keeping a sufficient supply of food in the home);
  - » The caregiver lacks the basic knowledge needed to parent an infant (e.g., not knowing that infants need regular feedings, expecting a baby not to cry, or misinterpreting infant responses or cues); or
  - » The caregiver lacks the basic knowledge needed to parent any child (e.g., not understanding limits on physical discipline, expectations or treatment of child are inconsistent with child’s development, etc.).

**OR**

A caregiver has a **physical disability** that seriously impairs their ability to provide adequate care, supervision, or protection for a child, and there are insufficient formal or informal supports (provided by other adults) to compensate for this condition, resulting in a risk of significant abuse/neglect. For example, a physical disability, without support from other adults, might prevent a caregiver from doing the following:

- Maintaining a safe household, to the extent that child health is compromised;
- Providing regular meals for the child(ren);
- Protecting the children from another person who endangers their safety, welfare, or well-being.

## **AND/OR**

The child is the primary caregiver for their disabled caregiver, and the time and energy spent providing support has a negative impact on the child's own functioning (e.g., the child's grades or health are seriously affected).

## **Dependency**

### Dependent child

A person with responsibility for care, custody, and control of the child does not have the ability and/or financial means to provide for the care of the child and, as a result, fails to provide necessary care with regard to: food, clothing, shelter, education, health care, medical care, or other care necessary for the child's emotional, physical, or mental health, or safety and general well-being. Lack of ability means that through no fault of their own, the caregiver is unable to provide necessary care due to problems such as financial constraints, mental health concerns, hospitalization, incarceration, or disability.

### Child living in non-related home without DCYF approval

The child is living in a non-related home on an extended basis without the consent and approval of DCYF or any agency court-licensed or authorized to place children in a non-related home (Delaware Code, Title 10, §901).

### Inability to complete adoption plan

The child has been placed with a licensed agency, which certifies it cannot complete a suitable adoption plan (Delaware Code, Title 10, §901).

### Out-of-state runaway

The report concerns a runaway child who is the resident of a state other than Delaware.

### Abandoned infant (Safe Arms)

A parent has surrendered an unharmed infant under the age of 14 days to a hospital emergency room.

## **Sexual Abuse/Exploitation**

### Sexual abuse

A caregiver, adult household member, relative, or any other person while exercising care, custody and control of the child:

- Had sexual contact with the child.

Sexual contact includes intercourse, any penetration, any intentional touching of the child's anus, breast, buttocks, or genitalia when such touching is sexual in

nature or intentionally having a child touch another person's anus, breast, buttocks, or genitalia. Sexual contact also includes touching through clothing.

For the purpose of screening, sexual contact may be inferred based on medical evidence reported by a health care provider.

- Engaged in sexually abusive/inappropriate behavior involving the child.

Examples include:

- » Inappropriate sexualized statements intended to entice or alarm the child;
- » Purposefully exposing child to sexual activity;
- » Repeatedly or purposefully exposing child to pornography; or
- » Exposing themselves to a child and such exposure is intended to entice or alarm.

For screening purposes, there should be a presumption against screening in, between children of similar ages, reports of non-abusive sexual contact and reports involving relatively minor incidents (e.g., unwanted kissing, inappropriate touching, or self-exposure between peers) where this appears to be a one-time incident and caregivers of both the perpetrator and victim are responding appropriately.

#### Sexual exploitation

A caregiver has actively involved the child in acts of exploitation or trafficking. Caregiver involves the child in obscene acts or engages the child in prostitution or pornography. This includes a child being commercially sexually exploited and/or sex trafficked by or with knowledge and consent of the caregiver. In this circumstance, an allegation of sexual abuse/sexual exploitation should be applied to the caregiver AND an allegation of trafficking should be applied to any third-party perpetrators.

Children and youth 17 years old and younger are sexually exploited when they have engaged in, been solicited for, or been forced to engage in sexual conduct or performance of sexual acts (e.g., stripping) in return for a benefit—such as money, food, drugs, shelter, clothing, gifts, or other goods—or for financial or some other gain for a third party. The sexual conduct may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed. Commercial sexual exploitation of children and youth may include prostitution, pornography, trafficking for sexual purposes, and other forms. The youth is treated as a sexual object and as a commercial object. The sexual exploitation of the child may profit a much wider range of people than the immediate beneficiary of the transaction.

### Risk of sexual abuse

Significant risk of sexual abuse refers to situations in which although the child has *not yet experienced harm* and there may have been no clear-cut sexually abusive actions, it can reasonably be concluded that the current circumstances represent a significant threat of sexual abuse *in the near future*.

*Select only if no other category of sexual abuse/exploitation has been selected.*

Examples include the following.

- A person who has previously sexually abused this or another child, including prior or current charges of child pornography AND is a household member or has regained access to the child AND child begins to exhibit potentially abusive sexual behaviors (see Table 1).
- The child discloses a fear that sexual abuse may occur and/or there are indications that the child is being groomed. Grooming refers to a deliberate and escalating pattern of actions taken to lower a child's inhibitions in preparation for sexual abuse (e.g., treating the child as "more special" than other children, talking about sexual topics that are age-inappropriate, exposing the child to pornography, deliberate self-exposure).
- A child is observed with verbal, physical, or behavioral indicators strongly suggesting that the child may have been or will be a victim of sexual abuse by a family or household member. Consider cases in which there is medical evidence associated with sexual abuse but is not conclusive (e.g., urinary tract infections, redness and irritation of the genital area) or extremely sexualized behavior/language on the part of the child. (See Table 1 and Table 2.)

For reports involving sexual contact between children, the following tables provide examples of behaviors for different age groups. Table 1 indicates behaviors that in young children are considered normal and common, less common, uncommon, and rarely normal. Behaviors that are uncommon or rarely normal should be considered as suspicious. Table 2 summarizes sexual behaviors for older children and behaviors that are considered indicative of abuse. Behaviors listed in the "abusive" category in Table 2 should be considered suspicious.

**TABLE 1**

**EXAMPLES OF SEXUAL BEHAVIORS IN CHILDREN AGES 2 THROUGH 6 YEARS<sup>1</sup>**

NORMAL, COMMON BEHAVIORS	LESS COMMON, NORMAL BEHAVIORS	UNCOMMON BEHAVIORS	RARELY NORMAL
<ul style="list-style-type: none"> <li>• Touching/masturbating genitals in public/private</li> <li>• Viewing/touching peer or new sibling genitals</li> <li>• Showing genitals to peers</li> <li>• Standing/sitting too close</li> <li>• Tries to view peer/adult nudity</li> <li>• Behaviors are transient, few, and distractible</li> </ul>	<ul style="list-style-type: none"> <li>• Rubbing body against others</li> <li>• Trying to insert tongue in mouth while kissing</li> <li>• Touching peer/adult genitals</li> <li>• Crude mimic of movements associated with sexual acts</li> <li>• Sexual behaviors that are occasionally, but persistently, disruptive to others</li> <li>• Behaviors are transient and moderately responsive to distraction</li> </ul>	<ul style="list-style-type: none"> <li>• Asking peer/adult to engage in specific sexual act(s)</li> <li>• Inserting objects into genitals</li> <li>• Explicit imitation of intercourse</li> <li>• Touching animal genitals</li> <li>• Sexual behaviors that are frequently disruptive to others</li> <li>• Behaviors are persistent and resistant to parental distraction</li> </ul>	<ul style="list-style-type: none"> <li>• Any sexual behaviors involving children who are four or more years apart</li> <li>• A variety of sexual behaviors displayed on a daily basis</li> <li>• Sexual behavior that results in emotional distress or physical pain</li> <li>• Sexual behaviors associated with other physically aggressive behavior</li> <li>• Sexual behaviors that involve coercion</li> <li>• Behaviors are persistent and child becomes angry if distracted</li> </ul>

<sup>1</sup> Nancy D. Kellogg Committee on Child Abuse and Neglect. (2009). The evaluation of sexual behaviors in children. *Pediatrics*, 124(3), 992–998.

**TABLE 2**

**SEXUAL BEHAVIORS IN CHILDREN**

SEXUAL BEHAVIORS	ABUSIVE SEXUAL BEHAVIORS
<b>Children, Ages 7–10</b>	
<ul style="list-style-type: none"> <li>• Fondle and touch own genitals; masturbate</li> <li>• Become more secretive about self-touching</li> <li>• Interest in others’ bodies becomes more game playing than exploratory curiosity (e.g., “I’ll show you mine if you show me yours”)</li> <li>• Boys may begin comparing size of penis</li> <li>• May develop extreme interest in sex, sex words, and dirty jokes</li> <li>• Begin to seek information or pictures that explain bodily functions</li> <li>• Touching may involve stroking or rubbing</li> </ul>	<ul style="list-style-type: none"> <li>• Sexual penetration</li> <li>• Genital kissing</li> <li>• Oral copulation (intercourse)</li> <li>• Simulated intercourse</li> <li>• Behavior involves coercion, threats, secrecy, violence, aggression, or developmentally inappropriate acts</li> </ul>
<b>Children, Ages 11 and 12</b>	
<ul style="list-style-type: none"> <li>• Continuation of masturbation</li> <li>• Focus on establishing relationships with peers</li> <li>• Sexual behavior with peers, e.g., kissing and fondling</li> <li>• Primarily heterosexual activity but not exclusively</li> <li>• Interest in others’ bodies, particularly the opposite sex, that may take the form of looking at photos or other published material</li> </ul>	<ul style="list-style-type: none"> <li>• Sexual play with younger children</li> <li>• Any sexual activity between children of any age that involves coercion, bribery, aggression, secrecy, or a substantial peer or age difference</li> </ul>
<b>Adolescents, Ages 13–17</b>	
<ul style="list-style-type: none"> <li>• Masturbation in private</li> <li>• Mutual kissing</li> <li>• Sexual arousal</li> <li>• Sexual attraction to others</li> <li>• Consensual sexual activity amongst peers</li> <li>• Behavior that contributes to positive relationships</li> </ul>	<ul style="list-style-type: none"> <li>• Masturbation causing physical harm or distress to self and others</li> <li>• Public masturbation</li> <li>• Unwanted kissing</li> <li>• Voyeurism, stalking, sadism (gaining sexual pleasure from others’ suffering)</li> <li>• Non-consensual groping or touching of others’ genitals</li> <li>• Coercive sexual intercourse/sexual assault</li> <li>• Coercive oral sex</li> <li>• Behavior that isolates the young person who displays the sexually abusive behavior and is destructive of their relationships with peers and family</li> </ul>
<p><b><i>Adapted from material presented in Araji (2004); cited in Boyd (2006) and Kambouropoulos, et al. (2005).</i></b></p>	

## **Human Trafficking (non-caregivers)**

### Sexual trafficking

Child/youth is being trafficked or commercially sexually exploited by a person who is not a caregiver. The extent to which a caregiver is involved in or aware of the abuse is addressed in separate screening criteria for both sexual abuse/exploitation/sexual exploitation and neglect/failure to protect. If this item is selected, an allegation of trafficking should be applied only to the alleged perpetrator(s) of the actual exploitation. Do not apply an allegation of trafficking to the caregiver.

Children and youth 17 years old and younger are sexually exploited when they have engaged in, been solicited for, or been forced to engage in sexual conduct or performance of sexual acts (e.g., stripping) in return for a benefit—such as money, food, drugs, shelter, clothing, gifts, or other goods—or for financial or some other gain for a third party. The sexual conduct may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed. Commercial sexual exploitation of children and youth may include prostitution, pornography, trafficking for sexual purposes, and other forms. The child/youth is treated as a sexual object and as a commercial object. The sexual exploitation of the child may profit a much wider range of people than the immediate beneficiary of the transaction.

### Labor trafficking

Child/youth is being trafficked or commercially exploited by a person who is not a caregiver. Labor trafficking means that a child or youth 17 years old and younger has been recruited, transported, harbored, received, isolated, advertised, solicited, or enticed for the purpose of servitude other than for sexual purposes.

Note: The extent to which a caregiver is involved in or aware of the abuse should be addressed in separate screening criteria for both neglect/failure to protect from trafficking or neglect/labor exploitation. If one of the above items is the only item selected, an allegation of trafficking should be applied only to the alleged perpetrator(s) of the actual exploitation. Do not apply an allegation of trafficking to the caregiver.

Note: If one of these items is the only allegation selected, no other SDM tools should be used in the investigation.

## **SECTION 4: OVERRIDES**

### **Override to Screen In Report**

#### Court order to investigate.

No screening criteria are selected; however, a court has ordered an investigation.

## Override to Screen Out Report

### Insufficient information to locate family.

Reporter was unable to provide sufficient information to identify or locate family. All efforts to identify or locate the family through other means have been exhausted without success.

### The information is identical to another accepted report.

A previous report contains the exact perpetrator, victim, and incident or behaviors. There is no new information relative to a screening decision. The previous report may remain open for investigation or the investigation has been completed.

### The alleged incident occurred more than one year ago. (Exception: Allegations of sexual abuse.)

All selected screening criteria relate to incidents or conditions that occurred more than one year ago and there are no incidents or conditions of concern within the past year.

### Infant prenatally exposed to medication as prescribed or MAT AND there are no other risk factors AND the provider is completing a plan of safe care.

*(Available only for infant or mother with positive toxicology or disclosure by mother. Not available for infant affected by substance.)*

The positive toxicology report or disclosure indicated that the substance used was:

- A prescribed medication AND the amount used is consistent with prescription; or
- A medication-assisted treatment (MAT) AND the mother is actively engaged and following a treatment plan.

AND

- There are no other risk factors.

AND

- The health care provider will prepare a plan of safe care.

### *Examples of Other Risk Factors*

- Caregiver is persistently disinterested in infant.
- Caregiver is unable to absorb important medical information.
- Caregiver is not feeding or changing infant when responsible to do so prior to mother's discharge or while visiting.
- Caregiver has poor balance or coordination.

- Caregiver's pattern of substance abuse is long-standing, with only brief periods of sobriety/being clean within the past year.
- Caregiver gave birth to one or more infants affected by substances or prenatally exposed to substances prior to this birth.
- Caregiver has prior CPS involvement related to substance abuse.
- Caregiver has a co-occurring mental health diagnosis AND is not engaged in or compliant with treatment.
- Caregiver has not accepted a plan of safe care, such as Smart Start or Parents as Teachers.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH AND THEIR FAMILIES  
SDM® SCREENING ASSESSMENT  
POLICY**

**PURPOSE AND POLICY**

The purpose of the screening tool is to determine whether DFS should respond to a child abuse and neglect report.

**WHICH CASES**

All reports, including reports on open investigations or treatment cases.

**WHO**

The intake worker completes the assessment and the supervisor reviews and approves.

**WHEN**

The intake worker completes the assessment as soon as possible, ideally during the reporting phone call. The assessment is documented as soon as possible and disposed no later than the end of the shift of the intake worker who received the report.

The supervisor reviews and approves assessments by the end of the shift.

**DECISION**

The assessment informs the decision to screen in the report (meaning that the report will receive a response, whether that be investigation, a link to a current open investigation, or family assessment), or to screen the report out (meaning that the report will not receive a response from DFS).

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH AND THEIR FAMILIES  
SDM® SCREENING ASSESSMENT  
PROCEDURES**

This section describes procedures for completing the SDM screening tool, which has five parts.

- Section 1:** Used to indicate the basic type of child abuse and neglect report that has been received and whether screening is required.
- Section 2:** Incorporates the child abuse/neglect screening criteria. Only select an item if the information received meets the definition as outlined in this manual.
- Section 3:** Used to record the initial screening decision for child abuse and neglect reports before consideration of overrides.
- Section 4:** Incorporates potential overrides for screening child abuse and neglect reports.
- Section 5:** Used to record the final screening decision, after overrides have been considered.

**SECTION 1: CHILD ABUSE/NEGLECT REPORT TYPE**

This section is used to record the basic type of report that has been received.

Select the type of report. If the report is intrafamilial, or relates to human trafficking, or relates to sexual abuse by a relative or other person while exercising care or control, the report will be indicated as requiring screening. All others do not require screening and no further completion is required.

**SECTION 2: MALTREATMENT TYPES**

**Type of Harm**

This section contains all categories for reports that would require a response.

Based on the reported information, review each of the abuse/neglect types to determine if the information provided meets any of the criteria, based on the definition. If the criteria are met, select the relevant item. If the criteria are not met, do not select the item.

If “risk of physical abuse,” “risk of neglect,” or “risk of emotional harm” items are selected, you must select the relevant parental risk factor(s) in the “Parental Risk Factors” row of the screening tool. This requirement does **not** apply to “risk of sexual abuse.”

Do not indicate a “risk of . . .” allegation when a more serious allegation within the same category has already been selected. For example, do not select “child injury” and “risk of physical abuse.” This overlap is not permitted because where there is an allegation that meets the definition of a child maltreatment item, selecting “risk of . . .” becomes redundant.

If multiple children in the family are alleged to have been abused or neglected, capture all the allegations on the same screening tool. Similarly, if there are multiple types of allegations in relation to one or more children in the family, capture all those allegations on the same tool.

### **Parental Risk Factors**

The “Parental Risk Factors” include several parental risk factors that the reporter may be alleging are present that may have contributed to the abuse/neglect or risk of abuse/neglect. The intake caseworker may also be aware of the presence of risk factors from previous contacts with the family per DCYF or DELJIS records.

For a parental risk factor to be selected, the information provided must meet the definitional requirements for that factor. It is useful to keep in mind that the definitions require a fairly high level of parental dysfunction in order to say that the risk factor exists.

If any abuse/neglect item is selected, and if any of the parental risk factors listed are present in the case, the caseworker must indicate the nature of any relevant parental risk factors. If any “risk of” allegation is selected, a corresponding parental risk factor **must** be selected. *The only exceptions to this are the allegations of “risk of sexual abuse” and “risk of trafficking.”*

### **SECTION 3: INITIAL CHILD ABUSE AND NEGLECT SCREENING DECISION**

This section is used to indicate the initial screening decision for child abuse and neglect reports. If one or more child abuse and neglect categories have been checked in Section 2, select the “Screen report in” box. If none of the categories in Section 2 have been selected, check the “Screen report out” box. “Screen out” means that the report has not been accepted as one that will be investigated/assessed by DFS because the allegation as reported did not meet the SDM definitional threshold for any of the maltreatment categories.

### **SECTION 4: CONSIDERATION OF CHILD ABUSE AND NEGLECT REPORT OVERRIDES**

This section is used to indicate whether, due to special circumstances, the initial screening decision may be overridden.

- **Override to Screen In Report:** This category would be used in instances where no child abuse and neglect category had been checked in Section 2, but the report was going to be screened in anyway. There are two ways this could happen:

- » There is a court order to investigate the allegation; or
- » The worker and/or supervisor believe that there are aggravating circumstances that warrant an investigation of a report that otherwise would have been screened out. If such a discretionary override is used, a clear and convincing rationale must be provided.
- **Override to Screen Out Report:** Select in circumstances where a child abuse and neglect category had been checked in Section 2 (i.e., the definitional threshold was met), but an investigation will not be conducted due to one or more of the circumstances listed.
- **No Overrides Apply:** Select this category if none of the potential overrides are applicable.

## SECTION 5: FINAL SCREENING DECISION

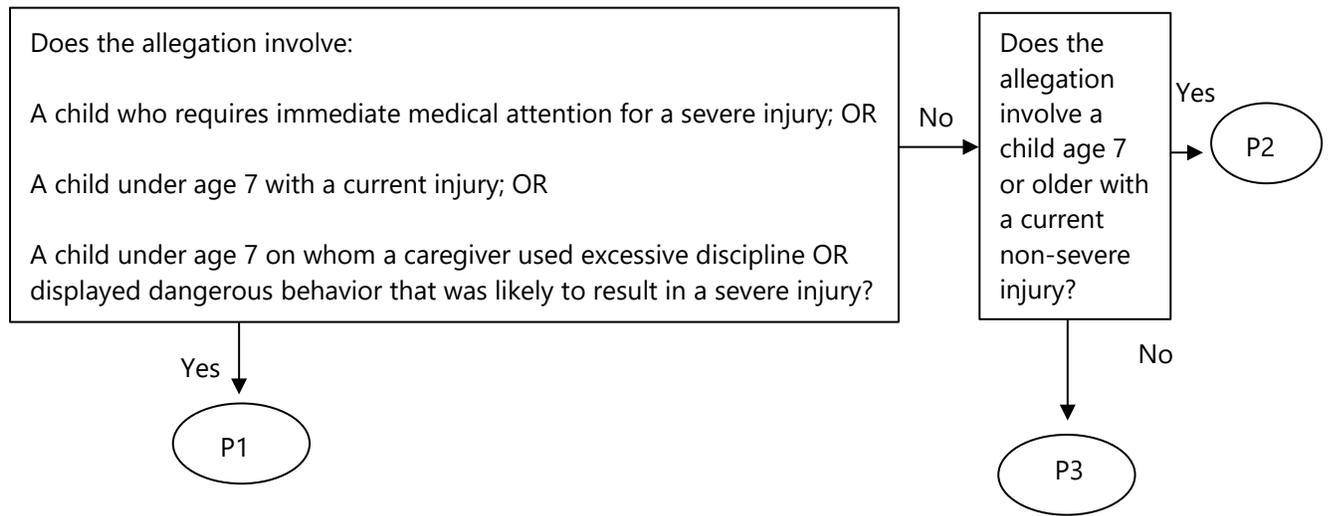
This section is used to show the final decision. The possible decisions are:

- **Screen in child abuse and neglect report:** One or more abuse/neglect items were selected (i.e., the definitional threshold has been met or the report will be investigated due to an override). If the report is screened in, indicate how that report will be handled.
  - » It will be investigated by DFS; or
  - » It will be linked to another current DFS investigation; or
  - » It will be handled via family assessment.
- **Screen out:** No abuse/neglect items were selected because the definitional threshold has not been met, or the report has been screened out due to an override.

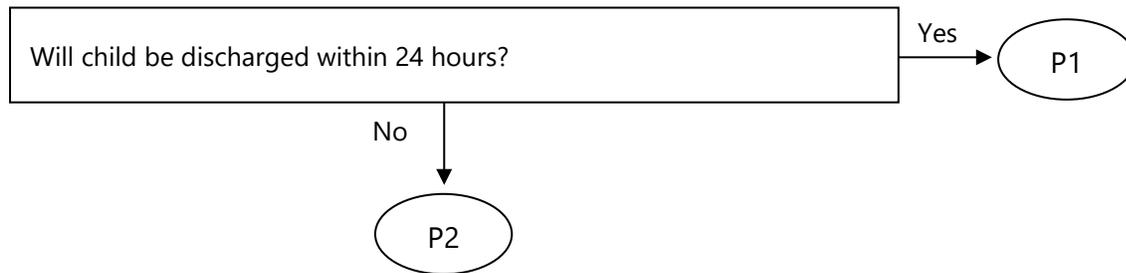
**SECTION 1: RESPONSE PRIORITY DECISION TREES**

*(Required only for screened-in reports that will be handled by DFS)*

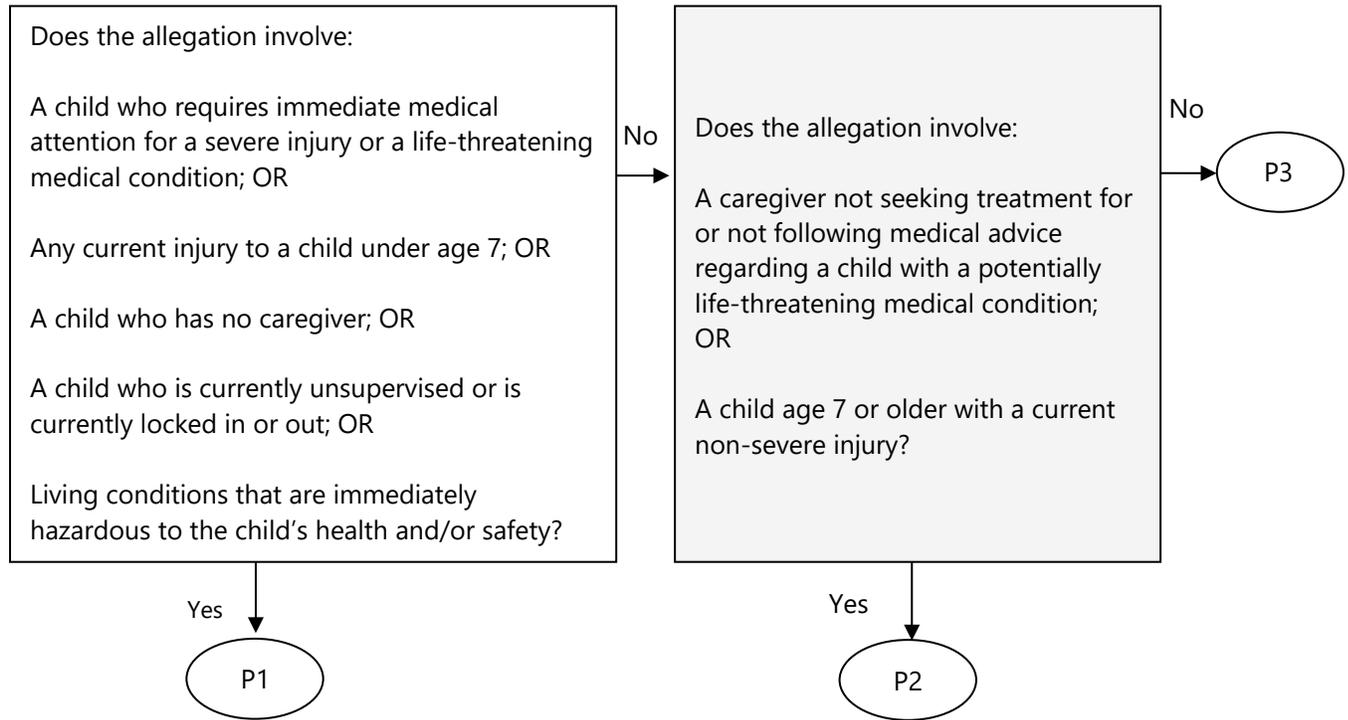
**Physical Abuse**



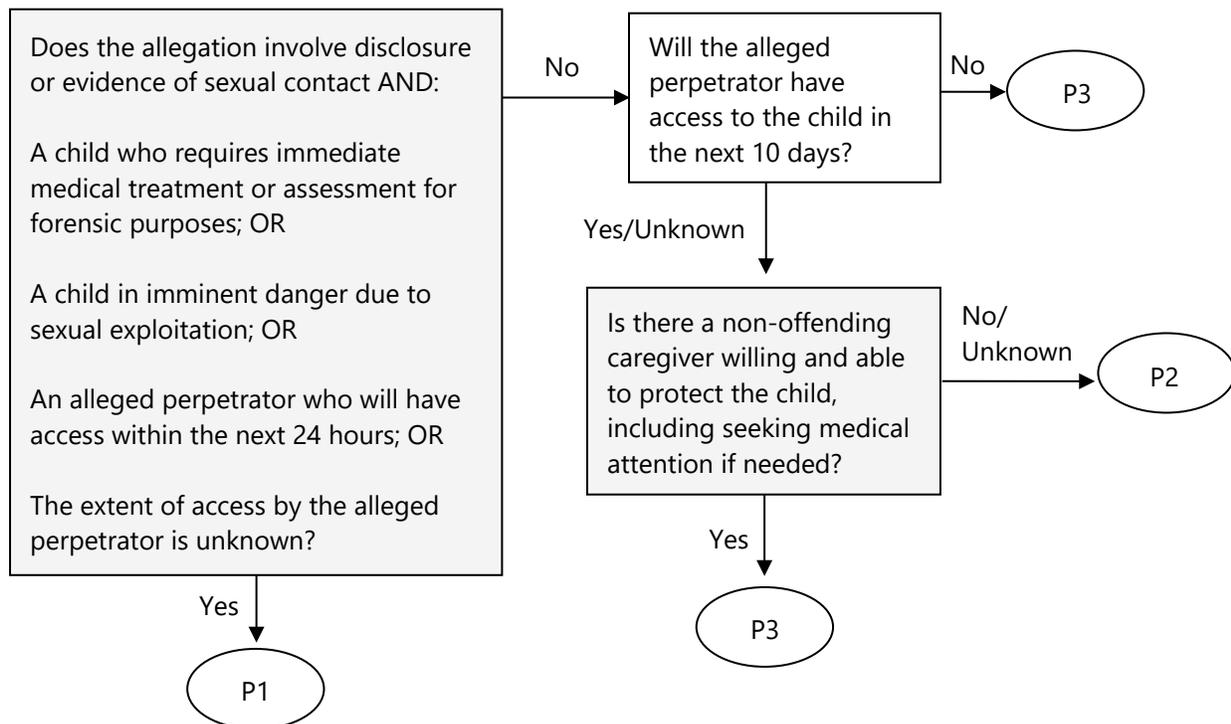
**Infant With Prenatal Substance Exposure**



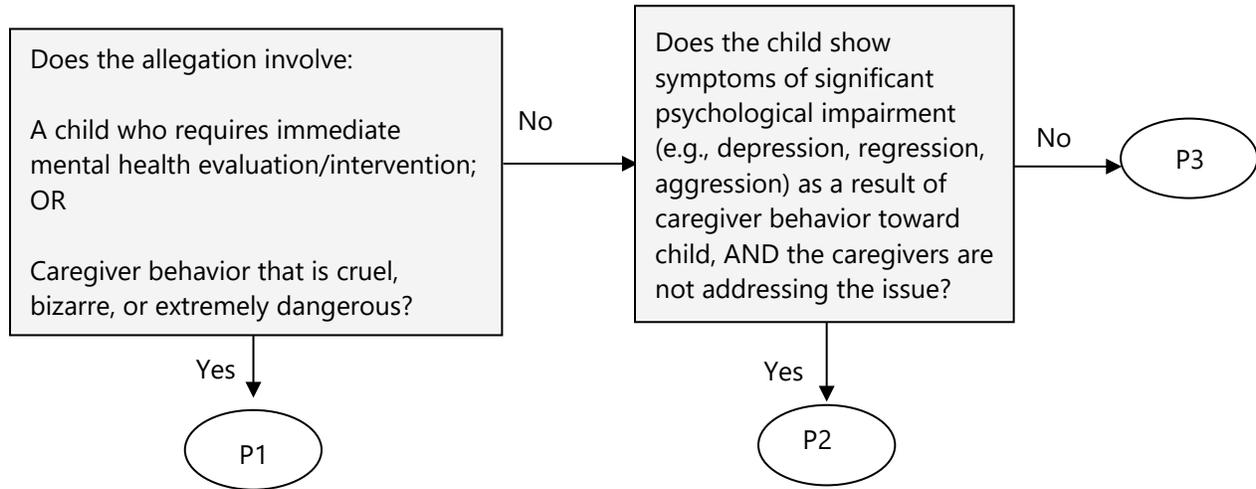
## Neglect



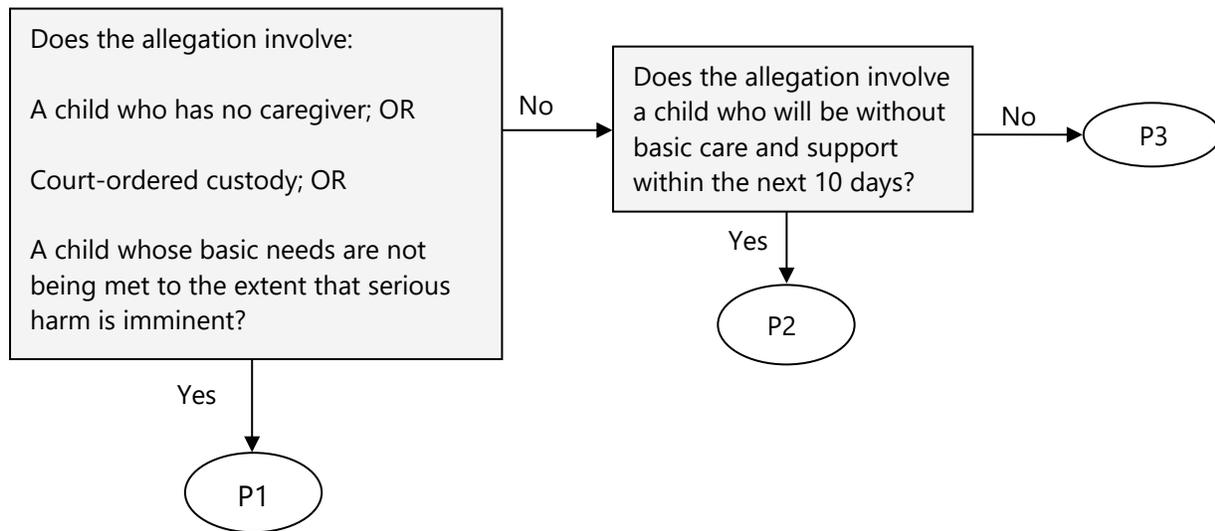
## Sexual Abuse, Exploitation, or Trafficking



### Emotional Abuse/Neglect



### Dependency



**SECTION 2: INITIAL RESPONSE PRIORITY**

- Priority 1: Within 24 hours
- Priority 2: Within three days
- Priority 3: Within 10 days

**SECTION 3: OVERRIDE CONSIDERATIONS**

- No overrides apply

**Policy**Override to Priority 1

- Law enforcement requests urgent response/MOU compliance
- Out-of-state runaway

Override to Priority 2 From Priority 1

- Child is in an alternative safe environment pending a three-day response

**Discretionary**

- Discretionary override to any priority (*specify*): \_\_\_\_\_

**SECTION 4: FINAL RESPONSE PRIORITY**

- Priority 1: Within 24 hours
- Priority 2: Within three days
- Priority 3: Within 10 days

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH AND THEIR FAMILIES  
SDM® RESPONSE PRIORITY ASSESSMENT  
DEFINITIONS**

**PHYSICAL ABUSE**

**Does the allegation involve a child who requires immediate medical attention for a severe injury; OR a child under age 7 with a current injury; OR a child under age 7 on whom a caregiver used excessive discipline OR displayed dangerous behavior that was likely to result in a severe injury?**

- The child requires immediate medical evaluation or treatment or is currently receiving emergency medical evaluation or treatment for a severe injury including blunt force trauma, bone fracture, serious burns and scalds, head trauma, internal injuries, poisoning, serious punctures and stabs, and suffocation. A severe injury is one that requires immediate medical attention. Do not include evaluation solely for forensic purposes, or medical evaluation or treatment that has concluded.
- The child is not yet 7 years old (or has the capability of a child under age 7 years due to developmental, physical, or emotional disability) and has a current injury of any severity. Do not consider a scar to be a current injury.
- Regardless of whether an injury has occurred, the caregiver used excessive discipline or acted in dangerous ways toward the child. Include any action that could reasonably result in severe injury. (A severe injury is one that requires immediate medical attention.)
  - » Excessive discipline: Striking a child with a closed fist in the head, chest, back, or abdomen with substantial force; burning, cutting, choking, or kicking; hitting with belt buckle, extension cord, or other dangerous object; using bondage; poisoning; throwing objects at the child that could cause severe injury; use or threatened use of a deadly weapon (consider age and vulnerability of the child); **OR**
  - » Dangerous behavior: The alleged perpetrator behaves in ways that are not related to discipline but are likely to result in serious injury to the child. Examples include: giving a young child excessive doses of medication; giving alcohol or drugs to a child; dangling the child from heights; exposing the child to dangerous extremes of temperature; using the child as a shield (e.g., in domestic violence cases); domestic violence incidents that occur while the child is present and in which weapons or objects have been used, or in which the child has attempted to intervene.

