

SDM® POLICY AND PROCEDURES MANUAL



CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

California SDM P & P Manual V 3.5.

Updated: October 2023

This version incorporates updates to the hotline tools, safety and risk assessments, and reunification assessment, and it is ADA compliant.

Structured Decision Making and SDM 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 and @Evident_Change on Twitter.

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SDM® OVERVIEW

California Department of Social Services

See policy and procedures sections for each tool for complete details.

SDM TOOL	DECISION	WHICH CASES	WHO	WHEN
Hotline tools	Should the referral be accepted for in-person response? If yes, how quickly to respond.	All referrals created in CWS/CMS	Worker receiving referral	Immediately Tool should be used <i>during</i> call with reporter to guide questions and screening assessment.
Safety assessment*	Can the child remain safely at home?	All in-person responses	Assigned worker	ALWAYS: Process completed during first face-to-face contact with at least one victim child in the household (record within 48 hours).
Risk assessment	Should intervention be provided? At what service level?	RECOMMENDED: all in-person responses. REQUIRED: all substantiated and inconclusive in-person responses.	Assigned worker	Within 30 calendar days of first face-to-face contact
Family strengths and needs assessment**	Focus of case plan	All open cases	Worker responsible for case plan	INITIAL: Prior to initial case plan REVIEW: Voluntary, within 30 days prior to case plan; court, within 65 days prior to case plan

SDM TOOL	DECISION	WHICH CASES	WHO	WHEN
Reunification assessment	Can child be returned home, should reunification efforts continue, or should the permanency goal be changed?	Cases with at least one child in out-of-home care with goal of return home	Assigned worker	At a minimum, every six months from point of removal. If adequate time has passed to demonstrate progress on the case plan, it is recommended to complete this assessment every 90 days.
Risk reassessment Closing safety assessment	Can this case be closed? If not, what level of service?	All open cases where ALL children are in the home.	Assigned worker	Division 31 = review every six months. Voluntary cases = No more than 30 calendar days prior to case plan completion or case closure recommendation. Involuntary cases = No more than 65 calendar days prior to case plan completion or case closure recommendation. All cases = sooner if new circumstances or new information that affects risk.

*The SDM safety assessment for family homes is used for allegations of harm by a legal caregiver. The SDM safety assessment for substitute care provider homes or safety assessment for congregate care should be used when the referral alleges maltreatment in out-of-home care.

**California's SDM family strengths and needs assessment (FSNA) is no longer updated and maintained as an active assessment, per CDSS guidelines. This legacy version is available for use in case planning during the transition period to full implementation of the Child and Adolescent Needs and Strengths assessment.

GENERAL INSTRUCTIONS FOR SDM® ASSESSMENTS

WHO IS BEING ASSESSED WITH EACH SDM ASSESSMENT?

GENERAL PRINCIPLES

- SDM assessments are household-based (see definition of household in the glossary).
- Each SDM assessment reflects a single household.
- If a child's caregivers do not live together, the child may be a member of two households.
- Household composition may change over time. Each SDM assessment reflects the child's **current** household at the time of that assessment.

DETAILED CONSIDERATIONS

- If a child's legally responsible caregivers do not reside together, the child is a member of two households: one with each legally responsible caregiver.
- If a child resides in a household with no legally responsible caregiver, the child is a member of two or three households: one where the child primarily resides, and one with each legally responsible caregiver.
- If a minor is a parent, the minor parent is a member of two or three households: one with the minor parent and their child (and any others in that household), and one with each legally responsible caregiver and the minor parent (and any others in that household).
- If a caregiver **temporarily** does not reside with the child, include the caregiver in the household unless there is substantial agreement that the caregiver will not return. (Examples include, but are not limited to, following arrest, during an extended business trip or military deployment, or following a crisis separation).

WHO IS INCLUDED AS A HOUSEHOLD MEMBER?

A household is a group of people, including the child, who typically reside together and function as a family unit (e.g., share meals, spend time together, provide supervision and care). Household members usually reside together; however:

- A non-resident is a household member if they have a familial or intimate relationship with an adult living with the child AND have significant in-home contact with the child (e.g., a person who spends 50% or more time, on average, in the household but who may not actually live there); and

- A resident is not a household member if they function separately from the child (e.g., a tenant in the residence who does not spend time with child).

WHICH HOUSEHOLD IS ASSESSED?

GENERAL PRINCIPLES

- SDM assessments are completed on the household(s) where there are allegations of abuse or neglect.
- If a child is a member of more than one household, complete an SDM assessment for each separate household for which there is alleged abuse or neglect.

DETAILED CONSIDERATIONS

- It does not matter which household is the household in which the child spends more time.
- Ideally, there is only one household with allegations in each referral and only one household with allegations in each case.
- If a referral or case must include more than one household with allegations, there will be two sets of SDM assessments in that referral or case.
 - » If household composition changes during an open referral or case, the next SDM assessment or assessments are done on each household that includes a child and a person causing harm.
 - » If a child is being removed from a custodial parent, a global assessment of a non-custodial parent identified may be completed if they will receive child welfare services, but an SDM assessment is not required.

SDM PRACTICE FOUNDATIONS

SDM item definitions are generally formatted in the following way.

ITEM OR "STEM"	NON-ACCIDENTAL OR SUSPICIOUS INJURY
DEFINITION (THRESHOLD)	The child has a current or previously unreported injury or impairment AND the caregiver deliberately caused the injury/impairment OR there is a basis to be suspicious that a caregiver caused it, and it was non-accidental. Basis for suspicion may include but is not limited to:
EXAMPLES	<ul style="list-style-type: none"> • Physician reports injury type is consistent with non-accidental injuries; • Injury to non-ambulatory child with no plausible alternative explanation; • Explanation for injury does not match injury; • Injury is in the shape of an object (e.g., loop marks); or • Credible disclosure by child to reporting party or other adult.

SDM DEFINITION AS THRESHOLD

SDM definitions set a shared threshold that must be met in order to select that item. Read the entire definition. One common mistake is applying a phrase or a piece of a definition without reading to the period.

BE AWARE OF “AND” AND “OR”

When you see a big “AND,” the circumstances stated on both sides of the “AND” must be true for the definition to apply. When you see a big “OR,” it means one or the other circumstance must be true for the definition to apply.

EXAMPLES ARE NOT ALL-INCLUSIVE LISTS

The examples in definitions offer an illustration about the threshold, nature, severity, etc., intended by the definition. An example that fits your situation does not necessarily mean the whole definition applies. Likewise, lack of a specific example does not necessarily mean the definition does not apply.

UNASKED IS DIFFERENT FROM UNKNOWN

Remember that information that has not been asked about is different from information that is unknown. If information cannot clearly distinguish between a yes or no response to a question, try asking additional questions, or asking questions in different ways. Sometimes the answer is simply “no” if we lack the information.

GLOSSARY OF SDM® ASSESSMENT TERMS

California Department of Social Services

CAREGIVER

An adult, parent, or guardian in the household who provides care and supervision for the child.

For the purpose of scoring several items on the risk assessment, if a household includes more than one caregiver, it is necessary to designate one caregiver as primary and one as secondary. This is done using the following decision tree.

1. Is caregiver the only caregiver with legal responsibility for child?
 - a. If yes, the answer is **Primary**.
 - b. If no, go to Question 2.
2. Does caregiver provide more care for child?
 - a. If yes, the answer is **Primary**.
 - b. If no, go to Question 3.
3. Is caregiver more responsible for reported harm to child?
 - a. If yes, the answer is **Primary**.
 - b. If no, the answer is **Secondary**.

FACILITY CAREGIVER

A person responsible for the child/youth's care and welfare (including a licensee, administrator, employee, volunteer, contractor, etc., of any facility licensed to care for children/youth) in accordance with California Penal Code § 11165.5.

FACILITY LEADERSHIP

A facility caregiver in a leadership position who can make or support a change to facility policy, practice, or care and/or implement a safety plan.

FAMILY

Parents, adults fulfilling the parental role, guardians, children, and others related by ancestry, adoption, or marriage; or as defined by the family itself.

HOUSEHOLD

A household is a group of people, including the child, who typically reside together and function as a family unit (e.g., share meals, spend time together, provide supervision and care). Household members usually reside together; however:

- A non-resident is a household member if they have a familial or intimate relationship with an adult living with the child AND have significant in-home contact with the child (e.g., a person who spends 50% or more time, on average, in the household but who may not actually live there); and
- A resident is not a household member if they function separately from the child (e.g., a tenant in the residence who does not spend time with child).

DOMESTIC VIOLENCE

Domestic violence (including intimate partner violence) includes circumstances in which one person chooses a pattern of behavior that exerts coercive power and control over the other person. As a result, family functioning is disrupted, and the child is or may be adversely impacted.

The perpetrator's pattern of behavior may include physical violence; emotional abuse; sexual abuse; constraining family or social relationships; controlling finances; undermining the victim's parenting, sobriety, or mental health; disrupting housing or creating housing instability; or any other behavior that has the impact of gaining power over or control of the victim.

IMMINENT DANGER OF SERIOUS HARM

Safety threats indicate an imminent danger of serious harm. This means that facility conditions or facility caregiver actions, omissions, or responses endanger the life or seriously jeopardize the physical or emotional health or overall safety of the children/youth in care.

PHYSICAL VIOLENCE

An adult household member physically assaults another adult household member. This violence may be in the context of domestic violence (i.e., pattern of behavior that exerts coercive power and control) OR may have no element of power and control. Household violence may be a single event or a pattern.

SUBSTANCE ABUSE

A caregiver's recurring use of alcohol or drugs causes functionally significant impairments, such as health problems, disability, or failure to meet major responsibilities at work, school, or home.

CHAPTER A:

SDM®

HOTLINE

TOOLS

SDM® HOTLINE TOOLS

California Department of Social Services

r: 10/23

Referral Name: _____ Referral Number: _____

Date Completed: _____ County: _____

IS THERE ANY INFORMATION THAT INDICATES THAT THE CHILD IS, OR MAY BE, AN INDIAN CHILD?

☐ No, not at this time.

☐ Yes: ☐ Child is an Indian child ☐ Reason to know ☐ Reason to believe

If yes: Were tribal social workers or representatives consulted during the information gathering and screening process as necessary for the tribe to determine membership or eligibility?

☐ Yes

☐ No

If no: ☐ Contact with tribe(s) attempted ☐ Contact with tribe(s) not attempted

STEP I. PRELIMINARY SCREENING

Review of screening criteria is not required if any of the following apply.

- ☐ Evaluate out (select all that apply)
 - ☐ No child under age 18 (do not apply in reports of death of the only child[ren] in household where death is suspected to be related to abuse or neglect)
 - ☐ Duplicate referral that contains no new information
 - ☐ Referred to another county
- ☐ Safely surrendered baby

If any of the above are selected, the screening decision has been made and the assessment is completed. No further SDM assessments are required.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

Does the report contain allegations of abuse or neglect in out-of-home care to a dependent or ward child/youth? Select one.

- ☐ **Yes** – When applying definitions of screening and response priority tools, the definition of “caregiver” should include “a person responsible for the child’s care and welfare (including a licensee, administrator, or employee of any facility licensed to care for children)” in accordance with Cal. Penal Code § 11165.5.
- ☐ **No** – Apply screening and response priority tool definitions using the standard Structured Decision Making® (SDM) definition of “caregiver.”

A. SCREENING CRITERIA

Elicit reporter’s concerns and select all the screening criteria below in which the described threshold is met. In some cases, you also may be prompted to select subtypes. Once you have completed this section, go to the corresponding response priority tree for that screening category unless the screening category indicates it is an automatic 24-hour response.

Physical Abuse

- ☐ Non-accidental or suspicious injury (If yes, select any below that apply)
 - ☐ Death of a child due to abuse (automatic 24-hour response)
 - ☐ Death of only child or all children in home; no other children reported to be in the home
 - ☐ Other children reported to be in the home
 - ☐ Severe (automatic 24-hour response)
 - ☐ Other injury (exclude very minor injuries unless the child is under 1 year old)
- ☐ Caregiver action that likely caused or will cause injury (other than very minor unless child is under 1 year old)
- ☐ Prior death of a child due to abuse AND there is a new child of any age in the home

Emotional Abuse

- ☐ Caregiver actions have led or are likely to lead to child’s severe anxiety, depression, withdrawal, or aggressive behavior toward self or others
- ☐ Emotional harm related to domestic violence

Neglect

- ☐ Severe neglect (If yes, select any below that apply)
 - ☐ Diagnosed malnutrition (automatic 24-hour response)
 - ☐ Non-organic failure to thrive
 - ☐ Child's health/safety is endangered
 - ☐ Death of a child due to neglect (automatic 24-hour response; if yes, select one below)
 - ☐ Death of only child or all children in home; no other children reported to be in the home
 - ☐ Other children reported to be in the home
- ☐ General neglect (If yes, select any below that apply)
 - ☐ Inadequate food
 - ☐ Inadequate clothing/hygiene
 - ☐ Inadequate/hazardous shelter
 - ☐ Inadequate supervision
 - ☐ Inadequate medical/mental health care
 - ☐ Caregiver absence/abandonment
 - ☐ Involving child in criminal activity
 - ☐ Failure to protect
- ☐ Threat of neglect (If yes, select any below that apply)
 - ☐ Prior failed reunification or severe neglect, and new child in household (in-home only)
 - ☐ Allowing child to use alcohol or other drugs
 - ☐ Prior death of a child due to neglect AND there is a new child of any age in the home. (in-home only)
 - ☐ Substance-affected newborn (in-home only)
 - ☐ Other high-risk birth (in-home only)

Sexual Abuse

- ☐ Any sexual act on a child by an adult caregiver or other adult in the household, or unable to rule out household member as alleged perpetrator
- ☐ Physical, behavioral, or suspicious indicators consistent with sexual abuse
- ☐ Sexual act(s) among siblings or other children living in the home
- ☐ Sexual exploitation (If yes, select any below that apply)
 - ☐ Caregiver actively involved child/youth in acts of exploitation or trafficking
 - ☐ Child/youth is exploited or trafficked by someone other than a caregiver.
- ☐ Threat of sexual abuse (If yes, select any below that apply)
 - ☐ Known or highly suspected sexual abuse perpetrator lives with child
 - ☐ Severely inappropriate sexual boundaries

B. SCREENING DECISION

- ☐ No concerns meet the threshold described for criteria above, evaluate out. Determine if cross-report to another agency is required.
 - ☐ *For differential response counties, proceed to Step IV. A. Path Decision for Evaluate Out.*
 - ☐ *For counties not implementing differential response, stop. No further SDM assessments required.*

- ☐ If one or more criteria are selected, an in-person response is required. Determine if cross-report to another agency is required. *Proceed to Step III. Response Priority.*

Tribal Agreement

If the child is an Indian child or there is reason to know a child is an Indian child, does the tribe agree with the final screening decision?

- ☐ Yes
- ☐ No:
- ☐ Unknown
 - ☐ Did not ask
 - ☐ No response from tribe by time of screening decision
 - ☐ Other: _____

Overrides

- ☐ Override to in-person response. No screening criteria are selected, but report will be opened as a referral. No further SDM assessments required. Select all that apply.
 - ☐ Interview per local protocol
 - ☐ Law enforcement's request
 - ☐ Tribal agency request
 - ☐ Residency verification
 - ☐ Response required by court order
 - ☐ Other local protocol (specify): _____
 - ☐ Other (specify): _____
- ☐ Override to evaluate out. One or more screening criteria are selected, but the report will be evaluated out. No further SDM assessments required. Select all below that apply.
 - ☐ Insufficient information to locate child/family
 - ☐ Another community agency has jurisdiction, AND the report does not allege abuse or neglect in out-of-home care to a dependent or ward child/youth. *(Cross-report should be made as required by state regulation.)*
 - ☐ Historical information only
- ☐ No override

Final Screening Decision

- ☐ Screen in
- ☐ Evaluate out

Is cross report required?

- ☐ Yes
- ☐ No

STEP III. RESPONSE PRIORITY

A. DECISION TREES

(Select below if applicable).

- ☐ Allegation concerns maltreatment by current substitute care provider AND county policy requires response within 24 hours (automatic 24-hour response)
 - ☐ Child is already in custody (automatic 24-hour response)

If none is applicable, complete the appropriate decision tree(s).

Physical Abuse

Do ANY of the following apply?

- ☐ Medical care currently required due to alleged abuse
- ☐ Caregiver's behavior is alleged to be dangerous or threatening to child's health or safety (reasonable person standard)
- ☐ Allegation of physical injury to non-mobile child or any child under age 2 (or capability equivalent)

If yes: Respond within 24 hours

If no: Proceed to next question

Is there a non-perpetrating caregiver or facility administrator aware of the alleged abuse who is demonstrating a response that is appropriate and protective of the child?

If yes: Respond within 10 days

If no: Proceed to next question

Do ANY of the following apply?

- ☐ Child is vulnerable or fearful
- ☐ There is prior history of physical abuse by this caregiver (in-home only)
- ☐ There is current concern that domestic violence will impact the safety of the child within the next 10 days (in-home only)

If yes: Respond within 24 hours

If no: Respond within 10 days

Emotional Abuse

Do either of the following apply?

- ☐ Child is exhibiting behavior that threatens the health or safety of the child or others AND caregiver is unable or unwilling to seek appropriate help or control the child's behavior
- ☐ Caregiver's behavior is alleged to be cruel, bizarre, or dangerous to the emotional health or safety of the child

If yes: Respond within 24 hours

If no: Respond within 10 days

Neglect

Do ANY of the following apply?

- ☐ Child requires immediate medical/mental health evaluation or care
- ☐ Child's physical living conditions are immediately hazardous to health or safety
- ☐ Child is currently unsupervised and in need of supervision
- ☐ Substance-exposed newborn will be discharged within 10 days AND no caregiver appears willing and able to provide for the infant upon discharge (in-home only)

If yes: Respond within 24 hours

If no: Respond within 10 days

Sexual Abuse

Is there current abuse/exploitation as evidenced by disclosure, credible witnessed account, or medical evidence?