**Does the allegation involve a child age 7 or older with a current non-severe injury?**

The current report involves a child who is at least 7 years of age AND there is a report that the child has a current injury that is not severe. Do not consider a scar to be a current injury.

**INFANT WITH PRENATAL SUBSTANCE EXPOSURE**

**Will child be discharged within 24 hours?**

The child is likely to be discharged within 24 hours. Exclude methadone if parent is part of a recovery program.

**NEGLECT**

**Does the allegation involve a child who requires immediate medical attention for a severe injury or a life-threatening medical condition; OR any current injury to a child under age 7; OR a child has no caregiver; OR a child is currently unsupervised or is currently locked in or out; OR living conditions that are immediately hazardous to the child's health and/or safety?**

- A child of any age is not receiving medical attention and has deteriorated to the point that urgent, immediate treatment (i.e., within 24 hours) is required to treat a life-threatening injury/condition. Examples of conditions include asthma, diabetes, breathing difficulties, etc.
- A child under the age of 7 has a current injury of any severity.
- There is no adult willing or able to take on a role of care, custody, and control for this child.
- A child is currently unsupervised or is currently locked in or out.
- Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening. Examples include the following.
  - » Leaking gas from stove or heating unit.
  - » Substances or objects accessible to the child that may endanger their health and/or safety.
  - » Exposed electrical wires.

- » Excessive garbage or rotted or spoiled food that threatens the child's health.
- » The child has suffered serious illness or significant injury due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites).
- » Evidence of human or animal waste throughout living quarters.
- » Guns and other weapons are not locked.
- » Methamphetamine production in the home.

**Does the allegation involve a caregiver not seeking treatment for or not following medical advice regarding a child with a potentially life-threatening medical condition; OR a child age 7 or older with a current non-severe injury?**

- Potentially life-threatening medical condition: A caregiver has not obtained medical attention—or has not consistently followed medical advice—for a potentially life-threatening condition. Examples include but are not limited to a caregiver who does not seek medical treatment (e.g., insulin, emergency inhalers, maintenance of equipment necessary to sustain breathing) for a child with a chronic or serious condition, or a caregiver who does not routinely provide necessary medications to a child with such conditions. Include children with severe malnourishment or dehydration whose needs are not appropriately met. While the situation is serious, it does not require a response in less than 24 hours.
- Child age 7 or older with a current non-severe injury: A non-severe injury is one that does not require medical attention to avoid loss of functioning or death.

**SEXUAL ABUSE, EXPLOITATION, OR TRAFFICKING**

**Does the allegation involve disclosure or evidence of sexual contact AND a child who requires immediate medical treatment or assessment for forensic purposes; OR a child in imminent danger due to sexual exploitation; OR an alleged perpetrator who will have access within the next 24 hours; OR the extent of access by the alleged perpetrator is unknown?**

The allegation involves disclosure or evidence of sexual contact with a child.

Sexual contact includes intercourse; any penetration; any intentional touching of the child's anus, breast, buttocks, or genitalia when such touching is sexual in nature; or intentionally having a child touch another person's anus, breast, buttocks, or genitalia. Sexual contact also includes touching through clothing.

## AND

- The child requires immediate medical attention due to the sexual abuse; **OR**
- The current report involves an allegation of sexual exploitation and the child is in imminent danger of harm (e.g., is engaged in prostitution or human trafficking); **OR**
- The alleged perpetrator will have access to the child within the next 24 hours; **OR**
- The extent of access by the alleged perpetrator is unknown.

### **Will the alleged perpetrator have access to the child in the next 10 days?**

The alleged perpetrator will have access to the child in the home within the next 10 days, or the alleged perpetrator has physically contacted the child away from the home or threatened to contact the child away from the home through any means (include physical, phone, Internet, and other contact).

### **Is there a non-offending caregiver willing and able to protect the child, including seeking medical attention if needed?**

A non-offending caregiver supports the child's disclosure and demonstrates the ability/willingness to prevent the alleged perpetrator from having access to the child **AND** the non-offending caregiver will not pressure the child to change their statement **AND** the non-offending caregiver will obtain medical treatment for the child if needed.

## EMOTIONAL ABUSE/NEGLECT

### **Does the allegation involve a child who requires immediate mental health evaluation/intervention; OR caregiver behavior that is cruel, bizarre, or extremely dangerous?**

- Immediate mental health evaluation/intervention: The child shows symptoms of severe psychological distress due to caregiver actions and requires immediate mental health evaluation and/or intervention. Examples include but are not limited to:
  - » The child is threatening to commit suicide, behaving in suicidal ways, or repeatedly engages in self-harming behavior (e.g., cutting);
  - » The child is currently acting out in extremely violent ways (e.g., using guns, knives, or explosives; fire-setting); or

- » The child is acutely depressed, anxious (e.g., unable to perform basic tasks of daily living), or withdrawn. Examples include an inability to engage in any social activity.
- Caregiver behavior that is cruel, bizarre, or extremely dangerous: Examples include but are not limited to:
  - » The caregiver harms self, others, or pets in the child's presence;
  - » The caregiver threatens to harm self, others, or the child's pet;
  - » Unusual forms of discipline that rely on humiliation, fear, and intimidation, such as forcing a 10-year-old to wear diapers or forcing the child to stand in a corner on one leg;
  - » Extreme rejection of the child, such as not speaking to the child for extended periods, acting as if the child is not present for long periods, or misusing time-out technique by using time limits far beyond what would be appropriate for the child's age/developmental status;
  - » A pattern of chronic or frequent belittling of the child that has resulted in harm to the child or a significant change in the child's behavior; or
  - » Domestic violence incidents in which the child is present and that involve weapons or result in serious injury to any adult.

**Does the child show symptoms of significant psychological impairment (e.g., depression, regression, aggression) as a result of caregiver behavior toward the child, AND the caregivers are not addressing the issue?**

The child has begun to display symptoms of psychological impairment as a result of caregiver behavior toward the child. Symptoms may include behavior extremes, low self-esteem, offending behavior, or depression. Specific indicators may include aggressiveness, destructive or antisocial behavior, emotional withdrawal or constant sadness, or inability to react with emotion. In younger children, indicators may include clinging or compulsively seeking affection and attention; unusual fears for the child's age (e.g., fear of going home or being left alone); difficulty eating or sleeping; frequent headaches, stomachaches, or nightmares; being easily startled; or regression to bedwetting, thumb sucking, or rocking, **AND** these or other symptoms are having a clear negative impact on the child's functioning at home, school, or in the community.

**AND**

The caregivers have not taken steps to seek treatment or otherwise address the issue.

## **DEPENDENCY**

**Does the allegation involve: a child who has no caregiver; OR court-ordered custody; OR a child whose basic needs are not being met to the extent that serious harm is imminent?**

- There is currently no adult willing or able to take on responsibility for the care, custody, and control of the child. Include Safe Arms cases and any child who falls under DCYF Policy 209.
- Custody is court-ordered.
- The child's basic needs (food, clothing, shelter, health care, medical care, supervision) are currently not met to the extent that the child is at imminent threat of serious injury/illness.

**Does the allegation involve a child who will be without basic care and support within the next 10 days?**

The child's caregiver is currently available and basic needs (food, clothing, shelter, health care, medical care) are currently met, but within the next 10 days either no caregiver will be available and/or the child's basic needs will go unmet to the extent that there will be an imminent threat of serious injury/illness.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH AND THEIR FAMILIES  
SDM® RESPONSE PRIORITY ASSESSMENT  
POLICY**

**PURPOSE AND POLICY**

The purpose of the response priority tools is to determine how quickly DFS should respond to screened-in child abuse and neglect reports.

**WHICH CASES**

The response priority portion is completed only for reports with a final screening decision of "screened in."

**WHO**

The intake worker completes the assessment and the supervisor reviews and approves.

**WHEN**

The intake worker completes the assessment as soon as possible, ideally during the reporting telephone call. The assessment is documented as soon as possible and disposed no later than the end of the shift of the intake worker who received the report.

The supervisor reviews and approves assessments by the end of the shift.

**DECISION**

The response priority component determines how quickly after acceptance (i.e., documentation of the completed screening and response priority decisions) that the assigned worker must make face-to-face contact with the family. Possible response times are as follows.

- **Priority 1:** Within 24 hours
- **Priority 2:** Within three days
- **Priority 3:** Within 10 days

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH AND THEIR FAMILIES  
SDM® RESPONSE PRIORITY ASSESSMENT  
PROCEDURES**

This section describes procedures for completing the response priority tools. The tool has four basic sections.

- **Section 1:** A series of five separate response priority decision trees. Use the decision tree indicated by the allegation type selected.
- **Section 2:** For recording the initial response priority decision.
- **Section 3:** For considering response priority overrides.
- **Section 4:** To record the final response priority decision.

**SECTION 1: RESPONSE PRIORITY DECISION TREES**

For each report, complete one decision tree for each type of alleged child abuse/neglect. For example, if the only allegation is physical abuse, complete only the physical abuse decision tree. If the allegations include both physical abuse and neglect, complete both of those decision trees.

For each tree, begin at the first question and determine whether “yes” or “no” is appropriate, using the definitions. To determine whether “yes” or “no” is the most appropriate response for each question, the intake worker should ask questions of the reporter until the response becomes clear. **If unable to determine the answer, respond to the question in the most protective way, i.e., answer “yes” to the question.**

Follow the branch of the tree determined by the “yes” or “no” response until reaching a termination point. The termination point indicates whether the SDM system recommends a response of 24 hours, less than three days, or less than 10 days. This is the initial response priority.

When multiple allegation types are reported (e.g., abuse and neglect), **complete all relevant decision trees and select the most urgent response time** as the initial response priority. It is not necessary to complete a decision tree for every allegation once a 24-hour response has been reached for any one allegation.

**If the report was screened in on an override**, no trees are required, and this section may be skipped.

## SECTION 2: INITIAL RESPONSE PRIORITY

Record the most urgent response time determined in Section 1 for any allegation.

## SECTION 3: OVERRIDE CONSIDERATIONS

### Override to Priority 1

A three- or 10-day indicated response priority must be overridden to a 24-hour response priority if:

- Law enforcement requests urgent response/MOU compliance: The memorandum of understanding (MOU) with all statewide law enforcement agencies, the Department of Justice, and the Children's Advocacy Center states that DFS must notify law enforcement when a potential crime has occurred; or
- The report involves an out-of-state runaway.

The worker and/or supervisor also may override the response priority to 24 hours if there are unique aggravating circumstances not captured with the questions and definitions of the decision trees, and those circumstances require an immediate response. A clear and compelling rationale must be documented for any discretionary override to 24 hours.

Note: Do not select an override to 24 hours (i.e., Priority 1) if the decision tree has already recommended a 24-hour response.

### Override to Priority 2 From Priority 1

A 24-hour response may be overridden (downward) to a three-day response if the child is in an alternative safe environment or if the worker and/or supervisor believe and can clearly document that an urgent response is not required.

### Discretionary override

A discretionary override may be used to increase or decrease the response priority by one level. Use a discretionary override when unique situations warrant a faster or slower response time. Provide a brief rationale.

It is expected that no more than 5–8% of all response priority decisions will involve the use of an override.

**If the report was screened in on an override**, use an override and professional judgment to assign a response priority time. For example, if the report was screened in on an override that there is a court order, the time constraints associated with the court order would inform the response priority decision.

All discretionary overrides must be approved by a supervisor or administrator. Supervisor approval is indicated when supervisor reviews, dates, and signs the form.

If no overrides are used, select "No overrides apply."

#### **SECTION 4: FINAL RESPONSE PRIORITY**

Indicate the final response priority level by selecting one answer. If an override was exercised, the final response priority will differ from the initial response priority. If no override was used, initial and final response priority will be the same. When there are multiple allegations, the final response priority for the report is determined by the allegation that results in the most urgent response.

**Report Name:** \_\_\_\_\_ **Report #:** \_\_\_\_\_

**County:** \_\_\_\_\_ **Worker:** \_\_\_\_\_

**Date of Assessment:** \_\_\_\_\_

**Assessment Type:**     Initial     Subsequent (mark one):     review/update     report/case closing

**Names of Children Assessed:** (If more than six children are assessed, add additional names and numbers on reverse)

1.
2.
3.

4.
5.
6.

**Are there additional names on reverse?**     Yes     No

**Household Name:** \_\_\_\_\_

**Factors Influencing Child Vulnerability**

(conditions resulting in child’s inability to protect self; mark all that apply to any child):

- |   |  |
|---|--|
| <input type="checkbox"/> Age 0–5 years                                    | <input type="checkbox"/> Diminished mental capacity (e.g., developmental delay, non-verbal)        |
| <input type="checkbox"/> Significant diagnosed medical or mental disorder | <input type="checkbox"/> Diminished physical capacity (e.g., non-ambulatory, limited use of limbs) |
| <input type="checkbox"/> School age, but not attending school             |  |

**SECTION 1: SAFETY THREATS**

Assess household for each of the following safety threats. Indicate whether currently available information results in reason to believe safety threat is present. Mark all that apply.

Yes    No

- 1. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by:
  - Serious injury or abuse to the child other than accidental.
  - Caregiver fears he/she will maltreat the child.
  - Torture of a child or unreasonable use of physical force.
  - Drug-exposed infant.
  
- 2. Current circumstances, combined with caregiver’s history of child maltreatment, suggest that the child’s safety may be of immediate concern.
  
- 3. Child sexual abuse is suspected, AND circumstances suggest that the child’s safety may be of immediate concern.
  
- 4. Caregiver is unwilling OR unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, sex/labor trafficking, or neglect.
  
- 5. Caregiver’s explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child’s safety may be of immediate concern.

Yes No

- 6. Family refuses access to or hides the child, or there is reason to believe the family is about to flee.
- 7. Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or critical mental health care (suicidal/homicidal).
- 8. Physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
- 9. Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
- 10. Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
- 11. Caregiver persistently describes the child in predominantly negative terms or acts toward the child in negative ways, AND these actions result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
- 12. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
- 13. Other (specify): \_\_\_\_\_

**SAFETY DECISION**

If no safety threats are present, select this safety decision.

- Safe.** No safety threats were identified at this time. No children are likely to be in imminent danger of serious harm, based on currently available information. Complete the investigation as required.

**SECTION 2: SAFETY-PLANNING CAPACITIES**

Complete this section only if one or more safety threats are selected. Mark all that apply.

**Child**

- a. Any child has the cognitive, physical, and emotional capacity to participate in safety interventions. If any child has this capacity, indicate his/her name(s): \_\_\_\_\_

**Caregiver**

Document caregiver capacities if present for any caregiver based on information gathered. (Select all that apply.)

- a. Caregiver is capable of participating in a child safety agreement.
- b. Caregiver is willing to participate in a child safety agreement.
- c. Caregiver has the support of at least one adult who was not involved in the allegation, and the supporting adult is willing and able to participate in a child safety agreement.
- d. Other: \_\_\_\_\_

For each safety-planning capacity selected, provide details that demonstrate its presence.

**SECTION 3: SAFETY INTERVENTIONS**

Consider each identified safety threat and the safety-planning capacity of the family and network to determine if a child safety agreement can be created to control for the danger. Remember that a child safety agreement should describe in detail the immediate action steps that the family and their network will take to help keep the child safe from the danger. If this is possible, select "Safe with agreement" and select the specific interventions being used from the list below. Document the child safety agreement and continue to the risk assessment. If it is impossible to create a child safety agreement, proceed to Section 4 and select "Unsafe."

- a. Safety interventions provided by the worker
- b. Safety interventions involving caregiver, other household members, or network
  - Alleged offender will leave the home, either voluntarily or in response to legal action.
  - Non-offending caregiver will move to a safe environment with the child.
  - Extended family members or network will participate as part of a child safety agreement action step.
  - Other safety intervention involving caregiver, other household members, or network.
 Describe: \_\_\_\_\_
- c. Safety interventions provided by agencies or service providers
  - Community agencies or services are part of a child safety agreement action step.
  - Formal tribal and/or Indian Child Welfare Act (ICWA) intervention is part of a child safety agreement action step.
  - Other safety intervention provided by agencies or service providers.
 Describe: \_\_\_\_\_
- d. The child will temporarily reside with an alternative care provider identified by the family and with worker monitoring. The caregiver has identified an alternative care provider for the child to reside elsewhere.

**SAFETY DECISION**

- Safe with agreement.** One or more safety threats are present; however, the child can safely remain in the home with a child safety agreement. Without effective preventive services, the planned arrangement for the child will be custody, removal, and placement with a protective resource (e.g., foster family, group home). Select all interventions used in the child safety agreement. **A child safety agreement is required.**  
Note: Refer to DFS Policy 411, "Considered Removal Team Decision Making Meeting."

**SECTION 4: PLACEMENT INTERVENTION**

**SAFETY DECISION**

- Unsafe.** One or more safety threats are present. A child safety agreement was considered but could not be created. As a result, custody and removal are the only protective interventions possible for one or more children because none of the safety interventions (a–d) adequately ensures the child’s safety. Without custody and removal, one or more children will likely be in danger of immediate harm. Note: Refer to DFS Policy 411, "Considered Removal Team Decision Making Meeting."

The following children require out-of-home intervention: *(enter names from page 1)*


**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® SAFETY ASSESSMENT  
DEFINITIONS**

**SECTION 1: SAFETY THREATS**

**1. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by:**

- Serious injury or abuse to the child other than accidental—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.
- Caregiver fears he/she will maltreat the child—Caregiver has reported they may maltreat the child AND/OR has threatened to cause harm AND/OR may retaliate against the child for DFS investigation AND this maltreatment or threat of action, if actually conducted, would result in serious harm.
- Torture of a child or unreasonable use of physical force—The caregiver has tortured a child or used physical force in a way that bears no resemblance to reasonable discipline or punished the child beyond the duration of the child’s endurance. Examples include, but are not limited to, having the child kneel on rice, hold or carry heavy objects for an extended time, or run laps to the point of collapse as punishment. Use this subcategory for caregiver actions that are likely to result in serious harm, but have not yet caused a serious injury.
- Drug-exposed infant—There is evidence that the mother used alcohol, drugs, or other substances during pregnancy, AND this has created imminent danger to the infant.

» Indicators of drug use during pregnancy include: drugs found in the mother’s or child’s system, mother’s self-report, diagnosed as high-risk pregnancy due to drug use, efforts on mother’s part to avoid toxicology testing, withdrawal symptoms in mother or child, pre-term labor due to drug use.

AND

» Indicators of imminent danger to the infant include:

- The infant is diagnosed as medically fragile as a result of drug exposure or the infant suffers adverse effects from introduction of drugs during pregnancy; AND
- The caregiver does not demonstrate ability to provide safe care of the infant. For example, caregiver is consistently disinterested in infant; caregiver does not hold infant, feed, change diapers; caregiver is unable to absorb necessary medical information or utilize equipment necessary to sustain life (e.g., apnea monitor); caregiver is co-sleeping with infant, especially while under the influence.

**2. Current circumstances, combined with the caregiver’s history of child maltreatment, suggest the child’s safety may be of immediate concern.**

This safety threat is used when there are no other safety threats present (i.e., no other safety threat definition has been met), but there are concerns that the family may be at a “tipping point” due to a combination of conditions near the definition of another safety threat and a prior history of child maltreatment. If the definition of any other safety threat is met, this threat may not be selected.

- There must be current circumstances that threaten child safety;

AND

- Related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.

Previous maltreatment includes any of the following:

- » Prior death of a child as a result of maltreatment.
- » Prior serious injury or abuse to the child other than accidental. 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, or any other physical injury that seriously impairs the health or well-being of the child *and required medical treatment*.
- » Failed reunification—the caregiver had reunification efforts terminated in connection with a prior CPS investigation.
- » Prior removal of a child—removal/placement of a child by CPS or other responsible agency or concerned party was necessary for the safety of the child.

- » Prior CPS substantiation—a prior CPS investigation was substantiated for maltreatment.
- » Prior inconclusive CPS investigation—factors to be considered include seriousness, chronicity, and/or patterns of abuse/neglect allegations.
- » Prior threat of serious harm to a child—previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against a child for previous incidents; prior domestic violence that resulted in serious harm or threatened harm to a child.
- » Prior service failure—failure to successfully complete court-ordered or voluntary services, indicating that the family or caregiver have not changed their behavior to address previous issues.
- » The family has a history of keeping the child at home, away from friends, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.

**3. Child sexual abuse is suspected, AND circumstances suggest that the child’s safety may be of immediate concern.**

Suspicion of sexual abuse may be based on indicators such as:

- The child discloses sexual abuse.
- The child demonstrates inappropriate or sexualized behavior, based on the child’s age and developmental level.
- Medical findings consistent with molestation.
- The caregiver or others in the household have been convicted, investigated, or accused of rape or sodomy, or have had other sexual contact with a child.
- The caregiver or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).

AND

The child’s safety may be of immediate concern if:

- The non-offending caregiver is not willing or able to be protective or is otherwise influencing or coercing the child victim regarding disclosure.

- A confirmed sexual abuse perpetrator, especially with known restrictions regarding any child under age 18, or an alleged trafficking perpetrator has access to the child.

**4. Caregiver is unwilling OR unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, sex/labor trafficking, or neglect.**

- The caregiver fails to protect the child from serious harm or threatened harm as a result of physical abuse, neglect, sex/labor trafficking, or sexual abuse by other family members, other household members, or others having regular access to the child. The caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage.

Suspicion of sex trafficking may be based on indicators such as the following.

- » Multiple runaway attempts
- » Unexplained access to money
- » High number of intimate partners reported for age
- » Sexually transmitted diseases and/or multiple terminated pregnancies
- » Branding
- » Controlling or older intimate partner
- » Has friend or relative involved in commercial sex
- » Found in area known for illegal commercial sex
- » Sexually explicit social networking profiles

Suspicion of labor trafficking may be based on indicators such as the following.

- » Appearing malnourished
- » Showing signs of physical injury and abuse
- » Lacking official identification documents
- » Working excessively long hours
- » Living at the place of employment
- » Branding

- An individual with known violent criminal behavior/history resides in the home, or the caregiver allows access to the child.

**5. Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.**

Assess this item based on the caregiver's statements by the end of the contact. It may be typical for a caregiver to initially minimize, deny, or give an inconsistent explanation, but,

through discussion, admit to the true cause of the child's injury. Such situations should be understood as a "normal" reaction and not as a safety threat. *However*, mark this safety threat if the caregiver's statements have not changed (i.e., to admit or accept the more likely explanation) by the end of the contact. Examples include, but are not limited to:

- Medical evaluation indicates, or medical professionals suspect, the injury is the result of abuse; the caregiver denies or attributes injury to accidental causes.
- The caregiver's description of the injury or cause of the injury minimizes the extent and impact of harm to the child.
- Factors to consider include the child's age, location of injury, special needs of the child (cognitive, emotional, or physical), or history of injuries.

Do not include situations in which the caregiver offers no explanation for a child injury.

**6. Family refuses access to or hides the child, or there is reason to believe the family is about to flee.**

- The child's location is unknown to DFS, and the family will not provide the child's current location.
- The family has removed or threatened to remove the child from whereabouts known to DFS to avoid investigation.
- The family has previously fled in response to a CPS investigation.
- The family is keeping the child at home, away from friends, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.
- The caregiver coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

**7. Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or critical mental health care (suicidal/homicidal).**

- Minimal nutritional needs of the child are not met, resulting in danger to the child's health, such as malnourishment.
- The child is without clothing appropriate to the weather. Consider the age of the child and whether clothing is the choice of the child or the provision of the parent.

- The caregiver does not seek treatment for the child’s immediate, chronic, and/or dangerous physical medical condition(s), or does not follow prescribed treatment for such conditions.
- The child has exceptional needs, such as being medically fragile, which the caregiver does not or cannot meet.
- The child shows significant symptoms of prolonged lack of emotional support of and/or socialization with the caregiver, including lack of behavioral control, severe withdrawal, and missed developmental milestones that can be attributed to caregiver behavior.
- The caregiver does not provide age- or developmentally appropriate supervision to ensure the safety and well-being of the child to the extent that 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 an unprotected window ledge, or be exposed to other serious hazards).
- The caregiver is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).
- The caregiver makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child’s care, OR the caregiver leaves the child alone (time period varies with age and developmental stage). Take into consideration the length of time, provisions for emergencies (e.g., able to call 911, neighbors able to provide assistance), and any needs or vulnerabilities of the children.

Exclude situations in which the caregiver chooses not to provide psychotropic or behavioral medications to a child unless the child is suicidal or homicidal.

**8. 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:

- Leaking gas from stove or heating unit.
- Substances or objects accessible to the child that may endanger his/her health and/or safety, such as chemicals, drugs, or drug paraphernalia.
- Lack of water or utilities (heat, plumbing, electricity), and no alternate or safe provisions are made.

- Open/broken/missing windows in areas accessible to children and/or unsafe structural issues in the home (e.g., walls falling down, floor missing).
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food that threatens health.
- Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites).
- Evidence of human or animal waste throughout living quarters.
- Guns/ammunition and other weapons are not safely secured and are accessible to children.
- Methamphetamine production in the home.
- The family has no shelter for the night, or is likely to be without shelter in the near future (e.g., the family is facing imminent eviction from their home and has no alternative arrangements; the family is without a permanent home and does not know where they will take shelter in the next few days or weeks) AND this lack of shelter is likely to present a threat of serious harm to the child (e.g., the child is likely to be exposed to extreme cold without shelter, the child is likely to sleep in a dangerous setting).

**9. Caregiver’s current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.**

The caregiver has abused legal or illegal substances or alcoholic beverages to the extent that the caregiver is unable, or will likely be unable, to care for the child; has harmed the child; or is likely to harm the child.

**10. Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.**

There is evidence of domestic violence in the home, AND the alleged perpetrator’s behavior creates a safety concern for the child.

Domestic violence perpetrators, in the context of the child welfare system, are parents and/or caregivers who engage in a pattern of coercive control against one or more intimate partners. This pattern of behavior may continue after the end of a relationship or when the couple no longer lives together. The alleged perpetrator’s actions often directly involve, target, and impact any children in the family.

Incidents may be identified by self-report, credible report by a family or other household member, credible sources, and/or police reports.

Do not include violence between any adult household member and a child. (Consider whether safety threat 1 or 4 applies.)

Do not include arguments that do not escalate beyond verbal encounters and are not otherwise characterized by threatening or controlling behaviors.

Examples may include:

- The child was previously injured in domestic violence incident.
- The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations associated with domestic violence.
- The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of domestic violence in the home.
- The child is at potential risk of physical injury (e.g., parent holding child while alleged perpetrator attacks parent).
- The child's behavior increases risk of injury (e.g., attempting to intervene during violent dispute, participating in the violent dispute).
- Use of guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.
- Evidence of property damage resulting from domestic violence.

**11. Caregiver persistently describes the child in predominantly negative terms or acts toward the child in negative ways, AND these actions result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.**

This threat is related to a persistent pattern of caregiver behaviors.

Examples of caregiver actions include the following:

- The caregiver describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
- The caregiver curses at and/or repeatedly puts the child down.
- The caregiver scapegoats a particular child in the family.

- The caregiver blames the child for a particular incident or family problems.
- The caregiver places the child in the middle of a custody battle (e.g., parent persistently makes negative comments about other parent).

**12. Caregiver’s emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.**

Caregiver appears to be mentally ill, developmentally delayed, or cognitively impaired, AND as a result, one or more of the following are observed:

- The caregiver’s refusal to follow prescribed medications impedes his/her ability to parent the child.
- The caregiver’s inability to control emotions impedes his/her ability to parent the child.
- The caregiver acts out or exhibits a distorted perception that impedes his/her ability to parent the child.
- The caregiver’s mental health status impedes his/her ability to parent the child.
- The caregiver 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, to be still for extended periods, be toilet trained, eat neatly; expected to care for younger siblings; or expected to stay alone).
- Due to cognitive delay, the caregiver lacks the basic knowledge related to parenting skills such as:
  - » Not knowing that infants need regular feedings;
  - » Failure to access and obtain basic/emergency medical care;
  - » Proper diet; or
  - » Adequate supervision.

**13. Other (specify).** Circumstances or conditions that pose an immediate threat of serious harm to a child not already described in safety threats 1–12.

**SAFETY DECISION**

**Safe.** No safety threats were identified at this time. No children are likely to be in imminent danger of serious harm, based on currently available information. Continue the investigation as required.

## SECTION 2: SAFETY-PLANNING CAPACITIES

### Child

- a. Any child has the cognitive, physical, and emotional capacity to participate in safety interventions.
  - Any child has an understanding of his/her family environment in relation to any real or perceived safety threats and is able to communicate at least two options to obtain immediate assistance if needed (e.g., calling 911, running to neighbor, telling teacher).
  - Any child is emotionally capable of acting to protect his/her own safety despite allegiance to his/her caregiver or other barriers.
  - Any child has sufficient physical capability to defend him/herself and/or escape if necessary.

### Caregiver

- a. Caregiver is capable of participating in a child safety agreement. Consider caregiver's cognitive, physical, and emotional capacity to follow through with all interventions necessary to protect the child from further danger.
- b. Caregiver is willing to participate in a child safety agreement. The caregiver has agreed to accept the worker's involvement and recommendations and to follow the action steps detailed on a child safety agreement that is sufficient to control for the danger.
- c. Caregiver has the support of at least one adult who was not involved in the allegation, and the supporting adult is willing and able to participate in a child safety agreement. The caregiver has a supportive relationship with at least one other family member, neighbor, or friend who can play an active role in a child safety agreement that is sufficient to control for the danger.
- d. Other. Note any other present safety-planning capacity that makes the worker confident that the caregiver and the network will be able to control for the danger.

## SECTION 3: SAFETY INTERVENTIONS

### Caregiver

- a. Safety interventions provided by the worker. Actions taken or planned by the worker that specifically address one or more safety threats. Examples include, but are not limited to, providing emergency aid such as food, transportation, or mentoring; planning return visits to the home to check on progress; or providing information and/or assistance in obtaining services or legal advice. This cannot be the only intervention selected when doing a child safety agreement.
- b. Safety interventions involving caregiver, other household members, or network. Applying the family's own strengths as resources to mitigate safety threats; or using extended family members, neighbors, tribal members, friends, or other individuals to mitigate the danger. Examples include, but are not limited to, engagement with a grandparent to assist with childcare, agreement by a neighbor to serve as a safety resource for a child, or commitment by 12-step sponsor or recovery support person to meet with caregiver daily.

One or more of the following interventions may apply. If "b" is selected, at least one of these options also must be selected.

- *Alleged offender will leave the home, either voluntarily or in response to legal action.* The alleged offender will temporarily or permanently leave the home.
  - *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 alternative location where the alleged offender will not have access to the child.
  - *Extended family members or network will participate as part of a child safety agreement action step.* A family member, friend, or other person in the family's life has agreed to be responsible for a specific activity on the child safety agreement.
  - *Other safety intervention involving caregiver, other household members, or network.* The family or their network will take other actions not described above. Describe in the space provided.
- c. Safety interventions provided by agencies or service providers. Community resources used as a safety intervention should be immediately available to the family and be able to reduce the threat of imminent danger of serious harm. Examples include, but are not limited to, use of shelters, food pantries, and other services provided by community

agencies or providers. *Not included* are long-term therapy or treatment, placement on a waiting list for services, or delays in contact and initiation of services to the family.

If "c" is selected, at least one of the following interventions also must be selected.

- *Community agencies or services are part of a child safety agreement action step.* This means involving a community-based or faith-related organization or other agency in activities to address safety threats (e.g., using a local food pantry).
- *Formal tribal and/or Indian Child Welfare Act (ICWA) intervention is part of a child safety agreement action step.* This includes, but is not limited to, use of tribal services from the child or caregiver's tribe or a tribal consortium, tribal resource center, or tribal health clinic.
- *Other safety intervention provided by agencies or service providers.* Agency professionals will take other actions. Describe in the space provided.

Note: For these items, *do not include* services such as long-term therapy or treatment or placement on a waiting list for services.

- d. The child will temporarily reside with an alternative care provider identified by the family and with worker monitoring.

The caregiver has identified an alternative care provider for the child to reside elsewhere. To select this intervention, the worker must document:

- The address of the child's temporary residence;
- The person in that household who will be responsible for the child;
- Background checks (criminal history and DFS history) on all persons in the residence;
- Completion of the relative/non-relative home safety assessment;
- Inclusion of the person responsible for the child into a child safety agreement to contain the threats to the child's safety; and
- A timeframe to reassess the agreement to make a decision for the longer-term residence of the child.

## SAFETY DECISION

**Safe with agreement.** One or more safety threats are present; however, risk to the child can be mitigated with a child safety agreement. Without effective preventive services, the planned arrangement for the child will be custody, removal, and placement with a protective resource (e.g., foster family, group home). Select all interventions used in the child safety agreement. **A child safety agreement is required.** Note: Refer to DFS Policy 411, "Considered Removal Team Decision Making Meeting."

## SECTION 4: PLACEMENT INTERVENTION

### SAFETY DECISION

**Unsafe.** One or more safety threats are present. A child safety agreement was considered but could not be created. As a result, custody and removal are the only protective interventions possible for one or more children because none of the safety interventions (a–d) adequately ensures the child’s safety. Without custody and removal, one or more children will likely be in danger of immediate or serious harm. **If the safety assessment was conducted during a family assessment response, a finding of Unsafe requires that the case be changed to an investigation response.** Note: Refer to DFS Policy 411, "Considered Removal Team Decision Making Meeting."

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® SAFETY ASSESSMENT  
POLICY**

**PURPOSE AND POLICY**

The purpose of the safety assessment is: 1) to help assess whether any child is likely to be in immediate danger of serious harm/maltreatment, which requires a protecting intervention, and 2) to determine what interventions should be initiated or maintained to provide appropriate protection.

**Safety versus risk assessment:** It is important to keep in mind the difference between safety and risk when completing this form. Safety assessment differs from risk assessment in that it assesses the child's present danger and the interventions currently needed to protect the child. In contrast, risk assessment looks at the likelihood of future maltreatment.

**WHICH CASES**

All cases in which the child is in his/her own home, including investigation, family assessment, and treatment.

Include investigations of allegations in non-approved relative homes and non-approved non-relative homes.

Exclude investigations or family assessments of allegations of out-of-state runaway and abandoned infant (Safe Arms).

Exclude assessment of institutional abuse, adoption, and permanency cases.

**WHICH HOUSEHOLD**

Assess the household of which the child is a member that is:

- Also the household of the alleged perpetrator (for investigation)
- Also the household receiving services (for treatment)

Keep in mind that although a child may not spend the majority of his/her time in the household, if he/she is routinely in that household, that defines the household. For example, if a child lives with his mother most of the time, but has regular visitation in his father's home, you would assess the father's household if he were the alleged perpetrator.

**WHO**

The worker who is responsible for the case.

## WHEN

A child's safety shall be assessed:

- At the time of the initial face-to-face contact with the identified victim and household caregivers;
- Prior to returning a child home;
- Within 30 working days prior to treatment case closure;
- Whenever circumstances suggest that the child's safety may be jeopardized, including, but not limited to:
  - » Change in family circumstances (e.g., birth of a baby, new household members, a person leaves the household, the household moves); or
  - » Change in ability of safety interventions to mitigate safety threats.

## AND

- When considering case closure (without transfer to treatment) *if the most recent safety assessment finding was safe with agreement or unsafe* to ensure that all prior and current safety threats have been resolved through the child safety agreement and/or treatment plan(s).

The safety assessment *process* is completed immediately. Documentation in For Our Children's Ultimate Success (FOCUS) system is completed within 48 hours.

For a new report, the safety assessment *process* is completed before ending the initial contact with the family. The process is also completed prior to a child returning to the home during the investigation if the child was out-of-home due to concerns about safety.

For a child who has already been protectively placed by law enforcement or other means, and for whom no safety assessment has been completed, the worker will complete a safety assessment within 24 hours of being informed.

## DECISION

The safety assessment provides structured information concerning the danger of immediate harm/maltreatment to a child. This information guides the decision about whether the child may remain in the home with no intervention, may remain in the home with safety interventions in place, or if out-of-home interventions are necessary.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® SAFETY ASSESSMENT  
PROCEDURES**

Workers should familiarize themselves with the items included on the safety assessment and the accompanying definitions. Workers will notice that the items on the tool are items they are probably already assessing. What distinguishes the SDM assessment is that it ensures every worker is assessing the same items in each case, and that the responses to these items lead to specific decisions. Once a worker is familiar with the items that must be assessed to complete the tool, the worker should conduct his/her initial contact as he/she normally would—using good social work practice to collect information from the child, caregiver, and/or collateral sources. The SDM assessment ensures that the specific items comprising the safety assessment are assessed at some time during the initial contact.

Record the date of the safety assessment. The date of assessment should be the date the worker made initial face-to-face contact with the child to assess safety, which may be different than the date the form is being completed in FOCUS.

Enter the type of safety assessment, which is either:

- **Initial.** Each household should have one, and only one, initial assessment. This should be completed during the first face-to-face contact with a household where there are allegations. However, if there are allegations in two households within a single report, there may be two initial safety assessments, one on each household.

A child may be a member of more than one household, and a report may involve more than one household. For example, a child lives with his mother most of the time, but visits with his father on weekends, holidays, and for an extended stay over the summer. There is an allegation that the boy's father physically abused him, and that his mother knew about the abuse and did not take action to prevent future harm to her son. In this case, the child would be a member of two households, and both households would have allegations. In this case, both households (mom's and dad's) would be assessed.

- **Review/update.** After the initial assessment, any additional safety assessment is most likely a review/update, unless it is completed at the point of closing an investigation or case.

- **Investigation closing.** This is a specialized review/update that is completed when considering closing a case after investigation without providing treatment services. This is required if the most recent safety finding was *safe with agreement* or *unsafe*.

Enter the name of the household assessed. In some reports, there may be more than one household with a safety assessment. To correctly link safety assessments to the correct households, enter the name of the household assessed. Typically, this would be the last name of the primary caregiver in the household. If both have the same last name, also include the first name.

Indicate (mark) whether any child vulnerabilities are present. Consider these vulnerabilities when reviewing safety items. Note that these vulnerability issues provide a context for safety assessment. The presence of one or more vulnerabilities does not automatically mean the child is unsafe. The presence of one or more child vulnerabilities does not mean a safety assessment is required.

The safety assessment consists of four sections:

1. **Safety Threats.** This is a list of critical threats that must be assessed by every worker in every case. These threats cover the kinds of conditions that, if they exist, would render a child in danger of immediate harm. Because not every conceivable safety threat can be anticipated or listed on a form, an "other" category permits a worker to indicate that some other circumstance creates a safety threat; that is, there is something other than the listed categories causing the worker to believe that the child is in immediate danger of being harmed.

Sometimes, a worker may identify that a safety threat was present at some time in the past, but is currently not present and is not likely to become a concern in the near future. In such cases, the worker must document carefully why the conditions do not present an imminent danger of serious harm.

Sometimes, a safety threat may be present now, but a temporary intervention is already in place (for example, child is in the hospital, or person causing harm has been temporarily removed). The safety threat should be considered present, and the temporary intervention *may* be considered part of a safety plan.

For this section, rely on information available at the time of the assessment. Workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is expected that not all facts about a case can be known immediately. Some information is inaccessible, and some is deliberately hidden from the worker. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the 12 safety threats and accompanying definitions. For each item, consider the most vulnerable child. If the safety threat is present, based on

available information, mark that item “yes.” If the safety threat is not present, mark that item “no.” If there are circumstances that the worker determines to be a safety threat, and these circumstances are not described by one of the existing items, the worker should mark “other” and briefly describe the threat.

If no safety threats are present, the safety decision is “Safe.” The child may remain in the home for the present.

- 2. Safety-Planning Capacities.** This section is completed only if one or more safety threats were identified. Mark any of the listed safety-planning capacities that are present for any child/caregiver. Consider information from the report; from worker observations; interviews with children, caregivers, and collaterals; and review of records. For “other,” consider any existing condition that does not fit within one of the listed categories but may support safety interventions for the safety threats identified in Section 1.

Safety-planning capacities are not justification that a child is safe. The presence of safety-planning capacity does not negate a safety threat that has been identified.

- 3. Safety Interventions.** This section is completed only if one or more safety threats are identified. If one or more safety threats are present, it does not automatically follow that a child must be placed. In many cases, it will be possible to initiate a temporary agreement that will mitigate the safety threat(s) sufficiently so that the child may remain in the home while the investigation continues or for the next 20–30 days for an ongoing treatment case. Consider the relative severity of the safety threat(s), the caregiver’s protective capacities, and the vulnerability of the child.

The safety intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the safety threat(s), and whether there is reason to believe the caregiver will follow through with a planned intervention. Simply because an intervention exists in the community does not mean it should be used in a particular case. The worker may determine that even with an intervention, the child would be unsafe; or the worker may determine that an intervention would be satisfactory, but has reason to believe the caregiver would not follow through. The worker should keep in mind that any single intervention may be insufficient to mitigate the safety threat(s), but a combination of interventions may provide adequate safety. Also keep in mind that the safety intervention is not the family service plan—it is not intended to “solve” the household’s problems or provide long-term answers. A child safety agreement permits a child to remain home during the course of the investigation.

If one or more safety threats are identified and the worker determines that interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child requires out-of-home interventions.

If one or more interventions will be implemented, mark each category that will be used. If an intervention that will be implemented does not fit in one of the categories, mark line 8 and briefly describe the intervention. Safety interventions 9 and 10 are used only when a child is unsafe and only a removal from the home can ensure safety.

When assessing the appropriateness of safety interventions, it is critical to review the assessed safety-planning capacities in section 2. For example, if caregiver is capable of participating in a child safety agreement is not marked, the rationale for implementing any safety interventions to keep the child in the home must be clearly documented.

If one or more safety threats are identified and the worker is able to identify sufficient safety interventions that lead the worker to believe the child may remain in the home for the present time, the safety decision is "Safe with agreement."

- 4. Placement Intervention.** If the worker determines that the child cannot be safely kept in the home even after considering a complete range of interventions, the safety decision is "Unsafe." It is possible the worker will determine that interventions make it possible for one child to remain in the home while another must be removed. If ANY child requires out-of-home intervention, the safety decision is "Unsafe."

If one or more children are out-of-home, enter the name of the child from page 1; if all children are out-of-home, mark as indicated.

Accurate completion of the safety assessment adheres to the following internal logic:

- If no safety threats are marked, there should be no interventions marked, and the only possible safety decision is, "Safe. No safety threats were identified at this time. No children are likely to be in imminent danger of serious harm, based on currently available information. Continue the investigation as required."
- If one or more safety threats are marked, there must be at least one intervention marked and the only possible safety decisions are:
  - » "Safe with agreement. One or more safety threats are present; however, the child can safely remain in the home with a child safety agreement. Without effective preventive services, the planned arrangement for the child will be custody, removal, and placement with a protective resource (e.g., foster family, group home). Select all interventions used in the child safety agreement"; or
  - » "Unsafe. One or more safety threats are present. A child safety agreement was considered but could not be created. As a result, custody and removal are the only protective interventions possible for one or more children because none of the safety interventions (a–d) adequately

ensures the child's safety. Without custody and removal, one or more children will likely be in danger of immediate harm."

- If one or more interventions are marked the safety decision that should be marked is "Safe with agreement."
- If either out-of-home intervention is marked as an intervention, the safety decision must be "Unsafe."

### **Child safety agreement**

The following must be included in any child safety agreement.

1. What is working well in this family? Document evidence of any protective capacities and family strengths that can be used to address safety threats (e.g., positive relationships, community affiliations, supports, achievements).
2. What is causing the immediate safety threats to the child(ren)? Describe the conditions or behaviors in the home that place any child at imminent threat of serious harm. Use language the family understands so it is clear to them what caused you to identify safety threats.
3. What needs to happen to keep the child(ren) safe, and who will assume responsibility for the actions needed? Explain how each of the safety threats will be contained. Who will take action? What will they do? When does their task need to be accomplished? For how long must the intervention continue? Also describe how the family and the worker will know everyone is completing their assigned tasks.
4. Signatures lines for family members, the worker, and his/her supervisor.

### **A Child Safety Agreement Is Required When Safety Decision Is Safe With Agreement.**

Note: The child safety agreement should be documented in the investigation contact in FOCUS.

The child safety agreement MUST be completed with the family, and a copy should be left with the family. The agreement must be signed by everyone who is a party to the child safety agreement, indicating that they understand and agree to their roles and responsibilities in implementing the agreement. Signing also signifies that participants understand the consequences of not fulfilling their responsibilities regarding the child safety agreement.

If safety threats have not been resolved by the end of the investigation/assessment, the child safety agreement will be provided to the treatment worker, and all remaining interventions will be incorporated into the family service plan.

The child safety agreement must be reviewed every 30 days during investigation or treatment. This is the maximum period before review, and the child safety agreement may be reviewed sooner as needed.

A case cannot be closed by investigation or treatment when there is an active child safety agreement. A child safety agreement review must be done to determine whether (1) the current child safety agreement should continue, (2) the current child safety agreement should be modified, (3) a new child safety agreement should be developed, or (4) a child safety agreement is no longer needed. The worker should document in a FOCUS Progress Note when a child safety agreement has been reviewed and discussed with the family. Numbers (2) and (3) will require new signatures. Number (4) will require a new safety assessment to document that safety threats have been resolved.

A word about the child safety agreement. The initial child safety agreement may rely on community and agency services and resources because the protective abilities of the family or caregiver(s) may be unknown or uncertain. Over time, the child safety agreement should be reviewed regularly, and the responsibility for providing for child safety should be transferred back to the caregiver(s), substituting the family's informal supports for formal and agency-provided supports as the caregiver's ability is developed or better understood. Each child safety agreement should be feasible and effective, meaning that the worker has confidence it will be completed as planned, and that it will be successful in providing for the child's safety. However, each child safety agreement should also employ the skills of the caregiver and family to the fullest extent possible.

### **Practice Considerations**

While safety is the prevailing concern of the first face-to-face contact, the manner of engaging the family will depend upon social work clinical skills. Whenever possible, the worker should use a strength-based approach to initiate the contact, while remaining observant for the presence or absence of safety threats. Many safety threats may be obvious and identified without invasive questioning. Others will benefit from candor, which will be more forthcoming when the family is approached with respect. The first face-to-face contact may be limited to assessing safety if there are significant safety issues. At other times, the worker will also begin to gather information regarding risk and/or strengths and needs items, as well as additional clinical information.

**Primary Care Provider Name:** \_\_\_\_\_ **Report #:** \_\_\_\_\_

- Type: DFS custody**     DFS foster home, contracted provider foster home  
 Approved relative, approved non-relative, pre-adoptive

**Exclude caregiver-initiated agreements and institutional settings.**

Name(s) of foster children in the household:

Name	Age	Name	Age
1.		3.	
2.		4.	

**Date of Report:** \_\_\_\_\_ **Date of Assessment:** \_\_\_\_\_

**Worker Name:** \_\_\_\_\_

**SECTION 1: SAFETY THREATS**

Assess household for each of the following safety threats. Indicate whether currently available information results in reason to believe safety threat is present for any foster/adoptive child currently residing in the household. Mark all that apply.

- 1. Care provider caused physical harm to the child or made a plausible threat to cause physical harm in the current investigation, as indicated by any of the following:
  - Injury or abuse to the child other than accidental;
  - Care provider fears he/she will maltreat the child and/or requests removal;
  - Threat to cause harm or retaliate against the child;
  - Torture of a child or unreasonable use of physical force;
  - Use of physical force or corporal punishment.
- 2. Current circumstances, combined with the care provider’s history of IA, standards review, or intrafamilial child maltreatment and/or incident reports, suggest that the child’s safety may be of immediate concern.
- 3. Child sexual abuse is suspected.
- 4. Care provider fails to protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, sex/labor trafficking, neglect, or emotional abuse.
- 5. Care provider’s explanation for the injury to the child is questionable or inconsistent with the type of injury.
- 6. Care provider hinders/refuses access to or hides the child.
- 7. Care provider does not meet the child’s needs for supervision, food, clothing, and/or medical or mental health care.
- 8. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
- 9. Care provider currently uses illegal substances OR care provider’s current use of a legal substance impairs his/her ability to supervise, protect, or care for the child.
- 10. Domestic violence exists in the household.
- 11. Care provider routinely describes the child in negative terms or acts toward the child in negative ways.
- 12. Care provider’s current emotional stability, developmental status, or cognitive deficiency impairs his/her current ability to supervise, protect, or care for the child.
- 13. Other (specify): \_\_\_\_\_

## SAFETY DECISION

If no safety threats are present, select this safety decision.

- Safe.** No safety threats were identified at this time. No children are likely to be in imminent danger of serious harm, based on currently available information. Continue to the risk assessment and complete the investigation as required.

## SECTION 2: SAFETY-PLANNING CAPACITIES

Complete this section only if one or more safety threats are selected. Mark all that apply.

### Child

- a. Any child has the cognitive, physical, and emotional capacity to participate in safety interventions. If any child has this capacity, indicate his/her name(s): \_\_\_\_\_

### Caregiver

Document caregiver capacities if present for any caregiver based on information gathered. (Select all that apply.)

- a. Caregiver is capable of participating in a child safety agreement.  
 b. Caregiver is willing to participate in a child safety agreement.  
 c. Caregiver has the support of at least one adult who was not involved in the allegation, and the supporting adult is willing and able to participate in a child safety agreement.  
 d. Other: \_\_\_\_\_

For each safety-planning capacity selected, provide details that demonstrate its presence.

## SECTION 3: SAFETY INTERVENTIONS

Consider each identified safety threat and the safety-planning capacity of the family and network to determine if a child safety agreement can be created to control for the danger. Remember that a child safety agreement should describe in detail the immediate action steps that the family and their network will take to help keep the child safe from the danger. If this is possible, select "Safe with agreement" and select the specific interventions being used from the list below. Document the child safety agreement and continue to the risk assessment. If it is impossible to create a child safety agreement, proceed to Section 4 and select "Unsafe."

- a. Safety interventions provided by the worker
- b. Safety interventions involving caregiver, other household members, or network
- Alleged offender will leave the home, either voluntarily or in response to legal action.
  - Non-offending caregiver will move to a safe environment with the child.
  - Extended family members or network will participate as part of a child safety agreement action step.
  - Other safety intervention involving caregiver, other household members, or network.  
Describe: \_\_\_\_\_
- c. Safety interventions provided by agencies or service providers
- Community agencies or services are part of a child safety agreement action step.
  - Formal tribal and/or Indian Child Welfare Act (ICWA) intervention is part of a child safety agreement action step.

Other safety intervention provided by agencies or service providers.

Describe: \_\_\_\_\_

- d. Temporary removal from the current placement during the investigation is necessary because the foster home is under investigation for allegations equal to Child Protection Registry Levels III or IV child abuse/neglect, AND there appears to be validity after interviewing the alleged victim.

**SAFETY DECISION**

- Safe with agreement.** One or more safety threats are present; however, the child can safely remain in the home with a child safety agreement. Protective interventions have been initiated, and the child will remain in the home as long as the safety interventions mitigate the safety threats. Select all interventions used in the child safety agreement. **A child safety agreement is required.** Note: Refer to DFS Policy 411, "Considered Removal Team Decision Making Meeting."

**SECTION 4: PLACEMENT INTERVENTION**

**SAFETY DECISION**

- Unsafe.** One or more safety threats are present. A child safety agreement was considered but could not be created. As a result, change of placement is the only protective intervention possible for one or more children. Removal from current placement is necessary because none of the safety interventions (a–d) adequately ensures the child’s safety. Without removal, one or more children will likely be in danger of immediate harm. Note: Refer to DFS Policy 411, "Considered Removal Team Decision Making Meeting."

Foster Children Removed	Foster Children Not Removed
1.	1.
2.	2.
3.	3.
4.	4.

**Supplemental Item:**

Is the child in current danger of harm due to his/her own behavior?

- No  
 Yes

If yes, describe the danger and the immediate action taken/recommended future actions.

Caseworker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Copy the appropriate individuals according to agency policy.**

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® PROVIDER SAFETY ASSESSMENT  
DEFINITIONS**

**GENERAL DEFINITIONS**

**Foster child:** Any child for whom the department has legal protective custody, including foster children for whom adoption is pending and has not yet been finalized.

**Care provider:** A person providing out-of-home care to children, including DFS foster homes, contracted provider foster homes, approved relative homes, approved non-relative homes, and pre-adoptive homes.

**SECTION 1. SAFETY THREATS**

**1. Care provider caused physical harm to the child or made a plausible threat to cause physical harm in the current investigation, as indicated by any of the following:**

- Injury or abuse to the child other than accidental.
- Caregiver has reported they may maltreat the child AND/OR has threatened to cause harm AND/OR may retaliate against the child for DFS investigation AND this maltreatment or threat of action, if actually conducted, would result in serious harm.
- Torture of a child or unreasonable use of physical force: Care provider has acted in a way that bears no resemblance to reasonable discipline. Examples include, but are not limited to, having the child kneel on rice, hold or carry heavy objects for an extended time, or run laps to the point of collapse as punishment. Use this subcategory for care provider actions that are likely to result in harm, but have not yet caused an injury.
- Use of physical force or corporal punishment.

**2. Current circumstances, combined with the care provider's history of IA, standards review or intrafamilial child maltreatment and/or incident reports, suggest that the child's safety may be of immediate concern.**

There must be both current concerns that threaten child safety;

AND

related previous reports/incidents that represent an emerging or unresolved pattern. Previous incidents may include any of the following:

- Prior incident reports, including any approval/licensing complaints or citations.
- Prior reports of abuse/neglect to the child.
- Evidence of prior unreported injuries or incidents.

### **3. Child sexual abuse is suspected.**

Suspicion of sexual abuse may be based on indicators such as the following.

- The child discloses sexual abuse.
- The child demonstrates inappropriate or sexualized behavior, based on the child's age and developmental level.
- Medical findings consistent with molestation.
- Care provider or others in household have been convicted, investigated, or accused of sexual misconduct with any 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 arrangements, showering/bathing practices, exposure to nudity or sexually explicit materials, etc.

### **4. Care provider fails to protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, neglect, sex/labor trafficking, or emotional abuse.**

- Care provider fails to protect the child from harm or threatened harm as a result of physical abuse, neglect, trafficking, 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.

Suspicion of sex trafficking may be based on indicators such as the following:

- » Multiple runaway attempts
- » Unexplained access to money
- » High number of intimate partners reported for age

- » Sexually transmitted diseases and/or multiple terminated pregnancies
- » Branding
- » Controlling or older intimate partner
- » Has friend or relative involved in commercial sex
- » Found in area known for illegal commercial sex
- » Sexually explicit social networking profiles

Suspicion of labor trafficking may be based on indicators such as the following.

- » Appearing malnourished
  - » Showing signs of physical injury and abuse
  - » Lacking official identification documents
  - » Working excessively long hours
  - » Living at the place of employment
  - » Branding
- An individual(s) with known violent criminal behavior/history resides in the household, or care provider allows access to the child.

**5. Care provider’s explanation for the injury to the child is questionable or inconsistent with the type of injury.**

Assess this item based on the care provider’s statements by the end of the contact. It may be typical for a care provider to initially minimize, deny, or give an inconsistent explanation, but, through discussion, admit to the true cause of the child’s injury. Such a situation should be understood as a “normal” reaction and not as a safety threat. However, mark this safety threat if the care provider’s statements have not changed (i.e., to admit or accept the more likely explanation) by the end of the contact.

- Medical evaluation indicates, or medical professionals suspect, injury is consistent with abuse; care provider denies injury or attributes injury to accidental causes.
- Care provider’s description or cause of the injury minimizes the extent and impact of harm to the child.

Do not include situations in which the care provider offers no explanation for a child injury.

**6. Care provider hinders/refuses access to or hides the child.**

- Care provider currently refuses or hinders access to the child.
- Care provider has removed or threatened to remove the child from whereabouts known to DFS to avoid investigation.

- Care provider keeps the child at home, away from friends, school, and other outsiders for extended periods of time.
- Care provider 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 meet the child's needs for supervision, food, clothing, and/or medical or mental health care.**

- Nutritional needs of the child are not met, resulting in danger to the child's health and/or safety; the child appears malnourished.
- Child is without clothing appropriate to the weather. Consider the age of the child and whether clothing is the choice of the child or the provision of the caregiver.
- Child has a medical/dental/vision condition AND the care provider does not seek treatment or does not follow prescribed treatment for such conditions.
- Child has special needs, such as being medically fragile, which care provider does not meet.
- Child has serious emotional symptoms, lack of behavioral control, or psychosomatic symptoms (e.g., sleep/appetite disturbance), and care provider does not seek or provide appropriate interventions.
- Care provider does not provide age- or developmentally appropriate supervision to ensure the safety and well-being of 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).
- Care provider is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) or incapacitated (e.g., injured, ill).
- Care provider makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care, OR care provider leaves the child alone (time period varies with age and developmental stage). Take into consideration the length of time, provisions for emergencies (e.g., able to call 911, neighbors able to provide assistance), and any needs or vulnerabilities of the children.

**8. 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:

- Leaking gas from stove or heating unit.
- Substances or objects accessible to the child that may endanger the health and/or safety of the child such as chemicals, drugs or drug paraphernalia.
- Lack of water or utilities (heat, plumbing, electricity) and no alternate or safe provisions made.
- Open/broken/missing windows in areas accessible to children and/or unsafe structural issues in the home (e.g., walls falling down, floor missing).
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food that threatens health.
- Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites).
- Evidence of human or animal waste throughout living quarters.
- Guns/ammunition and other weapons are not safely secured and are accessible to children.
- Unrestricted access to pool or other body of water as required by licensing policy.
- Blocked exits or unmarked exit routes.
- Missing or non-functioning smoke detectors.
- Un-gated stairways.
- Unsafe sleeping arrangements (e.g., an infant under age one sharing a bed, other conditions as defined in the DFS Home Environment Screening Guidelines or *Delacare*).

**9. Care provider currently uses illegal substances, OR care provider's current use of a legal substance impairs his/her ability to supervise, protect, or care for the child.**

- There is evidence to suspect that the care provider is using/abusing illegal substances.

OR

- There is evidence to suspect that the care provider is using/abusing legal substances (including alcohol and prescription medications when used improperly);

AND

- This use/abuse has impaired the care provider's ability to care for and/or protect the child.

**10. Domestic violence exists in the household.**

Domestic violence perpetrators, in the context of the child welfare system, are parents and/or caregivers who engage in a pattern of coercive control against one or more intimate partners. This pattern of behavior may continue after the end of a relationship or when the couple no longer lives together. The alleged perpetrator's actions often directly involve, target, and impact any children in the family.

- The child is or has been exposed to domestic violence in the household.
- Consider domestic violence to include physical assault by one adult on another; patterns of coercive control, including multiple incidents of intimidation, threats, or harassment between care providers; or involving an adult household member and another adult(s). Incidents may be identified by self-report, credible report by a family or other household member, credible sources, and/or police reports.
- Do not include domestic violence between any adult household member and a child.
- Do not include arguments that do not escalate beyond verbal encounters and are not otherwise characterized by threatening or controlling behaviors.

**11. Care provider routinely describes the child in negative terms or acts toward the child in negative ways.**

- Care provider describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).

- Care provider curses at and/or repeatedly puts the child down.
- Care provider scapegoats a particular child in the household.
- Care provider inappropriately blames the child for a particular incident or household problems.
- Care provider treats the child in markedly different ways than which he/she treats others, may stigmatize the child.
- 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).
- Care provider undermines the child's cultural or religious identity, sexual orientation, or gender identity.

**12. Care provider's current emotional stability, developmental status, or cognitive deficiency impairs his/her current ability to supervise, protect, or care for the child.**

- Care provider's refusal to take prescribed medications impedes his/her ability to care for the child.
- Care provider's inability to control his/her emotions impedes his/her ability to care for the child.
- Care provider acts out or exhibits distorted perception that impedes his/her ability to care for the child.
- Care provider's mental health status impedes his/her ability to care for the child.
- 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 children or stay alone).
- Care provider lacks the basic knowledge related to parenting skills:
  - » Does not know infants need regular feedings;
  - » Fails to access and obtain basic/emergency medical care;
  - » Does not understand what constitutes proper diet; or
  - » Does not understand what constitutes adequate supervision.

**13. Other (specify):**

Circumstances or conditions that pose an immediate threat of harm to a child not already described in safety threats 1–12.

**SAFETY DECISION**

**Safe.** No safety threats were identified at this time. No children are likely to be in imminent danger of serious harm, based on currently available information. Complete the investigation as required.

**SECTION 2: SAFETY-PLANNING CAPACITIES**

**Safety-Planning Capacities**

- a. Caregiver is capable of participating in a child safety agreement. The caregiver has the ability to participate in a child safety agreement. Consider caregiver’s cognitive, physical, and emotional capacity to follow through with all interventions necessary to protect the child from further danger.
- b. Caregiver is willing to participate in a child safety agreement. The caregiver has agreed to accept the worker’s involvement and recommendations and to follow the action steps detailed on a child safety agreement that is sufficient to control for the safety threat.
- c. Caregiver has the support of at least one adult who was not involved in the allegation, and the supporting adult is willing and able to participate in a child safety agreement. The caregiver has a supportive relationship with at least one other family member, neighbor, or friend who can play an active role in a child safety agreement that is sufficient to control for the danger.
- d. Other. Note any other present safety-planning capacity that makes the worker confident that the caregiver and the network will be able to control for the danger.

**SECTION 3: SAFETY INTERVENTIONS**

**Child**

- a. Any child has the cognitive, physical, and emotional capacity to participate in safety interventions.
  - Any child has an understanding of his/her family environment in relation to any real or perceived safety threats and is able to communicate at least

two options for obtaining immediate assistance if needed (e.g., calling 911, running to neighbor, telling teacher).

- Any child is emotionally capable of acting to protect his/her own safety despite allegiance to his/her caregiver or other barriers.
- Any child has sufficient physical capability to defend him/herself and/or escape if necessary.

## Caregiver

- a. Safety interventions provided by the worker. Actions taken or planned by the worker that specifically address one or more safety threats. Examples include, but are not limited to, providing emergency aid such as food, transportation, or mentoring; planning return visits to the home to check on progress; or providing information and/or assistance in obtaining services or legal advice. This cannot be the only safety intervention selected when doing a child safety agreement.
- b. Safety interventions involving caregiver, other household members, or network. Applying the family's own strengths as resources to mitigate safety threats; or using extended family members, neighbors, tribal members, friends, or other individuals to mitigate the danger. Examples include, but are not limited to, engagement with a grandparent to assist with childcare, agreement by a neighbor to serve as a safety resource for a child, or commitment by 12-step sponsor or recovery support person to meet with caregiver daily.

One or more of the following interventions may apply. If "b" is selected, at least one of these options also must be selected.

- *Alleged offender will leave the home, either voluntarily or in response to legal action.* The alleged offender will temporarily or permanently leave the home.
- *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 alternative location where the alleged offender will not have access to the child.
- *Extended family members or network will participate as part of a child safety agreement action step.* A family member, friend, or other person in the family's life has agreed to be responsible for a specific activity on the child safety agreement.

- *Other safety intervention involving caregiver, other household members, or network.* The family or their network will take other actions not described above. Describe in the space provided.

c. Safety interventions provided by agencies or service providers. Community resources used as a safety intervention should be immediately available to the family and be able to reduce the threat of imminent serious harm. Examples include, but are not limited to, use of shelters, food pantries, and other services provided by community agencies or providers. *Not included are* long-term therapy or treatment, being put on a waiting list for services, or delays in contact and initiation of services to the family.

If "c" is selected, at least one of the following interventions also must be selected.

- *Community agencies or services are part of a child safety agreement action step.* This means involving a community-based or faith-related organization or other agency in activities to address safety threats (e.g., using a local food pantry).
- *Formal tribal and/or Indian Child Welfare Act (ICWA) intervention is part of a child safety agreement action step.* This includes, but is not limited to, use of tribal services from the child or caregiver's tribe or a tribal consortium, tribal resource center, or tribal health clinic.
- *Other safety intervention provided by agencies or service providers.* Agency professionals will take other actions. Describe in the space provided.

Note: For these items, *do not include* services such as long-term therapy or treatment or placement on a waiting list for services.

d. Temporary removal from the current placement during the investigation is necessary because the foster home is under investigation for allegations equal to Child Protection Registry Levels III or IV child abuse/neglect, AND there appears to be validity after interviewing the alleged victim. The placement under investigation is an approved or licensed foster home and two additional conditions are met:

- The allegations are consistent with Child Protection Registry Level III or IV child abuse/neglect, which includes:
  - » Abandonment of a child age 0–17;
  - » Bizarre treatment that is extreme or significantly disproportionate to the precipitating event;

- » Blunt force trauma; head trauma; bone fracture; intentionally or recklessly inflicted burns or scalds; medically serious internal injury to the abdominal or chest area; dislocations and sprains; puncture/stab wounds requiring medical treatment; bruises, cuts, or lacerations requiring intervention by a medical professional;
  - » Poisoning;
  - » Suffocation;
  - » A child age 0–11 or disabled with moderate or significant care needs is left alone;
  - » Lack of supervision for a child age 6 or younger;
  - » Lock-in/out of a child age 0–11;
  - » Driving under the influence or operating a boat or vessel under the influence while a child is present;
  - » Diagnosed malnutrition;
  - » Non-organic failure to thrive;
  - » Other medical neglect;
  - » Severe physical neglect;
  - » Verbal innuendo or inappropriate sexualized statements to a child intended to entice or alarm;
  - » Exploitation;
  - » Child pornography;
  - » Sexual abuse;
  - » Shaken baby incidents; OR
  - » Child death.
- There appears to be validity to the allegations after the alleged victim has been interviewed.

## SAFETY DECISION

**Safe with agreement.** One or more safety threats are present; however, the child can safely remain in the home with a child safety agreement. Safety interventions have been initiated through a child safety agreement, and the child will remain in the home as long as the safety interventions mitigate the safety threats. Select all interventions used in the child safety agreement. **A child safety agreement is required.** Note: Refer to DFS Policy 411, "Considered Removal Team Decision Making Meeting."

## SECTION 4: PLACEMENT INTERVENTION

### SAFETY DECISION

**Unsafe.** One or more safety threats are present. A child safety agreement was considered but could not be created. As a result, removal is the only protective intervention possible for one or more children because none of the safety interventions (a–d) adequately ensures the child's safety. Without a removal, one or more children will likely be in danger of immediate or serious harm. If a child is placed out of home with an alternative care provider identified by the caregiver, a child safety agreement is required. Mark to indicate whether all children are being removed or if only some children are being removed.

Note: Refer to DFS Policy 411, "Considered Removal Team Decision Making Meeting."

### Supplemental Item

Is the child in current danger of harm due to his/her own behavior?

- The child is currently engaging in behaviors that place him/her at imminent risk of serious harm. Examples include but are not limited to children who run away from the foster home and place themselves in unsafe living/sleeping situations, children who engage in prostitution, and children who engage in self-harming behaviors that require medical intervention.
- The child's care provider has 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. If the care provider has not taken appropriate and reasonable steps to respond to the child's behavior, select one of the safety threats above.
- The care provider's current efforts, although appropriate, are insufficient to prevent the child from engaging in the behavior in the near future.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® PROVIDER SAFETY ASSESSMENT  
POLICY**

**PURPOSE AND POLICY**

The provider safety assessment is used to determine if a child may safely remain in a placement when concerns about safety in that placement have been raised or an allegation of maltreatment has been made. Although similar in structure to the safety assessment, the provider safety assessment uses a different threshold when determining that a child is in danger of imminent harm. The threshold for determining that a child needs a child safety agreement or needs to be removed to a different placement is lower for a provider than for a parent/caregiver because a child in placement is in the custody of DFS.

**WHICH CASES**

All investigations of alleged abuse/neglect by a care provider of a child in DFS custody, including the following:

- DFS foster homes
- Contracted provider foster homes
- Approved or non-approved relative homes
- Approved or non-approved non-relative homes
- Pre-adoptive homes

Exclude group homes, institutions, and residential treatment centers.

The provider safety assessment is completed *only* for foster children within the home. If the care provider has biological children in the home, complete the safety assessment for the safety of those biological children.

**WHEN**

As part of the investigation, prior to leaving the child in the home. The assessment must be documented within 48 hours of the first face-to-face contact with the alleged child victim. If needed, a subsequent provider safety assessment may be completed to assess changes in safety during the investigation.

**WHO**

The investigating worker.

**DECISION**

Guides the decision to remove a foster child from the care provider's home based on whether threats to safety are present in the household and whether interventions are available and appropriate to maintain placement.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® PROVIDER SAFETY ASSESSMENT  
PROCEDURES**

Workers should familiarize themselves with the items included on the safety assessment and the accompanying definitions. Workers will notice that the items on the tool are very similar to the items on the safety assessment used in intrafamilial investigations.