If yes: Proceed to next question

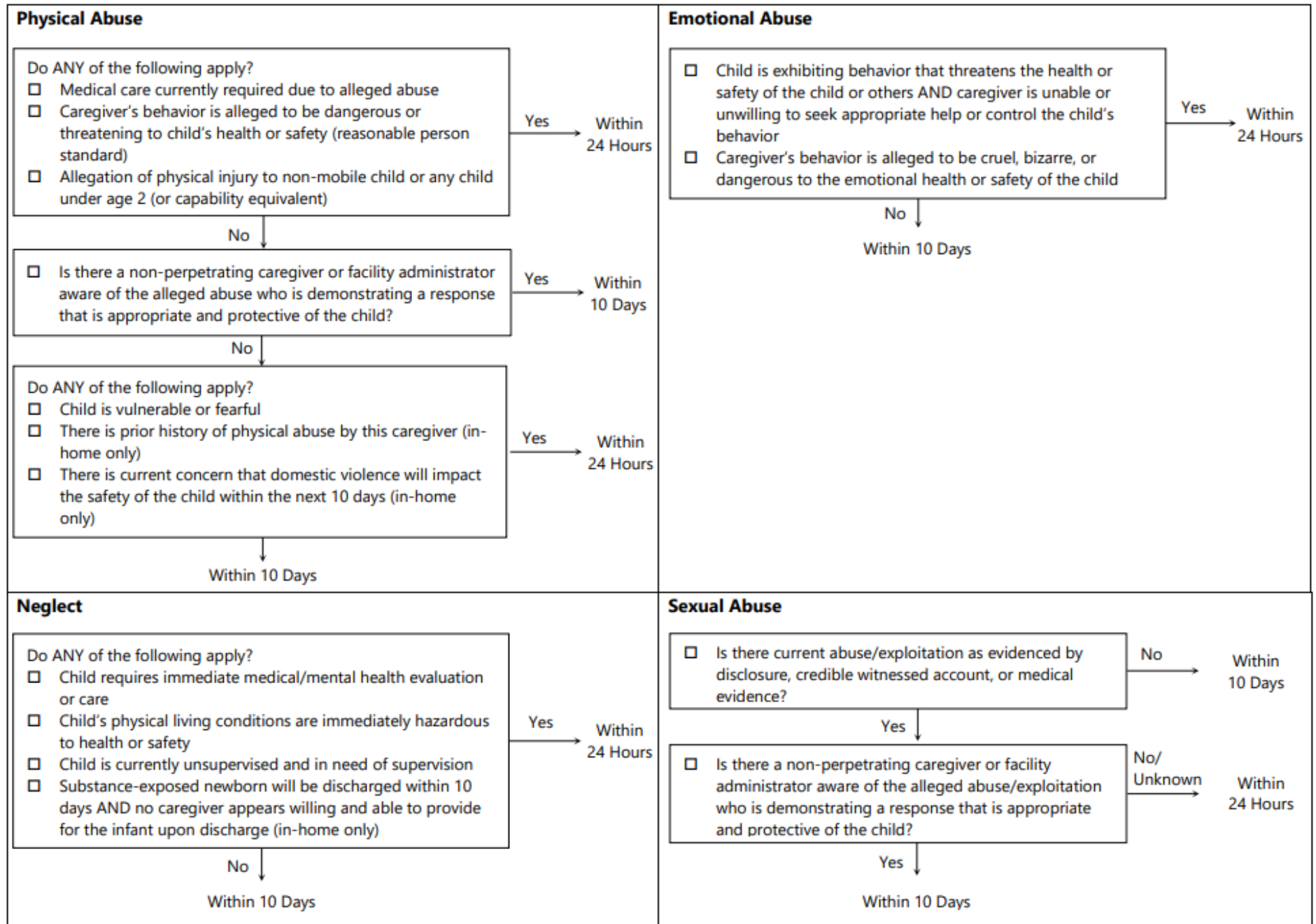
If no: Respond within 10 days

Is there a non-perpetrating caregiver or facility administrator aware of the alleged abuse/exploitation who is demonstrating a response that is appropriate and protective of the child?

If yes: Respond within 10 days

If no: Respond within 24 hours

Image placed here as a visual aid.



B. OVERRIDES

Policy

Increase to 24 hours whenever:

- ☐ Law enforcement requests an immediate response;
- ☐ Forensic considerations would be compromised by slower response; or
- ☐ There is reason to believe that the family may flee.

Decrease to 10 days whenever:

- ☐ Child safety requires a strategically slower response;
- ☐ The child is in an alternative safe environment; or
- ☐ The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period.

Discretionary

If applicable, select one and provide reason.

- ☐ Increase response time
- ☐ Decrease response time

Reason:

Seek supervisor review and approval for any override.

Final Response Priority

- ☐ 24 hours
- ☐ 10 days

STEP IV. PATH OF RESPONSE DECISION

A. PATH DECISION FOR EVALUATE OUT (FOR DIFFERENTIAL RESPONSE COUNTIES ONLY)

Review the following factors/considerations when making the path decision. Select yes or no for each as applicable based on information reported and/or available at the time of referral. If unknown at the time of report, answer no.

1. Prior investigations (Indicate number of prior investigations).

- ☐ Yes (Select below)
 - ☐ One or two
 - ☐ Three or more
- ☐ No

2. There is a prior failed reunification, or death of a child not due to abuse or neglect.

- ☐ Yes
- ☐ No

3. Current caregiver substance abuse, domestic violence, or mental health issues.

- ☐ Yes
- ☐ No

4. Identified need that can be addressed with community services.

- ☐ Yes (select any that apply)
 - ☐ Clothing
 - ☐ Counseling
 - ☐ Education
 - ☐ Financial
 - ☐ Housing
 - ☐ Medical
 - ☐ Food
 - ☐ Other (specify): _____
- ☐ No

5. Other

Specify: _____

- ☐ Yes
- ☐ No

Path Decision

- ☐ No response
- ☐ Path 1

B. PATH DECISION FOR IN-PERSON RESPONSE (FOR DIFFERENTIAL RESPONSE COUNTIES ONLY)

Review the following factors/considerations when making the path decision. Select yes or no for each as applicable based on information reported and/or available at the time of referral. If unknown at the time of report, answer no.

If the response priority decision is within 24 hours, the worker may bypass the criteria below and select "yes" for automatic Path 3 response.

Apply automatic Path 3?

- ☐ Yes. Skip to bottom and select Path 3.
- ☐ No. Answer the following questions.

1. There is a likelihood of caregiver arrest or juvenile court involvement as a result of alleged incident

- ☐ Yes
- ☐ No

2. Allegation involves sexual abuse

- ☐ Yes
- ☐ No

3. Prior investigations (indicate number of prior investigations)

- ☐ Yes (select below)
 - ☐ One or two
 - ☐ Three or more
- ☐ No

4. Prior child protective services (previous ongoing case)

- ☐ Yes
- ☐ No

5. Four or more alleged child victims

- ☐ Yes
- ☐ No

6. Caregiver has a current mental health issue

- ☐ Yes (select all that apply)
 - ☐ Primary caregiver
 - ☐ Secondary caregiver
- ☐ No

7. Primary caregiver has a history of abuse/neglect as a child

- ☐ Yes
- ☐ No

8. Any child with any of the following:

- ☐ Yes (select all that apply)
 - ☐ Mental health/behavioral problems
 - ☐ Developmental or physical disability
 - ☐ Medically fragile or failure to thrive
 - ☐ Positive toxicology screen at birth
 - ☐ Delinquency history
- ☐ No

9. Housing is unsafe or family is homeless

- ☐ Yes
- ☐ No

10. Prior injury to a child due to abuse or neglect

- ☐ Yes
- ☐ No

11. Domestic violence in the last 12 months

- ☐ Yes
- ☐ No

12. Caregiver has a current substance abuse issue

- ☐ Yes (select all that apply)
 - ☐ Primary caregiver
 - ☐ Secondary caregiver
- ☐ No

13. Other (specify)

Path Decision (Select one)

- ☐ Path 2
- ☐ Path 3

SDM® HOTLINE TOOLS DEFINITIONS

California Department of Social Services

IS THERE ANY INFORMATION THAT INDICATES THAT THE CHILD IS, OR MAY BE, AN INDIAN CHILD?

The duty to inquire begins at initial contact and continues until a tribe provides confirmation of tribal membership status or the court makes a finding that proper and adequate further inquiry has been conducted, and there is no reason to know whether the child is an Indian child.

Note: If known or reason to know exists, a social worker or representative from the tribe should be included in the information gathering and screening process, including the screening decision whenever possible. See [BIA list of ICWA designees](#) to support noticing and collaborative assessment.

This contact should not prevent or delay the agency from responding within the required timeframe when indicated.

REASON TO KNOW

Information at the time of the report **indicates** a child in the household is an Indian child, including the following.

- The child, family, or a person having interest in the child provides direct information that the child is an Indian child.
- The residence of the child, the child's parents, or Indian custodian is on a reservation or in an Alaskan Native village.
- Any participant in a court proceeding, officer of the court, Indian tribe, Indian organization, or agency provides information indicating the child is an Indian child.
- The child gives reason to know that the child is an Indian child.
- The child is or has been a ward of a tribal court.
- The parent or child possesses an identification card indicating membership or citizenship in a tribe.

REASON TO BELIEVE

Information at the time of the report **suggests** that either the child or a parent of the child may be eligible for membership in an Indian tribe or may have Indian ancestry. Further inquiry is required.

IF YES, WERE TRIBAL SOCIAL WORKERS OR REPRESENTATIVES CONSULTED DURING THE INFORMATION GATHERING AND SCREENING PROCESS?

A social worker or representative from the tribe was successfully contacted and included in the information gathering and screening process. Details of the contact must be documented in CWS/CMS, including which tribe(s) were contacted, a summary of information discussed, and the impact on decision making.

If contact with tribe was attempted but not successful, document efforts within CWS/CMS.

STEP I. PRELIMINARY SCREENING

REVIEW OF SCREENING CRITERIA IS NOT REQUIRED

Evaluate out.

No child under age 18.

The current referral may allege abuse or neglect, but the alleged victim is 18 years of age or older (including nonminor dependents).

Do not apply this item if the report concerns the death of the only child(ren) in the household where death is suspected to be related to abuse or neglect, or for nonminor dependents reported to be endangered by caregiver, per WIC 16504 (c).

Duplicate referral that contains no new information.

The report duplicates an existing referral (this is commonly known as a secondary referral). This report does not contain new allegations from an existing referral.

Referred to another county.

A referral has been received for a child who lives in another county. The caller was both referred to that county and provided with contact information, or the county was notified and the referral was recorded in that county. Refer to local protocol for this type of referral.

Safely surrendered baby

The referral concerns a child 72 hours of age or younger whose caregiver has voluntarily surrendered physical custody of the child to any employee on duty at a public or private hospital emergency room or any additional site approved as a Safe Surrender Site. Follow procedures outlined in ACIN I-88-10.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

Determine if the report contains allegations of abuse or neglect in out-of-home care to a dependent or ward child/youth.

A dependent or ward in out-of-home care is defined as a child/youth who is under the jurisdiction of the county child welfare or probation department AND is currently placed in a licensed foster home, group home, short-term residential therapeutic program, or residential treatment facility.

If yes: When applying definitions of screening and response priority tools, the definition of “caregiver” should include “a person responsible for the child’s care and welfare (including a licensee, administrator, or employee of any facility licensed to care for children)” in accordance with Cal. Penal Code § 11165.5.

If no: Apply screening and response priority tool definitions using the standard Structured Decision Making® (SDM) definition of “caregiver.”

A. SCREENING CRITERIA (Elicit reporter’s concerns and select all that apply)

Consider age, developmental status, and other child vulnerabilities when assessing referrals for allegations of abuse or neglect.

Physical Abuse (if not automatic 24-hour, go to physical abuse tree)

Non-accidental or suspicious injury.

The child has a current or previously unreported injury or impairment AND the caregiver deliberately caused the injury/impairment OR there is a basis to be suspicious that a caregiver caused it and it was non-accidental. Basis for suspicion may include but is not limited to:

- Physician reports that the injury type is consistent with non-accidental injuries;
- Injury to a non-ambulatory child with no plausible alternative explanation;
- Explanation for injury does not match injury;
- Injury is in the shape of an object (e.g., loop marks); or
- Credible disclosure by the child to the reporting party or other adult.

Identify the type of non-accidental or suspicious physical injury.

Death of a child due to abuse (automatic 24-hour).

There was a death of a child in the home; and circumstances are suspicious for abuse, or abuse has been identified as the cause of death in this report or investigation. Select one of the following options.

- Death of only child or all children in home; no other children reported to be in the home.
- Other children reported to be in the home.

Severe (automatic 24-hour).

A severe injury is one that, if left untreated, would cause permanent physical disfigurement, permanent physical disability, or death. 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.

Other injury (exclude very minor injuries unless the child is under 1 year old).

Any non-accidental or suspicious injury that is not severe.

Exclude very minor injuries, defined as those that involve only mild redness or swelling, minor welts/scratches/abrasions, or brief and minor pain. Any non-accidental injury to a child under 1 year old or a child who is non-ambulatory should not be considered very minor.

- Injuries caused to a child during a domestic violence incident.
- "Other" injuries may require assessment/treatment but are not life-threatening and are not likely to result in temporary or permanent disability or disfigurement. These may include bruises, welts, or abrasions in areas of the body that do not pose a threat of serious injury or disfigurement (arms, legs, buttocks).

Caregiver action that likely caused or will cause injury (exclude very minor injuries unless child is under 1 year old).

It is not necessary for a reporter to determine that an injury occurred. Examples of caregiver action that is likely to have caused or will cause injury include but are not limited to the following:

- Shaking or throwing an infant or child under 3 years old.
- Inappropriate physical discipline, such as choking, suffocation, tying child up, locking child in closet/kennel, physical activity exceeding child's ability to perform, etc.
- Hitting a child with enough force or using objects to strike a child that could cause a significant injury, such as a broken bone, concussion, significant bruising or lacerations, or internal injuries.
- Exposing a child to dangerous weather or environmental hazards (e.g., locking child out of the home, confining child to garage with dangerous fumes/exhaust, dropping child off far from home with no resources to get to a safe place).

- Dangerous behavior toward the child or in immediate proximity of the child, including violence by one or more adult household members occurring while the child is present in ways that the child could be physically injured. Consider combination of child location, type of incident (e.g., pushing, throwing objects, use of a weapon), and child vulnerability.
- Caregiver has made credible threats to cause physical harm to the child that, if carried out, would constitute child abuse, and it is likely that, without intervention, the caregiver will carry out these threats. **If threats are clearly for the sole purpose of emotional abuse, select “Caregiver actions have led or are likely to lead to child’s severe anxiety, depression, withdrawal, or aggressive behavior toward self or others” under emotional abuse. If the purpose cannot be discerned, select both this section and the emotional abuse item mentioned above.**

Prior death of a child due to abuse AND there is a new child of any age in the home.

There was a death of a child in the home due to abuse or circumstances were suspicious for abuse prior to the current referral AND there is a new child currently in the care of the identified/suspected perpetrator.

Emotional Abuse (go to emotional abuse tree)

Caregiver actions have led or are likely to lead to child’s severe anxiety, depression, withdrawal, or aggressive behavior toward self or others.

Caregiver action(s), statement(s), or threat(s) have led or are likely to lead to child’s emotional damage (e.g., severe anxiety, depression, withdrawal); behavioral concerns (e.g., untoward aggressive behavior toward self or others); and/or adverse impact on the child’s emotional development, including but not limited to delayed speech development, abnormal attachment behaviors, and impulse control behaviors. The adverse impact may result from a single event or from a consistent pattern of behavior and may be currently observed and/or predicted as supported by evidence-based practice. Types of emotional maltreatment include but are not limited to the following:

- Rejecting and/or degrading the child.
- Isolating and/or victimizing the child by means of cruel, unusual, or excessive methods of discipline.
- Exposing the child to brutal or intimidating acts or statements, including but not limited to:
 - » Harm or threatened harm to animals;
 - » Threats of suicide or harm to family members (including the child);
 - » Confining the child in places such as closets or animal cages; or
 - » Consistently scapegoating the child; consistently berating, belittling, blaming, targeting, or shaming the child.

The adverse impact on the child may or may not be apparent depending on the child’s age, cognitive abilities, verbal ability, and developmental level. Adverse impact is not required if the action/inaction is a single incident that demonstrates a serious disregard for the child’s welfare.

Emotional harm related to domestic violence.

The child has experienced, or is likely to experience, emotional harm related to exposure to domestic violence. The child may exhibit harm through symptoms of depression, significant anxiety or withdrawal, or self-destructive or aggressive behavior from witnessing or intervening in physical altercations, serious verbal threats, coercion, or intimidation by one adult household member against another.

Note: If a child has been injured or is threatened with injury, also select “non-accidental or suspicious injury” or “caregiver action that likely caused or will cause injury” under “Physical Abuse.”

Neglect

Severe neglect (if not automatic 24-hour, go to neglect tree).

Diagnosed malnutrition (automatic 24-hour).

The child has a current diagnosis by a qualified medical professional of severe malnutrition due to inadequate or unbalanced diet, OR a qualified medical professional states that there are indicators of malnutrition but a formal diagnosis has not yet been made.

Non-organic failure to thrive.

The child has a current diagnosis by a qualified medical professional of non-organic failure to thrive, OR a qualified medical professional states that there are indicators of failure to thrive but a formal diagnosis has not yet been made.

Child's health/safety is endangered.

The caregiver has willfully not provided adequate clothing, shelter, supervision, care, or medical care AND there is imminent danger of serious illness or injury; or serious illness, serious injury, or death has already occurred. Consider child's age, behavior, and vulnerability.

For example:

- The child's clothing is so inappropriate for weather that the child suffered hypothermia or frostbite;
- Housing conditions result in lead poisoning, severely exacerbated asthma due to smoke exposure, and/or multiple bites from pest infestations;
- There is methamphetamine production in the home/residence;
- Medical care has not been provided for an acute or chronic condition and, as a result, the child has required or is likely to require hospitalization or surgery; or the condition may worsen to the extent that unnecessary permanent disability, disfigurement, or death results;

- Caregiver is willfully not meeting child's mental health needs and child has demonstrated suicidal or homicidal behavior/ideation;
- Child is not supervised to the extent that the child has been seriously injured, is at risk of being seriously injured, or avoided serious injury only due to intervention by a third party;
- A young child is left in a motor vehicle during extreme temperature conditions;
- A caregiver behaves recklessly in proximity to child (e.g., driving under the influence with a child in the car, using weapons, etc.); or
- Caregiver is breastfeeding while using dangerous substances (type of substances and/or amount resulted in or is likely to result in serious injury/illness to child).

Death of a child due to neglect (automatic 24-hour).

There has been a death of a child in the home due to neglect or circumstances that are suspicious for neglect. Select one of the following options.

- Death of only child or all children in home; no other children reported to be in the home.
- Other children reported to be in the home.

General Neglect (go to neglect tree)

Consider age/developmental status of children. Minor or no injury or illness has occurred.

Note: General neglect does not include a parent's economic disadvantage and should be limited to circumstances in which the caregiver willfully or negligently fails to provide care. A child must be at substantial risk of suffering serious physical harm or illness to fall within the definition of general neglect (PC 11165.2, WIC 300(b)(1)(A-D)). This applies to all the following subcategories.

Inadequate food.

The caregiver willfully or negligently failed to provide sufficient food to meet minimal requirements for the child to maintain health and growth. The child experiences unmitigated hunger; lack of food has a negative impact on school performance. Caregiver's use of food stamps and/or food pantries as sources of food should not be considered failure to provide food.

Inadequate clothing/hygiene.

The caregiver has willfully or negligently failed to meet the child's basic needs for clothing and/or hygiene to the extent that the child's daily activities are negatively impacted and/or the child develops or suffers a worsening medical condition. Examples include but are not limited to:

- Sores, infection, or severe diaper rash;

- Inability to attend school due to persistent or recurring lack of clean clothing; and/or
- Experiencing shame or isolation from peers due to poor hygiene/extreme body odor.

Inadequate/hazardous shelter.

The residence contains hazards that have led or could lead to injury or illness of the child if not resolved. Examples include but are not limited to:

- Housing that is an acute fire hazard or has been condemned;
- Exposed heaters, gas fumes, or faulty electrical wiring;
- No utilities (e.g., water, electricity, heat source if needed) AND these are necessary based on current conditions and age/developmental status or special needs of the child;
- Pervasive and/or chronic presence of rotting food, human/animal waste, or infestations;
- Presence of poisons, guns, or drugs within reach of child; and/or
- Lack of safe sleeping arrangements for infant/child.

Inadequate supervision.

Caregiver is present but not attending to the child, or caregiver has made inadequate care arrangements for the child. Injury has occurred due to lack of supervision or been avoided due to third-party intervention. Examples include but are not limited to the following:

- Caregiver fell asleep in the apartment/house and young child wandered from the home into the hallway/street.
- Child plays with dangerous objects (e.g., sharp knife, gun, matches).
- Non-mobile infant left in car seat or carrier for extended periods of time.
- Caregiver is unable to care for child due to substance use, mental illness, or developmental disability.
- Caregiver does not protect child in the home from a sibling with violent behavior.

Inadequate medical/mental health care.

Child has a mild to moderate condition, and the caregiver is not seeking or following medical treatment, causing the child's condition to deteriorate; OR the child has a severe, chronic condition and the caregiver's care is partial, but important components of the child's medical needs are unmet.

Caregiver absence/abandonment.

- Caregiver is unable to care for the child due to incarceration, hospitalization, or unavoidable absence AND **there is no safe adult to care for the child**. If the caregiver is incarcerated, hospitalized, or absent and has made a plan of care for the child with a safe adult or is otherwise able to safely mitigate the impact of their absence on the child, this item should not be selected.
- Caregiver has deserted the child with no apparent plans for return. Abandonment may be indicated by quitting jobs, establishing another residence, and taking clothing and other belongings.
- Child is being discharged from a facility and caregiver refuses to accept child back into their home AND has not participated in discharge planning or caregiver cannot be found.
- Caregiver has kicked child out of the home/refuses child entry to the home and has not provided a safe alternative.
- Caregiver left child with family or friends who state an intention to discontinue care and caregiver refuses to accept child back or cannot be located.
- Child is or has been left without an identified caregiver for a period of time inappropriate to the child's age or developmental status. Consider presence of support systems such as relatives and neighbors and child's ability to access support systems by phone or access within immediate walking distance.

Involving child in criminal activity.

The caregiver causes the child to perform or participate in illegal acts that:

- Create danger of serious physical or emotional harm to the child;
- Expose the child to being arrested; or
- Force a child to act against their wishes.

Failure to protect.

- Note: Concerns related to domestic violence should be assessed under emotional abuse and physical abuse items. Caregiver knowingly left child in the care of a person known to neglect or abuse children; a person unknown to the caregiver; or a person known to be violent, use alcohol/drugs, or have serious mental health concerns to the extent that their ability to provide care is significantly impaired;
- Caregiver does not intervene despite knowledge (or reasonable expectation that the caregiver should have knowledge) that the child is being harmed (includes physical, sexual, or emotional abuse or neglect) by another person;
OR
- A child has been exploited by a third party, and the person responsible for the child's care is aware of the exploitation and has not acted protectively. This includes situations where the person responsible for the care of the child has been coerced or is otherwise complacent with exploitation.

Note: Screeners should explore a caregiver's knowledge and protective actions prior to applying allegations of failure to protect. Circumstances in which a child is trafficked and the caregiver may have acted protectively but was unable to keep the child safe should be assessed under "sexual exploitation: Child/youth is exploited or trafficked by someone other than a caregiver."

- » Children and youth aged 17 years old and younger are sexually exploited when they have engaged in, solicited for, or been forced to engage in sexual conduct or performance of sexual acts 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.

Threat of Neglect (go to neglect tree)

No event has occurred; however, current conditions exist where, without intervention, the child will be subject to one of the neglect categories above.

Prior failed reunification or severe neglect, and new child in household (in-home only).

There is credible information that a current caregiver had one or more children for whom there was:

- A failed reunification as a result of child abuse or neglect; OR
- A current caregiver was previously substantiated for severe neglect;

AND

- A new child is now living in the home and current conditions exist that create a substantial likelihood that the child will be neglected.

Allowing child to use alcohol or other drugs.

Caregiver provides (offers or knowingly allows the child to consume) alcohol, illegal drugs, or inappropriate prescription drugs to a child to the extent that it could endanger the child's physical health or emotional well-being or result in exposure to danger because the child's thinking and/or behavior are impaired. Consider child's age and substance type, including the following:

- Providing methamphetamine, heroin, cocaine, or similar drugs to a child of any age.
- Providing enough alcohol to result in intoxication.
- Providing alcohol over time so that the child is developing a dependency.
- Providing medications (includes prescription and over-the-counter) that are not prescribed for the child, for the purpose of altering the child's behavior or mood.
- Providing glue or other inhalants to a child of any age.

Examples of substance use that should not be included are:

- Use of small amounts of alcohol for religious ceremonies; and
- An older child is permitted to try a small amount of alcohol at a family occasion that did not result in intoxication.

Prior death of a child due to neglect AND there is a new child of any age in the home (in-home only).

There has been a death of a child in the home due to neglect or circumstances are suspicious for neglect prior to the current referral, AND new children are currently in the care of the identified/suspected perpetrator.

Substance-affected newborn (in-home only).

There is an infant born and identified as affected by substance use

AND

There is indication that the caregiver will be unable to fulfill the basic needs of the infant upon discharge from the hospital.

When assessing caregiver's ability to provide minimum sufficient level of safe care, consider factors such as willingness to implement a plan of safe care, demonstrations of safe care of other children, plans for safe feeding, and availability of and willingness to use a support network.

Note: California defines an "infant born and identified as affected by substance abuse" as an infant where substance exposure is indicated at birth AND subsequent assessment identifies indicators of risk that may affect the infant's health and safety. A positive toxicology screen at the time of the delivery of an infant is not in and of itself an indication of neglect. Screeners should explore and document the assessment completed pursuant to Section 123605 of the Health and Safety Code, which identifies indicators of risk affecting the infant's health and safety.

Other high-risk birth (in-home only).

No acts or omissions constituting neglect have yet occurred; however, conditions are present that suggest that the only reasons neglect has not occurred are the external supports of the hospitalization or the limited time since birth. Examples include but are not limited to the following:

- Sole caregiver or both caregivers have not attended to the newborn in the hospital.
- A caregiver with apparent physical, emotional, or cognitive limitations has no support system and may be unable or unwilling to meet the newborn's basic needs.

- A child was born with medical complications, and sole caregiver's or both caregivers' response suggests caregiver(s) will be unable to meet the child's exceptional needs (e.g., does not participate in medical education to learn necessary care, indicates denial of diagnosis, etc.).

Sexual Abuse (go to sexual abuse tree)

Any sexual act on a child by an adult caregiver or other adult in the household, or unable to rule out household member as alleged perpetrator.

Based on verbal or nonverbal disclosure, medical evidence, or credible witnessed act. If child knows that the alleged perpetrator is not a household member but does not know their identity, DO NOT SELECT.

Physical, behavioral, or suspicious indicators consistent with sexual abuse.

Suspicious indicators include but are not limited to the following:

- Toddler or elementary school-aged child displays highly sexualized aggressive behaviors.
- Pre-adolescent child has initiated sexual acts or activities with caregivers, family members, or peers that are outside age-appropriate exploration or development, and this has led to a concern that they are a victim of sexual abuse.
- Child complains of pain in the genital or anal area AND there are other indications of sexual abuse.

Sexual act(s) among siblings or other children living in the home.

Children living in the home engage in sexual behavior that is outside of normal exploration or involves coercion or violence.

Sexual exploitation.

Children and youth age 17 years 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 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.

Caregiver actively involved child/youth 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 caregiver. **In this circumstance, an allegation of sexual abuse should be applied to the caregiver AND any third-party perpetrators.**

Child/youth is exploited or trafficked by someone other than a caregiver.

Child/youth is being commercially sexually exploited by a person who is not a caregiver.

Select if an in-person response is needed to assess the extent to which a caregiver has acted protectively OR has the ability to protect the child from exploitation. **If this item is selected, an allegation of sexual abuse should be applied to *only* the alleged perpetrator(s) of the actual exploitation. Do not apply an allegation of sexual abuse to the caregiver.**

Threat of sexual abuse.

No sexual act or exploitation has occurred; however, the caregiver behaves in ways that create a substantial likelihood that the child will be sexually abused.

Known or highly suspected sexual abuse perpetrator lives with child.

An individual with a known or suspected criminal history of sexual crime, regardless of whether they have been arrested or convicted, lives in the same residence as the child.

Severely inappropriate sexual boundaries.

Note: This does not include incidents that are accidental or inadvertent unless the report indicates that the behavior is persistent or frequently occurring.

- Adults in the home allow children to see sexually explicit material, witness sexual acts, or hear sexual language that is inappropriate to their age/developmental status.
- AND
- This has resulted in the child exhibiting age-inappropriate sexual behavior OR emotional distress.
 - Adult(s) in the household exhibits behaviors suggesting the purpose is sexual gratification for the adult.

B. SCREENING DECISION

Evaluate out: No criteria are selected.

Select this decision if no criteria in Section A are selected, which means that the report does not meet statutory requirements for an in-person response. For differential response counties, proceed to

Step IV. A. Path Decision for Evaluate Out. For counties not implementing differential response, stop. No further SDM assessments required.

Consider whether a cross-report to another agency (Community Care Licensing, law enforcement, or other county jurisdiction or agency) as required by state statute and regulations and local policy; if so, select the checkbox. **Make the cross-report immediately or as soon as possible to the appropriate jurisdiction according to state and local policy.**

In-person response: One or more criteria are selected.

Select this decision if any criteria in Section A are selected, which means that at least one reported allegation meets statutory requirements for an in-person response. Proceed to Step III. Response Priority.

Consider whether a cross-report to another agency (Community Care Licensing, law enforcement, or other county jurisdiction or agency) as required by state statute and regulations and local policy; if so, select the checkbox. **Make the cross-report immediately or as soon as possible to the appropriate jurisdiction according to state and local policy.**

Tribal agreement with the final screening decision

If it has been indicated that the child is, or there is reason to know a child may be, an Indian child and contact with the tribe(s) has been made, review the assessment information and screening decision collaboratively with the tribe(s). Select if the tribe is in agreement with the final screening decision, is not in agreement, or if it is unknown.

Note: While agreement with the decision is not required, attempts to reach consensus are considered best practice.

Document details about the collaborative assessment and the tribe's position on the final screening decision in CWS/CMS.

OVERRIDES

In-person response. No criteria are selected, but report will be opened as a referral. No further SDM assessments required. Select all that apply.

Select this decision if no criteria in Section A are selected, which means that the report does not meet statutory requirements for an in-person response; however, a referral will be opened in the child welfare services case management system (CWS/CMS) for an in-person response due to local protocol or state regulation.

Interview per local protocol

Concern does not meet the criteria for in-person response, but it will be assigned based on MPP guidelines or local protocol. Select this override only after reviewing the appropriate SDM items and thresholds to confirm that an override is required.

Law enforcement's request

As allowable by MPP 31-101.4, despite not meeting criteria for assignment, a concern about abuse, neglect, or exploitation will be assigned for response based on law enforcement request and local protocol.

Tribal agency request

A local protocol determines that a tribe may request a courtesy interview for in-person CWS response.

Residency verification

Response required by court order

Other local protocol

Other

Evaluate out. One or more criteria are selected, but the report will be evaluated out. No further SDM assessments required. Select all that apply.

Insufficient information to locate child/family.

The caller was unable to provide enough information about the child's identity and/or location to enable an in-person response. Select ONLY after following county protocol for attempting to discern identity/location from information provided by caller.

Another community agency has jurisdiction, AND the report does not allege abuse or neglect in out-of-home care to a dependent or ward child/youth.

Local protocol determines that an agency such as law enforcement, probation, or court will be the investigating entity for this issue AND a child welfare response is not required. **Cross-report to law enforcement or the appropriate agency as required by state regulation.**

Historical information only.

Child is at least 10 years old AND the alleged maltreatment occurred more than one year ago, AND there were no reports of abuse or neglect since the alleged incident, AND the conditions that contributed to the alleged incident are no longer present. If reported incident is sexual abuse, all of the above criteria must apply AND the reported perpetrator must be either an unidentifiable non-household member or deceased.

STEP III. RESPONSE PRIORITY

A. DECISION TREES

Physical Abuse

Medical care currently required due to alleged abuse.

Medical care is immediately necessary and if not provided will seriously and possibly permanently affect the child's health and well-being. This includes treatment and/or evaluation of an injury that is needed or currently in progress. It does not include medical examination completed solely for forensic purposes.

Caregiver's behavior is alleged to be dangerous or threatening to child's health or safety (reasonable person standard).

Caregiver acted in brutal or dangerous ways; or the caregiver has made threats (other than empty threats or threats made solely for intimidation) of brutal or dangerous acts toward the child AND absent intervention, it is likely that the child will experience an injury within the next 10 days.

Include concerns of caregiver substance use/abuse or current mental health issues that may increase the risk of physical injury or result in physical injury.

Examples include but are not limited to:

- Hitting with closed fist;
- Hitting child's head, back, or abdomen with substantial force;

- Choking, kicking, or hitting with belt buckle or other dangerous object;
- Using restraints;
- Poisoning; or
- Other actions that could reasonably result in severe injury, such as:
 - » Dangling the child from heights;
 - » Exposing the child to dangerous temperature extremes; or
 - » Throwing objects at the child that could cause severe injury.

Allegation of physical injury to non-mobile child or any child under age 2 (or capability equivalent).

The child has not reached their second birthday, or a child of any age has the capability of a child younger than 2 years of age due to developmental, physical, or emotional disability.

Is there a non-perpetrating caregiver or facility administrator aware of the alleged abuse who is demonstrating a response that is appropriate and protective of the child?

A non-perpetrating caregiver or facility administrator is aware that physical abuse has been alleged AND demonstrates the ability to prevent the alleged perpetrator from having access to the child. The non-perpetrating caregiver or facility administrator will not pressure the child to change their statement and will obtain or has obtained medical treatment for the child as needed.

Child is vulnerable or fearful.

- A child is vulnerable if, due to age, developmental status, or physical disability, they are unable to protect themselves and/or will not be seen within the next week by other adults who would report concerns (e.g., school personnel).
- The child expresses credible fear of going/remaining home.

There is prior history of physical abuse by this caregiver (in-home only).

There is credible information that there are one or more prior investigations for physical abuse. (Include all investigations assigned for in-person response. If for a differential response county, include Path 2 and Path 3 referrals.)

Credible information includes statements by a reporter, verified information in CWS/CMS, or police reports.

There is current concern that domestic violence will impact the safety of the child within the next 10 days (in-home only).

There are physical altercations between the caregiver and another adult living in the home. Include situations where one of the adults does not live in the home but has substantial contact in the home, or has lived in the home but continues to behave in threatening ways toward household members.

Emotional Abuse

Child is exhibiting behavior that threatens the health or safety of the child or others AND caregiver is unable or unwilling to seek appropriate help or control the child's behavior.

Examples of behavior that threatens the health or safety of the child or others include but are not limited to the following:

- Attempted or threatened suicide.
- Cutting or other self-harmful behavior.
- Violent behavior toward others involving weapons.
- Threats of violence that involve weapons and there is reason to believe the child will carry out the threat.
- Violence toward very young or vulnerable children.
- Torturing or killing animals.
- Fire-setting behavior.

Caregiver's behavior is alleged to be cruel, bizarre, or dangerous to the emotional health or safety of the child.

Examples include but are not limited to the following:

- The caregiver harms himself, others, or pets in the child's presence.
- The caregiver threatens to harm himself, 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.
- 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.
- Domestic violence incidents that involve weapons or result in serious injury to any adult, or during which the child attempts to intervene or is directly in the path of violence.

Neglect

Child requires immediate medical/mental health evaluation or care.

Medical or mental health care is necessary. If not provided within the next 10 days, the child's health and well-being will be seriously, and possibly permanently, affected. In addition to medical conditions, this includes extreme dental and mental health conditions.

Child's physical living conditions are immediately hazardous to health or safety.

Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening. Examples include but are not limited to the following:

- Leaking gas from stove or heating unit.
- Substances or objects accessible to the child that may endanger their health and/or safety.
- Lack of water or utilities (e.g., heat, plumbing, electricity) and no alternative or safe provisions have been made.
- Open/broken/missing windows.
- Exposed electrical wires.
- Child has suffered serious illness or significant injury due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites).
- Guns and other weapons are not locked.

Child is currently unsupervised and in need of supervision.

Based upon local community standards, the child is not receiving appropriate supervision from their caregiver, and there is no appropriate alternative plan for supervision within the next 10 days. Examples include:

- Child is currently alone (time period varies with age and developmental stage).
- Caregiver does not attend to the child to the extent that need for care/protection goes unnoticed or unmet (e.g., child being harmed by another person in the home/failure to protect; the caregiver is present, but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards; a child with some suicidal ideation is not closely monitored).
- Child is presently receiving inadequate and/or inappropriate child care arrangements.
- Child has been abandoned and has no caregiver willing and able to provide care for a minimum of 10 days.
- Child/youth is being sexually exploited or trafficked, and information exists that the caregiver is unable or failing to provide supervision that would address immediate safety concerns within the next 10 days.

Substance-exposed newborn will be discharged within 10 days AND no caregiver appears willing and able to provide for the infant upon discharge (in-home only).

A newborn who is substance-exposed or otherwise at high risk has been discharged or will be discharged within 10 days, AND the sole caregiver or both caregivers appear unwilling and unable to provide for the child upon discharge OR there is reason to believe the caregiver will remove the child against medical advice. Indicators include the following.

- The caregiver uses substances, such as methamphetamine, heroin, or cocaine, that typically result in severely impaired ability to function.
- The frequency and/or quantity of caregiver substance use suggests a high probability that they will be unable to meet the needs of the newborn upon discharge.
- Prior failed reunification.

Sexual Abuse

Is there current abuse/exploitation as evidenced by disclosure, credible witnessed account, or medical evidence?

Disclosure may be verbal or nonverbal (e.g., extreme sexual acting-out behavior). Medical evidence includes medical findings related to sexual abuse and suspicious findings such as sexually transmitted diseases in young children.

Is there a non-perpetrating caregiver or facility administrator aware of the alleged abuse/exploitation who is demonstrating a response that is appropriate and protective of the child?

A non-perpetrating caregiver or facility administrator is aware that sexual abuse has been alleged, and they support the child's disclosure AND demonstrates the ability to prevent the alleged perpetrator from having access to the child. The non-perpetrating caregiver or facility administrator will not pressure the child to change their statement and will obtain or has obtained medical treatment for the child as needed.

B. OVERRIDES

Policy

Increase to 24 hours whenever:

Law enforcement requests an immediate response.

A law enforcement officer is requesting an immediate child protective services response.

Forensic considerations would be compromised by slower response.

Physical evidence necessary for the investigation will be compromised if the investigation does not begin immediately, OR there is reason to believe statements will be altered if interviews do not begin immediately.

There is reason to believe that the family may flee.

The family has stated an intent to flee or is acting in ways that suggest an intent to flee, OR there is a history of the family fleeing to avoid investigation.

Decrease to 10 days whenever:

Child safety requires a strategically slower response.

The child's current location is such that initiating contact may create a threat to the child's safety OR the value of coordinating a multi-agency response outweighs the need for immediate response.

The child is in an alternative safe environment.

The child is no longer in the same place or no longer with the caregiver who is the alleged perpetrator, and the child is not expected to return within the next 10 days (five days in Los Angeles).

The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period.

The incident being reported occurred at least six months prior to the report AND no other maltreatment is alleged to have occurred in the intervening time period.

FINAL RESPONSE PRIORITY

If reported concerns involve out-of-home care of a dependent or ward child/youth, the county where the approved or licensed facility is geographically located should respond to reports with a 24-hour response priority. Reports with a 10-day response priority should be referred to the placing county as soon as possible.

STEP IV. PATH OF RESPONSE DECISION

A. PATH DECISION FOR EVALUATE OUT (for differential response counties only)

For all referrals that are evaluated out, select yes or no to indicate whether any of the following are applicable based on information reported or available at the time of the report. If unknown at the time of report, answer no.

Prior investigations (indicate number of prior investigations)

Credible information shows that there have been prior investigated referrals alleging maltreatment by a current caregiver of the child. (Credible information includes statements by a reporter, verified information in CWS/CMS, or police reports.) Include all allegation types and all dispositions (e.g., substantiated, inconclusive, unfounded). For differential response history, include all Path 2 and Path 3 responses. If prior investigation history is present, indicate the number of prior investigations as either one or two, or three or more.

There is a prior failed reunification, or death of a child not due to abuse or neglect

Credible information shows that a current caregiver of the child has or has had a prior failed reunification for other children in their care, or a child in their care has died (not due to substantiated abuse or neglect).

Current caregiver substance abuse, domestic violence, or mental health issues

Credible information shows that there is a current concern for the caregiver in one of the following areas:

- A caregiver has a substance abuse problem. The caregiver's recurring use of alcohol or drugs causes functionally significant impairments, such as health problems, disability, or failure to meet responsibilities at work, school, or home.
- An adult household member exerts physical violence or patterns of power and control over another adult living in the home, impacting family functioning, regardless of whether children were present. This includes situations where one of the adults does not live in the home but has substantial contact in the home, or has lived in the home but continues to behave in threatening ways toward household members.
- A caregiver has current mental health concerns based on a diagnosis of a major mental illness (e.g., schizophrenia, bipolar disorder, depression) or exhibits symptoms that suggest a probability that such a diagnosis exists, such as hearing voices, paranoid thoughts, severe mood changes, suicidal thoughts or behavior, or extremely depressed affect.