Use of the safety assessment ensures that every worker is assessing the same items in each investigation of abuse/neglect by a care provider, and that the responses to these items lead to specific decisions. Once a worker is familiar with the items that must be assessed to complete the tool, the worker should conduct his/her initial contact as he/she normally would, using good social work practice to collect information from the child, care provider, and/or collateral sources. The SDM system ensures that the specific items comprising the safety assessment are assessed at some time during the initial contact.

Enter the primary care provider name and record the type of home being assessed. **Complete one assessment per report.**

Additionally, record the names of all foster children in the home and their ages, including children in adoptive status for whom the adoption has not yet been finalized.

Enter the date the safety assessment was completed, which should be the date the worker made initial face-to-face contact with the child(ren) to assess safety; that date may be different than the date for the form's completion in FOCUS.

The safety assessment consists of three sections:

- 1. Safety Threats.** This is a list of critical threats that must be assessed by every worker in every investigation of alleged abuse/neglect by a care provider. These threats cover the kinds of conditions that, should they exist, would render a child in danger of harm. Because not every conceivable safety threat can be anticipated or listed on a form, an "other" category permits a worker to indicate that some other circumstance creates a safety threat; that is, something other than the listed categories is causing the worker to believe that the child is in danger of being harmed.

For this section, rely on information available at the time of the assessment. Workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is not expected that all facts about a case be known immediately. Some information is inaccessible, and some is deliberately hidden from the worker. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the 12 safety threats and accompanying definitions. For

each item, consider all foster children in the home. If the safety threat is present, based on available information, mark that item. If there are circumstances that the worker determines to be a safety threat and these circumstances are not described by one of the existing items, the worker should mark "other" and briefly describe the threat.

If no safety threats are present, the safety decision is "Safe." The child may remain in the home for the present.

- 2. Safety-planning capacities.** This section is completed only if one or more safety threats were identified. Mark any of the listed safety-planning capacities that are present for any child/caregiver. Consider information from the report; from worker observations; interviews with children, caregivers, and collaterals; and review of records. For "other," consider any existing condition that does not fit within one of the listed categories but may support safety interventions for the safety threats identified in Section 1.

Safety-planning capacities are not justification that a child is safe. The presence of safety-planning capacity does not negate an identified safety threat.

- 3. Safety Interventions.** This section is completed only if one or more safety threats are identified. If one or more safety threats are present, it does not automatically follow that a child must be removed from the care provider's home. In many cases, it will be possible to initiate a temporary plan to mitigate the safety threat(s) sufficiently so that the child may remain in the home while the investigation continues.

The safety intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the safety threat(s), and whether there is reason to believe the care provider will follow through with a planned intervention. Simply because an intervention exists in the community does not mean it should be used in a particular case. The worker may determine that even with an intervention, the child would be unsafe; or the worker may determine that an intervention would be satisfactory, but has reason to believe the care provider would not follow through. The worker should keep in mind that any single intervention may be insufficient to mitigate the safety threat(s), but a combination of interventions may provide adequate safety. Also keep in mind that the safety intervention is not intended to solve the household's problems or provide long-term answers. A child safety agreement permits a child to remain home during the course of the investigation.

If one or more safety threats are identified and the worker determines that interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will be removed from the care provider's home.

If one or more interventions will be implemented, mark each category that will be used. Change of placement is necessary only when it is determined that no other interventions

are available or appropriate to mitigate safety threats that would allow the current placement to continue.

If one or more safety threats are identified and the worker is able to identify sufficient safety interventions that lead the worker to believe the child may remain in the home for the present time, the safety decision is "Safe with agreement."

- 4. Placement Intervention.** If the worker determines that the child cannot be safely kept in the home even after considering a complete range of interventions, the safety decision is "Unsafe." It is possible the worker will determine that interventions make it possible for one child to remain in the home while another must be removed. If ANY child requires out-of-home intervention, the safety decision is "Unsafe."

If one or more children are placed, list the names of foster children who are removed from the home and the names of any foster children who were not removed from the home.

Workers must also consider if the child has any behaviors that place him/her at imminent threat of serious harm *in spite of appropriate action by the care provider*. In such cases, the worker should document the concerns and describe how they will be mitigated over the short term until a long-term plan can be made.

Child safety agreement: A child safety agreement is required whenever the safety decision is Safe with agreement. The following must be included in any child safety agreement.

- What is working well in this family? Document evidence of any protective actions or family strengths that can be used to address safety threats (e.g., positive relationships, community affiliations, supports, achievements).
- What is causing the immediate safety threats to the child(ren)? Describe the conditions or behaviors in the home that place any child at imminent threat of serious harm. Use language the family understands so it is clear to them what caused you to identify safety threats.
- What needs to happen to keep the child(ren) safe, and who will assume responsibility for the actions needed? Explain how each of the safety threats will be contained. Who will take action? What will they do? When does their task need to be accomplished? For how long must the intervention continue? Also describe how the family and the worker will know that everyone is completing their assigned tasks.
- Signatures lines for family members, the worker, and his/her supervisor.

Note: The child safety agreement should be documented in FOCUS.

The child safety agreement MUST be completed with the care provider, and a copy should be left with the family.

The child safety agreement must be reviewed every 30 days during investigation or treatment. This is the maximum period before review, and the child safety agreement may be reviewed sooner as needed.

A case cannot be closed by investigation or treatment when there is an active child safety agreement. A child safety agreement review must be done to determine whether (1) the current child safety agreement should continue, (2) the current child safety agreement should be modified, (3) a new child safety agreement should be developed, or (4) a child safety agreement is no longer needed. The worker should document in a FOCUS Progress Note when a child safety agreement has been reviewed and discussed with the family. Numbers (2) and (3) will require new signatures. Number (4) will require a new safety assessment to document that safety threats have been resolved.

**Supplemental item:** Note that there is one supplemental item related to the child being a danger to themselves at the end of the assessment. If you select this item, you do not have to create a child safety agreement but you and your supervisor should consider what kinds of interventions may best support the child and their caregivers.

**DELAWARE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR FAMILIES**  
**SDM® FAMILY RISK ASSESSMENT**

**Primary Caregiver's Name:** \_\_\_\_\_  
**Were there allegations in this household?**     Yes     No  
**Caseworker:** \_\_\_\_\_

**Secondary Caregiver's Name:** \_\_\_\_\_  
**Office:** \_\_\_\_\_  
**Date of Assessment:** \_\_\_\_\_

<b>NEGLECT</b>	<b>Score</b>
N1. Current report is for neglect	
a. No .....	0
b. Yes .....	1 _____
N2. Prior screened-in reports (assign highest score that applies)	
a. None .....	0
b. One or more, <u>abuse</u> only.....	1
c. One or two for <u>neglect</u> .....	2
d. Three or more for <u>neglect</u> .....	3 _____
N3. Household has previously received ongoing child protection services	
a. No .....	0
b. Yes .....	1 _____
N4. Number of children in the household	
a. One, two, or three.....	0
b. Four or more.....	1 _____
N5. Age of youngest child in the home	
a. Two or older.....	0
b. Under 2 .....	1 _____
N6. Primary caregiver provides physical care consistent with child needs	
a. Yes .....	0
b. No .....	1 _____
N7. Primary caregiver mental health	
a. No problems.....	0
b. Past or current problems.....	1 _____
N8. Primary caregiver alcohol or drug use (check applicable items and add for score)	
a. <input type="checkbox"/> No problem.....	0
b. <input type="checkbox"/> Alcohol problem (current or historic).....	1
c. <input type="checkbox"/> Drug problem (current or historic).....	1 _____
N9. Characteristics of children in household (check applicable items and add for score)	
a. Neither b, c, or d apply .....	0
b. <input type="checkbox"/> Medically fragile or failure to thrive.....	1
c. <input type="checkbox"/> Developmental, physical, or learning disability .....	1
d. <input type="checkbox"/> Positive toxicology screen at birth .....	1 _____
N10. Housing (check applicable items and add for score)	
a. Neither b or c apply .....	0
b. <input type="checkbox"/> Housing is physically unsafe.....	1
c. <input type="checkbox"/> Homeless at any time during investigation ...	2 _____

<b>ABUSE</b>	<b>Score</b>
A1. Current report is for abuse	
a. No .....	0
b. Yes.....	1 _____
A2. Number of prior screened-in reports of abuse	
a. None .....	0
b. One.....	1
c. Two or more.....	2 _____
A3. Household has previously received ongoing child protection services	
a. No .....	0
b. Yes.....	1 _____
A4. Prior injury to a child resulting from abuse/neglect	
a. No .....	0
b. Yes.....	1 _____
A5. Primary caregiver's assessment of incident (check applicable items and add for score)	
a. Neither b or c apply .....	0
b. <input type="checkbox"/> Blames child for abuse/neglect .....	1
c. <input type="checkbox"/> Justifies abuse/neglect.....	2 _____
A6. Domestic/family violence between any adult household member in the past year	
a. No .....	0
b. Yes.....	2 _____
A7. Primary caregiver characteristics (check applicable items and add for score)	
a. Neither b, c, or d apply.....	0
b. <input type="checkbox"/> Provides insufficient emotional/psychological support .....	1
c. <input type="checkbox"/> Employs excessive/inappropriate discipline....	1
d. <input type="checkbox"/> Overly controlling/bullying.....	1 _____
A8. Primary caregiver has a history of abuse or neglect as a child	
a. No .....	0
b. Yes.....	1 _____
A9. Secondary caregiver alcohol or drug use	
a. No problem or no secondary carer .....	0
b. Alcohol and/or drug problem (check all applicable) .....	1 _____
<input type="checkbox"/> Alcohol <input type="checkbox"/> Drug	
A10. Characteristics of children/young people in household (check appropriate items and add for score)	
a. Neither b, c, or d apply.....	0
b. <input type="checkbox"/> Delinquent behavior .....	1
c. <input type="checkbox"/> Developmental or learning disability.....	1
d. <input type="checkbox"/> Mental health or behavioral problem.....	1 _____

**TOTAL NEGLECT RISK SCORE** \_\_\_\_\_

**TOTAL ABUSE RISK SCORE** \_\_\_\_\_

### SCORED RISK LEVEL

Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
<input type="radio"/> 0-1	<input type="radio"/> 0-1	<input type="radio"/> Low
<input type="radio"/> 2-4	<input type="radio"/> 2-4	<input type="radio"/> Moderate
<input type="radio"/> 5-8	<input type="radio"/> 5-7	<input type="radio"/> High
<input type="radio"/> 9+	<input type="radio"/> 8+	<input type="radio"/> Very High

### POLICY OVERRIDES

Mark **yes** if a condition shown below is applicable in this case. If any condition is applicable, override final risk level to very high.

- Yes  No 1. Sexual abuse case AND the perpetrator is likely to have access to the child.
- Yes  No 2. Non-accidental injury to a non-verbal child.
- Yes  No 3. Severe non-accidental injury.
- Yes  No 4. Caregiver(s) action or inaction resulted in death of a child due to abuse or neglect (past or current).

### DISCRETIONARY OVERRIDE

If a discretionary override is made, mark yes, mark override risk level, and indicate reason. Risk level may be overridden one level higher.

- Yes  No 5. If **yes**, override risk level (mark one):  Moderate  High  Very High

Discretionary override reason: \_\_\_\_\_

Supervisor review/approval of discretionary override: \_\_\_\_\_ Date: \_\_\_\_\_

**FINAL RISK LEVEL** (mark final level assigned):  Low  Moderate  High  Very High

Risk-Based Case Open/Close Guide	
Risk Level	Recommendation
Low	Close*
Moderate	Close*
High	Ongoing service
Very High	Ongoing service

\*When unresolved safety threats are still present at the end of the investigation (i.e., the most recent safety assessment finding was unsafe or safe with agreement), treatment services should be provided regardless of risk level.

## SUPPLEMENTAL ITEMS

**S1. Does the primary caregiver have biological children who are not in his/her care?**

- No
- Yes

**S2. Do all of the children in the household share the same biological parents?**

- No
- Yes

**S3. Indicate if the household is currently receiving Medicaid, SNAP (food stamps), or TANF.**

- Medicaid
- SNAP (food stamps)
- TANF
- No household member receives benefits from Medicaid, SNAP, or TANF

**S4. Either the primary or secondary caregiver has difficulty with cognitive function.**

Primary Caregiver

- No
- Yes

Secondary Caregiver

- No
- Yes

**S5. Primary caregiver's educational attainment.**

- No high school diploma, no GED
- GED
- High school diploma
- Some college
- Associate's degree
- Bachelor's degree
- Academic or professional degree beyond bachelor's degree

**S6. Household members make use of an informal support system in order to enhance the safety of their children.**

- No
- Yes

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® FAMILY RISK ASSESSMENT  
DEFINITIONS**

The risk assessment is composed of two indices: the neglect index and the abuse index. Both indices must be completed, regardless of the current allegation. Only one household can be assessed on a risk assessment tool. If two households are involved in the alleged incident(s), separate risk assessment tools should be completed for each household.

In applying the definitions, consider conditions that existed AT THE BEGINNING of the assessment/investigation. Also mark any risk items that emerged or occurred DURING the assessment/investigation, unless otherwise stated in the definition.

## **NEGLECT INDEX**

### **N1. Current report is for neglect**

The current report includes any type of neglect allegation or a dependent child allegation.

### **N2. Prior screened-in reports (assign highest score that applies)**

Where possible, history from other states should be checked.

Screened-in reports include those accepted for investigation or family assessment.

- Count prior screened-in reports involving any adult members of the current household who were alleged perpetrators. Include all household adults, regardless of whether they are current caregivers for any child. Include prior screened-in reports for child victims no longer in the household if the alleged perpetrator is still a member of the household.
- Do not count prior reports:
  - » In which allegations were perpetrated by an adult who is not part of the current household.
  - » A child in the home was identified as a perpetrator of abuse/neglect.
  - » That were screened out, including Progress Notes and other states' 'Information Only' reports.

- » In which the investigation was administratively discontinued or discontinued due to an erroneous report.
- None. No screened-in reports prior to the current investigation/assessment.
- One or more, abuse only. One or more screened-in reports, substantiated or not, for any type of *abuse* prior to the current investigation/assessment AND no prior neglect reports that were screened in. Abuse includes physical, emotional, or sexual abuse.
- One or two for neglect. One or two screened-in reports, substantiated or not, for any type of *neglect* prior to the current investigation/assessment, with or without prior abuse reports.
- Three or more for neglect. Three or more screened-in reports, substantiated or not, for any type of *neglect* prior to the current investigation/assessment, with or without prior abuse reports.

**N3. Household has previously received ongoing child protection services**

Where possible, history from other states should be checked.

Any member of the current household has previously received or is currently receiving ongoing child protection services as a result of a prior investigation/assessment in which caregiver was an alleged perpetrator. CPS service history includes voluntary or court-ordered intervention/CPS services.

- Include services as follows:
  - » Temporary care arrangements.
  - » Treatment services.
  - » Non-court-ordered services as arranged by CPS.
  - » Ongoing abuse/neglect services that were provided by other states.
- Exclude services or reports provided for reasons other than abuse/neglect (e.g., requests for assistance or homelessness).

**N4. Number of children in the household**

Include children who are temporarily absent but expected to return. (For example, count children who were removed from the home during the investigation, children who have run away but are expected to return, children who are incarcerated, children who are in residential mental health treatment, or children temporarily away at boarding school or camp.)

Note: If assessing a caregiver's household that will be receiving reunification/treatment services, score this item as if the child was residing in that household.

**N5. Age of youngest child in the home**

Age of the youngest child currently residing in the household where abuse/neglect allegedly occurred. If a child is removed as a result of the current investigation/assessment or otherwise is temporarily placed/residing outside of the household, count the child as residing in the household. If the child has permanently left the home (e.g., a court awards full custody/permanent guardianship to another caregiver during the investigation) as a result of the investigation, do not count. (Note: If assessing a non-custodial caregiver household that will be receiving treatment services, score this item as if the child was residing in the non-custodial household.)

**N6. Primary caregiver provides physical care consistent with child needs**

Physical care of the child includes feeding, clothing, shelter, hygiene, and medical care of the child. Consider the child's age/developmental status.

Answer No If:

- The current report of neglect relates to physical care AND is being substantiated. (Do not include failure to protect, inadequate supervision, or other neglect allegations unrelated to physical care.)

OR

- Regardless of whether there is a current neglect substantiation, the child has been harmed or his/her well-being has been threatened because of unmet physical needs. Needs may be considered unmet regardless of whether the cause is neglectful or due to situations outside of the parent's control. For example:
  - » Child has a significant medical/dental/vision condition that requires care and care is not being provided.
  - » Child persistently does not *have* clothing that is appropriate for weather conditions, OR clothing is persistently unwashed.
  - » Plumbing and heating in living environment is not consistent with local codes or standards, has potentially dangerous conditions (e.g., unlocked poisons, dangerous objects in reach of small child), is unsanitary, or is infested, AND these conditions persist regardless of any attempt parents/carers have made to rectify problems. If living environment concerns are to the degree that it is *unsafe*, also score N10.

- » Child frequently goes hungry or thirsty, has lost weight, or has failed to gain weight as appropriate to age group or situation.
- » The child is not being bathed regularly, resulting in dirt-caked skin and hair and a strong odor.

## **N7. Primary caregiver mental health**

### Mark If:

- A professional qualified to do so has diagnosed the primary caregiver with a mental health condition other than substance-related disorders.
- The primary caregiver has/had multiple reports for mental health/psychological evaluations, treatment, or hospitalizations.

If primary caregiver has never been diagnosed but appears to have (or have had) a mental health problem, consider obtaining an assessment prior to scoring. Do not count reports motivated solely by efforts to undermine the credibility of the primary caregiver or other ulterior motives (e.g., custody disputes).

## **N8. Primary caregiver alcohol or drug use**

### Mark If:

The primary caregiver has a past or current alcohol/drug abuse problem, including abuse of prescribed drugs, that interferes or interfered with his/her or the family's functioning. Any of the following may be true of the primary caregiver:

- A professional qualified to do so has diagnosed the primary caregiver with a substance-related disorder.
- If primary caregiver has never been diagnosed but appears to have (or have had) an alcohol or drug problem, including abuse of prescribed drugs, consider obtaining an assessment prior to scoring. If caregiver is unwilling to participate in an assessment, or for other reasons an assessment cannot be completed, also count if the primary caregiver:
  - » Self-identifies as an alcoholic or addict.
  - » Uses substances in ways that have negatively affected his/her:
    - Employment;
    - Marital or family relationships; or
    - Ability to provide protection, supervision, and care for the child.

- Has a current arrest or past conviction for use, possession, or distribution of illicit substances; crimes committed under the influence of substances; or crimes committed to obtain substances.
- Has a current arrest or past conviction for driving/boating under the influence.
- Has had multiple positive urine/blood samples.
- Has/had health/medical problems resulting from substance use.
- Has given birth to a child diagnosed with fetal alcohol spectrum disorder (FASD), or a child had a positive toxicology screen at birth.

Abuse of prescribed drugs should be scored.

#### **N9. Characteristics of children in household**

The items marked here should match item A10.

- Neither b, c, or d apply. No child in the household exhibits characteristics listed below.
- Medically fragile or failure to thrive. Any child in the household *has a current diagnosis* of medically fragile or failure to thrive as evidenced by caregiver's statement of such a diagnosis, medical records, and/or doctor's report.

*\*Medically fragile:* Infant has a medical condition that requires technological intervention and the condition, if untreated, is likely to result in death or serious harm. For example, child requires a trach/vent or central line feeding.

- Developmental, physical, or learning disability. Any child in the household who has a developmental, physical, or learning disability *that has ever been diagnosed by a professional* (e.g., doctor, school counselor, psychologist, etc.) as evidenced by caregiver's statement of such a diagnosis, medical/school records, and/or professional's statement.
- Positive toxicology screen at birth. Any child had a positive toxicology report at birth for alcohol or another drug/substance not used according to a doctor's prescription, and the primary or secondary caregiver is the birth mother.

#### **N10. Housing**

Score this item based on the family's housing conditions or situation *absent* any intervention by the worker or other engaged in a child safety agreement.

- Neither b or c apply. The family has housing that is physically safe.

- Housing is physically unsafe. The family has housing but the housing situation is physically unsafe to the extent that it does not meet the health or safety needs of the child (for example, exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, or rotting food).
- Homeless. The family was homeless or about to be evicted at any time during the investigation/assessment. Consider families that are highly housing insecure to be homeless. For example, if the family is transient, frequently changes homes, and/or has no stable place to stay from week to week, consider that family to be homeless. Alternatively, if the family has a stable place to stay (e.g., a relative's home) and the housing situation is unlikely to change in the near future (i.e., is unlikely to change in the next 90 days), the family would not be considered homeless (even if they are not the homeowners or signers on a lease).

## **ABUSE INDEX**

### **A1. Current report is for abuse**

The current report includes any type of abuse allegation. This includes the following:

- Physical abuse;
- Emotional abuse; or
- Sexual abuse.

### **A2. Number of prior screened-in reports for abuse**

Where possible, history from other states should be checked.

Screened-in reports include those accepted for investigation or family assessment.

- Count prior screened-in reports involving any adult members of the current household who were alleged perpetrators of abuse (physical, emotional, or sexual abuse/sexual exploitation). Include all household adults, regardless of whether they are current caregivers for any child. Include prior screened-in reports for children no longer in the household.
- Do not count the following:
  - » Prior screened-in reports of abuse in which allegations were perpetrated by an adult who is not part of the current household.
  - » Prior screened-in reports in which a child in the home was identified as the perpetrator of abuse/neglect.

- » Reports that were screened out including Progress Notes and other states' 'Information Only' reports.
- » Reports for which the resultant investigation was administratively discontinued or discontinued due to an erroneous report.
- None. No abuse investigations/assessments prior to the current investigation/assessment.
- One. One investigation/assessment, substantiated or not, for any type of *abuse* prior to the current investigation.
- Two or more. Two or more investigations/assessments, substantiated or not, for any type of *abuse* prior to the current investigation/assessment.

### **A3. Household has previously received ongoing child protection services**

Where possible, history from other states should be checked.

Any member of the current household has previously received or is currently receiving ongoing child protection services as a result of a prior investigation/assessment in which caregiver was an alleged perpetrator. CPS service history includes voluntary or court-ordered intervention/CPS services.

- Include services as follows:
  - » Temporary care arrangements.
  - » Treatment services.
  - » Non court-ordered services as arranged by CPS.
  - » Ongoing abuse/neglect services that were provided by other states.
- Exclude services or reports provided for reasons other than abuse/neglect (e.g., requests for assistance or homelessness).

### **A4. Prior injury to a child resulting from abuse/neglect**

Include all prior injuries to household children, regardless of whether or not the perpetrator is currently a member of the household. Also include any household adult (caregiver or not) who has previously injured a child in an incident of abuse or neglect.

- An adult in the household (even if he/she was not a caregiver) was previously substantiated for abuse or neglect that resulted in an injury to a child, whether or not he/she is a member of the current household.

- Though not previously reported or substantiated, there is now credible information that an adult in the household caused an injury to a child consistent with abuse or neglect, whether or not he/she is a member of the current household.

**A5. Primary caregiver’s assessment of incident**

- Neither b or c apply. The caregiver neither blames nor justifies the current abuse/neglect or alleged abuse/neglect.
- Blames child for abuse/neglect. An incident of abuse or neglect has occurred (whether substantiated or not) and the primary caregiver blames the child for the abuse or neglect. Blaming refers to the caregiver’s statement/belief that his/her action or inaction was the result of something that the child did or did not do (e.g., the child was hit by her stepfather because she talked back to him; caregiver claims that the child seduced him/her; caregiver says the child deserved to be hit because he/she misbehaved). Do not consider a caregiver to be blaming if he/she denies that the incident occurred or refuses to discuss the incident.
- Justifies abuse/neglect. An incident of abuse or neglect has occurred (whether substantiated or not) and the primary caregiver justifies the abuse or neglect. Justifying refers to the caregiver’s statement/belief that his/her action or inaction was appropriate and constitutes good parenting (e.g., claims that this form of discipline was how he/she was raised, states the reason kids these days are always in trouble is because parents are too lenient). Do not consider a caregiver to be justifying if he/she denies the incident occurred or refuses to discuss the incident.

**A6. Domestic/family violence between any adult household members in the past year**

In the previous year, there have been two or more physical assaults resulting in no or minor physical injury; one or more serious incidents resulting in serious physical harm and/or involving use of a weapon; or multiple incidents of intimidation, threats, or harassment between caregivers or involving an adult household member and another adult(s). Incidents may be identified by self-report, credible report by a family or other household member, credible sources, and/or police reports.

Do not include violence between any adult household member and a child where the child is the alleged perpetrator of the violence. Consider the child’s violent behavior under item A10.

Do not include arguments that do not escalate beyond verbal encounters and are not otherwise characterized by threatening or controlling behaviors.

#### **A7. Primary caregiver characteristics**

The characteristics below may have behaviors in common with the substantiation definitions for emotional abuse and/or neglect, but are separate and distinct from those categories. The definitions below should be considered as relating to the caregiver's behavior, independent of any impact (or lack of impact) on the child.

- Neither b, c, or d apply. The primary caregiver does not exhibit characteristics listed below.
- Provides insufficient emotional/psychological support. The primary caregiver consistently provides insufficient emotional/psychological support to the child, such as persistently depriving the child of affection or emotional support.
- Employs excessive/inappropriate discipline. The primary caregiver's disciplinary practices caused or threatened harm to a child because they were excessively harsh physically, excessively harsh emotionally, and/or inappropriate to the child's age or development. Discipline involves a pattern of behaviors by the caregiver to enforce rules or standards that are intended to instruct or correct the child.

Examples may include the following when done for the purpose of discipline or punishment:

- » Locking the child in room or closet;
  - » Holding the child's hand over fire;
  - » Hitting the child with dangerous object or fist;
  - » Depriving a child of physical and/or social activity for extended periods.
- Overly controlling/bullying. The primary caregiver over-controls or bullies the child and/or expects immediate compliance that is unreasonable given the child's age and/or development. This may be characterized by persistently berating/belittling of the child, a caregiver seeing his/her own way as the only way, or by little two-way communication between the caregiver and child.

#### **A8. Primary caregiver has a history of abuse or neglect as a child**

Based on credible statements by the primary caregiver or others, or any child protection history known to the agency, the primary caregiver was abused or neglected as a child (child protection history includes neglect and physical, sexual, or emotional abuse).

Note: Base your assessment of what the caregiver experienced as a child on *current* definitions of abuse/neglect regardless of what it was labeled at the time.

## **A9. Secondary caregiver alcohol or drug use**

### Mark If:

The secondary caregiver has a past or current alcohol/drug abuse problem, including abuse of prescribed drugs, that interferes or interfered with his/her or the family's functioning. Any of the following may be true of the secondary caregiver:

- A professional qualified to do so has diagnosed the secondary caregiver with a substance-related disorder.
- If secondary caregiver has never been diagnosed but appears to have (or have had) an alcohol or drug problem, including abuse of prescribed drugs, consider obtaining an assessment prior to scoring. If caregiver is unwilling to participate in an assessment, or for other reasons an assessment cannot be completed, also count if the primary caregiver:
  - » Self-identifies as an alcoholic or addict.
  - » Uses substances in ways that have negatively affected his/her:
    - Employment;
    - Marital or family relationships; or
    - Ability to provide protection, supervision, and care for the child.
- Has a current arrest or past conviction for use, possession, or distribution of illicit substances; crimes committed under the influence of substances; or crimes committed to obtain substances.
- Has a current arrest or past conviction for driving/boating under the influence.
- Has had multiple positive urine/blood samples.
- Has/had health/medical problems resulting from substance use.
- Has given birth to a child diagnosed with fetal alcohol spectrum disorder (FASD), or a child had a positive toxicology screen at birth.

Abuse of prescribed drugs should be scored.

## **A10. Characteristics of children/young people in household**

The items marked here should match item N9.

- Neither b, c, or d apply. No child in the household exhibits characteristics listed below.

- Delinquency behavior. Any child in the household has ever been involved with juvenile justice. Offending or antisocial behavior not brought to court attention but which creates stress within the household should also be scored, such as child who runs away or is habitually truant.
- Developmental or learning disability. Any child in the household has ever had a developmental or learning disability *that has been diagnosed by a professional* (e.g., physician, school counselor, psychologist, etc.) as evidenced by caregiver's statement of such a diagnosis, medical/school records, and/or professional's statement
- Mental health or behavioral problem. Any child in the household who has ever had a mental health or behavioral problems (includes attention deficit disorders) not related to a physical or developmental disability. This could be indicated by the following:
  - » A mental health diagnosis by a qualified professional;
  - » Receiving mental health treatment;
  - » Attendance in a special classroom because of behavioral problems; or
  - » Currently taking psychotropic medication.

## SUPPLEMENTAL ITEMS

- S1. Does the primary caregiver have biological children who are not in his/her care?**  
Mark yes if the primary caregiver has any biological children who are in the full-time care of another person. This may be through a prior placement of children with a foster parent (i.e., due to CPS involvement prior to this investigation), an informal care arrangement with a family member, full custody of the children being awarded to a prior partner, or any other reason. Do not include situations in which the primary caregiver shares custody of a child with another parent.
- S2. Do all of the children in the home share the same biological parents?**  
Mark yes if all of the children in the home have the same biological mother and father. Mark "no" if any child in the home has a parent different from the other children.
- S3. Indicate if the household is currently receiving Medicaid, SNAP, or TANF.**  
Mark if any household member is currently receiving services through Medicaid, SNAP (often referred to as food stamps), or the Temporary Assistance to Needy Families (TANF) program.

**S4. Either the primary or secondary caregiver has difficulty with cognitive function.**

Mark yes if either the primary or secondary caregiver has limited cognitive function due to a diagnosed condition such as developmental delay, dementia, Alzheimer's disease, or other condition that impairs cognition.

**S5. Primary caregiver's educational attainment.**

Indicate the highest level of education attained by the primary caregiver.

**S6. Household members make use of an informal support system in order to enhance the safety of their children.**

Mark yes if any household adult has a supportive relationship with an extended family member, neighbor, or friend who has helped the family address problems in the past (e.g., child care, providing for child safety, assisting in finding employment, offering help with transportation, etc.). Do not include a relationship with the worker or with other professionals engaged with the family. Mark "no" if the social support system offers the caregiver help, but he/she does not accept it.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® FAMILY RISK ASSESSMENT  
POLICY**

**PURPOSE AND POLICY**

Risk assessment identifies families with low, moderate, high, or very high probabilities of future abuse or neglect. By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their child in the next 18 to 24 months. The difference between risk levels is substantial. High-risk families have significantly higher rates of subsequent investigation and substantiation than low-risk families, and they are more often involved in serious abuse or neglect incidents.

When risk is clearly defined and objectively quantified, the choice between serving one family or another is simplified: Agency resources are targeted to higher-risk families because of the greater potential to reduce subsequent maltreatment.

The risk assessment is based on research on cases with substantiated abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent substantiated abuse and neglect. The tool does not predict recurrence but simply assesses whether a family is more or less likely to have another incident without intervention by the agency.

**WHICH CASES**

All intrafamilial reports of abuse, neglect, or dependency receiving an in-person response.

Exclude investigations or family assessments of allegations of out-of-state runaway and abandoned infant (Safe Arms).

**WHICH HOUSEHOLD**

Assess the alleged perpetrator's household.

Assess a non-custodial parent's household if the child will be removed from the custodial parent's household and placed with the non-custodial parent.

**WHO**

The worker who is responding to the report.

## WHEN

After the safety assessment has been completed and the worker has reached a conclusion regarding the allegation AND prior to the investigation being closed or transferred as an ongoing treatment case.

This is no later than 45 days from receipt of the report **unless a child has been removed from the home**. If a child has been removed from the home, complete the risk assessment within 20 days.

For children in out-of-home care with a return home goal, if a second parent living in a separate household will receive child welfare services, complete a base-line risk assessment within 30 days of identifying that parent in FOCUS.

## DECISION

Identifies the level of risk of future maltreatment. The risk level guides the decision to close an investigation or transfer a case for ongoing treatment services.

RISK-BASED CASE OPEN/CLOSE GUIDE	
RISK LEVEL	RECOMMENDATION
Low	Close*
Moderate	Close*
High	Ongoing service
Very High	Ongoing service

\*When unresolved safety threats are still present at the end of the investigation (i.e., the most recent safety assessment finding was unsafe or safe with agreement), treatment services should be provided regardless of risk level.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® FAMILY RISK ASSESSMENT  
PROCEDURES**

**The risk assessment is completed based on conditions that exist at the time the incident or risk of harm is reported and investigated and the prior history of the family.**

Only one household can be assessed on the risk assessment form. Always assess the household in which the child abuse/neglect incident is alleged. If a child is removed from his/her home and placed with a non-custodial parent (or if such a placement is planned), also complete a risk assessment on the household of the non-custodial parent.

**Scoring Individual Items:** A score for each assessment item is derived from the worker'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 worker to use discretionary judgment based on his/her assessment of the family. Sources of information used to determine the worker's endorsement of an item may include statements by the child, caregiver, or collateral persons; worker observations; reports; or other reliable sources.

The worker should refer to the definitions to determine his/her selection for each item.

After all index items are scored, the worker totals the score and indicates the corresponding risk level for each index. Next, the scored risk level (which is the higher of the abuse or neglect risk scores) is entered.

**Counting Prior CPS History:** Include prior investigations in which any adult household member was alleged as a perpetrator (N2, A2) and prior cases involving an adult household member (N3, A3).

**Policy Overrides:** After completing the risk assessment, the worker determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns and have been determined by the agency to warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. Policy overrides require supervisory approval.

Note: Mark yes or no as appropriate for each policy override.

1. Sexual abuse case AND the perpetrator is likely to have access to the child.
2. Non-accidental injury to a non-verbal child.

3. Severe non-accidental injury (e.g., 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 requires medical treatment* and seriously impairs the health or well-being of the child).
4. Caregiver's action or inaction resulted in death of a child due to abuse or neglect (past or current).

**Discretionary Override:** A discretionary override is applied by the worker to increase the risk level any case in which the worker believes the risk level set by the risk assessment is too low. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the risk assessment. Discretionary overrides may increase the risk level by one unit (e.g., from low to moderate OR moderate to high, but NOT from low to high). Discretionary overrides require supervisory approval.

After completing the override section, 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.

**Disposition:** FOCUS will display the recommended response based on the risk-based case open/close guide. Enter the actual case disposition (transferred as an ongoing treatment case or not). If the recommended response differs from the actual disposition, provide an explanation.

Examples of explanation include the following:

- Promoting a low- or moderate- risk family to a case:
  - » Unresolved safety threats. Based on SDM safety assessment, one or more safety threats could not be resolved.
- Not promoting a high- or very-high risk family to a case:
  - » Family refuses to cooperate with agency AND no legal recourse. Family was informed of their high or very high risk level and a transfer to treatment services was planned. However, the family has refused to participate in services. Prior to selecting this option, the worker must consult with his/her supervisor and/or the Department of Justice to determine that further legal action cannot be taken.
  - » Family is receiving or has been connected with community services that will address priority needs and/or contributing factors. The family is already engaged in services OR the worker will assist the family in making connections to community services (worker is certain that an appointment was made and verifies follow-through). These services are directly related to the priority needs that contribute to risk.