Identified need that can be addressed with community services

The reporter describes a service or resource need that does not rise to the level of screening threshold but could be addressed through a community agency.

Other (specify)

Specify any other information that was used in determining the final path decision for evaluate out.

B. PATH DECISION FOR IN-PERSON RESPONSE (for differential response counties only)

There is a likelihood of caregiver arrest or juvenile court involvement as a result of alleged incident

If conditions alleged by the reporter are true, they would constitute a crime against the child or would constitute the basis for a juvenile court dependency petition.

Allegation involves sexual abuse

Current allegation is for sexual abuse.

Prior investigations (indicate number of prior investigations)

Credible information shows that there have been prior investigated referrals alleging maltreatment by a current caregiver of the child. (Credible information includes statements by a reporter, verified information in CWS/CMS, or police reports.) Include all allegation types and all dispositions (e.g., substantiated, inconclusive, unfounded). For differential response history, include all Path 2 and Path 3 responses. If prior investigation history is present, indicate the number of prior investigations as either one or two, or three or more.

Prior child protective services (previous ongoing case)

There has been an open family maintenance, family reunification, or permanency planning case involving any current caregiver; or there have been previous ongoing child protective services in another jurisdiction.

Four or more alleged child victims

There are four or more children residing in the home who are alleged as victims of abuse or neglect in the current incident. Do not count children alleged to be "at risk" of abuse and/or neglect.

Caregiver has a current mental health issue

There is credible information that the primary, secondary, or both caregivers have a current mental health concern based on diagnosis of a major mental illness (e.g., schizophrenia, bipolar disorder, depression) or exhibit symptoms suggesting a probability that such a diagnosis exists, such as hearing voices, paranoid thoughts, severe mood changes, suicidal thoughts or behavior, or extremely depressed affect.

Primary caregiver has a history of abuse/neglect as a child

There is credible information that the primary caregiver was abused or neglected as a child.

Any child with any of the following (select all that apply):

Mental health/behavioral problems

Problems unrelated to a physical or developmental disability (includes ADHD/ADD), which may be indicated by a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, receipt of mental health treatment, attendance in a special classroom because of behavioral problems, or current psychoactive medication prescription.

Developmental or physical disability

A severe, chronic impairment that creates substantial functional limitations in three or more of the following life activity areas: self-care, language, learning, mobility, self-direction, potential for independent living, and potential for economic self-sufficiency as an adult.

Medically fragile or failure to thrive

A diagnosed medical condition that can become unstable and change abruptly, resulting in a life-threatening situation (e.g., uncontrolled diabetes, required use of monitor, non-ambulatory child who requires 24-hour care, required nasal gastric or gastrostomy tube, tracheotomy) or diagnosis of failure to thrive.

Positive toxicology screen at birth

Positive screen for alcohol or another drug at birth.

Delinquency history

Any child in the household has been referred to juvenile court for delinquent or status-offense behavior. Status offenses that have not been brought to court attention but have created stress within the household should also be scored, such as children who run away or are habitually truant.

Housing is unsafe or family is homeless

- The family has housing, but the current housing situation is physically unsafe to the extent that it does not meet the health or safety needs of the child (e.g., exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, rotting food).
- The family is homeless or was about to be evicted at the time the investigation began. Consider as homeless people who are living in a shelter and those living on a short-term basis with relatives or friends.

Prior injury to a child due to abuse or neglect

There is credible information that a current caregiver injured a child due to abuse or neglect prior to the current allegation.

Domestic violence in the last 12 months

An adult household member exerts physical violence or patterns of power and control over another adult living in the home, impacting family functioning. This includes situations where one of the adults does not live in the home but has substantial contact in the home, or has lived in the home and continues to behave in threatening ways toward household members.

Caregiver has a current substance abuse issue

There is credible information that the caregiver's recurring use of alcohol or drugs causes functionally significant impairments, such as health problems, disability, or failure to meet responsibilities at work, school, or home.

Specify whether this applies to the primary, secondary, or both caregivers.

Other (specify)

Specify any other critical risk factor that was used in determining the final path decision for in-person response.

SDM® HOTLINE TOOLS POLICY AND PROCEDURES

California Department of Social Services

The purpose of the hotline tools is to assess:

- Whether a referral meets the statutory threshold for an in-person CWS response;
- If so, how quickly to respond and the path of response; and
- If not, whether a referral to an alternative community response is appropriate.

	PRELIMINARY SCREENING AND APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE	RESPONSE PRIORITY	PATH OF RESPONSE DECISION*
Which Cases	All referrals that are created in CWS/CMS.	All referrals that meet statutory threshold for an in-person response, per the Preliminary Screening and Appropriateness of a Child Abuse/Neglect Report for Response tools.	All referrals that did not meet the statutory threshold for in-person response are assessed using A, Path Decision for Evaluate Out. All referrals that meet statutory threshold for in-person response are assessed using B, Path Decision for In-Person Response.
Who	Worker receiving the referral.	Worker receiving the referral.	Worker receiving the referral OR the designated differential response worker.
When	Immediately upon receipt of the call.	Immediately upon receipt of the call.	Referrals with a 24-hour response priority—complete immediately. Referrals with a 10-day response priority—complete within 24 hours. Referrals that are evaluated out—complete within five working days.
Decision	Does the referral meet statutory threshold for in-person CWS response (yes or no)?	How quickly to respond. First face-to-face contact should begin or be attempted within 24 hours or within 10 days.	Records the path of response decision and documents criteria present at the time of the referral.

*Path of response refers to the response track for referrals under the State of California differential response system. Refer to your local differential response program for specific definitions and practice guidelines related to response paths. The path of response decision is only used in counties with a differential response program.

APPROPRIATE COMPLETION

If a referral was/will be created in CWS/CMS, complete a hotline tool.

Complete all assessment header information as indicated.

- Record the referral number and date of the hotline assessment.
- Intake staff must inquire whether the reporting party has any information that indicates that a child in the household is or may be an Indian child, as required by WIC § 224.2(a) and ACL 20-38.
- If there is reason to believe that a child is or may be an Indian child, intake staff shall contact all appropriate tribe(s) as soon as possible for information gathering about the child's membership, citizenship, or eligibility.
- If known, or if there is reason to know, that a child is an Indian child, intake staff should make efforts to contact all appropriate tribe(s) as soon as possible for further information gathering and collaborative assessment and decision making. This contact should not prevent or delay the agency from responding within the required timeframe, when indicated.
- Details of the contact/attempted contact with tribe(s), a summary of information, and the impact on decision making must be documented in CWS/CMS.
- If intake staff are unable to contact the tribe(s) and the referral is screened in, child welfare staff are required to continue efforts to engage the tribe in information gathering and shared decision making throughout the investigation, as described in MPP 31-101.522.

STEP I. PRELIMINARY SCREENING

If the referral does not involve a child under 18 (does not apply in reports of death of the only child or all children in household where death is suspected to be related to abuse or neglect), is a duplicate referral, is being referred to another county, or concerns a safely surrendered baby, select the specific reason under "Review of screening criteria is not required."

In these cases, the screening decision is complete. Step II, Appropriateness of a Child Abuse/Neglect Report for Response; Step III. Response Priority; and Step IV. Path of Response Decision are not required.

Record the specific reasons in CWS/CMS.

STEP II. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

For reports of alleged maltreatment in out-of-home care to a dependent or ward child/youth ONLY, the definition of caregiver should include "a person responsible for the child's care and welfare (including a licensee, administrator or employee of any facility licensed to care for children)" in accordance with PC 11165.5. All other reports should be screened using the standard SDM definition for caregiver.

A. Screening Criteria

Based on the caller's concerns, select all criteria that apply. Do not select items if the caller's information does not reach the threshold of the definition for an item.

B. Screening Decision

Indicate the screening decision. If one or more criteria are selected, the referral is assigned for an in-person CWS response. (Proceed to Step III. Response Priority.) Note that not all referrals assigned for in-person response require the same investigatory action. Refer to state regulatory guidance, the Policy and Procedures sections of the SDM safety and risk assessments, and local protocol to determine the type of CWS response required and the SDM tools that will apply.

If no criteria are selected, the referral will be evaluated out (for differential response counties, go to Step IV. A. Path Decision for Evaluate Out.; all others require no further action).

Overrides

If an override is used to assign a referral for in-person response when no screening criteria are selected in Step II, Section A, no further SDM assessments are required.

Tribal Agreement

If it has been indicated that the child is an Indian child, or there is reason to know a child is an Indian child, and contact with the tribe(s) has been made, review the screening decision collaboratively with the tribe(s). While agreement with the decision is not required, document the tribe's position on the final screening decision.

STEP III. RESPONSE PRIORITY

A. Decision Trees

Allegation concerns maltreatment by current substitute care provider AND county policy requires response within 24 hours (automatic 24-hour response).

Select if the child is in out-of-home care as a dependent or ward child/youth, and the allegations concern the substitute care provider, AND county policy requires a response within 24 hours, making the referral an automatic 24-hour response. If not applicable, proceed to the decision trees.

Child is already in custody (automatic 24-hour response).

If a child has already been taken into protective custody, the referral will be an automatic 24-hour response. Workers in differential response counties should proceed to Step IV. Path of Response Decision.

Select the response priority decision tree that corresponds with the allegation type (physical abuse, emotional abuse, neglect, or sexual abuse). If there is more than one allegation, begin with the most serious allegation. Start with the first question, and gather information from the caller that will lead to an answer of yes or no. Be sure to consult definitions. The response will lead to either a decision regarding response time or to another question. Continue to ask as many questions as are required to arrive at a recommended response time.

Additional allegations.

Once a response time of 24 hours is reached, it is not necessary to complete additional decision trees, even if there are other allegations. If the first tree leads to a time of 10 days, complete additional decision trees until all allegations are completed or a 24-hour response time has been determined, whichever comes first.

B. Overrides

After completing all required decision trees, proceed to the overrides and determine whether any apply. Consider overrides even if response priority trees have been bypassed based on screening criteria.

Policy.

If 10 days is the presumptive response, consider whether any of the policy overrides to 24 hours apply. If 24 hours is the presumptive response, consider whether any of the policy overrides to reduce response priority by one level apply.

Discretionary.

If the caller reported any information, or information from any other source suggests that the child's safety, permanency, or well-being is best served by a different response time than the presumptive response, select whether the response time will be increased or decreased. For example, consider the ability to locate child/caregiver and protective capacities. Briefly describe the fact(s) that led to this conclusion. Discuss a discretionary override with a supervisor and obtain approval.

Final Response Priority

Indicate a final response priority.

If reported concerns involve alleged harm in out-of-home care to a dependent or ward child/youth, the county where the facility is geographically located should respond to reports with a 24-hour response priority. Reports with a 10-day response priority should be referred to the placing county as soon as possible.

STEP IV. PATH OF RESPONSE DECISION

Based on screening criteria, complete either Path Decision for Evaluate Out OR Path Decision for In-Person Response.

A. Path Decision for Evaluate Out (for differential response counties only)

If the county has a differential response system, all referrals that were evaluated out will be considered for Path 1 assignment. Select any applicable items listed that were present at the time of the referral based on reported information. Record the path decision for referrals that did not meet any screening criteria (No Response or Path 1).

B. Path Decision for In-Person Response (for differential response counties only)

If the county has a differential response system, all referrals that are assigned for in-person response should be forwarded to the differential response coordinator. If the response priority decision is within 24 hours, the worker may bypass the criteria and select "yes" for automatic Path 3 response. The criteria that resulted in the 24-hour response time would often also result in a Path 3 decision. Alternatively, the worker may review the criteria and base the path decision on the criteria.

Practice Considerations

Workers will make every effort to elicit information from the reporter to make the key hotline decisions of whether to initiate an in-person response, how quickly to respond, and the path of response. The worker should also elicit information regarding the reporter's knowledge of family strengths, use of services, and the reporter's perspective on family needs.

In all calls, workers will gather as much identifying information as the reporter has available, information on the family's language, cultural identity, current location of child and ability to locate, and issues that have an impact on the safety of responding workers (e.g., weapons, propensity to violence, dangerous animals).

Note: The following guidelines were developed in consultation with several SDM counties to provide recommendations for a consistent process to document subsequent referrals received for the same incident/allegation, or referrals of new information received prior to the first face-to-face contact. Some counties may use different CWS/CMS documentation practices to record these types of referrals. Whatever the county's method, ensure that these referral types are appropriately identified/coded so that it is clear that additional SDM assessments are not required.

1. Duplicate or secondary referrals

If, after gathering all information from the reporter, it is apparent that all of the allegations made by the reporter are identical to allegations made in an existing open referral, the worker should create a second referral in CWS/CMS and select items accordingly. This second referral may contain an additional description of the family/events but should not contain a new incident or allegation. No new hotline tool is required for a secondary referral. (If the second call contains information that would change screening, response priority, or path decision, that is an indicator that it is NOT a secondary referral.)

2. Associated referrals

If a second or subsequent call is received that does contain new information, but the worker has not yet made a first face-to-face contact with the family, the referrals should be combined in CWS/CMS as an associated referral. The hotline worker should complete a new hotline tool to determine whether the response should change. However, the investigating worker will complete only one safety and risk assessment that will be linked to all associated referrals. If the second call is received AFTER an initial safety assessment was completed but BEFORE a risk assessment was completed, the worker should associate the referrals in CWS/CMS. In WebSDM, complete the risk assessment in the first referral. With rare exceptions, a second safety assessment should be added to the first referral based on changing circumstances.

3. Changing decisions

Prior to worker contact with the family, it is possible that additional information will lead to different answers to the various components of the hotline tool. Retain the original completed tool to show what decision was made and the basis for that decision. If a field supervisor determines—based on new or additional information received prior to the initial in-person response but after the screening, response priority, or path decision has been made—that a screening, response priority, or path decision will be changed, the field supervisor should document the change in the response decision section of the automated case management system. Provide a brief explanation of the basis for the change. **The change must be consistent with decision criteria, or an appropriate override reason should be stated.**

CHAPTER B:

SDM® SAFETY

ASSESSMENT

California Department of Social Services

Referral Name: _____ Referral Number: _____

Worker Name: _____ Household Name: _____

- Initial
- Review/update
- Referral closing/case closing

☐ Yes

☐ No

IS THERE ANY INFORMATION THAT INDICATES THAT THE CHILD IS, OR MAY BE, AN INDIAN CHILD?

☐ No, not at this time.

☐ Yes. If yes: ☐ Child is an Indian child ☐ Reason to know ☐ Reason to believe

If the child is an Indian child or there is reason to know the child is an Indian child, were tribal social workers or representative(s) consulted during the information gathering and safety assessment process?

☐ Yes

☐ No

If no: ☐ Contact with the tribe(s) attempted ☐ Contact with tribe(s) not attempted

FACTORS INFLUENCING CHILD VULNERABILITY

Conditions impacting in child's ability to protect self; select all that apply to **any** child.

☐ Age 0–5 years

☐ Diminished mental capacity (e.g., developmental delay, nonverbal)

☐ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)

☐ Not readily accessible to community oversight

☐ Significant diagnosed medical or mental disorder

SECTION 1: SAFETY THREATS

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

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:

☐ Yes (select all that apply)

☐ Serious injury or abuse to the child other than accidental.

☐ Caregiver fears they will maltreat the child.

☐ Threat to cause harm or retaliate against the child.

☐ Excessive discipline or physical force.

☐ Substance-affected infant.

☐ No

2. CHILD SEXUAL ABUSE OR SEXUAL EXPLOITATION IS SUSPECTED, AND CIRCUMSTANCES SUGGEST THAT THE CHILD'S SAFETY MAY BE OF IMMEDIATE CONCERN.

- ☐ Yes
 - ☐ Sexual abuse
 - ☐ Commercial sexual exploitation
- ☐ No

3. CAREGIVER DOES NOT MEET THE CHILD'S IMMEDIATE NEEDS, RESULTING IN SERIOUS HARM OR IMMINENT DANGER OF SERIOUS HARM. SELECT ALL THAT APPLY.

- ☐ Yes
 - ☐ Supervision
 - ☐ Food, clothing, or hygiene
 - ☐ Medical or dental care
 - ☐ Mental health care
- ☐ No

4. THE PHYSICAL LIVING CONDITIONS ARE HAZARDOUS AND IMMEDIATELY THREATENING TO THE HEALTH AND/OR SAFETY OF THE CHILD.

- ☐ Yes
- ☐ No

5. CAREGIVER DESCRIBES OR SPEAKS TO THE CHILD IN PREDOMINANTLY NEGATIVE TERMS OR ACTS TOWARD OR IN THE PRESENCE OF THE CHILD IN NEGATIVE WAYS AND THESE ACTIONS RESULT IN SEVERE PSYCHOLOGICAL/EMOTIONAL HARM, RESULTING IN IMMEDIATE DANGER.

- ☐ Yes
- ☐ No

6. CAREGIVER DOES NOT PROTECT THE CHILD FROM SERIOUS HARM OR THREATENED HARM BY OTHERS. THIS MAY INCLUDE PHYSICAL ABUSE, SEXUAL ABUSE, OR NEGLECT.

- ☐ Yes
- ☐ No

7. 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

8. THE FAMILY REFUSES ACCESS TO THE CHILD, OR THERE IS REASON TO BELIEVE THAT THE FAMILY IS ABOUT TO FLEE.

- ☐ Yes
- ☐ No

9. DOMESTIC VIOLENCE EXISTS IN THE HOUSEHOLD AND POSES AN IMMINENT DANGER OF SERIOUS HARM TO THE CHILD. SELECT ALL THAT APPLY.

- ☐ Yes
- ☐ Physical harm
- ☐ Emotional harm
- ☐ No

10. OTHER: CURRENT CIRCUMSTANCES MEET THE THRESHOLD OF IMMINENT AND SEVERE DANGER BUT ARE NOT DESCRIBED WITHIN SAFETY THREATS 1–9.

- ☐ Yes
- ☐ No

Specify: _____

Note: Supervisor approval required.

SAFETY DECISION: IF NO SAFETY THREATS ARE PRESENT, COMPLETE THE SAFETY DECISION BELOW.

- ☐ **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. Complete the investigation and the risk assessment as required. No other work on this assessment needs to be completed.

SECTION 1A: CAREGIVER COMPLICATING BEHAVIORS

If yes is selected for any safety threats above, indicate whether any of the following behaviors are present. These are conditions that may make it more difficult or complicated to create safety for a child but do not by themselves create a safety threat. These behaviors must be considered when assessing for and planning to mitigate safety threats with a safety plan. Select all that apply to the household.

- ☐ Substance abuse
- ☐ Domestic violence
- ☐ Mental health
- ☐ Developmental/cognitive impairment
- ☐ Physical condition
- ☐ Other (specify): _____

SECTION 2: HOUSEHOLD STRENGTHS AND PROTECTIVE ACTIONS

Household Strengths: These are resources and conditions that increase the likelihood or ability to create safety for a child but in and of themselves do not fully address the safety threats.

Protective Actions: These are specific actions, taken by one of the child's current caregivers or by the child, that mitigate identified safety threats in the household.

Household strengths and protective actions should be assessed, considered, and built upon when creating a safety plan. *Select all that apply to the household.*

CAREGIVER PROBLEM SOLVING

Household Strengths

- ☐ At least one caregiver identifies and acknowledges the problem/safety threat(s) and suggests possible solutions.

Protective Actions

- ☐ At least one caregiver articulates specific strategies that, in the past, have been at least partially successful in mitigating the identified safety threat(s), and the caregiver has used or could use these strategies in the current situation.

CAREGIVER SUPPORT NETWORK

Household Strengths

- ☐ At least one caregiver has at least one supportive relationship with someone who is willing to be a part of their support network.
- ☐ At least one non-offending caregiver exists and is willing and able to protect the child from future harm.
- ☐ At least one caregiver is willing to work with the agency to mitigate safety threats, including allowing the caseworker(s) access to the child.

Protective Actions

- ☐ At least one caregiver has a stable support network that is aware of the safety threat(s), has been or is responding to the threat(s), and is willing to provide protection for the child.

CHILD PROBLEM SOLVING

Household Strengths

- ☐ At least one child is emotionally/intellectually capable of acting to protect themselves from a safety threat.

Protective Actions

- ☐ At least one child, in the past or currently, acts in ways that protect themselves from a safety threat(s).

CHILD SUPPORT NETWORK

Household Strengths

- ☐ At least one child is aware of their support network members and knows how to contact these individuals when needed.

Protective Actions

- ☐ At least one child has successfully pursued support, in the past or currently, from a member of their support network, and that person(s) was able to help address the safety threat and keep the child safe.

OTHER

Household Strengths

- ☐ Other, specify: _____

Protective Actions

- ☐ Other, specify: _____

SECTION 3: IN-HOME PROTECTIVE INTERVENTIONS

If safety threats have been identified in the household and after consideration of child vulnerabilities, household strengths, and protective actions, it is determined that a safety plan will allow the child to remain in the home, the safety decision is "safe with plan." Select the decision below.

If a safety plan that would allow the child to remain in the home safely cannot be created, go to Section 4.

SAFETY DECISION

- ☐ **Safe with plan.** One or more safety threats are present; however, the child can safely remain in home with a safety plan. In-home protective interventions have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Select all in-home interventions used in the safety plan.

- ☐ 1. Intervention or direct services by worker. (DO NOT include the investigation itself.)
- ☐ 2. Use of family, neighbors, or other individuals in the community as safety resources.
- ☐ 3. Use of community agencies or services as safety resources.

- ☐ 4. Inclusion of tribal, Indian community service agency, and/or ICWA staff as part of action steps on the safety plan.
- ☐ 5. Have the caregiver appropriately protect the victim from the alleged perpetrator.
- ☐ 6. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
- ☐ 7. Have the non-offending caregiver move to a safe environment with the child.
- ☐ 8. Legal action planned or initiated—child remains in the home.
- ☐ 9. Other (specify): _____

SECTION 4: PLACEMENT INTERVENTIONS

SAFETY DECISION

- ☐ **Unsafe.** One or more safety threats are present, and placement is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm. Select one response only.
 - ☐ 10. Have the caregiver voluntarily place the child outside the home, consistent with WIC § 11400 (o) and (p).
 - ☐ 11. A warrant or detention order will be sought immediately per local policy.
 - ☐ 12. Child placed in protective custody.

Tribal Agreement

If the child is, or there is reason to know a child is, an Indian child, is the tribe in agreement with the final safety decision?

- ☐ Yes
- ☐ No: _____
- ☐ Unknown: _____

SDM® SAFETY ASSESSMENT DEFINITIONS

California Department of Social Services

IS THERE ANY INFORMATION THAT INDICATES THAT THE CHILD IS, OR MAY BE, AN INDIAN CHILD?

The duty to inquire begins at initial contact and continues until a tribe provides confirmation of tribal membership status or the court makes a finding that proper and adequate further inquiry has been conducted and there is no reason to know whether the child is an Indian child.

Note: If the child is an Indian child or there is reason to know that a child is an Indian child or a member of an Indian tribe, a social worker or representative from the tribe should be included in the safety assessment and safety planning process. See [BIA list of ICWA designees](#) to support noticing and collaborative assessment.

This contact should not prevent or delay the agency from responding within the required timeframe when indicated.

REASON TO KNOW

Information at the time of the assessment **indicates** that a child in the household is an Indian child, including the following.

- The child, family, or a person having interest in the child provides direct information that the child is an Indian child.
- The residence of the child, the child's caregivers, or Indian custodian is on a reservation or in an Alaskan Native village.
- Any participant in a court proceeding, officer of the court, Indian tribe, Indian organization, or agency provides information indicating the child is an Indian child.
- The child gives reason to know that the child is an Indian child.
- The child is or has been a ward of a tribal court.
- The caregiver or child possesses an identification card indicating membership or citizenship in an Indian tribe.

REASON TO BELIEVE

Information at the time of the assessment **suggests** that either the child or a parent of the child may be eligible for membership in an Indian tribe or may have Indian ancestry. Further inquiry is required.

IF YES, WERE TRIBAL SOCIAL WORKERS OR REPRESENTATIVE(S) CONSULTED DURING THE INFORMATION GATHERING AND SAFETY ASSESSMENT PROCESS?

A social worker or representative from the tribe was successfully contacted and included in the safety assessment and safety planning process. Examples may include gathering key facts about the child's situation and the caregiver's behavior and impact on the child or exploring protective capacities and network members to support safety planning. Details of the contact must be documented in CWS/CMS, including which tribe(s) were contacted, a summary of information discussed, and the impact on decision making.

If contact with tribe was attempted but not successful, document efforts within CWS/CMS.

FACTORS INFLUENCING CHILD VULNERABILITY

Conditions impacting child's ability to protect self; select all that apply to **any** child in the household

AGE 0–5 YEARS

Any child in the household is under the age of 5. Younger children are considered more vulnerable, as they are less verbal and less able to protect themselves from harm. Younger children also have less capacity to retain memory of events. Infants are particularly vulnerable, as they are nonverbal and completely dependent on others for care and protection.

SIGNIFICANT DIAGNOSED MEDICAL OR MENTAL DISORDER

Any child in the household has a diagnosed medical or mental disorder that significantly impairs ability to protect themselves from harm, OR diagnosis may not yet be confirmed but preliminary indications are present and testing/evaluation is in process. Examples may include but are not limited to: severe asthma, severe depression, medically fragile (e.g., requires assistive devices to sustain life), etc.

NOT READILY ACCESSIBLE TO COMMUNITY OVERSIGHT

The child is isolated or less visible within the community (e.g., the family lives in an isolated community, the child may not attend a public or private school or be routinely involved in other activities within the community, etc.).

DIMINISHED DEVELOPMENTAL/COGNITIVE CAPACITY

Any child in the household has diminished developmental/cognitive capacity, which impacts ability to communicate verbally or to care for and protect self from harm.

DIMINISHED PHYSICAL CAPACITY (e.g., non-ambulatory, limited use of limbs)

Any child in the household has a physical condition/disability that impacts ability to protect self from harm (e.g., cannot run away or defend self, cannot get out of the house in an emergency situation if left unattended).

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 or could have caused a serious 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 or would have required medical treatment had a serious injury occurred.

Caregiver fears they will maltreat the child

The caregiver has reported credible fears that they will hurt the child in a way that would cause serious injury and/or requests placement.

Threat to cause harm or retaliate against the child

Threat of action that would result in serious harm, or household member plans to retaliate against child for child protective services (CPS) investigation.

Excessive discipline

The caregiver used physical discipline with a child that resulted or could easily result in serious injury. For example, the caregiver uses an object to strike the child hard enough to cause serious injury, or the caregiver is enraged or out of control during physical discipline.

Substance-affected infant

An infant is born affected by substances AND factors exist that create imminent danger to the infant.

- California defines an "infant born and identified as affected by substance abuse" as an infant where substance exposure is indicated at birth AND subsequent assessment identifies indicators of risk that may affect the infant's health and safety.

- When assessing imminent danger, consider factors such as type of substance present, level of toxicity or harm to the child, severity of withdrawal symptoms, or medical complications AND the caregiver's capacity to meet the infant's needs. Efforts to develop plans of safe care to prevent removal should be explored and documented per ACL 20-122 as a part of assessment of caregiver capacity.

2. CHILD SEXUAL ABUSE OR SEXUAL EXPLOITATION IS SUSPECTED, AND CIRCUMSTANCES SUGGEST THAT THE CHILD'S SAFETY MAY BE OF IMMEDIATE CONCERN

Child sexual abuse or sexual exploitation is suspected AND circumstances suggest that the child's safety may be of immediate concern. The child's safety may be of immediate concern if:

- There is not a non-offending caregiver, or the non-offending caregiver is not protective (blaming the child for the sexual abuse or the investigation or denying that the sexual abuse occurred) or is otherwise influencing or coercing the child victim regarding disclosure; or
- Continued access to a child by a confirmed sexual abuse perpetrator or trafficker, especially with known restrictions regarding any child under age 18, exists.

PRACTICE GUIDANCE

Sexual abuse

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

- The child discloses sexual abuse verbally.
- The child displays behaviors that strongly indicate sexual abuse (e.g., excessive, age-inappropriate sexualized behavior toward self or others).
- Medical findings consistent with sexual abuse or 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 the child.

Commercial sexual exploitation

The caregiver or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing the child to observe sexual performances or activities, or commercial sexual exploitation, including sex trafficking).

Children and youth aged 17 years old and younger are sexually exploited when they have engaged in, solicited for, or been forced to engage in sexual conduct or performance of sexual acts 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 the sexual exploitation of a child regardless of whether they happened using force, fraud, or coercion and whether they are live, filmed, or photographed.

3. CAREGIVER DOES NOT MEET THE CHILD'S IMMEDIATE NEEDS, RESULTING IN SERIOUS HARM OR IMMINENT DANGER OF SERIOUS HARM. *SELECT ALL THAT APPLY.*

One of the following conditions exists and cannot be mitigated via provision of resources to the family AND the child has been seriously harmed or is in imminent danger of being seriously harmed as a result.

Note: This item should not be selected based on a parent's economic disadvantage alone, and must reach the threshold of immediate and serious danger (physical harm or illness) to the child. See WIC 300(b)(1)(A-D)

Attempts to mitigate a lack of basic resources must be documented when selecting this safety threat as a part of reasonable efforts to maintain the child safely in the home.

Supervision

At least one of the following applies.

- The caregiver leaves the child alone (time period varies with age and developmental stage) in circumstances that create opportunities for serious harm (e.g., infant or toddler left alone).
- The caregiver is present but does not supervise the child to the extent that need for care goes unnoticed or is unmet in a situation that creates imminent danger (e.g., child can wander outdoors alone in unsafe areas, play with dangerous objects, or be exposed to other serious hazards).
- The caregiver knowingly makes childcare arrangements that do not provide minimal safety for the child (e.g., temporary caregiver is routinely intoxicated or has limited capacity suggesting they would be unable to meet the child's needs).
- The caregiver is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown), and there are no arrangements for the child that would ensure their safety.

Note: This item should not be applied based solely on a caregiver's inability to provide childcare due to financial difficulty.

Food, clothing, or hygiene

The caregiver does not meet the child's basic needs for food, clothing, or hygiene to the extent that the child is in imminent danger. Examples include the following.

- The child's nutritional needs are not met, resulting in immediate concerns about the child's health or safety. This may include severe malnutrition, morbid obesity, or similar nutritional concerns that put the child in imminent danger, as verified by a medical professional.

- The child is without adequate clothing/hygiene, resulting in danger to the child's health or safety. Consider impact, such as resulting sores, infection, or severe diaper rash that is left untreated; the age of the child; and whether clothing is the choice of the child or has been willfully and consistently not provided by the caregiver.

Medical or dental care

At least one of the following applies.

- The caregiver does not meet the child's exceptional needs, such as being medically fragile, resulting in declining health status likely to result in serious physical harm or death.
- The caregiver does not seek treatment for the child's immediate, chronic, and/or dangerous medical condition(s), or does not follow prescribed treatment for such conditions, likely to result in declining health status leading to serious physical harm or death (e.g. not providing follow-up care for a wound that is severely infected).

Note: The pursuit of traditional or alternative practices rather than prescribed treatment is included here IF there is evidence that the child's health status is gravely declining AND there is evidence that prescribed treatment would likely be effective.

Mental health care

The child is suicidal and/or is seriously self-harming AND the caregiver will not take protective actions.

4. 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. Examples include the following.

- Leaking gas from stove or heating unit.
- Lack of water or utilities (heat, plumbing, electricity), and no alternative or safe provisions have been made.
- Open/broken/missing windows.
- 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 and other weapons are not locked and not properly secured.
- Drug production in the home that threatens child safety.

- Substances (including drugs, drug paraphernalia or cleaning supplies) or objects within reach of child that may endanger their health and/or safety.

5. CAREGIVER DESCRIBES OR SPEAKS TO THE CHILD IN PREDOMINANTLY NEGATIVE TERMS OR ACTS TOWARD OR IN THE PRESENCE OF THE CHILD IN NEGATIVE WAYS AND THESE ACTIONS RESULT IN SEVERE PSYCHOLOGICAL/EMOTIONAL HARM RESULTING IN IMMINENT DANGER.

Severe emotional harm causing concern for imminent danger may include circumstances in which the child is a danger to self or others or has untoward aggressive behavior, debilitating depression or anxiety, or eating disorders that threaten severe injury or illness.

Examples of caregiver actions may include the following, if the impact on child reaches threshold above.

- The caregiver describes the child in a demeaning or degrading manner.
- The caregiver scapegoats a particular child in the family or blames the child for a particular incident or for family problems.
- The caregiver places the child in the middle of a custody battle.

6. CAREGIVER DOES NOT PROTECT THE CHILD FROM SERIOUS HARM OR THREATENED HARM BY OTHERS. THIS MAY INCLUDE PHYSICAL ABUSE, SEXUAL ABUSE, OR NEGLECT

The caregiver does not act protectively in the face of serious harm or threatened harm as a result of physical abuse, neglect, or sexual abuse by other family members, other household members, or others having regular access to the child.

Note: Concerns related to domestic violence should be assessed under Safety threat 9.

Examples may include the following.

- 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.
- An individual with known history of sexual abuse resides in the home, or the caregiver allows access to the child. Consider whether the caregiver (1) knew of the history and allowed access; or (2) upon learning of the history, has not prevented further access.
- The caregiver regularly takes the child to dangerous locations where drugs are manufactured or regularly administered (e.g., meth labs or drug houses), or locations used for sexual exploitation or pornography.

7. 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

Factors to consider include the child's age, location of injury, exceptional needs of the child, or chronicity of injuries.

- The injury requires medical attention AND medical assessment indicates the injury is likely to be the result of abuse or is inconsistent with the explanation provided by the caregiver; OR
- There was a suspicious injury that did not require medical treatment but covered multiple parts of the body, appeared to be caused by an object, or is in different stages of healing, AND/OR was located on an infant, or for older children, on the torso, face, or head.

AND one of the following is true:

- The caregiver denies abuse or attributes the injury to accidental causes; OR
- The caregiver's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury; OR
- The caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child.

8. THE FAMILY REFUSES ACCESS TO THE CHILD, OR THERE IS REASON TO BELIEVE THAT THE FAMILY IS ABOUT TO FLEE

This safety threat should only be identified when other threats are near, but do not reach the threshold in the definitions; the worker has made attempts to contact the child and been refused access by the caregiver; OR there is reason to believe the family is about to flee during an ongoing investigation after an initial safety assessment has been completed.

- The family currently refuses access to the child or cannot/will not provide the child's location.
- The family has removed the child from a hospital against medical advice to avoid investigation.
- The family has previously fled in response to a CPS investigation or there is credible information that the family is about to flee.
- The family has a history of keeping the child at home, away from peers, school, and other outsiders, for extended periods of time for the purpose of avoiding investigation.

9. DOMESTIC VIOLENCE EXISTS IN THE HOUSEHOLD AND POSES AN IMMINENT DANGER OF SERIOUS HARM TO THE CHILD.

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

Physical harm

Domestic violence may occur on more than one occasion OR on a single occasion that involved weapons or resulted in any injury to an adult or child as a result of the domestic violence incident.

Examples of physical abuse incidents may include the following.

- Increased potential for serious harm or death (e.g., strangulation, use of guns, knives, or other weapons used during the domestic violence incident).
- The child is at risk of physical injury based on their vulnerability and/or proximity to the incident. Examples include:
 - » Caregiver holding child while alleged perpetrator attacks the caregiver;
 - » Incident occurs in a moving vehicle while a child is present; and
 - » Attempting to intervene during a violent dispute.
- The child was previously injured in a domestic violence incident.

Emotional harm

The caregiver engages in behaviors associated with domestic violence in the presence of the child, resulting in serious emotional harm to the child.

Examples of emotional abuse incidents may include the following.

- The child exhibits trauma symptoms (e.g., severe anxiety, nightmares, insomnia) related to situations associated with domestic violence, and these could result in social, behavioral, emotional, or educational deficits.

PRACTICE GUIDANCE

Domestic violence perpetrators, in the context of the child welfare system, are parents and/or caregivers who can engage in a pattern of violence and/or coercive control (e.g., stealing phones, abusing pets, financial control) against one or more intimate partners.

This pattern of behavior may occur when the partners do not live together and after the end of a relationship. The alleged perpetrator's actions often directly involve, target, and impact children in the family.

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

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

10. OTHER: CURRENT CIRCUMSTANCES MEET THE THRESHOLD OF IMMINENT AND SEVERE DANGER BUT ARE NOT DESCRIBED WITHIN SAFETY THREATS 1–9.

Circumstances or conditions pose an immediate threat of serious harm to a child, which are not already described in safety threats 1–9. Supervisory approval is required for selection of this threat.

SAFETY DECISION

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. Complete the investigation and the risk assessment as required.

SECTION 1A: CAREGIVER COMPLICATING BEHAVIORS

SUBSTANCE ABUSE

Caregiver uses substances or alcoholic beverages to the extent that their ***caregiving*** abilities are significantly impaired.

DOMESTIC VIOLENCE

There are indications of a recent history of one or more physical assaults between intimate members of the household, or threats/intimidation or harassment that are known as a result of self-report or other credible report by a family or other household member, friend, other collateral contacts, and/or police reports.

MENTAL HEALTH

One or both caregivers appear to be mentally ill at the time of this incident or have known mental health concerns ***that impact care of children.***

DEVELOPMENTAL/COGNITIVE IMPAIRMENT

One or both caregivers may have diminished capacity as a result of developmental delays or cognitive issues ***that impact their ability to provide care and supervision of children.***

PHYSICAL CONDITION

One or both caregivers has a physical condition that impacts care and protection of the child in the household.

OTHER

Other caregiver complicating behaviors that make it more difficult or complicated to create safety for a child that must be considered when assessing for and planning to mitigate safety threats with a safety plan.

SECTION 2: HOUSEHOLD STRENGTHS AND PROTECTIVE ACTIONS

Household strengths are resources and coping skills/qualities in an individual or a family that contribute in positive ways to family life but do not, in and of themselves, directly enhance the child's protection from the safety threat(s) over time. These characteristics can be built upon for future planning and indicate the capability to be used in the safety planning process.

Protective actions are specific actions and/or activities that have been taken by the caregiver that directly address the safety threat and are demonstrated over time. These are observed activities that have been demonstrated in the past and can be directly incorporated into the safety plan for the family and child. They may also include actions taken by the child in some circumstances. Actions taken by the child should not be the basis for the safety plan but may be incorporated as part of the plan.

HOUSEHOLD STRENGTHS

The following strengths should be assessed, considered, and built upon when creating a safety plan to mitigate the safety threats. Select all that apply to the household.

At least one caregiver identifies and acknowledges the problem/safety threat(s) and suggests possible solutions.

The caregiver demonstrates an understanding of the issues that led to the current safety threats and participates in planning to mitigate the situation by suggesting possible solutions for mitigating the safety threat.

At least one caregiver has at least one supportive relationship with someone who is willing to be a part of their support network.

The caregiver has a supportive relationship with at least one other family member, neighbor, or friend who may be able to assist in safety planning. This support network member is someone who cares

about the child or family but may not, at this time, know what the safety threat is, or has not yet been asked to take action to ensure that the child is protected from those threats now and into the future.

At least one non-offending caregiver exists and is willing and able to protect the child from future harm.