**Documentation and Narrative:** When you document your risk assessment in FOCUS, several fields must be completed. Please refer to the guidance below when completing a risk assessment in FOCUS. The answer to every risk item must be documented in one of the following fields.

### **Narrative 1:**

1. Briefly summarize the date and content of each report.

This section should describe the date the report was received, whether the report was a P1, P2, or P3; include a summary of the allegations; and discuss the alleged perpetrator(s) and alleged victim(s). Also include information about linked reports received during the course of the investigation and whether the new reports alleged similar or different allegations.

2. Describe the key events or activities that occurred during the investigation.

Include who was interviewed within the family and their relationships and identify the completed collateral contacts. If the collateral contacts indicated any concerns about abuse/neglect, provide specifics. Also include, when applicable, whether:

- A multi-disciplinary investigation with law enforcement, the Department of Justice, and Children’s Advocacy Center was initiated. Specify the names of the involved law enforcement department and personnel and indicate if any charges were filed, the status of the charges, and any pending or current court orders related to the charges or criminal findings.
- Any medical or mental health interventions were needed/required and, if so, indicate the specifics and the outcome.
- Any courtesy requests that were made to an out-of-state CPS agency and, if so, the agency name, the nature of the courtesy request, and what was completed by that agency.
- DFS obtained custody of any of the children during the course of the investigation. If so, indicate which children, when, and why, and discuss any court hearings and future scheduled court hearings.
- Other key events occurred during the investigation (i.e., substance abuse evaluation, Protection from Abuse proceeding, etc.).

3. Describe household member history with DFS, the Division of Prevention and Behavioral Health Services (DPBHS), or the Division of Youth Rehabilitative Services (DYRS).

This section should provide a description of the family's prior DFS history to include substantiated and unsubstantiated findings, a history of voluntary and involuntary child placements or termination of parental rights (TPR), history of the family receiving ongoing DFS treatment services, and any known CPS history of case-related family members in another state.

Other history should include whether any of the children have any history with DPBHS or DYRS and, if so, provide a brief summary of that activity (e.g., DPBHS history for crisis intervention, DYRS history for community probation, etc.). Also include if any of the children are currently active with DPBHS.

Provide an analysis of the historical record review and how it does or does not support the scored risk level.

4. Describe the physical conditions of the home.

Discuss who resides in the home and where the home is located. Provide a description of the home including its cleanliness, furniture, utilities, food, and any safety hazards. Describe any concerns about the condition of the home. If the family is homeless or residing in a shelter or with friends/relatives, explain the surrounding circumstances that created the current living situation.

**Narrative 2:**

5. Describe the characteristics and behaviors of adult household members.

This section should include the following.

- Any information regarding the parent's substance abuse, domestic violence, or mental health status—history and/or current.
- Behavioral descriptions (e.g., Mother self-reports using crack cocaine on a weekly basis and has been using for six months, or Mother self-reports using while in the community with friends, but does not use at home). Make sure to include if the parent's substance abuse, domestic violence, or mental health status is having an impact on the child (e.g., Child reports that because Mother is spending her paycheck on alcohol, child does not have adequate food in the home so the child will ask the neighbors for food).
- Caregiver behaviors that we are worried about and the impact this places on the child.

- A description of the relationships in the home, both positive and negative. Include factors about the interactions, communication, boundaries, etc. Examples of things to include would be any domestic violence, parent-child conflict, close bonds, etc.

6. Document each child's well-being.

In this section, include all the information you gathered about each child such as school, grade level, whether academically or developmentally age appropriate (regular education or special needs), any diagnosed medical or mental health issues, any prescribed medications, any substance abuse issues (including pre-natal drug exposure or Fetal Alcohol Spectrum Disorder), any services/activities in which the children are involved, and a description of each child (how they presented upon interview). For children ages birth to 3 years, indicate if a referral was made to the Division of Public Health Child Development Watch program.

7. What are the family's strengths?

This section should identify any strengths, the capacity of the parents to protect the children, acts of protection by the parents to mitigate the harm or danger, healthy relationships, etc. Also include what is working well from all perspectives (parents, collateral contact reports, DFS, support network, etc.).

Conclusion:

8. Investigation Findings

Summarize how each party (alleged perpetrator, non-offending caregiver, child victims) responded to the allegations and if statements were consistent or conflictual.

- Discuss the perspectives of other professionals in relation to the allegations such as law enforcement, the teacher or school counselor, pediatrician, Probation and Parole, etc. Note if criminal charges are pending or what charges have been filed, whether any medical examinations are scheduled, or the results of medical examinations related to the allegations.
- Describe the caregivers' response (e.g., denial, blame, remorse) to the allegations and whether they were cooperative or not.
- Discuss identified safety threats and actions taken (e.g., child safety agreement or placement). Discuss whether a child safety agreement remains in place or if a child safety agreement had been in place but was terminated after review.

## 9. Investigation Outcome

- Is there a preponderance of the evidence to substantiate? Discuss the basis for the primary finding and, when applicable, the secondary and tertiary findings. Note the dates and times of pending family court hearings (e.g., dependency/neglect or substantiation) and the involved child(ren).
- When there is not a preponderance of the evidence to substantiate, describe any concerns about the family.
- Do ongoing services need to be provided by DFS? If so, include a harm or risk statement.
- When a decision is made to close a case, explain the reason. Always justify the closure of a substantiated case or a case with high or very high risk.

### Recommendations

- Discuss any recommendations that have been made to the family throughout the investigation, including any recommendations made at case closure or transfer. This can include any educational information that was provided, any services that were recommended, any referrals that were made during the course of the investigation, any recommendations that were made to the family to continue after case closure, and any recommendations/information that was provided to the family about why their case is being transferred to DFS treatment.
- When a case is being transferred to DFS treatment, discuss whether a child safety agreement is in place and the conditions.
- Note any other involved professionals or agencies and highlight issues or activities that may require the immediate attention of DFS treatment staff (i.e., scheduled substance abuse assessment, scheduled family team meeting, Best Interest Meeting at school, etc.) or other professionals.

**Case Name:** \_\_\_\_\_ **Case#:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**County Name:** \_\_\_\_\_ **Worker Name:** \_\_\_\_\_ **Worker ID#:** \_\_\_\_\_

**Initial Risk Statement:** Using information from the SDM® safety assessment and risk assessment completed in the investigation phase of the case, identify the initial risk statement for the family.

**SECTION 1: HOUSEHOLD CONTEXT**

**1A. Caregivers**

Identify the caregiver(s).

**Caregiver A:** \_\_\_\_\_

Primary

Secondary

**Caregiver B:** \_\_\_\_\_

Primary

Secondary

**1B. Other Household Members**

Role may be child, grandmother, tertiary caregiver, etc.

Name	Role/Relationship Within the Household

**1C. Connecting Culture, Identity, and Caregiving/Parenting:** What culture(s) does the caregiver/family identify with? Consider traditions, family roles, holidays, and values. Include in the narrative how the caregiver/family feels their culture influences their parenting styles and techniques.

**1D. Trauma History**

Identify any struggles each caregiver is having in managing their trauma experiences, e.g., any symptoms they are experiencing and their impact on the child, and/or ways in which the caregiver has coped or recovered from trauma in the past, and/or ways they are coping currently and the impact that this has had or may have on parenting. Be sure to identify which caregiver has experienced trauma, the specifics of their traumatic experience(s), and the impact they report it having on their parenting.

**1E. Past Experiences With the Child Welfare System**

Has the caregiver/family had prior interactions with the child welfare system? If so, what does the family say about those experiences?

**SECTION 2A: CAREGIVER STRENGTHS AND NEEDS GUIDE**

In the areas below, indicate whether the caregiver’s behaviors in each domain:

1. Are strengths and are actively helping to create child safety, permanency, or well-being;
2. Are neither significant strengths nor barriers for the child;
3. Are barriers to the child’s long-term safety, permanency, or well-being; or
4. Contribute to imminent danger of serious physical or emotional harm to the child.

Always select the highest priority that applies, e.g., if caregiver actions fit definitions 3 and 4, select 4.

Note: Domains identified as 4 below should lead to a consultation with a supervisor to consider whether a new safety assessment and safety plan are needed.

Domain	A	B
<b>SN1. Physical Health</b>		
Describe:		
<ul style="list-style-type: none"> <li>• Ways in which the caregiver’s physical health presents an imminent threat of serious physical or emotional harm to the child, or prevents them from creating child safety over the long term; and</li> <li>• Ways in which the caregiver’s physical health helps them create safety for the child OR has no effect on child safety.</li> </ul>		
Narrative:		

Domain	A	B
<b>SN2. Mental Health and Coping Skills</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Struggles the caregiver is having with their mental health and the impact that is having on the child; and</li> <li>• Ways the caregiver has responded successfully to mental health problems in the past (including use of formal providers, such as therapists or other mental health providers) and the ways their actions have positively impacted the child.</li> </ul> <p>Narrative:</p>		
<b>SN3. Developmental/Cognitive Abilities</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Struggles the caregiver is having with their cognitive and developmental abilities (include any developmental disabilities) and any impact that is having on the child; and</li> <li>• Ways the caregiver's cognitive abilities help support the child or ways the caregiver has addressed or compensated for challenges in their developmental or cognitive capacity. Include any use of formal providers.</li> </ul> <p>Narrative:</p>		
<b>SN4. Substance Use</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Struggles the caregiver is having with substance use and the impact that is having on the child; and</li> <li>• Ways the caregiver has avoided substance use OR responded successfully to substance use problems in the past OR ways they are coping with substance use problems currently. Include any use of support groups or formal substance abuse programs or providers.</li> </ul> <p>Narrative:</p>		
<b>SN5. Legal System</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Ways in which caregiver's legal or court interactions are challenging and might be impacting them and the child; and</li> <li>• Ways the caregiver has used the court and legal system to support themselves and the child.</li> </ul> <p>Narrative:</p>		

In the areas below, indicate whether the caregiver's behaviors in each domain:

1. Are strengths and are actively helping to create child safety, permanency, or well-being;
2. Are neither significant strengths nor barriers for the child;
3. Are barriers to the child's long-term safety, permanency, or well-being; or
4. Contribute to imminent danger of serious physical or emotional harm to the child.

Always select the highest priority that applies, e.g., if caregiver actions fit definitions 3 and 4, select 4.

Note: Domains identified as 4 below should lead to a consultation with a supervisor to consider whether a new safety assessment and safety plan are needed.

Domain	A	B
<b>SN6. Daily Parenting Behaviors and Routines</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Struggles the caregiver is having with routine child care (e.g., setting limits, discipline, struggling to express love or affection toward the child) and the impact this is having on the child; and</li> <li>• Ways in which caregiver behaviors and routines are a good match for the child's needs and/or help support the child's learning, growth, and development.</li> </ul> <p>Narrative:</p>		
<b>SN7. Basic Needs and Management of Financial Resources</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Struggles the caregiver is having with meeting basic needs or managing their financial resources and the impact that is having on the child. Describe in particular any difficulties with duration or stability of employment; and</li> <li>• Ways in which the caregiver is able to successfully meet family's and child's basic needs.</li> </ul> <p>Narrative:</p>		
<b>SN8. Domestic Violence</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Patterns of violence or control in the caregiver's intimate relationships and the impact this is having on the protective caregiver and the child; and</li> <li>• Ways in which the caregiver has responded to violence or control that have helped to protect the child.</li> </ul> <p>Narrative:</p>		

In the areas below, indicate whether the caregiver's behaviors in each domain:

1. Are strengths and are actively helping to create child safety, permanency, or well-being;
2. Are neither significant strengths nor barriers for the child;
3. Are barriers to the child's long-term safety, permanency, or well-being; or
4. Contribute to imminent danger of serious physical or emotional harm to the child.

Always select the highest priority that applies, e.g., if caregiver actions fit definitions 3 and 4, select 4.

Note: Domains identified as 4 below should lead to a consultation with a supervisor to consider whether a new safety assessment and safety plan are needed.

Domain	A	B
<b>SN9. Other Adult Household and Family Relationships</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Conflicts in the home or family relationships and the impact those conflicts are having on the child; and</li> <li>• Ways in which family members are supportive of each other and/or supportive of the child.</li> </ul> <p>Narrative:</p>		
<b>SN10. Social Support System</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Ways in which the caregiver's social support system outside of the household (e.g., with neighbors, family members, community groups, clubs, and affiliations) adversely impacts the child and/or limitations to that social support network that may be a long-term barrier for the family; and</li> <li>• Ways in which social supports contribute positively to the caregiver and/or the child.</li> </ul> <p>Narrative:</p>		
<b>SN11. Physical Characteristics of the Household</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Ways in which the physical characteristics of the household and/or the caregiver's response to that household may be harmfully impacting the family and child; and</li> <li>• Ways in which the physical characteristics of the household and/or the caregiver's response to that household are a support to the child.</li> <li>•</li> </ul> <p>Narrative:</p>		

In the areas below, indicate whether the caregiver's behaviors in each domain:

1. Are strengths and are actively helping to create child safety, permanency, or well-being;
2. Are neither significant strengths nor barriers for the child;
3. Are barriers to the child's long-term safety, permanency, or well-being; or
4. Contribute to imminent danger of serious physical or emotional harm to the child.

Always select the highest priority that applies, e.g., if caregiver actions fit definitions 3 and 4, select 4.

Note: Domains identified as 4 below should lead to a consultation with a supervisor to consider whether a new safety assessment and safety plan are needed.

Domain	A	B
<b>SN12. Community Environment and Neighborhood</b>		
<p>Describe:</p> <ul style="list-style-type: none"> <li>• Ways in which the community environment and neighborhood and/or the caregiver's response to that environment may be harmfully impacting the family and child (e.g., challenges in keeping the child safe in dangerous neighborhoods, etc.); and</li> <li>• Ways in which the community environment helps support the caregiver and/or child, and/or actions the caregiver has taken to protect the child from challenges in the environment or neighborhood.</li> </ul> <p>Narrative:</p>		
<b>SN13. Other</b>		
<p>The caregiver engages in additional actions that:</p> <p>N/A Not applicable</p> <ol style="list-style-type: none"> <li>1. Are strengths and actively help to create child safety, permanency, or well-being.</li> <li>2. Are barriers to the child's long-term safety, permanency, or well-being.</li> <li>3. Contribute to imminent danger of serious physical or emotional harm to the child.</li> </ol> <p>Describe: What is this area? What are the caregiver's challenges in this area? What are their strengths? What is the impact on the child as a result?</p> <p>Narrative:</p>		

**SECTION 2B: PRIORITIZATION**

All items entered as 4 that are going to be addressed in the service plan should be addressed by both a safety plan and the case plan. These items are priorities for case closure.

All items entered as 3 should be strongly considered for the case plan but are not required to be fully resolved for case closure.

All items entered as 1 should be considered as potential resources and aids when addressing items entered as 4 and 3.

Scoring (4 or 3)	Domain Name	Caregiver
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

STRENGTHS	
Domain Name	Caregiver
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

### SECTION 3: CHILD STRENGTHS AND NEEDS GUIDE

Repeat this section for each child in the family.

**Section Completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Child's Placement Status:**     Intact     In Placement    **Placement Date (if applicable):** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **Child's Date of Birth:** \_\_\_\_\_

**Race (mark all that apply):**  African American/Black     American Indian/Alaska Native     Asian/Pacific Islander  
 Latino/a     Multiracial     White     Other

**Ethnicity:** \_\_\_\_\_

**Tribal Affiliation:**     Yes     No    **Tribe Name:** \_\_\_\_\_  
**Federally Recognized:**     Yes     No

**Sexual Orientation:**     Heterosexual     Gay     Lesbian     Bisexual     Other     Not discussed

**Gender Identity/Expression:**     Female     Male     Transgender     Other

**Religious/Spiritual Affiliation:** \_\_\_\_\_

**Other Cultural Identity Important to Child (e.g., immigration status, disability status):** \_\_\_\_\_

#### A. Household Context

Consider the area of household context and describe as a narrative in the boxes below.

##### A1. Culture

What culture(s) does the child identify with? Consider race, ethnicity, religion, traditions, family roles, holidays, values and other characteristics the child considers cultural.

##### A2. Legal Systems

Identify and explain any involvement the child has with the legal system and how this involvement impacts their daily functioning. Include involvement in family court, juvenile court, drug court, probation, or parole.

- The child requires mixing.
- The child has upcoming family court involvement.

A3. Efforts to Locate Permanent Home

Identify all relatives who have been contacted about providing a safe and appropriate placement for the child and the outcome of these home studies. Consider efforts made to maintain the child's connections with siblings as well.

A4. Trauma History

Identify any struggles the child is having in managing their trauma experiences, e.g., any symptoms they are experiencing and their impact on the child, and/or ways in which the child has coped or recovered from trauma in the past, and/or ways they are coping currently and how this effects their daily functioning. Be sure to identify which child(ren) has experienced trauma, the specifics of their traumatic experience(s), and the impact they report it having on their daily functioning.

**B. Child Domains**

Indicate whether the behaviors of the child in each domain (1) are strengths and actively help create safety, permanency, or well-being for themselves; (2) are neither significant strengths nor barriers for the child; (3) are barriers to the child's long-term safety, permanency, or well-being; or (4) contribute to imminent danger of serious physical or emotional harm to the child.

Always select the highest priority that applies, e.g., if child actions fit definitions 3 and 4, select 4.

Domains and behaviors identified as 4 on the following table must relate directly to a safety threat identified on the most recent SDM safety assessment. If there are no safety threats currently identified, do not rate any of the below domains as 4.

<p><b>CSN1. Physical Health/Disability</b></p> <p><input type="checkbox"/> Immunizations are current.</p> <p>The child:</p> <p><input type="checkbox"/> 1. Is in good physical health.</p> <p><input type="checkbox"/> 2. Has minor health problems or disabilities that are being addressed with minimal intervention and/or medication.</p> <p><input type="checkbox"/> 3. Has health care needs or disabilities that require routine interventions.</p> <p><input type="checkbox"/> 4. Has serious health/disability needs that require ongoing treatment and interventions by professionals or trained caregivers AND/OR the child has an unmet medical need.</p> <p>Narrative:</p>
<p><b>CSN2. Child Development</b></p> <p>The child's:</p> <p><input type="checkbox"/> 1. Cognitive/intellectual and/or physical development is advanced.</p> <p><input type="checkbox"/> 2. Cognitive/intellectual and/or physical development is age-appropriate.</p> <p><input type="checkbox"/> 3. Cognitive/intellectual and/or physical development is limited.</p> <p><input type="checkbox"/> 4. Cognitive/intellectual and/or physical development is severely limited.</p> <p>Narrative:</p>

**CSN3. Education**

Not applicable; the child is not of mandatory school age AND is not enrolled in an educational setting.

Also indicate if the child (mark all that apply):

- Has an individualized education program.
- Has an educational surrogate parent.
- Needs an educational surrogate parent.
- Is required by law to attend school but is not attending.

The child:

- 1. Has outstanding academic achievement.
- 2. Has satisfactory academic achievement.
- 3. Has academic difficulty.
- 4. Has severe academic difficulty.

Narrative:

**CSN4. Emotional/Behavioral Health**

The child:

- 1. Is emotionally and behaviorally high functioning.
- 2. Does not have an emotional/behavioral health concern OR the child has an emotional/behavioral health concern, but no additional intervention is needed.
- 3. Has an emotional/behavioral health concern, AND it is an ongoing barrier.
- 4. Has an emotional/behavioral health concern that directly contributes to danger to the child.

Narrative:

**CSN5. Substance Use**

Not applicable given the child's age and/or developmental status.

The child('s):

- 1. Actively chooses an alcohol- and drug-free lifestyle.
- 2. Does not use or experiment with alcohol/drugs.
- 3. Alcohol and/or other drug use results in disruptive behavior and conflict.
- 4. Chronic alcohol and/or other drug use results in severe disruption of functioning.

Narrative:

**CSN6. Family Relationships**

The child's:

- 1. Relationships within their family contribute to the child's safety, permanency, and well-being.
- 2. Relationships within their family do not impact the child's safety permanency, and well-being.
- 3. Relationships within their family interfere with long-term safety, permanency, and well-being.
- 4. Relationships within their family contribute to danger of serious physical or emotional harm to the child.

Narrative:

**CSN7. Social Relationships**

- Not applicable given the child's age and/or developmental status.

The child:

- 1. Has strong social relationships.
- 2. Has adequate social relationships.
- 3. Has limited social relationships.
- 4. Has poor social relationships.

Narrative:

**CSN8. Relationship With Substitute Care Provider (if child is in care)**

- Not applicable; the child is not in care.

The child:

- 1. Has developed a strong attachment to at least one substitute care provider.
- 2. Has no conflicts with the substitute care provider.
- 3. Has some conflicts with the substitute care provider that have resulted or may result in the child feeling unsafe or unaccepted in the placement; however, with support, these issues can be mitigated.
- 4. Has serious conflicts with one or more members of the current substitute care provider's household.

Narrative:

**CSN9. Independent Living (if age 14 or older)**

- Not applicable.

The young adult:

- 1. Is actively preparing for independent living and functioning as a young adult.
- 2. Is making progress toward preparing for independent living and functioning as a young adult.
- 3. Is attempting to prepare for adulthood but lacks the confidence, emotional maturity, and/or sufficient skills to live independently.
- 4. Is not prepared or is unable to prepare for independent living and functioning as a young adult.

Narrative:

**CSN10. Other Identified Child Strength or Need (not covered in CSN1–CSN11)**

Not applicable.

An additional need or strength has been identified that:

- 1. Actively helps the child create safety, permanency, and well-being for themselves.
- 2. Is a barrier to the child’s long-term safety, permanency, or well-being.
- 3. Contributes to imminent danger of serious physical or emotional harm to the child.

Description of behaviors:

Narrative:

**C. Priority Needs and Strengths**

All items entered as 4 that are going to be addressed in the service plan should be addressed by both a safety plan and the case plan. These items are priorities for case closure.

All items entered as 3 should be strongly considered for the case plan but are not required to be fully resolved for case closure.

All items entered as 1 should be considered as potential resources and aids when addressing items entered as 4 and 3.

Scoring (4 or 3)	Domain Name	Child(ren)

STRENGTHS	
Domain Name	Child(ren)

## SECTION 4: REVISED RISK STATEMENT AND SAFETY GOAL

### Revised Risk Statement

Using the initial risk statement and after assessing and working with the family, write a revised risk statement that will be part of the family service plan and guide the goals and services for the family. The risk statement should include what will or could happen to the child if or when the caregiver takes or fails to take what action. If the intake caseworker has created an initial risk statement, ensure that it matches the items entered as 4 and 3 and then create, modify, or amend that risk statement as needed to reflect the priority areas of child and caregiver needs.

### Safety Goal

Using the risk statement, work with the family to write a brief statement of what the caregiver and the safety network members will do differently to prevent the harm described in the risk statement, and for how long this changed behavior will be demonstrated. (If no safety threats/dangers were identified on the safety assessment, leave this section blank.)

## OPTIONAL WORKSHEET FOR THE FIELD

This worksheet helps the family and social workers discuss critical areas that could be impacting the family. Consider whether these areas are strengths or barriers for the family and begin to work on a plan together.

In the categories below, indicate whether the caregiver's behaviors:

1. Are strengths and are actively helping to create child safety, permanency, or well-being;
2. Are neither significant strengths nor barriers for the child;
3. Are barriers to the child's long-term safety, permanency, or well-being; or
4. Contribute to imminent danger of serious physical or emotional harm to the child.

Item	Caregiver Name	Caregiver Scoring	Next Steps
SN1. Physical Health			
SN2. Mental Health and Coping Skills			
SN3. Developmental/ Cognitive Abilities			
SN4. Substance Use			
SN5. Legal System			
SN6. Daily Parenting Behaviors and Routines			
SN7. Basic Needs and Management of Financial Resources			
SN8. Domestic Violence			
SN9. Other Adult Household and Family Relationships			
SN10. Social Support System			
SN11. Physical Characteristics of the Household			
SN12. Community Environment and Neighborhood			
SN13. Other:			

Use the below grid to capture information from discussions with the family to use in completing the guide.

<b>SN1. Physical Health</b>	<b>SN2. Mental Health and Coping Skills</b>
<b>SN3. Developmental/ Cognitive Abilities</b>	<b>SN4. Substance Use</b>
<b>SN5. Legal System</b>	<b>SN6. Daily Parenting Behaviors and Routines</b>
<b>SN7. Basic Needs and Management of Financial Resources</b>	<b>SN8. Domestic Violence</b>
<b>SN9. Other Adult Household and Family Relationships</b>	<b>SN10. Social Support System</b>
<b>SN11. Physical Characteristics of the Household</b>	<b>SN12. Community Environment and Neighborhood</b>
<b>SN13. Other:</b>	

**CONNECTING CULTURE, IDENTITY, AND CAREGIVING/PARENTING**

What culture(s) does the caregiver/family identify with? Consider traditions, family roles, holidays, and values. Include in the narrative how the caregiver/family feels their culture influences their parenting styles and techniques.

**GENOGRAM**

Who is in the family? Include first and last names, nicknames, ages, dates of birth, three generations of family, etc. Try to include at least three generations. List “?” when unsure of any information.

**ECOMAP**

Include both informal, extra-familial social networks that care about the child and family AND professionals currently working with the family, the role of those professionals, and how long they have worked together.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
FAMILY STRENGTHS AND NEEDS GUIDE  
DEFINITIONS**

**SECTION 1: HOUSEHOLD CONTEXT**

**C. Connecting Culture, Identity, and Caregiving/Parenting**

Culture is a system of shared actions, values, beliefs, and traditions that guide the behavior of families and communities. For this item, cultural identity may refer to their race, ethnicity, religion, traditions, family roles, holidays, values, or any other social identity that reflects the unique characteristics of the family.

Keep in mind that family members may identify with multiple cultures and that a person's dominant cultural identification may shift with the context. For example, in some situations, it may be more important to the caregiver to identify as a disabled person than to identify with an ethnic group. Cultural identity is not limited to identification with a non-mainstream culture and may refer to the mainstream culture.

For this item, consider how the family's culture, cultural identity, and norms may influence or shape parenting and caregiving.

In particular, consider the following:

- How the caregiver identifies themselves;
- Any historical experiences of oppression/discrimination that are important or relevant to this caregiver;
- Any current experiences of oppression/discrimination this caregiver might be experiencing; and
- Any coping skills, strengths, and survival skills this caregiver has developed or demonstrated in facing oppression/discrimination.

How do all of the above influence or shape the caregiver's beliefs about parenting or child rearing? How do all of the above influence or shape their actions with their children?

## D. Trauma

Trauma may occur when a person has experienced, witnessed, or been confronted with an event or events of actual or threatened death or serious injury, or a threat of serious physical harm to self or others. Trauma may be caused by many experiences, e.g., serious physical harm; sexual abuse; bullying; domestic violence; natural disasters; or long-term exposure to extreme poverty, neglect, or verbal abuse. Often, these experiences will have an effect on the way that caregivers function in their day-to-day life, including their parenting practices. Be sure to identify which caregiver has experienced trauma, the specifics of their experience(s), and the self-described impact of their trauma history on their parenting.

## E. Past Experiences With the Child Welfare System

Has the caregiver/family had prior interactions with the child welfare system? If so, what does the family say about those experiences?

- What worked well during that experience?
- What was challenging?
- What, if anything, do they hope can be different this time?

## SECTION 2A: CAREGIVER STRENGTHS AND NEEDS GUIDE

**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 interaction between domains (e.g., a need in the domain of substance use may affect parenting practices, resource management/basic needs, and/or other areas of functioning). With this in mind, assess the caregiver's functioning in each domain as it relates to their ability to effectively provide for the child's safety.

**SN1. Physical Health**—The caregiver's physical health AND/OR the caregiver's response to physical health challenges:

1. Is a strength and is actively helping to create child safety, permanency, or well-being.  
The caregiver is in excellent to good health AND/OR the caregiver regularly accesses health resources for self-care when needed (e.g., medical/dental) and is physically able to meet the child's most important needs.

The caregiver may also have a medical condition but is consistently able to meet the child's needs (e.g., caregiver has a well-controlled chronic illness and is able to participate in most of the child's activities, and the child is not experiencing a sense of loss).

In all of these cases, the child reports or displays signs that they are well cared for and that their caregiver's health has no negative impact on them.

2. Is neither a significant strength nor barrier for the child.  
The caregiver is in fair health, or the caregiver has no significant conditions or illnesses that affect family functioning, or the caregiver has an illness that has only very minor impact on the child.
3. Is a barrier to the child's long-term safety, permanency, or well-being.  
The caregiver has some health concerns or conditions that affect family functioning AND/OR impact the child in some way.

These may include but are not limited to:

- Caregiver struggles to meet child's needs because of health limitations (e.g., chronic medical condition, physical disability);
- Caregiver has an illness that causes the child fear because the caregiver has not properly explained it or prepared the child for it; or
- Caregiver refuses self-care for chronic, non-life-threatening conditions.

In all of these situations, the child reports or displays some signs of worry or stress, but this does not reach the level of preventing the child from participating in their own activities and does not result in the level of imminent or serious harm to the child listed as follows.

4. Contributes to imminent danger of serious physical or emotional harm to the child.  
The caregiver has one or more serious health conditions that significantly limit their ability to meet the child's needs. Examples include but are not limited to the following.

- The caregiver has some serious, chronic, or potentially life-threatening health problem(s) or condition(s) that affect their ability to care for and/or protect the child.
- As a result of the illness or condition, the caregiver cannot meet the child's needs for food, clothing, shelter, supervision, hygiene, etc.

In these situations, the child reports or displays signs that they are spending substantial time worrying about the caregiver's health, may have to assume parenting responsibilities for self or siblings in ways that are interfering with their own development, or may experience intense loss/grief when caregiver is not emotionally or physically available (e.g., repeated caregiver hospitalizations, a caregiver so incapacitated that they cannot respond to the child).

In all of these situations, the caregiver's condition has reached the point where the child is experiencing some significant physical or emotional harm or harm is likely to occur.

**SN2. Mental Health and Coping Skills**—The caregiver’s mental health AND/OR response to challenges to their mental health:

When assessing the caregiver’s mental health and coping skills, consider whether the caregiver has any diagnosed or suspected mental health conditions AND whether these conditions affect their ability to parent and protect the child. The condition itself does not necessitate a score of 1. Mental health also includes consideration of the caregiver’s coping to the extent that some behaviors may not rise to the level of diagnosis but nonetheless affect family functioning. For example, severe unmanaged stress may not indicate a mental health diagnosis, but may negatively impact the child. Similarly, a caregiver with exceptional coping skills may be able to parent and protect the child through extraordinarily stressful family conditions.

1. Is a strength and is actively helping to create child safety, permanency, or well-being.  
The caregiver has no mental health issues AND/OR the caregiver demonstrates the ability to cope with adversity, crises, and their own mental health problems (diagnosed or undiagnosed) in an extremely constructive manner. The caregiver understands their own emotional needs and is effectively meeting them in ways that do not interfere with their ability to provide care for the child.

The child reports or displays signs that they are aware they will be cared for well no matter what the caregiver struggles with and also may know how to access assistance for self if necessary.

2. Is neither a significant strength nor barrier for the child.  
The caregiver may struggle from time to time with adversity, crises, or mental health problems (diagnosed or undiagnosed), but this area is neither a significant strength nor a significant barrier for the caregiver. They are able to manage any mental health problem to the point that there is only very minor impact on the child.

3. Is a barrier to the child’s long-term safety, permanency, or well-being.  
The caregiver suffers from some mental health problem (diagnosed or undiagnosed) and can be at times overwhelmed and temporarily distracted from the child’s needs due to their own mental health difficulties. These can include times when the caregiver displays symptoms such as depression, low self-esteem, or apathy.

The caregiver may also have occasional difficulty dealing with situational stress, crises, or problems, and as a result of this, some of the child’s basic needs may be temporarily missed or attended to less.

In these situations, the child reports or displays signs of stress, loss, or grief, but such worry does not interfere with their participation in their own activities (such as school or community life) and the child is not experiencing the level of imminent or serious harm listed below.

4. Contributes to imminent danger of serious physical or emotional harm to the child.  
The caregiver displays chronic or severe mental health problems, challenges, or symptoms including, but not limited to: bipolar disorder, schizophrenia, suicidal ideation, personality disorders, depression, etc. These symptoms impair the caregiver's ability to perform in one or more areas of parental functioning; employment; education; or provision of food, clothing, shelter, supervision, hygiene, etc. for the child (e.g., problems that require the caregiver to be hospitalized or otherwise removed from the child).

As a result of these difficulties, the child reports or displays signs of being seriously affected in some significant way. This can include the child spending substantial time worrying about how the caregiver is coping to the extent that the child is not engaging in play or is struggling in school, having to assume parenting responsibilities for self or siblings in ways that interfere with the child's own development or functioning, etc. All of this is causing or has the potential to cause serious physical or emotional harm to the child.

**SN3. Developmental/Cognitive Abilities**—The caregiver's developmental and cognitive abilities AND/OR their response to the challenges in their developmental and cognitive abilities:

When assessing the caregiver's cognition, consider if there are any diagnosed or suspected cognitive conditions, including developmental disabilities, traumatic brain injury, or dementia/Alzheimer's disease AND the impact that such conditions have on the caregiver's ability to adequately parent and protect the child.

1. Is a strength and is actively helping to create child safety, permanency, or well-being.  
The caregiver demonstrates high levels of developmental functioning (e.g., has consistently shown the ability to understand complex and essential child care information, think clearly, read, write, and use basic math skills to ensure their child's basic needs are met the vast majority of the time).

Caregiver may also have some developmental limitations but is consistently able to meet the child's basic needs with the assistance of family- or agency-provided help.

In these cases, the child reports or displays signs that they are consistently well cared for and that any caregiver developmental/cognitive limitations have no negative impact on them.

2. Is neither a significant strength nor barrier for the child.  
The caregiver has no history of developmental or cognitive limitations, or the caregiver may struggle in some way with their thinking or development, but this area is neither a significant strength nor barrier to their care of the child and has very minor impact on the child.

3. Is a barrier to the child’s long-term safety, permanency, or well-being.  
The caregiver may have some documented cognitive or learning challenges AND/OR has demonstrated some difficulty understanding basic or essential child care information, thinking clearly, reading, writing, or using basic math skills AND these difficulties have made it harder for them to parent effectively.

Examples can include but are not limited to the following.

- Ways in which the caregiver struggles with simple child care tasks.
- Ways in which the caregiver’s cognitive or developmental limitations create difficulties in supporting the child’s own developmental needs.

In all of these cases, the child reports or displays signs that some basic needs may be unmet due to caregiver incapacity, but there has been no imminent or serious physical or emotional harm of the level listed below.

4. Contributes to imminent danger of serious physical or emotional harm to the child.  
The caregiver has significant difficulty understanding or remembering fundamental parenting information or simple developmental functions, such as reading, writing, or basic math. As a result of this, the child reports or displays signs that they have been harmed or there is a high likelihood of serious physical or emotional harm.

Examples of these behaviors or conditions can include but are not limited to the following.

- Poor decision making about how much to feed a child and how often.
- Poor decision making about how to decide when a child needs medical care.
- Unreasonable child development expectations (e.g., whether it is reasonable to expect a 6-month-old child to be fully potty trained).

**SN4. Substance Use**—The caregiver’s substance use AND/OR response to difficulties in their substance use:

Consider both selling of illegal and prescription drugs AND alcohol, illegal drugs, and prescription drugs not used according to prescription.

1. Is a strength and is actively helping to create child safety, permanency, or well-being.  
The caregiver has no history of substance abuse, or the caregiver may have a history of substance abuse but has maintained consistent recovery where they can perform all major tasks of caring for their child.

In these cases, the child reports or displays signs that they are consistently well cared for and that there are no signs that any prior caregiver substance abuse has any negative impact on them.

2. Is neither a significant strength nor barrier for the child.

The caregiver may have some history of substance abuse and either is in early recovery or is in recovery with some minor relapses that have little to no negative impact on the child. This area is neither a major strength nor barrier for the caregiver and has minimal impact on the child positively or negatively.

3. Is a barrier to the child's long-term safety, permanency, or well-being.

The caregiver's alcohol and drug use impairs their ability to parent and results in behaviors that sometimes impede their ability to meet their child's basic needs (food, clothing, shelter, supervision, hygiene, etc.) or emotional well-being. Select this response if there is a history of substance use which has resulted in prior agency involvement and the caregiver is suspected or confirmed to be currently using.

The child reports or displays signs that they are aware of the caregiver's substance use or they have seen or are aware of the effects of this use on the caregiver's behavior. Caregiver actions continue to have some negative impact on the child and their functioning, but it has not reached the point of imminent or serious harm listed below.

4. Contributes to imminent danger of serious physical or emotional harm to the child.

The caregiver's use of alcohol or drugs results in behaviors that seriously and consistently prevent their ability to meet the child's basic needs (food, clothing, shelter, supervision, hygiene, etc.) to the extent that the child has been seriously harmed by abuse or neglect. The caregiver may be in the early stages of recovery and still engaging in behaviors that could harm the child, resulting in a need for intensive support to preserve child safety.

Examples can include but are not limited to the following.

- The caregiver's physical absence or distraction to the extent that the child is in danger (e.g., forgets to feed child, leaves child alone or unsupervised).
- The caregiver is at times under the influence of alcohol or drugs and becomes violent toward or near the child.
- The caregiver exposes the child to drugs, drug paraphernalia, or drug-related violence. In all of these cases, the child reports or displays signs that they have been seriously physically or emotionally harmed or there is high likelihood that such harm will take place.

**SN5. Legal System**—The caregiver’s current connections or work with the legal system or the court system:

1. Is a strength and is actively helping to create child safety, permanency, or well-being.  
The caregiver has had no legal problems whatsoever and has had no need for contact with the legal system (past or present) OR the caregiver has had some legal problems/challenges but has been or is able to make good use of lawyers, legal systems, and self-advocacy in order to protect self and the child’s best interests.

The child reports or displays signs that they are thriving and receiving what they need from the caregiver and that the caregiver’s interactions with the legal system are having no negative impact on the child whatsoever.

2. Is neither a significant strength nor barrier for the child.  
The caregiver may have some minor legal problems, but they have had very minor impact on the child.

3. Is a barrier to the child’s long-term safety, permanency, or well-being.  
The caregiver is currently facing some legal problems that are impacting or could impact the child’s health and welfare. These could include issues of minor criminal behavior, visitation or custody, housing, etc.

In all of these cases, the caregiver’s actions appear to impact the child negatively in some way, either through the caregiver being distracted and unable to focus on the child’s best interests, or in struggling to accept help or advocate on the child’s behalf.

In all of these cases, the child reports or displays signs that there is some impact from the caregiver’s actions, but it does not constitute the imminent or serious harm listed below.

4. Contributes to imminent danger of serious physical or emotional harm to the child.  
The caregiver faces some significant legal problems, makes use of the court in some ways, or refuses to make use of the court in some ways that negatively impact the child’s safety, permanency, or well-being.

Examples of these may include but are not limited to the following.

- The caregiver has been arrested or is allegedly involved in criminal activity that the child is aware of, has witnessed, and is affected by.
- The caregiver continually seeks sole custody of the child when from all accounts joint custody appears to be a better long-term support for the child.

In all of these examples, the child has suffered some physical or emotional harm as a result of the caregiver's actions or there is high likelihood the child will suffer some kind of emotional or physical harm if there is not some shift in the caregiver's actions with the court and legal system.

**SN6. Daily Parenting Behaviors and Routines**—The caregiver's daily parenting actions and routines with their child:

Consider that safe and appropriate parenting may be demonstrated differently in different cultures. For example, in some cultures, over-displays of affection or a parent who engages in physical play with a child may be frowned upon. This should not be interpreted as inappropriate parenting unless there is evidence that this behavior is harmful to the child.

1. Are strengths and are actively helping to create child safety, permanency, or well-being.  
The caregiver displays a consistent ability to set regular, daily routines and expectations well matched to the child's age and development. These occur in areas such as discipline, communication, education, and nurturing.

When the child struggles, the caregiver consistently provides nonviolent responses and reactions that encourage and promote the child to use their unique abilities and strengths to problem solve and manage the challenges they are facing.

In both of the above, the child reports or displays signs that they know that they are extremely loved and valued. Additionally, the child is growing in developmentally expected ways and is learning to manage themselves and their challenges well.

2. Are neither significant strengths nor barriers for the child.  
The caregiver displays basic knowledge of age-appropriate and developmentally appropriate routines and implements them in such a way that this is neither a significant strength nor barrier. There is little negative or positive impact on the child as a result of the caregiver's efforts in this area.

The child reports or displays signs that they are cared for and/or that they are on track developmentally, if not thriving.

3. Are barriers to the child's long-term safety, permanency, or well-being.  
The caregiver's parenting behaviors are a barrier to the child's growth and development in some way. For example:

- Caregiver may seldom set limits or expectations for the child or may set limits or expectations that are somewhat outside of the child's developmental potential; or

- When the child errs or struggles, the caregiver may at times fail to respond at all or may respond in an exaggerated way by blaming the child, calling the child names, making use of physical discipline that does not injure the child, etc. As a result of all of this, the child reports or displays worry over the relationship with their caregiver or confusion about their schedule, discipline, or expectations, but this does not reach the level of imminent or serious harm listed below.

4. Contribute to imminent danger of serious physical or emotional harm to the child.

The caregiver engages in parenting behaviors and expectations that cause or are at significant risk for causing serious harm to the child. These can include but are not limited to the following.

- Caregiver sets no limits/expectations or sets limits/expectations that are far beyond the range of child's developmental range.
- When child errs or struggles, the caregiver intervenes with physical or verbal violence, resulting in serious physical or emotional harm to the child.
- Caregiver does not control impulses to lash out at the child, and child has been injured by caregiver in the course of discipline or is likely to be seriously injured.
- Caregiver communicates dislike of the child or tells the child that they are unworthy or unimportant.

In all of these situations: As a result of caregiver actions, the child reports or displays signs of physical or emotional harm. The child's relationship with the caregiver may be completely or almost entirely characterized by fear or mistrust, AND/OR the child may be regularly regarding themselves as a failure or a problem.

**SN7. Basic Needs and Management of Financial Resources**—The caregiver's resources and resource management:

1. Are strengths and are actively helping to create child safety, permanency, or well-being. The caregiver consistently provides adequate food, clothing, shelter, supervision, hygiene, and other basic needs the child requires to stay healthy and safe. When the caregiver struggles with limited income or resources, they are able to secure assistance independently as needed (e.g., use of food pantries, Temporary Assistance to Needy Families, Supplemental Nutrition Assistance Program/food stamps, assistance from family and friends, etc.).

The child reports or displays signs that their basic needs are consistently and regularly met.

2. Are neither significant strengths nor barriers for the child.

The caregiver meets the child's basic needs on most days, although not 100% of the time. When the caregiver struggles in this area, there is little to no impact on the child as a result of the caregiver's actions.

3. Are barriers to the child's long-term safety, permanency, or well-being.

The caregiver is faced with regular challenges in providing for basic needs or in managing resources and struggles in this area. These struggles may include but are not limited to the following.

- The caregiver struggles to find consistent housing and/or the family may be homeless; however, there is limited immediate harmful impact or threat of harm to the child.
- The caregiver may have limited/no income and is unable to secure regular assistance consistently or independently.
- The food and/or clothing that the caregiver provides sometimes does not meet the child's basic needs.
- The caregiver does not adequately manage available resources which results in difficulty providing for basic care needs related to health and safety (i.e., getting to necessary medical appointments, purchasing medications, providing supervision), however this condition is not chronic and the child has not experienced harm or a threat of harm.

In all of the above, the child reports or displays signs that they are aware of the struggle in meeting basic needs and have been affected in some way, but the child has not experienced significant physical or emotional harm or is not at risk of imminent harm as listed below.

4. Contribute to imminent danger of serious physical or emotional harm to the child.

The caregiver regularly struggles to provide for basic needs and manage resources. Examples may include but are not limited to the following.

- Homelessness resulting in the child's exposure to situations or people that have caused harm or threat of harm to the child.
- Malnourishment, spoiled food, or a lack of food exists in the family.
- The child chronically presents with clothing that is unclean and inappropriate for weather conditions to the extent that the child experiences physical harm (e.g., rash from soiled clothing, frostbite from inappropriate clothing).

- Caregiver lacks resources or severely mismanages available resources, which results in unmet basic care needs related to health and safety. Caregiver may consistently leave child's basic needs unmet while using resources for other priorities.

In all of these cases, the child reports or displays signs that the conditions and the struggles the caregiver is facing are combining to harmfully impact the child or are placing the child at significant risk of harm.

**SN8. Domestic Violence**—The caregiver's intimate relationships AND/OR the ways the caregiver has responded to violence within the intimate relationships in their life:

When scoring this item, keep in mind that domestic violence may refer to violence or threats/intimidation between any adult household members, regardless of the nature of the relationship between them. Domestic violence behaviors include both physical violence and a pattern of controlling/intimidating behavior.

Violence committed by the caregiver toward a minor child should be scored under item SN7. Violence between a caregiver and their intimate partner should be scored here, under SN9.

Violence between a caregiver and another adult in the household who is not an intimate partner should be scored in SN10.

1. Are strengths and are actively helping to create child safety, permanency, or well-being. There is no violence between the caregiver and their intimate relations OR the caregiver has shown a consistent ability to protect themselves and their child when confronted by violent or controlling people with whom they are in a relationship.

Other examples of this include but are not limited to the following.

- Caregiver consistently responds nonviolently to situations involving conflict and frustration (although this does not preclude incidents of self-defense or self-protection), and this nonviolent response helps keep the child safe.
- Caregiver demonstrates skills at resolving conflict with intimate relationships and dealing with frustration effectively without violence.
- The caregiver is involved in intimate relationships with people who do not seek to control each other's behavior in any way.

In all of the above, the child reports or displays a sense of safety and security regarding the intimate relationships in which their caregiver engages.

2. Are neither significant strengths nor barriers for the child.

There may be singular or extremely minor uses of power or control in the intimate relationships in which the caregiver engages, but the caregiver manages these to the extent that the child is physically and emotionally protected OR the caregiver is not involved in any intimate partner relationships at this time.

The child reports or displays signs that the caregiver and their intimate relationships seem to have very minor impact on them positively or negatively.

3. Are barriers to the child's long-term safety, permanency, or well-being.

When facing situations involving conflict or frustration, the caregiver or another adult with whom they are in an intimate relationship uses violent or controlling responses, including threats, intimidation, or some physical or emotional abuse.

The child reports or displays signs that these behaviors have not, to this point, resulted in serious or imminent physical or emotional harm to the level listed below, though they may have resulted in harm to other adults.

The caregiver is engaged in a relationship characterized by domestic violence that prevents caregiver from creating safety for the child over the long term. When facing situations involving conflict or frustration, the caregiver or another adult in the relationship uses violent responses that have not resulted in serious physical or emotional harm to the child but may have resulted in harm to other adults. The adult does not control violent impulses, but has not caused significant injury to another person.

OR

The caregiver is engaged in a relationship in which they or another adult member of the household seeks to control another through threats, intimidation, or emotional abuse, AND this pattern of behaviors has not yet resulted in physical or emotional harm to the child.

The caregiver may currently be engaged in domestic violence counseling, but they require continuing support to preserve child safety.

*Note: Also include caregivers who are the victims of domestic violence if the behavior of their abuser meets the definition above. Scoring a victim of domestic violence as 3 does not indicate that the caregiver is responsible for their partner's behavior but rather that the caregiver will require assistance to ensure the safety of themselves and/or the child.*

4. Contribute to imminent danger of serious physical or emotional harm to the child.  
The caregiver is engaged in a relationship characterized by domestic violence that presents an imminent threat of serious physical or emotional harm to the child. When facing situations involving conflict or frustration, the adult uses violent responses that have resulted in serious injury to the child OR the adult uses violent responses consistently and the child is aware (sight or sound) of these incidents, resulting in significant physical or emotional harm to the child. Symptoms of emotional harm to the child include but are not limited to: fear of alleged perpetrator, bedwetting, nightmares, aggression toward siblings/peers, anxiety, protective behaviors toward victim, fear of loss of caregiver, thumb sucking (and other indicators of developmental regression), and DSM diagnoses related to experiences of domestic violence.

OR

The adult seeks to control the caregiver or another adult member of the household through threats, intimidation, or emotional abuse AND this pattern of behaviors has/is likely to result in serious physical or emotional harm to the child. Examples include not permitting the caregiver to leave the home to procure necessary food for the child or using violence/threats toward the child to control the caregiver.

Evidence of caregiver behavior may include multiple reports to law enforcement or reports by family members of violent or controlling behaviors. To select this response, this caregiver behavior must result in serious harm or potentially result in serious harm to the child.

*Note: Also include caregivers who are the victims of domestic violence if the behavior of their abuser meets the definition above. Scoring a victim of domestic violence as 4 does not indicate that the caregiver is responsible for their partner's behavior but rather that the caregiver will require assistance to ensure the safety of themselves and/or the child.*

**SN9. Other Adult Household and Family Relationships**—The caregiver's relationships with **OTHER** adult members of the household and family relationships, including child custody:

1. Are strengths and are actively helping to create child safety, permanency, or well-being.  
Adults in the household display regular positive interactions with each other (e.g., mutual affection, respect, open communication, empathy) and share responsibilities for critical household activities.

Internal and external stressors (e.g., illness, financial problems, divorce, special needs) may be present, but household members problem solve together and resolve disputes through conversation. There is no violence or intimidation in the home.

The child reports or displays a sense of certainty that all adults in the household care for and support each other and treat each other well.

2. Are neither significant strengths nor barriers for the child.

There may be “good days” and “bad days” between adults in the household, but neither are very intense and neither appear to have a strong impact on the child OR there are no other adult members in the household besides the primary caregiver.

The child reports or displays signs of no particular problems with adult household relationships but also appears to not expect much benefit from how the adults interact with each other.

3. Are barriers to the child’s long-term safety, permanency, or well-being.

Stressors are present. There may be limited cooperation and/or minimal positive interactions between household members. There also may be examples of yelling, intimidation, coercion, or verbal abuse by household members. There are few examples of cooperation or problem solving.

- Custody and visitation issues characterized by frequent conflicts. The child is aware of these conflicts and concerned by them.
- The caregiver’s pattern of adult relationships creates signs of stress for the child.
- The caregiver has a history of adult relationships with persons who present threats to or have harmed the child. However, the caregiver is not currently involved in such relationships.

In all of these cases, the child is aware of these conflicts and reports or displays signs of concern, sadness, or a general sense of being upset by these relationships; however, it does not reach the level of imminent or serious harm listed below.

4. Contribute to imminent danger of serious physical or emotional harm to the child.

Relationships and interactions between household members are causing or are likely to cause imminent, serious physical or emotional harm to the child. Examples include but are not limited to the following.

- Differences and disagreements between household members quickly escalate and regularly lead to intimidation, emotional or verbal abuse, or physical violence.
- The child reports that they regularly “put themselves in the middle” of arguments between different adult household members.
- Custody and visitation issues are characterized by harassment and/or severe conflict, such as multiple reports to law enforcement and/or child protective services AND the child is showing signs of emotional harm, including withdrawal, depression, or severe anxiety.

- The caregiver’s current adult relationship places the child at risk for maltreatment and/or contributes to severe emotional distress. For example, the caregiver’s partner has a history of harming this child or other children.

In all of these cases, the child has been witness to or subject to the adults’ arguments and interactions and, as a result, is experiencing some significant impact (e.g., has been physically harmed or shows signs of emotional harm, including severe anger, withdrawal, depression, or anxiety).

**SN10. Social Support System**—The caregiver’s social support system or relationships with their support system outside of the household:

Consider the caregiver’s interactions with persons who are not intimate partners or members of the immediate household. The caregiver’s social support system includes culture, community social interactions (e.g., with neighbors, family members, community groups, clubs, and affiliations) AND/OR virtual/social media networks (e.g., chat rooms, Facebook friends). When scoring this item, consider the caregiver’s interactions with persons who are not intimate partners or members of the immediate household.

1. Are strengths and are actively helping to create child safety, permanency, or well-being.  
The caregiver regularly interacts with an extended network of family; friends; neighbors; and/or cultural, religious, or other communities that provide support and meet a wide range of needs for the caregiver and/or the child.

These may be concrete needs, such as money, food, placement, child care, transportation, or supervision, or “softer” kinds of support, such as role modeling for the caregiver or child, parenting and emotional support, guidance; etc.

In all of these cases, the child either reports or displays signs of feeling supported as a result of these extended network relationships.

2. Are neither significant strengths nor barriers for the child.  
The network of extended family, friends, and community that surround the caregiver and child may be limited or have minimal effect on the caregiver or child. It neither hurts the family nor provides much in the way of support.

The child reports or displays no particular problems and no particular benefits from these relationships.

3. Are barriers to the child’s long-term safety, permanency, or well-being.  
The network and social supports in which the family is in involved are minimal AND/OR create conflict or concern. Examples include but are not limited to the following.

- The caregiver sometimes wants or needs help and support but has a limited support system.
- The caregiver is reluctant to use available supports.

The social support system enhances conflict in the family and/or encourages negative behaviors. In all of these cases, the child reports or displays some stress around these relationships and may have some unmet needs as a result, but this does not reach the level of imminent or serious harm listed below.

4. Contribute to imminent danger of serious physical or emotional harm to the child.

The caregiver and child are extremely socially isolated, because the caregiver either has no support system; does not use the resources they have through extended family, friends, and community; or seriously struggles to maintain these relationships.

The caregiver also may have a network of extended friends and family; however, this network encourages behaviors that harm the child (e.g., encourages the caregiver to drink to excess/use drugs, to continue in relationships characterized by violence, etc.).

The caregiver may consistently avoid relationships or may have fleeting relationships that are destroyed by caregiver actions.

In each case, as a result of the above, the child has experienced or has nearly experienced harm of some kind. Examples include but are not limited to: significant social isolation with impaired social development outside of the home, needs going unmet because caregiver cannot secure support, physical or emotional harm caused by someone in the network, etc.

**SN11. Physical Characteristics of the Household**—The caregiver’s household AND/OR the caregiver’s response to that household:

1. Is a strength and is actively helping to create child safety, permanency, or well-being.

The caregiver’s household is well maintained, with any dangers to the child placed out of reach; the child has age-appropriate and developmentally appropriate space for play, work, or sleep. In situations where the household environment can be dangerous or a challenge, the caregiver ensures that the child is safe and can successfully manage the environment.

Overall, the child reports or displays signs of feeling safe in their home.

2. Is neither a significant strength nor barrier for the child.

The household environment may have some strengths or concerns (e.g., cleanliness, organization), but these have neither a positive or negative impact on the child.

3. Is a barrier to the child’s long-term safety, permanency, or well-being.  
The child’s household itself is becoming a barrier to safety through either disrepair or disorganization. Examples include but are not limited to the following.

- Dangerous items that could hurt the child are left around the house.
- Exposed wires or choking hazards are left within the child’s reach.
- Environmental hazards that could hurt the child, such as mold and lead paint, are left in the home. The caregiver provides housing, but it is in poor repair due to inadequate utilities or housekeeping. The caregiver may have difficulty negotiating with their landlord for necessary repairs to bring the home up to standard/code. More serious injuries could result if changes are not implemented.

4. Contributes to imminent danger of serious physical or emotional harm to the child.  
The household environment poses an immediate threat of serious harm to the child, and the caregiver has not been able to find and/or implement an effective response to the concern.

Examples of these behaviors or conditions include but are not limited to the following.

- Dangerous items lefts around the home that have hurt the child.
- Disorganization or chaos in the household to the point where the child is experiencing some kind of physical or emotional harm.
- Inoperable plumbing, heating, or wiring exists and causes an imminent threat of harm to the child.

In all of these cases, the child reports or displays signs that they have been seriously physically harmed or are likely to experience serious harm without intervention.

**SN12. Community Environment and Neighborhood**—The community environment where the caregiver resides AND/OR the caregiver’s response to that environment:

1. Is a strength and is actively helping to create child safety, permanency, or well-being.  
The caregiver’s community environment is a place of safety and support for both the family and the child OR, in situations where the community environment can be dangerous, the caregiver either ensures the child is safe or teaches the child to ensure they are safe and how to manage this environment.

Overall, the child reports or displays signs of feeling safe in their neighborhood AND/OR knows how to ask for help and make sure they are safe in their community.

2. Is neither a significant strength nor barrier for the child.  
The community environment is neither a particular strength nor a barrier. There may be some concerns in the surrounding neighborhood, but the caregiver manages this with very minor impact on the child.
3. Is a barrier to the child's long-term safety, permanency, or well-being.  
The community environment surrounding the household presents challenges, including crime, gang activity, or disrepair.

Other examples include but are not limited to the following.

- Known violent crime occurs near the home.
- Known illegal drug sales and/or use occur publicly near the home.

In all of these situations, conditions have not resulted in imminent or serious harm to the child at the level listed below, but the child does report some fears, and without intervention, these could become more severe.

4. Contributes to imminent danger of serious physical or emotional harm to the child.  
The community environment poses a regular and immediate threat of serious harm to the child, and the caregiver has not been able to find an effective response to the concern.

Examples of these behaviors or conditions include but are not limited to the following.

- Regular, dangerous, violent crime that has targeted the caregiver or child.
- Significant intimidation near the family home.

In all of these situations, the child reports or displays signs that they have been significantly harmed, very likely could be harmed, or have been exposed to the violence or intimidation in the neighborhood to the point that they have been impacted negatively in some way.

**SN12. Other**—The caregiver engages in additional actions that:

N/A Not applicable.

1. Are strengths and actively help to create child safety, permanency, or well-being.  
The worker or caregiver has identified an exceptional strength and/or skill that has a positive impact on family functioning. The worker and/or family perceive this strength as something they can build on to achieve progress in important areas. Please describe.

2. Are barriers to the child's long-term safety, permanency, or well-being.  
A caregiver has a challenge or need that has a moderate to significant impact on family functioning but has not resulted in harm or imminent danger of harm to the child. The family perceives that they would benefit from services and support that address the need. Please describe.
3. Contribute to imminent danger of serious physical or emotional harm to the child.  
A caregiver has a challenge or need that has a serious impact on family functioning, placing the child in imminent danger of serious harm. Please describe.

## **SECTION 3: CHILD STRENGTHS AND NEEDS GUIDE**

### **B. Child Domains**

#### **CSN1. Physical Health/Disability**

Indicate whether the child's immunizations are current.

Immunizations are current.

The child:

1. *Is in good physical health.* The child demonstrates good health and hygiene care, involving awareness of nutrition and exercise. The child receives routine preventive and medical/dental/vision care and immunization.
2. *Has minor health problems or disabilities that are being addressed with minimal intervention and/or medication.* Child has adequate health. Minimal interventions are those that typically require no formal training (e.g., oral medications).
3. *Has health care needs or disabilities that require routine interventions.* Minor health/disability needs. Routine interventions are those that are typically provided by lay persons after minimal instruction (e.g., glucose testing and insulin, cast care).
4. *Has serious health/disability needs that require ongoing treatment and interventions by professionals or trained caregivers AND/OR the child has an unmet medical need.* Those who provide treatment/interventions have received substantial instruction (e.g., g-tube feeding, paraplegic care, or wound dressing changes).

## **CSN2. Child Development**

The child's:

1. *Cognitive/intellectual and/or physical development is advanced.* The child's physical and cognitive skills are above their chronological age level.
2. *Cognitive/intellectual and/or physical development is age-appropriate.* The child's physical and cognitive skills are consistent with their chronological age level.
3. *Cognitive/intellectual and/or physical development is limited.* The child does not exhibit most physical and cognitive skills expected for their chronological age level.
4. *Cognitive/intellectual and/or physical development is severely limited.* Most of the child's physical and cognitive skills are two or more age levels behind chronological age expectations.

PHYSICAL AND COGNITIVE DEVELOPMENTAL MILESTONES		
AGE LEVEL	PHYSICAL SKILLS	COGNITIVE SKILLS
<b>0 to 1 Year</b>		
0 to 4 weeks	Lifts head when on abdomen. Head momentarily to midline when on back. Equal extremity movements. Sucking reflex. Grasp reflex (no reaching, and hand usually closed). Increasing body tone and stabilization of basic body functions, growing capacity to stay awake.	Looks at face transiently. By three to four weeks, smiles selectively to mother's voice and human voice leads to quieting of cries. Cries if uncomfortable or in state of tension; undifferentiated initially, but gradually varies with cause (e.g., hungry, tired, pain).
1 to 3 months	Head to 45 degrees when on abdomen, erect when sitting. Bears fraction of weight when held in standing position. Uses vocalizations. By 2 to 3 months, grasps rattle briefly. Puts hands together. By 3 to 4 months, may reach for objects, suck hand/fingers. Head is more frequently to midline and comes to 90 degrees when on abdomen. Rolls side to back.	Increased babbles and coos. Most laugh out loud, squeal, and giggle. Smiles responsively to human face. Increases attention span.
3 to 6 months	Rolls from abdomen to back, then from back to abdomen. Bears increasing weight when held upright. No head lag when pulled to sitting. Head, eyes, and hands work well together to reach for toys or human face. Inspects objects with hands, eyes, and mouth. Takes solid food well.	Spontaneously vocalizes vowels, consonants, a few syllables. Responds to tone and inflection of voice. Smiles at image in mirror.
6 to 9 months	Sits without support. Increasingly mobile. Stands while holding on. Pushes self to sitting. Grasps objects, transfers objects. Feeds self finger foods, puts feet to mouth, may hold own bottle. Approaching nine months, pulls self to standing.	Says mama/dada randomly. Begins to imitate speech sounds. Many syllable sounds (ma, ba, da). Responds to own name, beginning responsiveness to "no, no."
9 to 12 months	Crawls with left-right alternation. Walks with support, stands momentarily, and takes a few uneasy steps. Most have neat pincer grasp. Bangs together objects held in each hand. Plays pat-a-cake. About 50% drink from cup by themselves.	Imitates speech sounds. Correctly uses mama/dada. Understands simple command ("give it to me"). Beginning sense of humor.

**PHYSICAL AND COGNITIVE DEVELOPMENTAL MILESTONES**

AGE LEVEL	PHYSICAL SKILLS	COGNITIVE SKILLS
<b>1 to 2 Years</b>		
12 to 15 months	Stands well alone, walks well, stoops, and recovers. Neat pincer grasp. Can put a ball in a box and a raisin in a bottle. Can build a tower of two cubes. Spontaneous scribbling with palmer grasp of crayon. About 50% use spoon with minimal spilling. Most drink from cup unassisted.	Three- to five-word vocabulary. Uses gestures to communicate. Vocalizing replaces crying for attention. Understands "no." Shakes head for no. Sense of "me" and "mine." About 50% imitate household tasks.
15 to 18 months	Runs stiffly. Walks backwards. Attempts to kick. Climbs on furniture. Crude page turning. Most use spoon well. About 50% can help in little household tasks. Most can take off pieces of clothing.	Vocabulary of about 10 words. Uses words with gestures. About 50% begin to point to body parts. Vocalizes "no." Points to pictures of common objects (e.g., dog). Knows when something is complete such as waving bye-bye. Knows where things are or belong. More claiming of mine. Beginning distinction of "you" and "me," but does not perceive others as individuals like self. Resistant to change in routine. Autonomy expressed as defiance. Words are not important discipline techniques.
18 to 24 months	While holding on, walks up stairs, then walks down stairs. Turns single pages. Builds tower of four to six cubes. Most copy vertical line. Strings beads or places rings on spindles. Helps dress and undress self. Can wash and dry hands. Most can do simple household tasks.	Markedly increased vocabulary (mostly nouns). Consistently points to body parts. Combines two to three words. Names pictures of common objects. Follows simple directions. Matches colors frequently, but uses color names randomly. Uses number words randomly. May indicate wet or soiled diapers. Asks for food or drink. Understands and asks for "another." Mimics real life situations during play. Self-centered, but distinguishes between self and others. Conscious of family group.
<b>2 Years</b>	Jumps in place with both feet. Most throw ball overhead. Can put on clothing; most can dress self with supervision. Can use zippers, buckles, and buttons. Most are toilet trained. Good steering on push toys. Can carry a breakable object. Can pour from one container to another. By 30 months, alternates feet on stair climbing, pedals tricycle, briefly stands on one foot; builds eight-cube tower, proper pencil grasp, imitates horizontal line.	Learns to avoid simple hazards (stairs, stoves, etc.). By 30 months, vocabulary reaches 300 words. Identity in terms of names, gender, and place in family are well established. Uses "I," but often refers to self by first name. Says phrases and three- to four-word sentences. By 36 months, vocabulary reaches 1,000 words, including more verbs and some adjectives. Understands big versus little. Interest in learning, often asking, "What's that?"

PHYSICAL AND COGNITIVE DEVELOPMENTAL MILESTONES		
AGE LEVEL	PHYSICAL SKILLS	COGNITIVE SKILLS
<b>3 Years</b>	Most stand on one foot for five seconds. Most hop on one foot. Most broad-jump. Toilets self during daytime. By 38 months, draws picture and names it. Draws two-part person.	Counts to three. Tells age by holding up fingers. Tells first and last name (foster children may not know last name). Most answer simple questions. Repeats three or four digits or nonsense syllables. Readiness to conform to spoken word. Understands turn-taking. Uses language to resist. Can bargain with peers. Understands long versus short. By end of third year, vocabulary is 1,500 words.
<b>4 to 5 Years</b>	Most hop on one foot, skip alternating feet, balance on one foot for 10 seconds, catch bounced ball, do forward heel-toe walk. Draws three-part person. Copies triangles, linear figures (may have continued difficulty with diagonals, and may have rare reversals). Most dress independently, other than back buttons and shoe tying. Washes face and brushes teeth. Laces shoes.	By end of fifth year, vocabulary is more than 2,000 words including adverbs and prepositions. Understands opposites (day/night). Understands consecutive concepts (big, bigger, biggest). Lots of why and how questions. Correctly counts five to 10 objects. Correctly identifies colors. Dogmatic and dramatic. May argue about parental requests. Good imagination. Likes silly rhymes, sounds, names, etc. Beginning sense of time in terms of yesterday, tomorrow, sense of how long an hour is, etc. Increasingly elaborate answers to questions.
<b>6 to 11 Years</b>	Practices, refines, and masters complex gross and fine motor and perceptual skills.	Concrete operational thinking replaces egocentric cognition. Thinking becomes more logical and rational. Develops ability to understand others' perspectives.
<b>12 to 17 Years</b>	Physiological changes at puberty promote rapid growth, maturity of sexual organs, and development of secondary sex characteristics.	In early adolescence, precursors to formal operational thinking appear, including limited ability to think hypothetically and to take multiple perspectives.
		During middle and late adolescence, formal operational thinking becomes well developed and integrated in a significant percentage of adolescents.

Note: Adapted from "Developmental Milestones Summary," Institute for Human Services, (1990); "Developmental Charts" provided by Jeffery Lusko, Orchards Children's Service, Southfield, MI; and "Early Childhood Development From Two to Six Years of Age," Cassie Landers, UNICEF House, New York, NY.

### **CSN3. Education**

Not applicable; the child is not of mandatory school age AND is not enrolled in an educational setting.

Also indicate if the child (mark all that apply):

- Has an individualized education program.
- Has an educational surrogate parent.
- Needs an educational surrogate parent.
- Is required by law to attend school but is not attending (i.e., frequent expulsion/suspension, truancy, unlikely to graduate/advance with class).

The child:

1. *Has outstanding academic achievement.* The child is working above grade level and/or is exceeding the expectations of the specific educational plan. (e.g., academic awards achieved)
2. *Has satisfactory academic achievement.* The child is working at grade level and/or is meeting the expectations of the specific educational plan.
3. *Has 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.
4. *Has 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.

### **CSN4. Emotional/Behavioral Health**

The child:

1. *Is emotionally and behaviorally high functioning.* Child routinely manages their own behavior at or above developmentally expected ability and as a result, is functioning at a high level at home, at school, and in social relationships.

2. *Does not have an emotional/behavioral health concern OR the child has an emotional/behavioral health concern, but no additional intervention is needed.*  
The child may demonstrate some behavioral or emotional responses that are situationally and/or developmentally appropriate that do not interfere with school, family, or community functioning. Child has emotional or behavioral concerns that are being effectively managed through an intervention, service, or treatment program that does not require additional caregiver support (e.g., child receives limited in-school support and is not on medication).
3. *Has an emotional/behavioral health concern, AND it is an ongoing barrier.* (Mild behavioral stability and limited emotional adjustment.)

The child displays:

- Periodic mental health symptoms and/or concerns (including but not limited to: depression, somatic complaints, antisocial behavior, hostile behavior, or apathy).

OR

- Some difficulties dealing with situational stress, crises, or problems, which impair the child's functioning.

AND one of the following must also be true:

- » This is interfering with child's sense of well-being, development, or ability to form relationships.

OR

- » The child's behavioral condition is being managed through a treatment program that requires minimal to moderate caregiver support.

4. *Has an emotional/behavioral health concern that directly contributes to danger to the child.* (Behavioral instability.)

The child's ability to perform in one of more areas of functioning is severely impaired due to emotional, behavioral, and/or chronic and severe mental health symptoms.

#### **CSN5. Substance Use**

Drugs include illegal substances as well as misuse of prescription and over-the-counter medications, bath salts, inhalants, synthetic drugs, incense when used for intoxicating properties, etc.