There is at least one caregiver who has done nothing to contribute to the existence of the safety threat. This non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a threat to the safety of the child, and the non-offending caregiver may be willing to become part of a support network and protect the child going forward.

At least one caregiver is willing to work with the agency to mitigate safety threats, including allowing caseworker(s) access to the child.

In the current investigation or assessment, the caregiver allows CPS to have contact with the child for the purpose of assessing child safety. This includes interviews and observation of children in the household. The caregiver accepts the involvement and initial service recommendations of the worker or other individuals working through referred community agencies, including tribal or Indian community service agencies, and/or the use of ICWA program resources. The caregiver cooperates with the continuing investigation/assessment, allows the worker and intervening agency to have contact with the child, and supports the child in all aspects of the investigation or ongoing intervention.

At least one child is emotionally/intellectually capable of acting to protect themselves from a safety threat.

At least one child has the intellectual or emotional capacity to ask for help. They understand their family environment in relation to any real or perceived threats to safety and is able to communicate at least two options for obtaining immediate assistance if needed (e.g., calling 911, running to neighbor, telling teacher).

At least one child is aware of their support network members and knows how to contact these individuals when needed.

When faced with a potentially dangerous situation, at least one child can currently name adults who care about them and who would be able to help them in the future. Child also has strategies for how to reach the adults.

Other.

Other qualitative actions, resources, and coping demonstrated by the caregiver or family that could be built upon in a safety plan but do not, by themselves, fully address the safety threat.

PROTECTIVE ACTIONS

The following actions should be assessed, considered, and built upon when creating a safety plan. Select all that apply to the household.

At least one caregiver articulates specific strategies that, in the past, have been at least partially successful in mitigating the identified safety threat(s), and the caregiver has used or could use these strategies in the current situation.

At least one caregiver in the household has been able to protect the child from similar threats in the past through their own actions or by using resources. The caregiver is able to describe both the current threats and the strategies they are using to mitigate them currently.

At least one caregiver has a stable support network that is aware of the safety threats(s), has been or is responding to the threat(s), and is willing to provide protection for the child.

A caregiver regularly interacts, communicates and makes plans 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 (including tribal ICWA programs, Indian organizations, and/or family members, which can include non-related tribal members). The caregiver has informed these network members of the threats and they have assisted in the situation by providing protection to the child (e.g., members of the support network have provided food when needed, assistance to prevent utility shut-off, or a planned safe place for the child to stay in the event of violence in the household; not allowing an offending caregiver to have unplanned forms of contact, etc.).

At least one child, in the past or currently, acts in ways that protect themselves from a safety threat(s).

Prior to the current threat, in response to similar circumstances where a threat has been present or circumstances leading to a threat were escalating, the child has been able to protect themselves. For example, the child was able to remove themselves from the situation, called 911 to seek assistance, or was able to find another way to mitigate the safety threat.

At least one child has successfully pursued support, in the past or currently, from a member of their support network, and that person(s) was able to help address the safety threat and keep the child safe.

When faced with one of the safety threats, the child was able to seek help from and receive the necessary assistance from someone in the identified support network (e.g., family members, friends, professionals) AND can currently name adults who care about them and would be able to help if a similar situation arose in the future.

Other.

Other actions of protection taken by the caregiver, a household member, safety network member, and/or the child, which mitigate one or more of the safety threats.

SECTION 3: IN-HOME PROTECTIVE INTERVENTIONS

SAFETY DECISION

Safe with plan

One or more safety threats are present; however, the child can safely remain in home with a safety plan. In-home protective interventions, to be monitored and supported by network members, have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Select all in-home interventions used in the safety plan.

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes. Follow county policies whenever applying any of the safety interventions.

1. Intervention or direct services by worker. (DO NOT include the investigation itself.)

Actions taken or planned by the investigating worker or other CPS staff that specifically address one or more safety threats. Examples include the following: creating a plan of safe care for substance-affected infants addressing immediate danger, providing information about nonviolent disciplinary methods, child development needs, or parenting practices; providing emergency material aid such as food; planning return visits to the home to check on progress; providing information on obtaining restraining orders; and providing definitions of child abuse laws and informing involved parties of the consequences of violating these laws. THIS DOES NOT INCLUDE the investigation itself or services provided to respond to family needs that do not directly affect safety.

2. Use of family, neighbors, or other individuals in the community as safety resources.

This includes applying the family's own strengths as resources to mitigate safety concerns or using extended family members, neighbors, or other individuals to mitigate safety concerns. Examples include: family's agreement to use nonviolent means of discipline; engaging a grandparent to assist with child care; agreement by a neighbor to serve as a safety net for an older child; agreement by a network member or 12-step sponsor to meet with the caregiver daily and call the worker if the caregiver's behavior is placing or has placed the child imminent danger;

OR

The caregiver's decision, *as part of a safety plan*, to have the child cared for by a friend or relative for a limited period of time, such as overnight or for a few days.

3. Use of community agencies or services as safety resources.

Involving a community-based or faith-related organization or other agency in activities to address immediate safety threats (e.g., using a local food pantry). DOES NOT INCLUDE long-term therapy or treatment, or being put on a waiting list for services.

4. Inclusion of tribal, Indian community service agency, and/or ICWA program staff as part of action steps on the safety plan.

This includes but is not limited to participation of the following people in the safety plan.

- Tribal family services from the child's/caregiver's tribe or a tribal consortium
- Indian resource center staff
- Indian health clinic staff
- Tribal TANF (Temporary Assistance for Needy Families)
- Title VII Indian education programs, which may not be affiliated with a tribe
- A county-based dedicated Indian specialist or service unit staff

5. Have the caregiver appropriately protect the victim from the alleged perpetrator.

A non-offending caregiver has acknowledged the safety threats and is able and willing to protect the child from the alleged perpetrator. A non-offending caregiver who had prior knowledge of the alleged perpetrator's actions but took no action prior to the safety assessment should not be the only safety resource or intervention. Examples include agreement that the child will not be alone with the alleged perpetrator or agreement that the caregiver will restrain the alleged perpetrator from physical discipline of the child.

6. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.

Temporary or permanent removal of the alleged perpetrator. Examples include: arrest of alleged perpetrator, non-perpetrating caregiver "kicking out" alleged perpetrator who has no legal right to the residence, or the alleged perpetrator agrees to leave.

7. Have the non-offending caregiver 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 perpetrator will not have access to the child. Examples include a domestic violence shelter, home of a friend or relative, or hotel.

8. Legal action planned or initiated—child remains in the home.

Legal action has already commenced, or will be commenced, that will immediately and effectively mitigate identified safety threats and is identified in the safety plan. This includes family-initiated actions (e.g., restraining orders, mental health commitments, change in custody/visitation/guardianship) and CPS-initiated actions (file petition and child remains in the home with the intention of initiating Family Maintenance services). This includes actions taken by the child's tribe and tribal court to intervene or take jurisdiction of the Indian child's case.

9. Other (specify).

The family or worker identifies a unique intervention for an identified safety concern that does not fit within items 1–8.

SECTION 4: PLACEMENT INTERVENTIONS

SAFETY DECISION

Unsafe

One or more safety threats are present, and placement is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm. Check one response only.

10. Have the caregiver voluntarily place the child outside the home, consistent with WIC § 11400 (o) and (p).

A voluntary agreement is signed between the caregiver and the CPS agency to place the child in an approved resource family placement, tribally approved home, or tribally specified home, and the caregiver is cooperating with the agency to provide needed consents and information to fund this voluntary placement. This voluntary agreement is consistent with Welfare and Institutions Code (WIC) § 11400 (o) and (p). The caregiver understands that if they withdraw consent for voluntary placement and identified safety threats are still present, other interventions to ensure the child's safety will need to be considered.

11. A warrant or detention order will be sought immediately per local policy.

Local policy and guidance indicate that application for a removal order is needed.

Note: if a warrant is not granted, an updated safety assessment should be completed to reassess in-home protective interventions.

12. Child placed in protective custody.

One or more children are protectively placed pursuant to WIC § 309 and are entitled to notice and a hearing within 72 judicial hours.

Note: If the only safety threat selected was safety threat 3 (caregiver not meeting immediate needs), CWS should not select “unsafe” unless they have made and documented attempts to mitigate any concerns due solely to lack of basic resources, as part of reasonable efforts to maintain the child safely in the home.

Tribal agreement with safety decision

If it has been indicated that a child is, or there is reason to know a child is, an Indian child and contact with the tribe(s) has been made, review the safety decision collaboratively with the tribe(s). While agreement with the decision is not required, document efforts to gain agreement and the tribe’s position on the final safety decision.

SDM® SAFETY ASSESSMENT POLICY AND PROCEDURES

California Department of Social Services

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 protective 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 of immediate/serious harm and the interventions currently needed to protect the child. In contrast, risk assessment looks at the likelihood of any future maltreatment.

WHICH CASES

Complete an SDM safety assessment for:

- All referrals that are assigned for in-person response
- Any open referrals or cases in which changing circumstances require an updated safety assessment due to:
 - » Change in family circumstances;
 - » Change in information known about the family; or
 - » Change in the ability of safety interventions to mitigate safety threats.

Note: If the referral alleges maltreatment by a substitute care provider or congregate care provider, use the [substitute care provider or congregate care safety assessment](#).

A safety assessment is NOT required in the following circumstances.

- An in-person response is required for an incident involving *only* a third-party perpetrator of sexual exploitation, and there are no allegations regarding the caregiver.
OR
- A child fatality is suspected to be a result of abuse or neglect AND there are no remaining minor children in the household. Note: Record the results of these investigations in CWS/CMS.

WHO

The social worker who is responding to the referral.

WHEN

For a new referral, the safety assessment *process* is completed, using the safety assessment field guide, before leaving a child in the home, or returning a child to the home during the investigation, following the initial face-to-face contact with all child victims. The safety assessment form should be completed within two working days of the first contact.

- 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 social worker will complete a safety assessment within two working days of the referral.
- For open referrals or cases in which changing circumstances prompt a new safety assessment, the safety assessment *process* is completed immediately. The safety assessment *form* is completed within two working days.
- If a safety plan was initiated, there must be an updated safety assessment documenting that the safety threats have been resolved. If safety threats remain unresolved, a case should be opened.¹
- A safety assessment must be done prior to closing a case. A case will not be closed if safety threats in the household are present.

DECISION

The safety assessment provides structured information concerning the danger of immediate/serious harm/maltreatment to a child. This information guides the decision about whether the child may remain in the home with no intervention (safe), may remain in the home with safety interventions in place (safe with plan), or must be protectively placed (unsafe).

APPROPRIATE COMPLETION

Workers should familiarize themselves with the items that are 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 SDM is that it ensures that 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 their initial contact as they normally would—using good social work practice to collect information from the child, caregiver, and/or collateral sources. SDM ensures that the specific items that comprise the safety assessment are assessed at some time during the initial contact.

The decision logic for the safety assessment is:

¹ If the child is no longer living in the household that has unresolved safety threats, and that parent refuses services, the case may be closed.

- If no safety threats are selected, the only possible safety decision is "Safe: No safety threats were identified at this time." No in-home interventions or placement interventions need to be reviewed; the assessment is complete.
- If one or more safety threats are selected, the worker must determine whether an in-home safety plan will mitigate the safety threat or whether the child must be placed.
- If a safety plan can be developed with the caregivers, only interventions 1 through 9 can be selected and the safety decision is "Safe with Plan: One or more safety threats are present; however, the child can safely remain in the home with a safety plan." In-home protective interventions have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Placement (interventions 10 and 11) should not be selected as an intervention if other interventions are selected.
- If a safety plan cannot be developed with the caregivers, then placement intervention 10 or 11 must be selected and the safety decision must be "Unsafe: One or more safety threats are present, and placement is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm."

Complete all assessment header information as indicated:

- Record the date of the safety assessment. The date of assessment is typically the date that the worker made initial face-to-face contact with the child to assess safety, which may be different than the date that the form is completed in WebSDM.
- When working with a family, the worker must inquire whether any child in the household is or may be an Indian child, as required by WIC §224.2(a). Indicate whether there is any information at the time of assessment showing there is reason to know or reason to believe that a child in the household may be an Indian child. When reason to know or reason to believe exists, further inquiry is required in accordance with MPP 31-101-111, and the investigating social worker should contact all appropriate tribe(s) as soon as possible for further information gathering and decision making as described in MPP 31-105.114. Contact with the tribe should not delay a decision about immediate safety for the child; however, such contact is likely to create more possibilities for safety assessment and planning. Details of the contact/attempted contact with tribe(s), a summary of information, and the impact on assessment and decision making must be documented in CWS/CMS, and efforts to contact the tribe must continue through investigations as outlined in MPP 31-101.552.
- Enter the type of safety assessment, which is either:
 - » **Initial.** Each referral should have one initial assessment, completed during the first face-to-face contact with at least one child victim in the household where there are allegations. However, if there are allegations in two households within a single referral, there may be two initial safety assessments.
 - » **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 a referral or case. A review/update includes a safety assessment completed on a second household where there are no allegations.
 - » **Referral closing.** This is a specialized review/update that is completed when considering closing a referral without promoting it to a case when a safety threat has been documented at some point during the investigation. This option only appears in WebSDM when completing a safety assessment on a referral.

- » **Case closing.** This is a specialized review/update that is completed when considering closing a case. This option only appears in WebSDM when completing a safety reassessment on an open ongoing case.
- Enter the name of the household assessed. In referrals where there is more than one household, and there are allegations regarding each household, a safety assessment is required on both. Enter the name of the household assessed.
 - » Also indicate (select) whether there are allegations in the household being assessed. If at least one alleged perpetrator resides in the household, there are allegations in that household.
 - » If the household is being assessed for safety as a potential placement (e.g., a non-custodial parent), select "no."
- Indicate (select) whether any child vulnerabilities are present. Consider these vulnerabilities when reviewing safety items. Note that these vulnerability issues provide a context for assessing safety. The presence of one or more vulnerabilities does not automatically mean that the child is unsafe.

The safety assessment consists of five sections:

SECTION 1: SAFETY THREATS

This is a list of 10 critical threats (nine identified and defined and an "other") 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, serious harm.

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. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the safety threats and accompanying definitions.

For each item, consider the most vulnerable child. If the safety threat is present, based on available information, select "yes" for that item. If the safety threat is not present, select "no" for that item. Because not every conceivable safety threat can be anticipated or listed on a form, the "other" category permits a worker to indicate that some other circumstance creates a safety threat. 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 select "other" and briefly describe the threat. Supervisor review or consultation should occur whenever a worker selects safety threat 10 to ensure that the circumstances are not described within another safety threat and that the description clarifies why the circumstances meet the intended threshold of immediate and severe danger.

SAFETY DECISION

If there are no identified safety threats in the household, the safety decision is "safe." Select "safe" and the safety assessment is completed.

SECTION 1A: CAREGIVER COMPLICATING BEHAVIORS

This section is completed only when there are safety threats identified as present in the household. If “yes” was selected for any of the safety threats and there is evidence that one or more caregivers are experiencing substance abuse, mental health concerns, domestic violence, or cognitive/developmental or physical health concerns, indicate all that apply. These are conditions which make it more difficult or complicated to create safety for a child, but do not by themselves constitute a safety threat. These behaviors must be considered when assessing for and planning to mitigate safety threats. Select all that apply to the household. Additionally, when completing the subsequent risk assessment and the family strengths and needs assessment, be attentive to these concerns.

SECTION 2: HOUSEHOLD STRENGTHS AND PROTECTIVE ACTIONS

This section is completed only if one or more safety threats were identified. Select any of the listed protective capacities that are present for any child/caregiver. Consider information from the referral; 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 protective interventions for the safety threats identified in Section 1.

SECTION 3: IN-HOME PROTECTIVE INTERVENTIONS

This section is completed only if one or more safety threats are identified and the worker has determined that a safety plan can be developed with the family that will protect the child in their home while the investigation continues. 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 plan that will mitigate the safety threat(s) sufficiently so that the child may remain in the home while the investigation continues. When determining whether a safety plan can be developed, consider the relative severity of the safety threat(s), any complicating behaviors by the caregiver that may impact safety planning, household strengths and protective actions, the vulnerability of the child, and the in-home safety interventions that are available.

The in-home protective intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential category of interventions and determine whether an intervention in that category 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 while any single intervention may be insufficient to mitigate the safety threat(s), a combination of interventions may provide adequate safety.

Also keep in mind that the safety intervention is not the case plan—it is not intended to “solve” the household’s problems or provide long-term answers. A safety plan permits a child to remain home during the course of the investigation by listing specific, timely actions that address the identified safety threats.

If one or more interventions will be implemented, select each category that will be used. If there is an intervention that will be implemented that does not fit in one of the categories, select line 9 and briefly describe the intervention. Safety interventions 10 and 11 are used only when a child is unsafe and only a placement can ensure safety.

SAFETY PLAN

Individual counties should use their own safety plan form. The following must be included in any safety plan:

- Each safety threat that has been identified and a description of the conditions or behaviors in the home that place any child at imminent threat of serious harm. The worker should use language the family understands so it is clear to them what caused the worker to identify the threat.
- Detailed information for each planned safety intervention: What needs to happen to keep the child safe? Explain how safety threat(s) will be mitigated. What will the family do to keep the child safe? What will other people outside the family do? This should include a written statement of actions or behaviors, to be taken by a responsible party, that will keep the child safe in the current conditions.
- Who is participating in the plan, the role of each participant, and information that describes how the safety plan will be monitored (e.g., who is responsible for each intervention action), and the timeframe in which each intervention will remain in place.
- Signature lines for family members, the worker, and their supervisor.

A safety plan is required when the safety decision is “safe with plan.”

Note: The safety plan should be documented and recorded in the case management system according to policy.

The safety plan **MUST** be developed in partnership with and agreed to by the family, and a copy should be left with the family.

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

PRACTICE GUIDANCE

When it is known or there is reason to know that a child is an Indian child, active efforts, as described in MPP 31-002(a)(1), must be made prior to removal of the child, except in the case of emergency removal of an Indian child when there is imminent physical harm or danger.

The safety plan should be developed in consultation with the tribe, with consideration given to the prevailing social and cultural conditions and way of life of the child's tribe as described in MPP 31-127-23. Consider the use of tribal resources, tribal community service agencies, and/or ICWA program staff to help the family address the identified safety threats and participate in the safety plan.

SECTION 4: PLACEMENT INTERVENTIONS

This section is only completed when, after considering complicating behaviors that may impact safety planning, household strengths and protective actions, the vulnerability of the child, and the in-home safety interventions that are available, the worker determines that placement is the only intervention for protection of the child.

If one or more safety threats are identified and the worker determines that in-home interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will be placed by selecting placement interventions 10, 11, or 12.

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 strengths-based approach in the initial contact, while remaining observant for the presence or absence of safety threats. Most safety threats are salient and can be discerned 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.

For all cases in which the child or caregiver knows their tribe and membership status, the social worker must contact the tribe to engage and team with the designated ICWA agent or tribal family services department.

Resources for American Indian/Alaska Native children vary depending on a tribe's resources and the location of the child and family (rural versus urban, proximity to tribal resources, or proximity to urban Indian community resources). The child's/caregiver's tribe may provide resources through tribal family services or through a tribal consortium. Some urban areas have resources through Indian resource centers, Indian health clinics, Tribal TANF (Temporary Assistance for Needy Families), or Title VII Indian education programs (which may not be affiliated with a tribe). Some counties have a dedicated Indian specialist or specialty unit dedicated to serving Indian children, which can assist with engagement and

access to resources. They may also have current contact information to assist the child/caregivers in obtaining official membership with their tribe.

It is recommended that children and caregivers who know their tribe or have a tribal affiliation contact the tribe (lists of designated ICWA agents are available at the Bureau of Indian Affairs website, [bia.gov](https://www.bia.gov)). Many tribes have public websites that provide information about their ICWA or family service programs.