Not applicable given the child's age and/or developmental status.

The child('s):

1. *Actively chooses an alcohol- and 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. *Does not use or experiment with alcohol/drugs.* 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. The child has no demonstrated history or current problems related to substance use.
3. *Alcohol and/or other drug use results in disruptive behavior and conflict.* The child engages in consistent but infrequent use of substances. Conflict may occur in school/community/family/work relationships. Use may have broadened to include multiple drugs.
4. *Chronic alcohol and/or other drug use results in severe disruption of functioning.* Disruption of functioning may be indicated by the loss of relationships, job, school suspension/expulsion/drop-out, police involvement, and/or physical harm to self or others. The child may require medical intervention to detoxify.

**CSN6. Family Relationships**

For children in voluntary or court-ordered placement, score the child's family, not the child's placement family.

The child's:

1. *Relationships within their family contribute to the child's safety, permanency, and well-being.* The child's relationships within their family are nurturing/supportive. 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.
2. *Relationships within their family do not impact the child's safety, permanency, and well-being.* The child's relationships within their family are adequate. The child experiences positive interactions with family members and feels safe and secure in the family, despite some unresolved family conflicts.
3. *Relationships within their family interfere with long-term safety, permanency, and well-being.* The child's relationships within their family are strained. 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.

4. *Relationships within their family contribute to danger of serious physical or emotional harm to the child.* The child's relationships within their family are harmful. 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.

### **CSN7. Social Relationships**

In regard to relationships with adults, consider the child's relationships with those who are not immediate family members or foster family members. Relationships with teachers may be considered under education. This domain would include coaches, neighbors, agency workers, club leaders, mentors, etc. Specify who these adults are in the narrative.

In regard to peer relationships, consider the child's relationships with other children in school and the community. Exclude relationships with siblings.

Not applicable given the child's age and/or developmental status.

#### The child:

1. *Has 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. *Has adequate social relationships.* The child demonstrates adequate social skills. The child maintains stable relationships with others; occasional conflicts are minor and easily resolved.
3. *Has limited social relationships.* The child demonstrates inconsistent social skills and has limited positive interactions with others. Conflicts are more frequent and serious, and the child may be unable to resolve them.
4. *Has 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.

### **CSN8. Relationship With Substitute Care Provider (if child is in care)**

Consider the wishes and feelings of the child as appropriate. Indicate whether the child's wishes and feelings assist in the development of strengths or create struggles for the child.

When assessing this item, keep in mind that the child may have different relationships with adults and with children in the home. Consider both when documenting strengths and needs.

Not applicable; the child is not in care.

### The child:

1. *Has developed a strong attachment to at least one substitute care provider.* The child has developed a nurturing/supportive relationship with at least one substitute care provider. There is positive interaction/attachment between the child and carer or others in carer household; the child is supported and has a sense of belonging.
2. *Has no conflicts with the substitute care provider.* The child has adequate relationships with all members of the household. There are generally positive interactions between the child and substitute care provider and others in the provider's household; age-appropriate attachments exist despite some problems.
3. *Has some conflicts with the substitute care provider that have resulted or may result in the child feeling unsafe or unaccepted in the placement; however, with support, these issues can be mitigated.* The child has limited relationships with the substitute care provider and other members of the household. Problems limit positive interactions and appropriate attachments with one or more members of the substitute care provider's household.
4. *Has serious conflicts with one or more members of the current substitute care provider's household.* Significant problems/conflict are present in the placement. Chronic problems severely interfere with interactions and attachments with one or more members of the substitute care provider's household.

The child has a history of failed placements, or the child has special needs that are not being met by the current placement.

### **CSN9. Independent Living (if age 14 or older)**

Independent living includes:

- Financial knowledge (handling money, banking, budgeting, bill payment);
- Work skills (e.g., having self-supporting employment) OR secondary education preparation;
- Time management;
- Housing; and
- Completing daily activities such as hygiene, laundry, housekeeping, grocery shopping, cooking, basic health care, etc.

Not applicable.

### The young adult:

1. *Is actively preparing for independent living and functioning as a young adult.*
2. *Is making progress toward preparing for independent living and functioning as a young adult.* The young adult has had an opportunity to demonstrate and/or practice the skills included in independent living. It may be considered a strength if the young adult is aware they are not fully prepared but are making progress. The young adult is participating in formal or informal independent living services.
3. *Is attempting to prepare for adulthood but lacks the confidence, emotional maturity, and/or sufficient skills to live independently.* The young adult may have developed only some or none of the skills necessary for independent living. The young adult may be fully confident of their ability to live independently, contrary to their actual skills/abilities (e.g., young adult may be delaying completion of tasks to receive an extension; young adult may lack a support system to provide advice after aging out).
4. *Is not prepared or is unable to prepare for independent living and functioning as a young adult.* The young adult may:
  - Have sex offense charges and be ineligible for federal housing programs;
  - Be in an out-of-state facility where independent living planning is impeded; or
  - Have developmental delays that impede independent functioning.

### **CSN10. Other Identified Child Strength or Need (not covered in CSN1–CSN11)**

Not applicable.

### An additional need or strength has been identified that:

1. *Actively helps the child create safety, permanency, and well-being for themselves.* (Child indicator of strength.) The 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. *Is a barrier to the child's long-term safety, permanency, or well-being.* (Child indicator of slight need.) The child has a need that has a moderate impact on family functioning. The family perceives they would benefit from services and support to address the need.
3. *Contributes to imminent danger of serious physical or emotional harm to the child.* (Child indicator of significant need.) The 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.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
FAMILY STRENGTHS AND NEEDS GUIDE  
POLICY**

The family strengths and needs guide (FSNG) is used to evaluate the presenting strengths and needs of each family. This guide is used to systematically identify critical family needs and plan effective interventions. The FSNG serves several purposes.

- It ensures that all social workers consistently consider each family's strengths and needs in an objective format when assessing need for services.
- It provides an important family service planning reference for workers and supervisors.
- The initial FSNG, when periodically recompleted, permits social workers and their supervisors to assess changes in family functioning and thus assess the effect of services on the case.
- In the aggregate, FSNG needs data provide management with information on the problems families face. These profiles can be used to develop resources to meet client needs.

**WHICH CASES**

All treatment cases.

All permanency cases (child portion only).

The child strengths and needs guide (CSNG) is completed to aid in the development of a child service plan for each child who will be included in a child service plan and for whom a case is established in FOCUS.

This includes child-only FOCUS cases.

**WHICH HOUSEHOLD**

Always assess the household where the allegation occurred.

Additionally, always assess any household receiving services. This may be the child's primary residence, if it is also the residence of the alleged perpetrator, or the household of a non-custodial parent, if it is the residence of the alleged perpetrator.

Complete an initial FSNG on all legal guardians/biological parents (e.g., biological mother and biological father, biological mother and grandmother who has legal guardianship).

An FSNG is not required if the parent/guardian cannot be located after reasonable efforts. (See Reasonable Efforts policy to locate absent parents.)

With supervisory approval, a household may be exempted from being assessed (e.g., when a child is placed with a non-custodial parent/permanent guardian and the initial FSNG of the non-custodial parent's household identified no needs).

## **WHO**

The assigned caseworker responsible for developing and monitoring the family service plan or child service plan.

## **WHEN**

**Initial:** Prior to the initial family service plan, within six weeks of transfer to treatment.

**Review:** Every 90 days.

Review the CSNG within five days of each change in the child's placement. Note any significant changes in the CSNG and write a new plan for the child's care if any such changes exist.

## **DECISION**

Identifies the three highest-priority needs of caregivers and all of the child's needs, which must be addressed in the family service plan. Goals, objectives, and interventions in a family service plan should relate to one or more of the priority needs.

The household context section also helps the worker explore family dynamics that may be crucial to selecting effective interventions with the family.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
FAMILY STRENGTHS AND NEEDS GUIDE  
PROCEDURES**

**APPROPRIATE COMPLETION**

**Initial Risk Statement**

The risk statement summarizes the main worries about the household in clear, behaviorally based language that describes the caregiver actions (or inactions) that constitute a threat to the safety of the child or risk to child safety, permanency, or well-being and the anticipated impact of these actions (or inactions).

In FOCUS, the risk statement should automatically populate from the most recent Structured Decision Making® (SDM) safety assessment into the FSNG. It may be revised as needed in Section 4.

**Section 1: Household Context**

Prior to assessing individual household members, consider information about the family that will assist in planning.

Next, consider the caregivers and their role. Identify each caregiver and determine which caregiver should be considered primary and which caregiver should be considered secondary. Then, identify other household members and their roles. This includes all children in the home, in addition to other adult household members.

In the next contextual element, the worker should have a conversation with the family about their perspective on the connections they see between their culture, identity, and caregiving and how their culture influences their parenting styles and techniques. For example, the family may have a perspective that causes them to be mistrustful of government institutions (e.g., the family may identify with a group that has/had a troubled relationship with government authorities or the caregiver may have had negative experiences as a foster child). In this situation, providing only agency-based services to the family in the family service plan may not support change, because the family may not be able to fully trust their service providers. A strategy that relies more on community or cultural resources may have a greater chance of success.

Increasingly, the field of child protection is becoming aware of the impact that trauma has on the functioning of caregivers, children, and family systems. Discuss any possible history of trauma with the family and help them to consider how it affects their roles and relationships.

Finally, the worker should discuss previous experiences the family has had with the child welfare system. This context is intended to assist in the selection of activities and services for inclusion in the family service plan. In preparation for this conversation, it is best practice to have researched and understood the FOCUS of a family's previous involvement with the child welfare system. Note the outcomes of previous involvement and discuss the family's perspective and experiences of that involvement.

## **Section 2A: Caregiver Strengths and Needs Guide**

For each domain, use the definitions and consider the caregiver's behavior to determine whether the caregiver's behaviors in each domain:

- Are strengths and are actively helping to create child safety, permanency, or well-being;
- Are neither significant strengths nor barriers for the child;
- Are barriers to the child's long-term safety, permanency, or well-being; or
- Contribute to imminent danger of serious physical or emotional harm to the child.

Always select the highest priority that applies, e.g., if caregiver actions fit definitions 3 and 4, select 4.

Note: Domains identified as 4 should lead to a consultation with a supervisor to consider whether a new SDM® safety assessment and safety plan are needed. Each domain of functioning must be assessed for the primary and secondary (if present) caregiver.

The final domain is "Other," where behaviors not considered in any other domain may be assessed. "Not applicable" may be selected if there are no such behaviors.

The worker must briefly document the caregiver's behaviors that were observed and meet the definition (1, 2, 3, or 4) assigned for each domain.

## **Section 2B: Prioritization**

After discussing FSNG findings with the family and finalizing the scoring, workers should begin prioritizing the barriers and using family strengths identified in this process to create the family service plan. Caseworkers should start by prioritizing all domains that receive a 4 or 3 and use their critical thinking and clinical skills to prioritize within those. There is no expectation that all caregiver barriers will be addressed at once, although all items with a score of 4 must ultimately be addressed at some point in a family service plan. Remember that the best plans are ones that are ultimately created together with the family. Objectives, tasks, and use of services should be selected with the caregiver in collaborative conversations.

### **Section 3: Child Strengths and Needs Guide**

The CSNG is completed for each child in the household. This includes both children in out-of-home care and children who remain in the home. All household children are assessed, including children who are not alleged victims.

In the areas on the CSNG, indicate whether the child's behaviors in each domain:

- Are strengths and are actively helping to create safety, permanency, or well-being for themselves;
- Are neither significant strengths nor barriers for the child;
- Are barriers to the child's long-term safety, permanency, or well-being; or
- Contribute to imminent danger of serious physical or emotional harm to the child.

Always select the highest priority that applies, e.g., if child's actions fit definitions 3 and 4, select 4. For each domain, the worker should describe child behaviors that would indicate whether the child has strengths and/or struggles in that area.

Complete the Priority Needs and Strengths tables to aid in creation of the family service plan and/or the child service plan. The domain item number and description of all of the child's most serious needs (4s first, then 3s) should be entered in the order of concern. Next, the worker should identify child strengths (1s) from the domains that can help to mitigate the most serious needs identified.

As best practice, the child should be included in planning to the fullest extent possible. For children ages 14 and older who are also residing in out-of-home care, any creation of or revisions to their child service plan must be completed with the child. Additionally, at the option of the child, up to two members of their case planning team should also participate in planning. These two members should be chosen by the child and should not be either their worker or their foster parent.

### **Section 4: Revised Risk Statement and Safety Goal**

Using the initial risk statement (from the FSNG header) and after assessing and working with the family, write a revised risk statement that will be part of the family service plan and guide the goals and services for the family. The risk statement should include what will or could happen to the child if or when the caregiver takes or fails to take what action and should be informed by those domains marked as 4s and 3s on the FSNG.

Using the risk statement, the worker should then work with the family to write a brief statement of what the caregiver and the safety network members will do differently to address the concerns described in the risk statement, and for how long this changed behavior will be demonstrated. If no safety threats/dangers were identified on the SDM safety assessment, leave the safety goal blank.

The risk statement and safety goal are important context for the FSNG, because any caregiver behavior that contributes directly to a safety threat must be addressed in the family service plan. Additionally, the new behavior toward which a caregiver is working is described in the safety goal.

**DELAWARE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR FAMILIES**  
**SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES**

r: 12-20

**Case Name:** \_\_\_\_\_ **Case #:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**County Name:** \_\_\_\_\_ **Worker Name:** \_\_\_\_\_ **Worker ID#:** \_\_\_\_\_

---

- | <b>R1. Number of Prior Neglect or Abuse CPS Investigations</b>  | <b>Score</b> |
|---|--------------|
| a. None.....  | 0            |
| b. One.....   | 1            |
| c. Two or more.....   | 2            |
| <hr/>   |              |
| <b>R2. Household Has Previously Received Ongoing Child Protection Services</b>                                      |              |
| a. No.....  | 0            |
| b. Yes.....   | 1            |
| <hr/>   |              |
| <b>R3. Primary Caregiver Has a History of Abuse or Neglect as a Child</b>   |              |
| a. No.....  | 0            |
| b. Yes.....   | 1            |
| <hr/>   |              |
| <b>R4. Child Characteristics</b> <i>(mark applicable items)</i>   |              |
| a. No child has any of the characteristics below.....   | 0            |
| b. Yes <i>(mark all that apply)</i> .....   | 1            |
| <input type="checkbox"/> One or more children in household has a developmental disability                           |              |
| <input type="checkbox"/> One or more children in household has a learning disability                                |              |
| <input type="checkbox"/> One or more children in household has a physical disability                                |              |
| <input type="checkbox"/> One or more children in household is medically fragile or diagnosed with failure to thrive |              |

**The following case observations pertain to the period since the last assessment/reassessment.**

- |   |   |
|---|---|
| <b>R5. New Investigation, New FAIR Family Assessment, or New Treatment Response for Abuse or Neglect Within the Review Period</b> |   |
| a. No.....  | 0 |
| b. Yes.....   | 1 |
| <input type="checkbox"/> New Investigation  |   |
| <input type="checkbox"/> New FAIR Family Assessment   |   |
| <input type="checkbox"/> New Treatment Response   |   |
| <hr/>   |   |
| <b>R6. Caregiver Has Not Addressed Alcohol or Drug Abuse Problem Within the Review Period</b> <i>(mark one)</i>                   |   |
| a. No history of alcohol or drug abuse problem.....   | 0 |
| b. Yes, alcohol or drug abuse problem; problem is being addressed.....  | 0 |
| c. Yes, alcohol or drug abuse problem; problem is <u>not</u> being addressed.....   | 1 |
| <hr/>   |   |
| <b>R7. Problems With Adult Relationships</b>  |   |
| a. None applicable.....   | 0 |
| b. Yes, harmful/tumultuous relationships with adults, or domestic/family violence.....  | 1 |
| <hr/>   |   |
| <b>R8. Primary Caregiver Has/Had a Mental Health Problem</b>  |   |
| a. No.....  | 0 |
| b. Yes.....   | 1 |
| If yes, is the primary caregiver in treatment?  |   |
| <input type="checkbox"/> Yes, primary caregiver is currently in treatment.  |   |
| <input type="checkbox"/> No, primary caregiver is not currently in treatment.   |   |

**R9. Primary Caregiver Provides Physical Care Consistent With Child's Needs**

- a. Yes, care is consistent with needs.....0
- b. No, care is not consistent with needs .....1

**R10. Caregiver Behavior Has Changed in Ways Consistent With Family Service Plan Goals**

(score based on the caregiver demonstrating the least progress)

**P S**

- a. Demonstrates new skills consistent with family service plan objectives OR is actively engaged in services and activities to gain new skills consistent with family service plan objectives.....0
- b. Does not demonstrate new skills consistent with family service plan objectives AND/OR participation is minimal and insufficient to contribute to achieving family service plan objectives.....1
- No secondary caregiver

**TOTAL SCORE** \_\_\_\_\_

**SCORED RISK LEVEL**

Assign the family's risk level based on the following chart:

<u>Score</u>	<u>Risk Level</u>
0 to 1	<input type="radio"/> Low
2 to 4	<input type="radio"/> Moderate
5 to 7	<input type="radio"/> High
8 and up	<input type="radio"/> Very High

**POLICY OVERRIDES**

Mark each condition applicable in the current review period. If any condition is applicable, override final risk level to very high.

- 1. Current sexual abuse case  
AND perpetrator has access to child or is unknown  
AND caregiver(s) has not demonstrated ability to protect child.
- 2. Non-accidental physical injury to a non-verbal child  
AND perpetrator has access to child or is unknown  
AND caregiver(s) has not demonstrated ability to protect child.
- 3. Severe non-accidental physical injury requiring hospitalization or medical treatment  
AND perpetrator has access to child or is unknown  
AND caregiver(s) has not demonstrated ability to protect child.
- 4. Caregiver(s) action or inaction resulted in death of a child due to abuse or neglect (past or current).

**DISCRETIONARY OVERRIDE**

If a discretionary override is made, mark yes, mark override risk level, and indicate reason. Risk level may be overridden one level higher or lower.

Yes  No 5. If **yes**, override risk level (mark one):  Low  Moderate  High  Very High  
Discretionary override reason: \_\_\_\_\_

Supervisor's Review/Approval of Discretionary Override: \_\_\_\_\_ Date: \_\_\_\_\_

**FINAL RISK LEVEL** (mark final level assigned):  Low  Moderate  High  Very High

## RECOMMENDED DECISION

Final Risk Level	Recommendation
Low	Close*
Moderate	Close*
High	Continue Services
Very High	Continue Services

\*Unless there are unresolved safety threats. If the most recent safety assessment finding was conditionally safe, the case must remain open.

## PLANNED ACTION

- Continue Services
- Close

If recommended decision and planned action do not match, explain why:

## SUPPLEMENTAL ITEMS

- S1. Is additional extended family support available?
- No, the family has no additional supports beyond household members.
  - Yes, the family has additional support beyond the household.
- S2. Is the perpetrator(s) or alleged perpetrator(s) residing in the home?
- No, the perpetrator or alleged perpetrator no longer resides in the home.
  - Yes, the perpetrator or alleged perpetrator resides in the home.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES  
DEFINITIONS**

**R1. Number of Prior Neglect or Abuse CPS Investigations**

Where possible, history from other states should be checked.

Score the item based on the count of all investigations and family assessments, substantiated or not, that were assigned for CPS investigation for any type of abuse or neglect prior to the investigation resulting in the current case.

- Count prior screened-in reports involving any adult members of the current household who were alleged perpetrators. Include all household adults, regardless of whether they are current caregivers for any child. Include prior screened-in reports for child victims no longer in the household if the alleged perpetrator is still a member of the household.
- Do not count prior investigations in which:
  - » Allegations were perpetrated by an adult who is not part of the current household;
  - » No household adult was investigated or substantiated as a perpetrator of abuse/neglect (e.g., in which a child in the home was identified as a perpetrator of abuse/neglect and no concurrent allegations were made regarding a household adult); or
  - » The allegation was found upon investigation and assessment to be malicious in consultation with the Department of Justice.

**R2. Household Has Previously Received Ongoing Child Protection Services**

Where possible, history from other states should be checked.

Score 1 if household has received services prior to the investigation resulting in the current case. Any member of the current household has previously received ongoing child protection services as a result of a prior investigation/assessment in which caregiver was an alleged perpetrator, either in Delaware or in another state.

**R3. Primary Caregiver Has a History of Abuse or Neglect as a Child**

Score 1 if credible statements by the primary caregiver or others, or any child protection records known to the agency, indicate that the primary caregiver was abused or neglected as a child (child protection includes neglect and physical, sexual or emotional abuse).

Statements can be considered credible if they are not contradicted by more reliable evidence and are made by a person who is trustworthy in this matter in the worker's professional opinion.

Note: Base your assessment of what the caregiver experienced as a child on current definitions of abuse/neglect, regardless of what it was labeled at the time.

#### **R4. Child Characteristics**

Score this item based on credible caregiver statements that a child has been diagnosed, statements from a physician or mental health professional, or review of records. Mark each characteristic that is present and score 1 if any characteristic is present.

- Score 0 if no child in the household exhibits characteristics listed below.
- Score 1 if any child has any of the characteristics below.
  - » Developmental disability: A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments as evidenced by caregiver's statement of such a diagnosis, medical/school records, and/or professional's statement. Examples include intellectual disability, ADHD, and autism spectrum disorders.
  - » 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 yet have one, or who is in preschool.
  - » Physical disability: A severe acute or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include paralysis, amputation, and blindness.
  - » Medically fragile: Medically fragile describes a child who has any condition diagnosed by a physician that can become unstable and change abruptly, resulting in a life-threatening situation; and that requires daily, ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members; and that requires the routine use of a medical device or of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living; and the child lives with ongoing threat to their continued well-being. Examples include a child who requires a trach vent for breathing or a g-tube for eating, a child on dialysis, a child with severe diabetes.
  - » Failure to thrive: A diagnosis of failure to thrive by a physician.

***The following case observations pertain to the period since the last assessment/reassessment.***

**R5. New Investigation, New FAIR Family Assessment, or New Treatment Response for Abuse or Neglect Within the Review Period**

Score 1 if at least one investigation, FAIR family assessment, or treatment response has been initiated within the review period, i.e., **within the prior 90 days**. This includes open or completed FAIR Family Assessments/investigations, regardless of assessment/investigation conclusion, that have been initiated since the initial assessment or last reassessment. Select the types of any responses during the review period in the checkboxes provided.

**R6. Caregiver Has Not Addressed Alcohol or Drug Abuse Problem Within the Review Period**

Indicate whether the primary and/or secondary caregiver has a current alcohol/drug abuse problem that interferes with the caregiver's or the family's functioning and they are not addressing the problem.

Drugs include illegal substances as well as misuse of prescription and over-the-counter medications, methylenedioxypyrovalerone (a.k.a. bath salts), inhalants, synthetic drugs, incense when used for intoxicating properties, etc.

If both caregivers have a substance abuse problem, rate the more negative behavior of the two caregivers. Not addressing the problem is evidenced by:

- Substance use that affects or affected the caregiver's employment, criminal involvement, or marital/family relationships; or that affects or affected their ability to provide protection, supervision, and care for the child;
- An arrest since the last assessment/reassessment for driving under the influence or refusing breathalyzer testing;
- Self-report of a problem;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use; or
- Child's diagnosis with Fetal Alcohol Syndrome or Exposure (FAS or FAE) or child had positive toxicology screen at birth and the primary or secondary caregiver was the birth parent.

Score the following:

- Score 0 if there is no historic or current alcohol or drug abuse problem that meets the definition of a problem above.
- Score 0 if there is an alcohol or drug abuse problem, and the problem is being addressed. The problem may have recently been addressed (e.g., through services in the review period), or may be of longstanding (e.g., the caregiver addressed the issue in the past, and has remained sober). Consider the problem to have been addressed if the caregiver has changed their behaviors regarding use. Do not consider a problem to be addressed if the caregiver is attending services/counseling/meetings, etc. but continues to use.
- Score 1 if there is an alcohol or drug abuse problem, and the problem is not being addressed.

Legal, non-abusive prescription drug use should not be scored.

#### **R7. Problems With Adult Relationships**

Score this item based upon current status of relationships among adults in the household. The household includes persons who live in the home and anyone who has significant in-home contact with the children due to a familial or intimate relationship with a household member. Consider only relationships within the review period (i.e., the 90 days prior to assessment).

- Score 0 if not applicable or there are no problems observed.
- Score 1 if yes, there are harmful/tumultuous adult relationships or domestic/family violence.
  - » There are adult relationships that are harmful to domestic functioning or to the care the child receives (but not at the level of domestic violence).
  - » 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.

#### **R8. Primary Caregiver Has/Had a Mental Health Problem**

- Score 0 if the primary caregiver does not have a current or past mental health problem.
- Score 1 if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver:
  - » Has been diagnosed with a mental health condition other than substance-related disorders by a professional qualified to do so; or

- » Has/had multiple reports for mental health/psychological evaluations, treatment, or hospitalizations.

If primary caregiver has never been diagnosed but appears to have (or have had) a mental health problem, consider obtaining an assessment prior to scoring. Do not count reports motivated solely by efforts to undermine the credibility of the primary caregiver or other ulterior motives (e.g., custody disputes).

If the primary caregiver has or had a mental health problem, indicate if they are current receiving treatment for the problem. Current treatment includes, but is not limited to, outpatient therapy, use of prescribed psychotropic medication, or inpatient treatment.

**R9. Primary Caregiver Provides Physical Care Consistent With Child's Needs**

Physical care of the child includes feeding, clothing, shelter, hygiene, and medical care of the child. Consider the child's age/developmental status.

Score 1 if:

- The child has been harmed or their well-being has been threatened because of unmet physical needs. Needs may be considered unmet regardless of whether the cause is neglectful or due to situations outside of the parent's control. For example:
  - » Child has a significant medical/dental/vision condition that requires care and care is not being provided;
  - » Child persistently does not have clothing that is appropriate for weather conditions, OR clothing is persistently unwashed;
  - » Living environment has plumbing or heating that is not consistent with local codes or standards, has potentially dangerous conditions (e.g., unlocked poisons, dangerous objects in reach of small child), is unsanitary, or is infested AND these conditions persist regardless of any attempt parents/caregivers have made to rectify problems;
  - » Child frequently goes hungry, thirsty, has lost weight, or failed to gain weight as appropriate to age group or situation;
  - » Child has been diagnosed with morbid obesity AND the caregiver has not taken actions consistent with doctor's recommendations; or
  - » The child is not being bathed regularly, resulting in dirt-caked skin and hair and a strong odor, or lack of hygiene contributes to a rash or other skin condition.

**R10. Caregiver Behavior Has Changed in Ways Consistent With Family Service Plan Goals**  
(Score based on the caregiver demonstrating the least progress)

“Family service plan goals” specifically refers to changes in parental behavior that are described in the FOCUS family service plan. Score this item based on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with changed/improved behaviors. 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.

- Demonstrates new skills consistent with family service plan objectives OR is actively engaged in services and activities to gain new skills consistent with family service plan objectives. The caregiver is demonstrating behavioral change consistent with the objectives in the family service plan. This may include participation in activities identified on the family service 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, and not just compliance with attendance. Compliance with services and activities without demonstration of acquisition of new skills consistent with family service plan objectives is not sufficient for scoring.
- Does not demonstrate new skills consistent with family service plan objectives AND/OR participation is minimal and insufficient to contribute to achieving family service plan objectives. This may include complete refusal to participate in services or activities, or participation which has failed to result in behavior change. Caregivers who are demonstrating some progress toward family service plan objectives but insufficient progress overall should be scored here.

**Supplemental Items**

- S1. Is additional extended family support available?  
Mark yes if any household adult has a supportive relationship with an extended family member, neighbor, or friend who has helped the family address problems in the past (e.g., child care, providing for child safety, assisting in finding employment, offering help with transportation, etc.). Do not include a relationship with the worker or with other professionals engaged with the family. Mark no if the social support system offers the caregiver help, but they do not accept it or if household adults do not have supportive relationships with others.
- S2. Is the perpetrator(s) or alleged perpetrator(s) residing in the home?  
Mark yes if the confirmed or alleged perpetrator(s) of maltreatment in the current incident (i.e., the incident that resulted in this open case) is currently residing in the home or a member of the household. Mark no if the confirmed or alleged perpetrator(s) of maltreatment in the current incident no longer resides in the home and is no longer a member of the household.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES  
POLICY**

The family risk reassessment combines items from the original risk assessment with additional items that evaluate a family's progress toward family service plan goals.

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 comprised of a single index.

**WHICH CASES**

All open treatment cases in which all children remain in the home, or cases in which all children have been returned home and family services will be provided.

If some children remain in the home and all children in placement have a permanency goal other than reunification, consider all children to be in the home and apply the risk reassessment.

If some children remain in the home and any child in placement has a permanency goal of reunification, *do not* consider all children to be in the home and apply the reunification assessment.

**WHO**

The caseworker.

**WHEN**

Ninety days after the initial family service plan and every 90 days thereafter.

The assessment must be completed sooner if there are new circumstances or new information that would affect risk.

**DECISION**

The risk reassessment guides the decision to keep a case open or to close it.

RISK-BASED CASE OPEN/CLOSE GUIDE	
RISK LEVEL	RECOMMENDATION
Low	Close, if there are no unresolved safety threats
Moderate	Close, if there are no unresolved safety threats
High	Case remains open
Very High	Case remains open

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES  
PROCEDURES**

**APPROPRIATE COMPLETION**

**R1 Through R4.** Using the definitions, determine the appropriate response for each item and enter the corresponding score. Items R1 and R2 refer to the time period PRIOR to the investigation that led to the opening of the current case. Scores for these items should be identical to corresponding items on the initial risk assessment unless additional information has become available.

**R3** may change if new information is available or if there has been a change in who is the primary caregiver.

**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).

**R5 Through R9.** 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.

**R10** is an assessment of caregiver's progress toward family service plan objectives. "Family service plan goals" specifically refers to the service behavioral change that the FOCUS family service plan is meant to support. Score this item based on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with family service plan objectives. If there are two caregivers, rate progress for each. If progress differs between caregivers, score based on the caregiver demonstrating the least amount of progress.

After entering the score for each individual item, enter the total score and indicate the corresponding risk level.

**Policy Overrides**

As on the initial risk assessment, the agency has determined that 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 initial risk assessment or last reassessment. If one or more policy override conditions exist, mark each reason for the override and mark "very high" for the final risk level. Policy overrides require supervisory review.

Many of the policy overrides ask the worker to determine if a caregiver has demonstrated an ability to protect the child. Examples of the caregiver(s) demonstrating an ability to protect the child include, but are not limited to:

- Caregiver has consistently prevented the perpetrator or suspected perpetrator from having unsupervised contact with the child;
- Caregiver was the perpetrator or suspected perpetrator, but has completed family service plan activities AND changed their behaviors such that they are no longer likely to repeat the action that harmed the child;
- Caregiver has changed the way they select the persons allowed to be alone with the child and demonstrated that they can select appropriately; and/or
- Caregiver has successfully complied with any safety plans in place and has progressed to a safety plan that relies on family resources and informal supports instead of DFS interventions.

### **Discretionary Override**

A discretionary override is used by the case worker whenever the worker believes that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment, in which the worker could only increase the risk level, the risk reassessment permits the worker to increase or decrease the risk level by one step. The reason a worker may now decrease the risk level is that after working with the family for several months, the worker has acquired significant knowledge of the family. If a discretionary override applies, mark yes, indicate the reason, and mark the override risk level. Discretionary overrides require supervisory approval.

The worker then indicates the final risk level.

### **Planned Action**

FOCUS will display the recommended response based on the risk-based case open/close guide. Enter the actual case action (continuing case or closing case). If the recommended response differs from the actual action, provide an explanation.

Examples of explanations include the following:

- Continuing a low- or moderate-risk case:
  - » *Unresolved safety threats.* Based on SDM safety assessment, one or more safety threats could not be resolved.
- Closing a high-risk case:

- » *The family is high risk due to historical risk factors.* The family is assessed as high risk due to historical risk factors that will not change (e.g., prior history of investigations, a mental health problem that is currently well managed) AND has achieved family service plan goals AND has demonstrated safety (actions of protection taken by the caregiver that mitigate the danger, demonstrated over time) AND has a sufficient safety network in place to assist with the family's recurrence prevention plan. The family has made a plan to prevent future child maltreatment in the home and is able to obtain sufficient services and supports within the community to follow the plan without DFS involvement.

**DELAWARE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® REUNIFICATION REASSESSMENT**

r: 10-22

**Case Name:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_

**Case #:** \_\_\_\_\_ **Household Assessed:** \_\_\_\_\_

**Is this the removal household?**       Yes       No

**A. REUNIFICATION RISK REASSESSMENT**

	<b>Score</b>
<b>R1. Risk Level on Most Recent Investigation/FAIR Risk Assessment (not reunification risk level or risk reassessment level)</b>	
a. Low.....	0
b. Moderate.....	3
c. High.....	4
d. Very high.....	5
e. No risk assessment completed.....	4
<b>R2. Has There Been a New Substantiation Since the Initial Risk Assessment or Last Reunification Reassessment?</b>	
a. No.....	0
b. Yes.....	2
<b>R3. Caregiver Behavior Has Changed in Ways Consistent With Family Service Plan Goals (score based on caregiver demonstrating least progress)</b>	
a. Demonstrates new skills consistent with all family service plan objectives.....	-2
b. Demonstrates some new skills consistent with family service plan objectives OR is actively engaged in services and activities to gain new skills consistent with family service plan objectives.....	-1
c. Demonstrates few new skills consistent with family service plan objectives.....	0
d. Demonstrates no new skills consistent with family service plan objectives AND/OR participation is minimal and insufficient to contribute to achieving family service plan objectives.....	4
<b>Total Score</b>	

**REUNIFICATION RISK LEVEL**

Assign the risk level based on the following chart.

Score	Risk Level
-2 to 1	<input type="radio"/> Low
2 to 3	<input type="radio"/> Moderate
4 to 5	<input type="radio"/> High
6 and above	<input type="radio"/> Very High

**OVERRIDES**

**Policy Overrides:** *(increases risk level to very high)* Indicate if any of the following are true in the current review period.

- 1. Current sexual abuse case  
AND perpetrator has access to child or is unknown  
AND caregiver(s) has not demonstrated ability to protect the child.
- 2. Non-accidental physical injury to a non-verbal child  
AND perpetrator has access to child or is unknown  
AND caregiver(s) has not demonstrated ability to protect child.

- 3. Severe non-accidental physical injury requiring hospitalization or medical treatment AND perpetrator has access to child or is unknown AND caregiver(s) has not demonstrated ability to protect the child.
- 4. Caregiver(s) action or inaction resulted in death of a child due to abuse or neglect (past or current).

**Discretionary Override:** *(risk level may be adjusted up or down one level. If decreasing risk, refer to "risk one pager.")*

Override Risk Level:

- Lower
- Higher

Discretionary Override Reason: \_\_\_\_\_

**Supervisor Approval for Override:**       **Yes**    **No**

**FINAL REUNIFICATION RISK LEVEL** (mark one):    Low    Moderate    High    Very High

**Supervisor's Review/Approval of Discretionary Override:**

\_\_\_\_\_ Date: \_\_\_\_\_

\* To be completed for each household to which a child may be returned (e.g., father's home, mother's home).

1. Describe the evidence and observations of caregiver behaviors used to answer risk items above.

2. Describe the supports provided by worker to family during the review period to families identified as high or very high risk to reduce risk.

**B. VISITATION PLAN EVALUATION** (See definitions below.)

- Visitation assessment not required because a therapist or other professional has recommended that the child not have contact with the caregiver. Assess as "unacceptable."

Evaluate compliance with the planned visitation frequency and the quality of visits, based on the worker's direct observation whenever possible and supplemented by observation of the child, reports by foster parents, etc. Complete for each child **who is placed out of home.**

Child Name: \_\_\_\_\_

<b>Household</b>
Number of completed visits: _____
Number of scheduled visits: _____
Percentage of completed visits: _____
Visitation frequency score: <input type="checkbox"/> 90 to 100% Total <input type="checkbox"/> 65 to 89% Routine <input type="checkbox"/> 26 to 64% Sporadic <input type="checkbox"/> 0 to 25% Rare

Compliance With Visitation Plan (fill in from above)	Visitation Quality	
	Strong or Adequate	Limited or Destructive
Total		
Routine		
Sporadic		
Rare		

NOTE: Shaded cells indicate acceptable visitation.

**Overrides:**

- Policy override: Visitation is supervised for safety. Override to unacceptable.
- Discretionary override:
  - Move from acceptable to unacceptable
  - Move from unacceptable to acceptable

Discretionary Override Reason: \_\_\_\_\_

**Supervisor Approval for Override:**       **Yes**     **No**

1. Describe the evidence and observations of caregiver behaviors used to answer visitation items above.

2. Describe the supports provided by worker to family during the review period to help the family improve the frequency or quality of visitation.

**C. IF RISK LEVEL IS LOW OR MODERATE AND CAREGIVER HAS ATTAINED AN ACCEPTABLE SCORE ON THE VISITATION PLAN, COMPLETE A REUNIFICATION SAFETY ASSESSMENT. OTHERWISE GO TO SECTION D, PLACEMENT/PERMANENCY PLAN GUIDELINES.**

- Safety assessment not required—Caregiver is incarcerated.
- Safety assessment not required—Caregiver consistently refuses to allow the child to return to the home (requires supervisory approval).

**Safety Threats**

Prior to assessing current safety, the worker should review the safety assessment that led to removal.

**1. Are any safety threats identified on the safety assessment that resulted in the child’s removal still present?**

- Yes. List and describe currently existing safety threat(s).
- No. List the initial safety threat(s) and describe below how the initial safety threat(s) were ameliorated or mitigated after the child’s removal.

Describe details:

**If yes, are there one or more safety interventions that can and will be incorporated into a new in-home safety agreement to address the safety threats?**

- Yes. One or more safety interventions have been identified to mitigate safety threats and allow reunification to proceed with an in-home safety agreement in place.
- No. No safety interventions are available and appropriate to mitigate safety threats if the child were to be reunified at this time.

If yes, complete a new in-home safety agreement.

**2. Have any new safety threats been identified since the child’s removal OR are there any other circumstances or conditions present in the reunification household that, if the child were returned home, would present an immediate risk of serious harm?**

- Yes
- No

If yes, describe details:

**If yes, are there one or more safety interventions that can and will be incorporated into a new in-home safety agreement to address these safety threats?**

- Yes. One or more safety interventions have been identified to mitigate safety threats and allow reunification to proceed with an in-home safety agreement in place.
- No. No safety interventions are available and appropriate to mitigate safety threats if the child were reunified at this time.

If yes, complete a new in-home safety agreement.

### SECTION 3: REUNIFICATION SAFETY DECISION

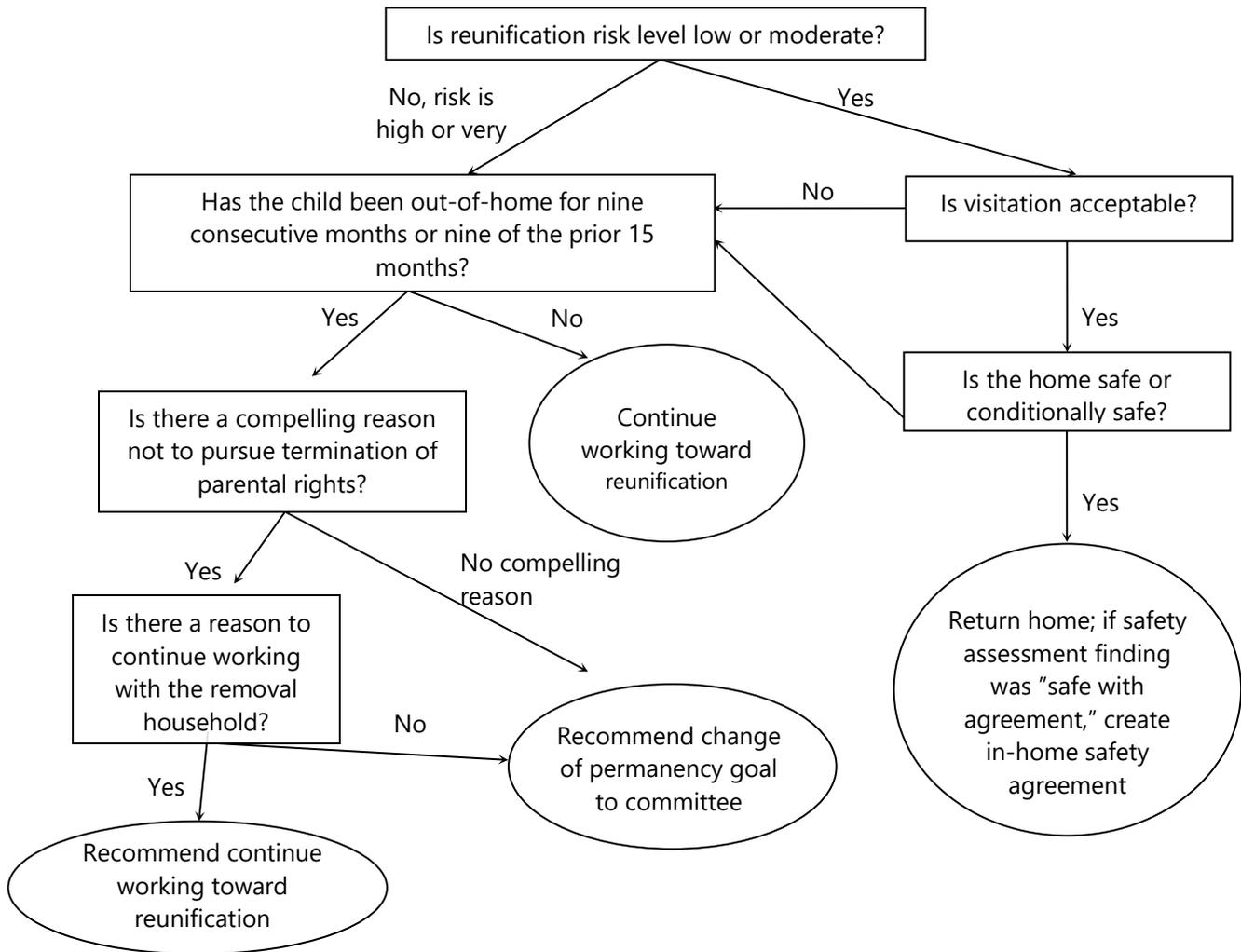
Identify the safety decision by marking the appropriate line below. This decision should be based on the assessment of all safety threats, safety interventions, and any other information known about the case. Select one line only.

- 1. **Safe.** No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- 2. **Safe With Agreement.** One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home. CHILD SAFETY AGREEMENT REQUIRED.
- 3. **Unsafe.** One or more safety threats are present, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm.

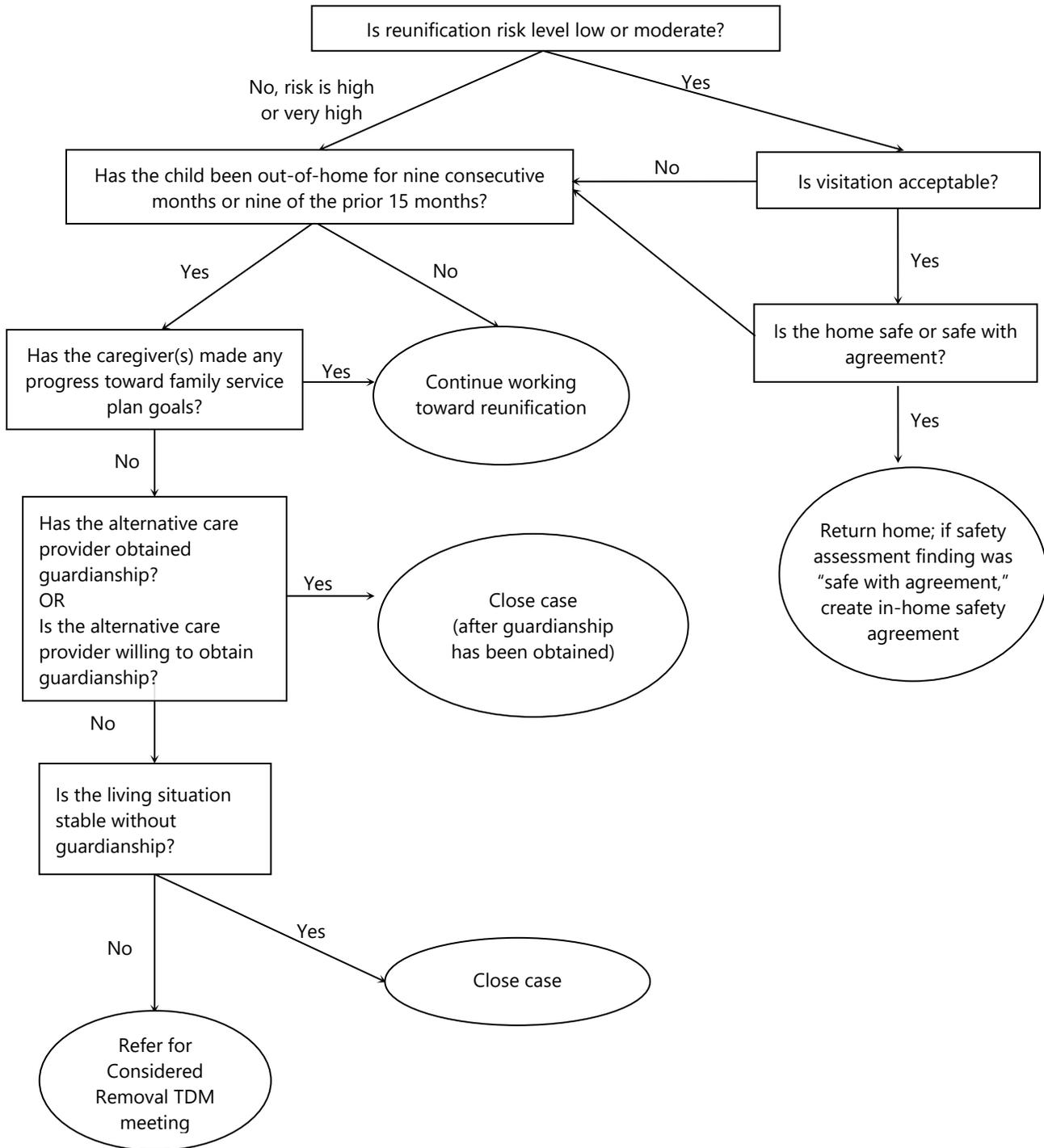
### D. PLACEMENT/PERMANENCY PLAN GUIDELINES

Complete for each child receiving family reunification services and enter results in Section E. Consult with supervisor and appropriate statutes and regulations.

#### Decision Tree for Children in DFS Custody



### Decision Tree for Children NOT in DFS Custody



**OVERRIDES** (select one)

- No override applicable.
- Discretionary

Provide reason: \_\_\_\_\_

- Change Recommendation to:     Return Home                       Continue Working Toward Reunification  
    Change Permanency Goal     Close Case         Obtain Custody

**Supervisor Approval for Override:**     Yes     No

**E. RECOMMENDATION SUMMARY**

- All children remain in placement.
- The following children will be recommended for return home (*enter names*):


**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® REUNIFICATION REASSESSMENT  
DEFINITIONS**

**A. REUNIFICATION RISK REASSESSMENT**

**R1. Risk Level on Most Recent Investigation/FAIR Risk Assessment (not reunification risk level or risk reassessment level)**

The risk level on the most recent investigation or Family Assessment and Intervention Response (FAIR) risk assessment is used to score this item. If there is no initial investigation risk assessment for this family, mark "No risk assessment completed" and score as 4.

**R2. Has There Been a New Substantiation Since the Initial Risk Assessment or Last Reunification Assessment?**

Rate this item based on whether new allegations of maltreatment have been received (for this household) since the last assessment (if done at case opening) or reassessment.

- Score 0 if no new allegation of maltreatment was substantiated; if a report was received but not accepted for investigation/assessment; or if no new reports have been received concerning this household.
- Score 2 if a new allegation of maltreatment was received and substantiated.

**R3. Caregiver Behavior Has Changed in Ways Consistent With Family Service Plan Goals (score based on caregiver demonstrating least progress)**

"Family service plan goals" specifically refers to changes in parental behavior that are described in the FOCUS family service plan. Score this item based on whether a caregiver has demonstrated or is beginning to demonstrate skills consistent with changed/improved behaviors. 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.

- Demonstrates new skills consistent with all family service plan objectives. Score -2 if the caregiver is *demonstrating all behavioral changes* consistent with all family service plan outcomes (e.g., is able to manage substance use/abuse to provide for 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). The caregiver may have changed their behavior through participation in activities identified in the family service plan or through

activities not specifically identified on the plan. Compliance with/attendance at services is *not* sufficient to score a caregiver at this level.

- Demonstrates some new skills consistent with family service plan objectives OR is actively engaged in services and activities to gain new skills consistent with family service plan objectives. Score -1 if the caregiver has demonstrated some behavioral change consistent with family service plan outcomes. The caregiver is participating in services and trying out new skills to improve family functioning OR has made progress but is not fully complying with activities in the family service plan. Engagement in services and activities means 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 family service plan objectives is not sufficient for scoring.
- Demonstrates few new skills consistent with family service plan objectives. Score 0 if the caregiver has demonstrated minor behavioral change consistent with family service plan outcomes. The caregiver is minimally participating in services, but has made little progress toward changing their behavior. Caregivers who are demonstrating minimal progress toward family service plan objectives but insufficient progress overall should be scored here.
- Demonstrates no new skills consistent with family service plan objectives AND/OR participation is minimal and insufficient to contribute to achieving family service plan objectives. Score 4 if the caregiver has demonstrated no behavioral change consistent with family service plan outcomes. The caregiver refuses services, sporadically follows the family service plan, or has not demonstrated the necessary skills due to a failure or inability to participate. This may include complete refusal to participate in services or activities, or participation which has failed to result in behavior change.

## **Overrides**

After determining the scored risk level, assess whether any override conditions are present. Consider only the most recent review period. If this is the first reunification reassessment, consider the period since the initial risk assessment. If this is *not* the initial reunification reassessment, consider the period since the last reunification reassessment. Overrides require supervisory approval.

## Policy Override

Indicate whether a policy override condition exists. The presence of one or more mandatory policy override conditions increases the risk level to very high. Provide details for the override. Supervisor approval is needed.

- Current sexual abuse AND the perpetrator has access to the child or is unknown AND the caregiver has not demonstrated an ability to protect the child.*

One or more of the children in this household are or have been a victim of sexual abuse. The perpetrator is likely to have unmanaged access to the victim or is unknown, and any alternative caregiver has not demonstrated an ability to protect the child from that likely perpetrator.
- Non-accidental physical injury to a nonverbal child AND the perpetrator has access to the child or is unknown AND the caregiver has not demonstrated an ability to protect the child.*

A nonverbal child in the household has a physical injury, the perpetrator is likely to have unmanaged access to the child or is unknown, and any alternative caregiver has not demonstrated an ability to protect the child from that likely perpetrator.
- Severe non-accidental physical injury requiring hospital or medical treatment AND the perpetrator has access to the child or is unknown AND the caregiver has not demonstrated an ability to protect the child.*

Any child in the household has a serious physical injury (defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, or severe cuts) AND the child requires medical treatment. The perpetrator is likely to have unmanaged access to the child or is unknown, and any alternative caregiver has not demonstrated an ability to protect the child from that likely perpetrator.
- Caregiver action or inaction resulted in the death of a child due to abuse or neglect (past or current).*

Any child in the household has died as a result of actions or inactions by the caregiver. This child fatality may have occurred prior to the current case.

## Discretionary Override

A discretionary override is used by the ongoing worker whenever the worker believes that the risk score does not accurately reflect the household's actual risk level. Unlike the initial risk assessment, in which the worker could only increase the risk level, the reunification reassessment permits the worker to increase or decrease the risk level by one. The reason a worker may now want to decrease the risk level is that the worker has acquired significant knowledge about the

household. If the worker applies a discretionary override, the reason should be specified, and the final reunification risk level should be selected. Supervisor approval is needed.

## B. VISITATION PLAN EVALUATION

**Visitation Frequency:** Visits that are appreciably shortened by late arrival/early departure are considered missed. Do not consider as missed visits those that were missed due to child unavailability or the child's refusal to attend visits. Also do not consider as missed visits those not attended due to illness of a child living with the caregiver or severe weather. 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.

For children with informal visitation arrangements, the caseworker should discuss with the family the *minimum acceptable frequency* of visitation when the family service plan is being finalized. For example, the family and worker might agree that the caregiver and child should meet at least once every two weeks (or once per week, or three times per month, etc.). Then the worker and family should agree upon a method that the family, child, and/or foster family will use to inform the worker when a visit has taken place.

To calculate visitation percentage, consider each household separately. For each household, divide the number of visits the caregiver successfully attended by the number of visits scheduled in the review period.

- Total: Caregiver regularly attends visits or calls in advance to reschedule (90 to 100% compliance).
- Routine: Caregiver may miss visits occasionally and rarely requests to reschedule visits in advance (65 to 89% compliance).
- Sporadic: Caregiver misses or cancels visits, or reschedules many scheduled visits at the last minute (i.e., less than 24 hours prior to visit; 26 to 64% compliance).
- Rare: Caregiver does not visit or attends 25% or fewer of the allowed visits (0 to 25% compliance). Also mark "rarely" if any of the following conditions are present:
  - » *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 children).

- » *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.
- » *Caregiver has been unable to visit child.* The caregiver has not visited the child during the review period because they are unable due to physical incapacity (e.g., hospitalization), incarceration, or because the caregiver could not be located.

**Visitation Quality:** Quality of visit is based on direct observation by the assigned worker, service provider, or responsible parties whenever possible. If more than one caregiver is at the visit, assess the quality of the visit for the household as a whole, considering both the actions of the caregivers and the impact on the child during the visit.

When visitation is not supervised, workers may rely on other information, including reports by the child or caregiver, child or therapist reports, the physical condition of children when they return from parenting time, any significant changes in child behaviors after visits, observation of caregiver preparation for visitation (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	
<b>Strong or Adequate</b>	<p>Caregiver:</p> <ul style="list-style-type: none"> <li>• Consistently demonstrates protective and supportive behaviors toward the child that are consistent with family service plan outcomes.</li> <li>• Often reinforces appropriate roles and boundaries for child (e.g., preserves parent-child relationship; takes on adult roles and responsibilities).</li> <li>• Demonstrates an ability to recognize child’s behaviors and cues; generally responds appropriately to behaviors and cues.</li> <li>• Identifies the child’s physical and emotional needs; responds adequately to these needs.</li> <li>• Demonstrates effective behavior management strategies.</li> <li>• Generally puts child’s needs ahead of their own.</li> <li>• Demonstrates a focus on the child during visits; shows empathy to child.</li> <li>• Conducts self appropriately during visits.</li> <li>• Participates in school, other child activities, medical appointments.</li> <li>• Visitation may have progressed to include extended visits, but extended visits are not required to score as adequate/strong.</li> </ul>
<b>Limited or Destructive</b>	<p>Caregiver:</p> <ul style="list-style-type: none"> <li>• Demonstrates an ability to recognize child’s cues and behaviors, but needs guidance in establishing an appropriate response to these cues and behaviors or is unable to respond appropriately.</li> <li>• May struggle or have severely limited ability to reinforce appropriate roles and boundaries for child (e.g., preserve parent-child relationship; take on adult roles and responsibilities), and requires prompting to do so.</li> <li>• Recognizes a need to set limits with child, but enforces limits or behavior management in an inconsistent or detrimental manner. OR may not recognize a need to set limits.</li> <li>• May demonstrate 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.</li> <li>• Occasionally or rarely puts child’s needs ahead of their own.</li> <li>• In destructive situations, the following may be present: <ul style="list-style-type: none"> <li>» May have ignored redirection by supervising worker.</li> <li>» May not be focused on child during parenting time and/or conducts self inappropriately during visit (e.g., arriving for parenting time while substance-affected; reinforcing parentification of child; making obviously false promises to child such as “I’m buying you a pony”; or cursing at/violently arguing with worker in presence of child).</li> </ul> </li> </ul>

**Overrides Policy: Visitation is supervised for safety.** Consider visitation to be supervised for safety if unsupervised visits are not permitted because DFS has determined visitation must be monitored to ensure the child is not harmed. Also include court-ordered supervision and visitation that is permitted only as therapeutic visitation.

## Overrides

After determining the visitation level quantity and quality, assess whether any override conditions are present.

### Policy Override

If the visitation is supervised for safety, override to unacceptable. Supervisory approval is required.

### Discretionary Override

A worker may determine that unusual circumstances exist that warrant changing an “acceptable” response to an “unacceptable” response or changing unacceptable to acceptable. The reason for this change must be documented, and supervisory approval is required (e.g., quality of visits was strong, and 64% of visits were completed; all missed visits were due to documented medical emergencies).

## C. REUNIFICATION SAFETY ASSESSMENT

### Safety Threats

Prior to assessing current safety, the worker should review the safety assessment that led to removal.

**1. Are any safety threats identified on the safety assessment that resulted in the child’s removal still present?**

Identify whether the safety threat(s) that resulted in the child’s removal have been resolved. Review the original safety assessment, list the initial safety threat(s), and describe how the initial threat(s) were resolved OR, if not resolved, what the current circumstances are that would pose an immediate threat of harm if the child were reunified.

Consider how safe the child would be if they were returned home at this time. Consider current conditions in the home, current caregiver characteristics, child characteristics, and interactions between the caregiver and child during family time.

**If yes, are there one or more safety interventions that can and will be incorporated into a new in-home safety agreement to address the safety threats?**

Identify whether any safety interventions are available and appropriate to address any identified threats. Review the definitions (provided elsewhere in this manual) of safety threats and safety interventions.

- 2. Have any new safety threats been identified since the child's removal OR are there any other circumstances or conditions present in the reunification household that, if the child were returned home, would present an immediate risk of serious harm?**

Identify whether any new safety threats have emerged during the review period. Review the SDM definitions. If any new threats are identified that would pose an immediate threat of serious harm to a child if he/she were reunified, describe the conditions and circumstances. Be behaviorally specific and avoid jargon.

**If yes, are there one or more safety interventions that can and will be incorporated into a new in-home safety agreement to address these safety threats?**

Identify whether any protective interventions are available and appropriate to address any newly identified danger(s). Use the safety threat and safety intervention definitions (provided elsewhere in this manual) to determine whether there are any new safety threats.

### **Reunification Safety Decision**

- 1. Safe.** No safety threats were identified at this time. No children likely to be in immediate danger of serious harm, based on currently available information.
- 2. Safe With Agreement.** One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home. **A child safety agreement is required.**
- 3. Unsafe.** One or more safety threats are present, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm.

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® REUNIFICATION REASSESSMENT  
POLICY**

The purpose of the reunification reassessment is to structure critical case management decisions for children in placement who have a reunification goal by:

1. Routinely monitoring critical case factors that affect goal achievement;
2. Helping to structure the case review process; and
3. Expediting permanency for children in substitute care.

**WHICH CASES**

All treatment cases in which at least one child is in placement with a goal of reunification. If more than one household is receiving reunification services, complete one tool for each household.

Include all children who are out-of-home due to safety threats, including those who are not in DFS custody.

Exclude Fast Track cases.

**WHO**

The caseworker.

**WHEN**

Ninety days after the first family service plan after placement and every 90 days thereafter until the child is reunified with his/her family or has a change in permanency goal. *Each review process should begin with a reunification reassessment and, if required, an FSNG.*

**DECISION**

The reunification reassessment guides decision making regarding the recommendation to the permanency committee. The assessment may guide the worker to:

- Return a child to the removal household<sup>2</sup> or to another household with a legal right to placement (non-removal household);
- Recommend that the family continue working toward reunification;
- Recommend that reunification services end and the permanency plan be reviewed;
- Recommend that the case be closed (in very limited circumstances); or
- Recommend that DFS refer for a Considered Removal TDM meeting if custody needs to be obtained.

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<sup>2</sup> Removal household is that household from which the child was removed. If designation is unclear due to joint custody, then the household where the most serious maltreatment occurred is to be designated the removal household. Non-removal households are those with legal rights to the child (e.g., father's home, mother's home).

**DELAWARE DEPARTMENT OF SERVICES  
FOR CHILDREN, YOUTH, AND THEIR FAMILIES  
SDM® REUNIFICATION REASSESSMENT  
PROCEDURES**

**APPROPRIATE COMPLETION**

Following the principles of family-centered practice, the reunification reassessment is completed in conjunction with each appropriate household and begins when a case is first opened. The family service plan should be shared with the household at the beginning so that the household understands what is expected. The reunification assessment form should be shared with the household at the same time so that the household understands exactly what will be used to evaluate reunification potential and the threshold they must reach. Specifically, inform them of their original risk level, and explain that this will serve as the baseline for the reunification reassessment (unless a new allegation is investigated, in which case the new risk level will be used). Explain that a new substantiation or failure to progress toward family service plan goals would increase their risk level, and that progress toward family service plan goals will reduce their risk level. Explain that both the quantity and quality of their visitation will be considered, and that they must attend at least 65% of their visits and have at least adequate quality (discuss what adequate quality would look like in family-friendly language). Provide information on the reunification safety assessment and explain that if everything else would permit reunification, the final consideration is safety. They must either demonstrate that no safety threats are present or there must be a plan to address any identified safety threats.

**A. REUNIFICATION RISK REASSESSMENT**

**R1.** The baseline for all reunification reassessments is the risk level. This is the research-based component of SDM. Generally, the correct risk level will be the final risk level from the original household risk assessment. However, if a household has experienced one or more subsequent investigations, WHETHER OR NOT THE ALLEGATION WAS SUBSTANTIATED, there should be a new risk assessment completed on that household. In this case, enter the most recent risk assessment result. (Do not use a prior risk reassessment or a reunification reassessment risk level.)

**R2.** Consider only the period of time since the original assessment (if this is the first reunification reassessment) or the most recent reunification reassessment. If there has been a new SUBSTANTIATION in this period, enter yes (score of 2). If not, enter no (score of 0).

**R3.** Determine progress toward family service plan goals in consultation with the household and all service providers who have been working with the household toward these goals. Consider only the period of time since the original assessment (if this is the first reunification reassessment) or the most recent reunification reassessment. If there are two caregivers and progress differs, score based on the least amount of participation/progress.

Mark the reunification risk level that corresponds to the total score.

### **Overrides**

Consider only the period of time since the original assessment (if this is the first reunification assessment) or the most recent reunification reassessment. Overrides require supervisory approval.

Policy Overrides. Indicate whether a policy override condition exists. The presence of one or more mandatory policy override conditions increases the risk level to very high. Provide details for the override. Supervisor approval is needed.

Discretionary Override. A caseworker uses a discretionary override whenever the worker believes the risk score does not accurately reflect the household's actual risk level. Unlike the initial risk assessment, in which the worker could only increase the risk level, the reunification reassessment permits the worker to increase or decrease the risk level by one. The reason a worker may now want to decrease the risk level is that after a minimum of three months, the worker has acquired significant knowledge about the household. If the worker applies a discretionary override, the reason should be specified. If the worker decreases the risk level by one, please refer to the "risk one pager" and select an appropriate rationale from there.

## **B. VISITATION PLAN EVALUATION**

If visitation frequency and quality were identical for all children in the family, indicate that the matrix applies to all children. If visitation varied among children, complete one matrix for each child.

- **Determine visitation frequency.** For children with informal visitation arrangements, the caseworker should discuss with the family the *minimum acceptable frequency* of visitation when the family service plan is being finalized. For example, the family and worker might agree that the parent and child should meet at least once every two weeks (or once per week, or three times per month, etc.). Then the worker and family should agree upon a method that the family, child, and/or foster family will use to inform the worker when a visit has taken place.
- **Determine visitation quality.** Consider multiple sources of information, e.g., social worker observation, caregiver report, foster parent report, child report, etc.

On the matrix, locate the row corresponding to the household's visitation frequency and the column corresponding to the household's visitation quality. Write the child's name where the row and column intersect. If this appears in the shaded area, the household is considered to have adequate visitation. If the mark appears outside of the shaded area, visitation is considered inadequate.

## Overrides

Policy Overrides. DFS has determined that reunification would not be considered if there is a requirement that all visits be supervised for the child's safety. Visits should be considered to be supervised for safety when there is court-ordered supervision or when only therapeutic visitation is permitted.

Discretionary Override. A worker may determine that unusual circumstances exist that warrant changing an adequate response to an inadequate response, or changing inadequate to adequate. The reason for this change must be documented, and supervisory approval is required (e.g., quality of visit was strong, and 64% of visits were completed; all missed visits were due to documented medical emergencies).

### C. REUNIFICATION SAFETY ASSESSMENT

Prior to assessing the current safety, the worker should review the safety assessment that led to removal. Consider how safe the child would be if he/she were returned home at this time.

Consider current conditions in the home, current caregiver characteristics, child characteristics, and interactions between the caregiver and child during visitation. In the narrative, be brief but as specific as possible. Avoid labels and jargon.

Complete the reunification safety assessment section. If any safety threats are present and they can be addressed with an in-home safety agreement containing safety interventions, ensure the in-home safety agreement meets the following requirements.

**Child safety agreement:** The following must be included in any child safety agreement.

1. What is working well in this family? Document evidence of any protective capacities and family strengths that can be used to address safety threats (e.g., positive relationships, community affiliations, supports, achievements).
2. What is causing the immediate safety threats to the child(ren)? Describe the conditions or behaviors in the home that place any child at imminent threat of serious harm. Use language the family understands so it is clear to them what caused you to identify safety threats.
3. What needs to happen to keep the child(ren) safe, and who will assume responsibility for the actions needed? Explain how each of the safety threats will be contained. Who will take action? What will they do? When does their task need to be accomplished? For how long must the intervention continue? Also describe how the family and the worker will know everyone is completing their assigned tasks.

NOTE: The in-home safety agreement must include at least one safe adult. This adult *cannot* be the alleged perpetrator.

4. Signatures lines for family members, the worker, and supervisor.

### **A Child Safety Agreement Is Required When Safety Decision Is Safe With Agreement.**

Note: The child safety agreement should be documented in the reunification reassessment and reviewed under the "Reviews" hyperlink in FOCUS.

The child safety agreement MUST be completed with the family, and a copy should be left with the family. The agreement must be signed by everyone who is a party to the child safety agreement, indicating that they understand and agree to their roles and responsibilities in implementing the agreement. Signing also signifies that participants understand the consequences of not fulfilling their responsibilities regarding the child safety agreement.

The child safety agreement must be reviewed every thirty days. This is the maximum period before review, and the child safety agreement may be reviewed sooner as needed.

A case cannot be closed when there is an active child safety agreement. A child safety agreement review must be done to determine whether (1) the current child safety agreement should continue, (2) the current child safety agreement should be modified, (3) a new child safety agreement should be developed, or (4) a child safety agreement is no longer needed. The worker should document in a FOCUS Progress Note when a child safety agreement has been reviewed and discussed with the family. Numbers (2) and (3) will require new signatures. Number (4) will require a new safety assessment to document that safety threats have been resolved.

### **D. PLACEMENT/PERMANENCY PLAN GUIDELINES**

After completing the reunification risk reassessment, visitation plan evaluation, and reunification safety assessment (if indicated), complete the decision tree appropriate to the child's custody situation (i.e., in DFS custody or not in DFS custody).

Compelling reasons not to pursue termination of parental rights include the following.

- Caregiver is making progress on family service plan objectives and there is an existing relationship between the caregiver and child.
- DFS is working with relatives to develop a plan of custody and/or guardianship with an expectation that it will be achieved within the next six months.
- The child is 12 years of age or older and has been diagnosed with a mental illness requiring long-term treatment, has serious delinquency charges, or has a history of delinquent acts that would seriously hinder locating an adoptive resource.

- The child is 12 years of age or older, has a relationship with his/her family, and does not wish to be adopted.
- The parent is in prison or hospitalized and will be released within the next six months, the child has an existing relationship with the parent, and the parent will be able to assume parenting upon release.

The caregiver may be considered to have made progress on family service plan goals if they have scored "a" or "b" on item R3 of Section A. If there are two caregivers, assess the caregiver making the least progress.

When considering if the living situation is stable without guardianship, consider if:

- The caregiver consents to allowing the child to remain with the alternative care provider indefinitely;
- The alternative care provider intends to continue to provide care to the child indefinitely;
- The caregiver remains accessible to the child and alternative care provider; and
- The current plan for placement has been mutually agreed upon by the caregiver and alternative care provider.

If these four conditions are met, the living situation may be considered stable, even if guardianship has not been obtained.

Begin at the top of the tree and answer yes or no to each question until a terminal point is reached. Termination points include:

- Return home;
- Recommend that reunification services continue;
- Recommend changing the permanency goal;
- Close the case (for children in placement but not in DFS custody); and
- Refer for Considered Removal TDM meeting (for children in placement but not in DFS custody).

## **Overrides**

Consider whether any overrides are applicable. If no overrides apply, mark “No override applicable (policy or discretionary).” If an override will be applied, indicate whether it is a policy or a discretionary override and mark the specific reason.

Discretionary Override. Unique considerations exist that warrant an alternative decision. If implementing a discretionary override, indicate the permanency plan goal that is being recommended.

## **E. RECOMMENDATION SUMMARY**

The SDM recommendation summary is designed to record worker decisions. In addition to the SDM reunification reassessment, the worker should consider all relevant regulations and consult with their supervisor.

Indicate if all children will remain in placement and which children, if any, will be reunified at this time.