For children/caregivers who have lost contact with their tribe, are from unrecognized or terminated tribes, or are unsure of their status with a tribe, resources will exist through local Indian resource centers, tribal TANF, or Title VII Indian education programs. Resources are available to assist the social worker and caregivers in tracing Indian ancestry, such as the US Department of the Interior and the US Children's Bureau.

CHAPTER C: SDM® SAFETY ASSESSMENT FOR CONGREGATE CARE

SDM® SAFETY ASSESSMENT FOR CONGREGATE CARE

California Department of Social Services

r: 10/23

PROVIDE THE FOLLOWING INFORMATION

- Referral name
- Referral number
- Child/youth name
- Placing county
- Facility name
- Facility type
- Facility county
- County conducting this safety assessment
- Worker
- Date of assessment
- Name of tribe (if applicable)

ASSESSMENT TYPE

- ☐ Initial
- ☐ Review/update (if initial safety assessment for congregate care had a safety decision of "safe with plan")

IS THERE ANY INFORMATION THAT INDICATES THAT THE CHILD/YOUTH IS, OR MAY BE, AN INDIAN CHILD/YOUTH?

- ☐ No, not at this time
- ☐ Yes: ☐ Child is an Indian child ☐ Reason to know ☐ Reason to believe

If yes: Were tribal social workers or representatives consulted during the information gathering and screening process as necessary, for the tribe to make a membership or eligibility determination?

- ☐ Yes
- ☐ No

If no: ☐ Contact with tribe(s) attempted ☐ Contact with tribe(s) not attempted

SECTION 1: CONTEXT

PERSON ALLEGED TO BE CAUSING HARM

Select all that apply.

- ☐ Facility staff (including but not limited to administration, volunteers, and temporary staff)
- ☐ Other child/youth at the facility
- ☐ Parent/guardian/Indian custodian/family²
- ☐ Other (describe): _____
- ☐ Unknown

FACTORS INFLUENCING CHILD/YOUTH VULNERABILITY

Select all that apply.

- ☐ Child/youth is younger than most other children/youth at the facility.
- ☐ Child/youth has conditions that impact their ability to protect themselves. Select all that apply.
 - ☐ Child/youth has diminished mental capacity (e.g., developmental delay, nonverbal).
 - ☐ Child/youth has a medical condition.
 - ☐ Child/youth has a mental health or trauma history that currently impairs ability to protect themselves.
 - ☐ Child/youth has diminished physical capacity (e.g., non-ambulatory, limited use of limbs).
 - ☐ Other (describe): _____
- ☐ Child/youth has a history of being sexually exploited or sexually trafficked.
- ☐ Child/youth is new to the facility within the last 30 days.
- ☐ Child/youth identifies as LGBTQ+.
- ☐ Child/youth wears distinctive cultural or religious attire or expresses themselves in ways that demonstrate their religion or culture.
- ☐ Child/youth and facility staff experience a language barrier.
- ☐ Other: _____

FACILITY FACTORS THAT MAY CONTRIBUTE TO CHILD/YOUTH VULNERABILITY

Select all that apply.

- ☐ Facility combines children/youth of different ages.
- ☐ Facility does not appear to provide supervision required to meet child/youth needs.
- ☐ Facility combines children/youth of different gender identities.
- ☐ Facility combines children/youth who have different degrees of acuity or disruptive behavior.
- ☐ Facility has a pattern of community care licensing (CCL) complaints or concerns.
- ☐ Facility utilizes physical or hands-on restraints.

² Selecting this will prompt the question "Are you sure you need to complete the congregate care assessment and not the caregiver assessment?" and will bring up a link to the policy.

☐ Other: _____

SECTION 2: SAFETY THREATS

Assess child/youth for each of the following safety threats. Indicate whether current information suggests a threat of imminent, serious harm is present. Select all that apply.

1. FACILITY CAREGIVER CAUSED PHYSICAL HARM TO THE CHILD/YOUTH OR MADE A PLAUSIBLE THREAT TO CAUSE SERIOUS PHYSICAL HARM.

- ☐ Yes (select all that apply)
 - ☐ Injury or abuse to the child/youth occurred, other than accidental.
 - ☐ Facility caregiver has threatened to harm or retaliate against the child/youth.
 - ☐ Facility caregiver fears they will maltreat the child/youth.
 - ☐ Facility caregiver has used physical discipline or excessive physical force against the child/youth.
- ☐ No

2. FACILITY CAREGIVER'S EXPLANATION FOR AN INJURY TO THE CHILD/YOUTH IS QUESTIONABLE OR INCONSISTENT WITH THE TYPE OF INJURY, AND THE NATURE OF THE INJURY SUGGESTS THAT THE CHILD/YOUTH MAY BE IN IMMINENT DANGER OF SERIOUS HARM.

- ☐ Yes
- ☐ No

3. CHILD/YOUTH SEXUAL ABUSE IS SUSPECTED, AND CIRCUMSTANCES SUGGEST THAT THE CHILD/YOUTH MAY BE IN IMMINENT DANGER OF SERIOUS HARM.

- ☐ Yes
- ☐ No

4. CHILD/YOUTH ABUSE THROUGH COMMERCIAL SEXUAL EXPLOITATION IS SUSPECTED, AND CIRCUMSTANCES SUGGEST THAT THE CHILD/YOUTH MAY BE IN IMMINENT DANGER OF SERIOUS HARM.

- ☐ Yes
- ☐ No

5. FACILITY CAREGIVER ACTS TOWARD THE CHILD/YOUTH IN NEGATIVE WAYS THAT RESULT IN SEVERE PSYCHOLOGICAL/EMOTIONAL HARM.

- ☐ Yes
- ☐ No

6. FACILITY CAREGIVER DOES NOT MEET THE CHILD/YOUTH'S IMMEDIATE BASIC NEEDS, AND THIS RESULTS IN IMMINENT DANGER OF SERIOUS HARM.

☐ Yes (select all that apply)

☐ Food

☐ Clothing

☐ Medical/dental care

☐ Mental health care

☐ Other: _____

☐ No

7. FACILITY PHYSICAL CONDITIONS ARE HAZARDOUS TO THE POINT OF IMMINENT DANGER OF SERIOUS HARM TO THE CHILD/YOUTH.

☐ Yes

☐ No

8. FACILITY CAREGIVER DOES NOT PROTECT THE CHILD/YOUTH FROM SERIOUS HARM BY PEERS.

☐ Yes

☐ No

9. FACILITY CAREGIVER DOES NOT PROTECT THE CHILD/YOUTH FROM SERIOUS HARM BY OTHER ADULTS.

☐ Yes

☐ No

10. FACILITY CAREGIVER DOES NOT RESPOND TO AND ADDRESS THE FOLLOWING CHILD/YOUTH ACTIONS, AND THIS RESULTS IN IMMINENT DANGER OF SERIOUS HARM.

☐ Yes (select all that apply)

☐ Self-harm

☐ Missing from care

☐ Aggressive/assaultive behavior

☐ Substance use

☐ Other (describe) _____

☐ No

11. OTHER SAFETY THREAT

- ☐ Yes (describe): _____
- ☐ No

Supervisor approval: _____

If no safety threats are present, select the safety decision below.

SAFETY DECISION

- ☐ **Safe.** No safety threats were identified at this time. Based on currently available information, child/youth is not in imminent danger of serious harm. Child welfare services (CWS) staff should complete the investigation and partner with other counties, tribe(s), and CCL as needed. Do not complete any further sections of this assessment.

SECTION 3: PROTECTIVE CAPACITIES

CHILD/YOUTH

Select all that apply.

- ☐ Child/youth acknowledges the safety threat.
- ☐ Child/youth is willing and able to participate in a safety plan.
- ☐ Child/youth has shown in the past that they can take action to protect themselves.
- ☐ Child/youth reports having a trusting relationship with at least one facility staff member.
- ☐ Child/youth reports having a trusting relationship with at least one family member or support network member, AND they are willing to share the details of the safety threat with them.
- ☐ Other (describe): _____

FACILITY

Select all that apply.

- ☐ Facility staff and leadership acknowledge the safety threat.
- ☐ Facility staff shared details of the safety threat with all relevant members of the Child and Family Team, including any tribal representative.
- ☐ Facility leadership and staff are willing and able to participate in a safety plan.
- ☐ Other (describe): _____

SECTION 4: PROTECTIVE INTERVENTIONS

If safety threats have been identified, consider the protective capacities above and determine whether a safety plan will allow the child/youth to safely remain in the facility. If so, the safety decision is “safe with plan”; select that decision below and identify interventions that will be used to immediately address the safety threat. If a safety plan that would allow the child/youth to remain in the facility safely cannot be created, skip to Section 5.

SAFETY DECISION

- **Safe with plan.** One or more safety threats are present. Facility leadership, the child/youth, and other members of the Child and Family Team have agreed to participate in a safety plan. This plan will allow the child/youth to safely remain in the facility, as long as the interventions continue to mitigate the safety threats. Develop a formal safety plan with clear intervention and monitoring details and share it with the facility caregivers, facility leadership, child/youth, tribe (if applicable), and child/youth’s family/legal guardian, and other relevant team members.

Note: If a safety plan is implemented, a Child and Family Team Meeting (CFTM) should be convened, and a new safety assessment should be completed within 30 days.

Select all interventions that will be used to immediately help address the safety threat.

- ☐ Intervention or direct services provided by a CWS worker (do not include fact-finding actions from the investigation itself).
- ☐ Use of Child and Family Team members, support network, and/or community agencies as participants on the safety plan.
- ☐ Use of resources and/or recommendations from tribal representatives as part of the safety plan.
- ☐ Alleged perpetrator has been arrested, fired, or suspended from facility. (This cannot be the only item on the safety plan.)
- ☐ Facility will change staffing levels to address the safety threat.
- ☐ Facility will change behavior plan/response to child/youth.
- ☐ Facility will change location of child/youth within the facility and/or separate them from particular peers.
- ☐ Other (describe): _____

SECTION 5: PLACEMENT CHANGE

SAFETY DECISION

- **Unsafe.** One or more safety threats are present. All interventions above have been considered, and none of them will address the safety threat. A placement change is the only intervention possible to address the safety threat for the child/youth. Without the placement change, the child/youth will remain in imminent danger of serious harm.

➤ County CWS that is responsible for child/youth will transfer the child/youth to a new placement immediately.

TRIBAL AGREEMENT WITH FINAL SAFETY DECISION

Complete only if the child/youth is an Indian child or there is reason to know the child is an Indian child/youth.

Is the tribe(s) in agreement with the final safety decision?

- ☐ Yes
- ☐ No; reasoning: _____
- ☐ Unknown

SECTION 6: OTHER ACTIONS THAT MAY BE NEEDED

1. DURING THE COURSE OF THIS SAFETY ASSESSMENT, WERE OTHER CHILDREN/YOUTH IDENTIFIED AT THE FACILITY WHO MAY HAVE BEEN ABUSED OR NEGLECTED?

- ☐ Yes; report to the child abuse hotline
- ☐ No
- ☐ Unknown

2. IS LICENSING AWARE OF THE CURRENT INVESTIGATION?

- ☐ Yes
- ☐ No; report to licensing
- ☐ Unknown; determine if licensing is aware and file report if needed

3. IS A REPORT TO LAW ENFORCEMENT REQUIRED?

- ☐ Yes
- ☐ No

SDM® SAFETY ASSESSMENT FOR CONGREGATE CARE DEFINITIONS

California Department of Social Services

IS THERE ANY INFORMATION THAT INDICATES THAT THE CHILD/YOUTH IS, OR MAY BE, AN INDIAN CHILD/YOUTH?

REASON TO KNOW

Information exists at the time of the assessment of a reason to know that the child/youth is an Indian child/youth, including the following.

- The child/youth, the family, or a person having interest in the child/youth provides direct information that the child/youth is an Indian child/youth.
- The residence or domicile of the child/youth, the child/youth's parent/guardians, or an Indian custodian is on a reservation or other tribal lands or in an Alaska Native village.
- Any participant in a court proceeding, an officer of the court, an Indian tribe(s), an Indian organization, or an agency provides information indicating the child/youth is an Indian child/youth.
- The child/youth's words or actions reasonably suggest they are an Indian child/youth.
- The child/youth is or has been a ward of a tribal court.
- The parent or child/youth possesses an identification card indicating membership or citizenship in an Indian tribe(s).

REASON TO BELIEVE

Information exists at the time of the assessment that *suggests* that either the child/youth or a parent/guardian of the child/youth may be eligible for membership in an Indian tribe(s) or may have Indian ancestry. Further inquiry is required.

IF YES, WAS THE TRIBAL REPRESENTATIVE INCLUDED IN THE INFORMATION-GATHERING AND SAFETY ASSESSMENT PROCESS?

A social worker or representative from the tribe was successfully contacted and included in the safety assessment and safety planning process. Examples may include gathering key facts about the child's situation and the facility caregiver's behavior and impact on the child or exploring protective capacities and network members to support safety planning. Details of the contact must be documented in CWS/CMS, including which tribes were contacted, a summary of information discussed, and the impact on decision making.

If contact with tribe was attempted but not successful, document efforts in CWS/CMS.

SECTION 1: CONTEXT

PERSON ALLEGED TO BE CAUSING HARM

Identify whether the person alleged to have caused the harm is a facility staff member (including but not limited to administration, volunteers, temporary staff), another child/youth at the facility, a parent/guardian/Indian custodian of the child/youth, a third party, or unknown.

Note: If only “parent/guardian/Indian custodian/family” is selected, consider whether the safety assessment for family homes would be more appropriate to complete.

FACTORS INFLUENCING CHILD/YOUTH VULNERABILITY

Conditions or child/youth characteristics that leave child/youth more susceptible to being harmed in these settings.

Child/youth is younger than most other children/youth at the facility.

Determine the age of the children/youth the facility serves and whether the child/youth alleged to have been harmed is younger than most of the other children/youth served. Consider whether the child’s chronological age is consistent with their developmental stage.

Child/youth has conditions that impact their ability to protect themselves. Select all that apply.

Child/youth has diminished mental capacity (e.g., developmental delay, nonverbal).

The child/youth has a developmental/cognitive delay that impacts their ability to communicate verbally or to care for themselves and protect themselves from harm. Only include children/youth who are nonverbal due to diminished mental capacity. Examples include but are not limited to the following.

- Child/youth who has Down syndrome, impacting their cognitive functioning.
- Child/youth’s autism impacts their ability to communicate their needs.
- Child/youth who has a cognitive delay, impacting their ability to understand and follow directions or read social cues.

Note: If the child/youth is nonverbal or has limited speech due to a language barrier, select the language barrier item below.

Child/youth has a medical condition.

The child/youth has a diagnosed medical condition that impairs their ability to protect themselves from harm. This item can also be selected if a diagnosis is not yet confirmed but preliminary indications are present.

Child/youth has a mental health or trauma history that currently impairs ability to protect themselves.

The child/youth has indicators of a mental health condition, has a known mental health condition, has a noted trauma history, or experienced a recent traumatic incident that currently impairs their ability to protect themselves from harm.

Child/youth has diminished physical capacity (e.g., non-ambulatory, limited use of limbs).

The child/youth has a physical condition or disability that impacts their ability to protect themselves from harm.

Other

Describe any other factor influencing child/youth vulnerability.

Child/youth has a history of being sexually exploited or sexually trafficked.

The child/youth has a history of being sexually exploited or trafficked.

- Children/youth age 17 years 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 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 the sexual exploitation of a child/youth regardless of whether they are live, filmed, or photographed.
- Commercial sexual exploitation of children/youth may include prostitution, pornography, trafficking for sexual purposes, and other forms of sexual exploitation. The child/youth is treated as a sexual object and as a commercial object. The sexual exploitation of the child/youth may profit a much wider range of people than the immediate beneficiary of the transaction.

Child/youth is new to the facility within the last 30 days.

The child/youth arrived at the facility within the last 30 days.

Child/youth identifies as LGBTQ+.

The child/youth identifies as lesbian, gay, bisexual, transgender, queer, or questioning their sexual orientation, gender identity, or gender expression.

Child/youth wears distinctive cultural or religious attire or expresses themselves in ways that demonstrate their religion or culture.

The child/youth wears attire representing their culture (hajib, yarmulke, etc.) and/or demonstrating their religious expression (long hair, braided hair).

Child/youth and facility staff experience a language barrier.

The child/youth does not speak English as their primary language.

Examples could include a child/youth who speaks American Sign Language (ASL) or another language such as Spanish. Consider children/youth who are unable to speak for their needs despite English being their primary language.

Other.**FACILITY FACTORS THAT MAY CONTRIBUTE TO CHILD/YOUTH VULNERABILITY**

These conditions within the facility or their staff may impact child/youth's ability to protect themselves or affect the facility's ability to protect the child/youth.

Facility combines children/youth of different ages.

Facility places any two of these age groups together as part of facility daily activities: pre-school-, elementary school-, middle school-, or secondary school-age children/youth. Consider a child/youth's development level in conjunction with their chronological age.

Facility does not appear to provide the supervision required to meet child/youth needs.

Facility staff do not appear to provide for the supervision needs of the children/youth, which may increase their vulnerability to harm. Supervision needs are dependent on individual child/youth characteristics and their interactions with others. The required level of supervision may be higher than licensing standards for staff-to-child/youth ratios.

Facility combines children/youth of different gender identities.

Facility places children/youth of different gender identities together during activities of daily living, which may increase their real or perceived sense of vulnerability.

Activities include but are not limited to sleeping, bathing/showering, or dressing.

Facility combines children/youth who have different degrees of acuity or disruptive behavior.

Facility places children/youth together who have various levels of behavior, acting out, or aggression. Examples include but are not limited to the following.

- A child/youth with no known drug use history has been placed in a unit with youth known to smoke marijuana. After a month, the child/youth with no previous drug use history has begun smoking marijuana with the other youth.
- A child/youth with no known history of sexual exploitation, sexual abuse, or leaving their placement has been moved to a unit with other children/youth who are known to leave the facility and there are concerns for sexual exploitation. The child/youth has begun leaving the facility and there is information to believe the child/youth is being sexually exploited by the same perpetrators as the other children/youth.

Facility has a pattern of community care licensing (CCL) complaints or concerns.

Facility has experienced a pattern of CCL complaints that could affect the current concerns related to safety. A pattern of complaints can include a high number of reports over a short period of time (i.e., three reports in a two-week period), a lower number of reports that are consistently present over a longer period of time (i.e., two reports a month for six months), or multiple reports of the same safety concern. For more information on complaints, see <https://www.ccl.dss.ca.gov/carefacilitysearch/>

Facility utilizes physical or hands-on restraints.

Facility staff use hands-on, manual restraints to limit the movement of children/youth in their care. Physical restraints may include forced escorts, holding, prone restraints, or other containment techniques.

Other.

Describe any other facility factor influencing child/youth vulnerability.

SECTION 2: SAFETY THREATS

1. FACILITY CAREGIVER CAUSED PHYSICAL HARM TO THE CHILD/YOUTH OR MADE A PLAUSIBLE THREAT TO CAUSE SERIOUS PHYSICAL HARM.

Facility caregiver took an action that caused one or more of the following or stated they intended to take an action that likely would cause one or more of the following.

Injury or abuse to the child/youth occurred, other than accidental.

The facility caregiver caused a non-accidental injury OR took an action that could have caused non-accidental injury to the child/youth.

Facility caregiver has threatened to harm or retaliate against the child/youth.

The facility caregiver stated or demonstrated that they intended either to take an action that would result in physical harm to the child/youth or that they plan to retaliate against the child/youth. Retaliation could include the facility caregiver demanding the child/youth's silence in exchange for not physically harming them.

Facility caregiver fears they will maltreat the child/youth.

The facility caregiver has reported credible fears that they will hurt the child/youth in a way that would cause serious injury or harm, and facility administration has not taken adequate actions to mitigate the threat.

Facility caregiver has used physical discipline or excessive physical force against the child/youth.

The facility caregiver used physical methods to discipline the child/youth, OR facility caregiver injured or nearly injured the child/youth by using excessive physical force. Do not select this item in the case of brief, approved physical restraints that facility caregiver used to prevent imminent harm to the child/youth or others.

2. FACILITY CAREGIVER'S EXPLANATION FOR AN INJURY TO THE CHILD/YOUTH IS QUESTIONABLE OR INCONSISTENT WITH THE TYPE OF INJURY, AND THE NATURE OF THE INJURY SUGGESTS THAT THE CHILD/YOUTH MAY BE IN IMMINENT DANGER OF SERIOUS HARM.

The child/youth has an injury that requires medical attention, and medical assessment indicates the injury is likely to be the result of abuse; OR has a suspicious injury that did not require medical treatment, but other information about the injury does not match with the explanation that the facility caregiver provided.

Note: Factors to consider include the child/youth's age, location of injury, exceptional needs of the child/youth, and chronicity of injuries.

3. CHILD/YOUTH SEXUAL ABUSE IS SUSPECTED, AND CIRCUMSTANCES SUGGEST THAT THE CHILD/YOUTH MAY BE IN IMMINENT DANGER OF SERIOUS HARM.

Select this item if sexual abuse is occurring or is suspected of occurring and actions taken by facility are not adequately protecting that child/youth.

Sexual abuse is unwanted sexual activity involving applied force, threats, or manipulation.

Note: Select Item 4 when commercial sexual exploitation occurs or is suspected.

4. CHILD/YOUTH ABUSE THROUGH COMMERCIAL SEXUAL EXPLOITATION IS SUSPECTED, AND CIRCUMSTANCES SUGGEST THAT THE CHILD/YOUTH MAY BE IN IMMINENT DANGER OF SERIOUS HARM.

Select this item if commercial sexual exploitation is occurring or is suspected of occurring and there is reason to believe the child/youth is in imminent danger of serious harm. Examples of facility actions to adequately protect and respond to that child/youth include but are not limited to the following.

- Reach out to the child/youth's CFT members before, during, and after they go missing from care (see ACIN I-14-19).
- Continually reevaluate the child/youth's needs, in discussion with the child/youth, with regard to cell phone usage (see [I-32-21](#)).
- Determine caregiver's role in using harm reduction strategies with children/youth who have experienced commercial sexual exploitation (see [ACIN I-31-22](#)).

Children/youth aged 17 years old and younger are sexually exploited when they have engaged in or been forced to engage in sexual conduct or performance of sexual acts 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. Force, fraud, and coercion are not required to constitute commercial sexual exploitation.

Note: Children/youth may engage in this sexual conduct in an effort to meet unmet needs or as a means for survival. If actions taken by the facility are not adequately protecting the child/youth, select this item and consider whether any other safety threat may also be relevant in these situations.

5. FACILITY CAREGIVER ACTS TOWARD THE CHILD/YOUTH IN NEGATIVE WAYS THAT RESULT IN SEVERE PSYCHOLOGICAL/EMOTIONAL HARM.

Facility caregiver engages in a regular pattern of behavior that impairs the child/youth's emotional development, self-worth, or self-confidence. If the impact on the child/youth reaches the above threshold, examples of facility caregiver actions include but are not limited to the following.

- Describing the child/youth in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
- Cursing at or repeatedly putting the child/youth down.
- Scapegoating the child/youth.
- Encouraging other children/youth in the facility to harm the child/youth.
- Blaming the child/youth for a particular incident or for facility problems that child/youth is not responsible for.
- Threatening to retaliate against the child (e.g., telling the child/youth they will be in trouble if they report abuse or neglect, demanding their silence). Do not include threats of physical harm.

6. FACILITY CAREGIVER DOES NOT MEET THE CHILD/YOUTH'S IMMEDIATE BASIC NEEDS, AND THIS RESULTS IN IMMINENT DANGER OF SERIOUS HARM.

The facility caregiver is unable or unwilling to address critical areas among the following, AND the child/youth has been seriously harmed or is in imminent danger of being seriously harmed as a result.

- **Food:** The child/youth's basic nutritional or specialized dietary needs are not met, resulting in danger to the child/youth's health and/or safety, including malnutrition or morbid obesity.
- **Clothing:** The child/youth is without clothing or shoes needed for their health or safety. Consider the age of the child/youth and whether clothing is the choice of the child/youth or has been provided or withheld by the facility caregiver.
- **Medical/dental care:** The facility caregiver does not seek treatment for the child/youth's immediate, chronic, and/or serious medical condition(s), or does not follow prescribed treatment for such conditions, resulting in child/youth declining in health status (e.g., not providing insulin for a child/youth with diabetes, not providing follow-up care for an infected wound, or not providing care for a broken bone). Consider lack of dental care that results in medical concerns.
- **Mental health care:** The facility caregiver does not seek or follow prescribed treatment for the child/youth's imminent, chronic, and/or serious mental health condition(s) AND the child/youth has been seriously harmed or is in imminent danger of being seriously harmed as a result. Examples include but are not limited to the following.
 - » Child/youth is experiencing suicidal ideation or other mental health distress, and the facility is not taking steps to engage a behavioral health team.
 - » Child/youth has demonstrated self-harming behaviors (e.g., using sharp objects such as knives and razors on themselves) and they have access in the facility to objects that would allow them to self-harm.

- » Child/youth is prescribed medication that they report is helping to address their mental health symptoms, but the facility does not ensure they have access to their medication.

7. FACILITY PHYSICAL CONDITIONS ARE HAZARDOUS TO THE POINT OF IMMINENT DANGER OF SERIOUS HARM TO THE CHILD/YOUTH

Facility conditions are causing or have the potential to cause imminent serious harm to child/youth's health or safety.

Consider situations including but not limited to the following.

- Leaking gas from stove or heating unit.
- Lack of water or utilities (heat, plumbing, electricity) and no alternative or safe provisions.
- Open/broken/missing windows.
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food that threatens health.
- Evidence of human or animal waste throughout living quarters.

Note: Physical conditions may be suboptimal, or the CWS investigator may have reason to believe they do not meet California licensing standards. If so, contact licensing. This item should be selected only if the "imminent danger" threshold is reached.

8. FACILITY CAREGIVER DOES NOT PROTECT THE CHILD/YOUTH FROM SERIOUS HARM BY PEERS.

The facility caregiver does not or cannot protect the child/youth from threatened or actual serious physical or emotional harm by other children/youth. Consider the age and developmental stage of the child/youth and impact on them from the other child/youth's action.

Examples include but are not limited to the following.

- Physical harm toward a child/youth by a peer.
- Child/youth sexual abuse by a peer.
- A pattern of or a significant threat, act of intimidation, and/or coercion from peers that impacts the child/youth's safety, emotional development, or self-worth. Consider the use of social media as well.

9. FACILITY CAREGIVER DOES NOT PROTECT THE CHILD/YOUTH FROM SERIOUS HARM BY OTHER ADULTS.

The facility caregiver does not or cannot protect the child/youth from serious physical harm, emotional harm, or threatened harm by other adults, including family members or other adults who have regular access to the child/youth.

Examples include but are not limited to the following.

- The facility caregiver does not provide supervision necessary to protect the child/youth from harm by an adult who comes to the facility and physically, sexually, or emotionally abuses the child/youth.
- An adult with known violent criminal behavior history or sexual abuse history as a perpetrator has regular, unmonitored access to the child/youth. Include regardless of whether the facility caregiver (1) knew of the history and allowed access; or, (2) upon learning of the history, has not prevented further access.
- The child/youth returns from a visit with an adult/relative and has injuries, but the facility continues to allow contact between the child/youth and the adult/relative.
- A facility caregiver is unable or unwilling to stop a fellow staff member from harming child/youth. Select this and any relevant safety threat above. Note: In situations where the child/youth is being sexually exploited and trafficked by a facility caregiver, select this item AND safety threat 3.

Note: If an adult harms a child/youth after they have run away, consider (1) if the adult already had regular access to this child/youth that the facility caregiver was aware of and/or (2) if safety threat 10 is more applicable.

10. FACILITY CAREGIVER DOES NOT RESPOND TO AND ADDRESS THE FOLLOWING CHILD/YOUTH ACTIONS, AND THIS RESULTS IN IMMINENT DANGER OF SERIOUS HARM.

The facility caregiver cannot or does not take action in order to protect the child/youth when a child/youth demonstrates behavior that can cause them or others serious harm, OR the facility caregiver takes actions that worsen the situation when a child/youth falls victim to behavior that can cause themselves serious harm.

This includes but is not limited to situations where the facility caregiver is unable or unwilling to respond to the following child/youth actions.

Self-harm

Child/youth physically harms self or threatens to physically harm self, AND the facility caregiver does not respond to protect child/youth (e.g., refuses to take action to support child/youth, refuses to separate them from items they could harm themselves with, does not watch child/youth more closely despite evidence they may harm themselves).

Missing from care

Child/youth regularly leaves the facility without permission and without supervision, AND the facility caregiver does not take actions to try to prevent the child/youth from going missing from care (e.g., follow the child/youth, attempt to engage with them to build a preventive plan, inform local law enforcement) or plan for their safety if they leave (e.g., provide the child/youth with a "go bag" for basic hygiene items, create a safety plan).

Aggressive/assaultive behavior

Child/youth physically harms a peer or threatens to physically harm a peer, AND the facility caregiver does not take actions to try to deescalate the situation and/or protect child/youth involved. Do not select this item when a child/youth has aggressive behaviors but has not harmed or threatened to harm their peers.

Substance use

Child/youth has used/abused legal or illegal substances or alcoholic beverages to the extent of impairment to their control of their actions or abilities; AND the facility caregiver does not take actions to prevent or respond to the substance use, or they actively encourage it.

Other (describe)

Include other child/youth actions that put the child/youth in imminent danger of serious harm where the facility caregiver does not or cannot respond.

Note: If facility caregiver does not seek needed medical or mental health care after a child/youth engages in behavior that can cause them serious harm, select this item AND consider safety threat 5.

11. OTHER SAFETY THREAT (Describe)

Circumstances or conditions pose an imminent threat of serious harm to the child/youth that are not already described in safety threats 1–10. Supervisory approval is required for selection of this threat.

SAFETY DECISION

Safe

No safety threats were identified at this time. Based on currently available information, child/youth is not in imminent danger of serious harm. CWS staff should complete the investigation and partner with other counties and CCL as needed. Complete Section 6; then, this assessment is complete.

SECTION 3: PROTECTIVE CAPACITIES

Protective capacities are resources, coping skills, qualities, or actions that the facility or the child/youth demonstrates that could assist in responding to the safety threats indicated above.

CHILD/YOUTH PROTECTIVE CAPACITIES

Child/youth acknowledges the safety threat.

The child/youth can clearly describe and demonstrates an understanding of the issues that led to the current safety threat.

Child/youth is willing and able to participate in a safety plan.

The child/youth has agreed to participate in a plan to imminently address the safety threat AND has the physical and emotional capacity to participate in that plan.

Child/youth has shown in the past that they can take action to protect themselves.

The child/youth has demonstrated an ability to take steps to protect themselves from harm in the past (e.g., reporting safety concerns to a safe adult, leaving an unsafe situation, asking for help).

Child/youth reports having a trusting relationship with at least one facility staff member.

The child/youth has at least one supportive relationship with someone at the facility whom they confide in.

Child/youth reports having a trusting relationship with at least one family member or support network member, AND they are willing to share the details of the safety threat with them.

The child/youth has at least one supportive relationship with a family member or support network member, AND they are willing to disclose at least some details of the threat to that person.

Other (describe)

The child/youth demonstrates other actions and/or coping skills or accesses resources that may help them respond to the safety threat.

FACILITY

Facility staff and leadership acknowledge the safety threat.

Facility leadership AND at least one other facility caregiver who has day-to-day responsibility for the child/youth can clearly describe and demonstrates an understanding of the issues that led to the current safety threat.

Facility staff shared details of the safety threat with all relevant members of the Child and Family Team, including any tribal representatives and any other relevant supports.

A facility caregiver has described the concerns and actions that led to the safety threat to the child/youth's family, any tribal representatives, and any other key members of their Child and Family Team. Relevant details may also be shared with supports the child/youth and family wish to include, such as their lawyer.

Facility leadership and staff are willing and able to participate in a safety plan.

Facility leadership AND at least one facility caregiver who has day-to-day responsibility for the child/youth have agreed to participate in a plan to immediately address the safety threat, AND facility leadership is willing to commit the staff and resources to that plan.

Other (describe)

The facility demonstrates other actions, is accessing resources, and/or is making responses to the concerns that allow them to immediately respond to the safety threat.

SECTION 4: PROTECTIVE INTERVENTIONS

Protective interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes.

SAFETY DECISION

Safe with plan

One or more safety threats are present; however, the child/youth can safely remain in the facility with a safety plan. Protective interventions have been initiated through a safety plan that CWS, the facility, and the child/youth will be a part of. The child/youth will remain in the facility as long as the interventions continue to mitigate the safety threats. Complete a formal safety plan with intervention details and

share it with the child/youth, facility caregivers, facility leadership, tribe (if applicable), and child/youth's family/legal guardian. Decisions to share information should be done in consultation with the child.

Note: If a safety plan is implemented, a CFTM is needed, and an updated safety assessment should be conducted within 30 days.

Select all interventions that apply.

Intervention or direct services provided by a CWS worker (*do not* include fact-finding actions from the investigation itself).

Actions that the investigating worker or other CWS staff take or plan that specifically address one or more safety threats.

Examples include providing information about expected facility actions in response to a child/youth going missing from care or to signs of exploitation, providing information about child/youth development needs, or planning return visits to the facility to check on progress. *Does not include* the fact-finding activities of the investigation itself or services provided to respond to child/youth needs that do not directly respond to the indicated safety threats.

Use of Child and Family Team members, support network, and/or community agencies as participants on the safety plan.

Family, extended family, or support networks have actionable items on the safety plan.

Examples include but are not limited to the family agreeing to regularly visit the child/youth at the facility, or a close family friend agreeing to regularly meet with the child/youth and ask about the events that led to the safety threat to ensure the safety threat is no longer present. Action steps should include a backup plan of what steps participants will take if the threat is present and not being controlled for.

Use of resources and/or recommendations from tribal representatives as part of the safety plan.

A tribe(s), Indian community, ICWA program, or other tribal resource has actionable items on the safety plan.

Examples include regular visits from a tribal social worker or representative of that tribe or from a staff member at a community-based agency who is aware of the safety threat and is willing to ask about it to ensure it is no longer happening.

Other tribal resources include but are not limited to:

- Tribal family services from the child/youth's or parent/guardian/Indian custodian's tribe(s) or a tribal consortium;
- Indian resource centers;
- Indian health clinics;
- Title VII Indian education programs, which may not be affiliated with a tribe; and
- A county-based dedicated Indian specialist or service unit.

Alleged perpetrator has been arrested, fired, or suspended from facility. (This cannot be the only item on the safety plan.)

Facility leadership has fired, suspended, or removed a facility caregiver who is an alleged perpetrator; and the alleged perpetrator no longer has access to child/youth.

Note: Consider facility plan to ensure the alleged perpetrator does not have access to the child/youth, such as removing their keys, informing CCL, etc. If a facility has taken this action and the final determination of the assessment is "safe with plan," the safety plan must include other action items in addition to the termination or suspension of the staff.

Examples of other action items include what the child/youth will do if they become triggered by a similar event and what the facility will do to ensure the fired or suspended staff will not have access to the child/youth in the community.

Facility will change staffing levels to address the safety threat.

Facility leadership has added new staff or shifted staff to support the child/youth in a manner that directly responds to the safety threat.

Facility will change behavior plan/response to child/youth.

Facility staff have made significant changes to the behavior plan and have new strategies for responding to the child/youth that will directly respond to the safety threat.

Facility will change location of child/youth within the facility and/or separate them from particular peers.

Facility leadership has moved the child/youth or a peer to a new part of the facility in a way that will directly respond to the safety threat.

Other

CWS, the child/youth, tribe (if applicable), their family or support network, and/or facility caregivers will take other actions that immediately respond to the safety threat in a manner not captured in the above interventions.

SECTION 5: PLACEMENT CHANGE

SAFETY DECISION

Unsafe

One or more safety threats are present. All interventions above have been considered, and none of them will address the safety threat. A placement change is the only intervention possible to address the safety threat for the child/youth. Without the placement change, the child/youth will remain in imminent danger of serious harm.

Note: Parent/guardians, Indian custodians, legal caregivers, and children/youth's legal representatives must be contacted if a placement change is being made. Decisions to share information should be done in consultation with the child/youth. Additionally, if the child/youth is known to be an Indian child or there is reason to know that the child/youth is an Indian child/youth and a placement change is to be made, the affiliated tribe(s) must be contacted.

County CWS that is responsible for child/youth will transfer the child/youth to a new placement immediately.

The county child welfare or probation office that is responsible for the child/youth's care will take steps to move the child/youth to a new placement immediately.

Note: If a transfer is not possible immediately, a safety plan must be initiated that controls for the threat while a new placement is sought.

TRIBAL AGREEMENT WITH FINAL SAFETY DECISION

Complete only if the child/youth is an Indian child or there is reason to know they are an Indian child/youth.

Is the tribe(s) in agreement with the final safety decision?

If it has been indicated that the child/youth is an Indian child or there is reason to know they are an Indian child/youth and contact with the tribe(s) has been made, review the safety decision

collaboratively with the tribe(s). While agreement with the decision is not required, document efforts to gain agreement and the tribe's position on the final safety decision.

SECTION 6: OTHER ACTIONS THAT MAY BE NEEDED

DURING THE COURSE OF THIS SAFETY ASSESSMENT, WERE OTHER CHILDREN/YOUTH IDENTIFIED AT THE FACILITY WHO MAY HAVE BEEN ABUSED OR NEGLECTED?

If in the course of this safety assessment the CWS staff became aware of other children/youth who are suspected to have been abused or neglected, call the child abuse hotline for the county that placed the child/youth in this facility.

IS LICENSING AWARE OF THE CURRENT INVESTIGATION?

Determine whether a report to licensing has been made; if not, file report. CWS staff should include licensing when possible during their investigation to create continuity in planning and collaboration in decision making.

IS A REPORT TO LAW ENFORCEMENT REQUIRED?

Determine whether a report to law enforcement is required.

SDM® SAFETY ASSESSMENT FOR CONGREGATE CARE POLICY AND PROCEDURES

California Department of Social Services

The purpose of the safety assessment for congregate care is: (1) to help assess whether any child/youth is likely to be in imminent danger of serious harm, which requires protective intervention; and (2) to determine what interventions should be initiated or maintained to provide appropriate protection.

Unlike the Structured Decision Making® (SDM) safety assessment that is used in household-based settings, the congregate care safety assessment is a child-based assessment and should be used to guide decision-making related to the safety of an identified child/youth in a congregate care setting.

- **Other reporting:** If, in the course of an assessment or investigation, other children/youth are suspected to have been abused or neglected, the worker should call the child abuse hotline of the county that placed that child/youth at the facility.
- **Safety versus risk assessment:** It is important to keep in mind the difference between safety and risk when completing this assessment. Safety assessment looks at the child/youth's *present* danger of *imminent and serious harm* and the interventions currently needed to protect the child/youth. In contrast, risk assessment looks at the likelihood of future child welfare system involvement.

WHICH CASES

This safety assessment should be used for all investigations of alleged abuse and neglect by a congregate care facility staff member. In accordance with California Penal Code § 11165.5, a facility caregiver is a person responsible for the child/youth's care and welfare (including a licensee, administrator, or employee, volunteer, contractor, etc. of any facility licensed to care for children/youth).

This includes but is not limited to the following situations:

- The alleged perpetrator is clearly a facility caregiver at a congregate care facility.
- The abuse and neglect occurred while a child/youth was at a congregate care facility.
- There is reasonable suspicion that a congregate care provider or staff member failed to protect the child/youth or fulfill their obligation to protect a child/youth in their care.
- Any open referrals or cases in which changing circumstances may place the child/youth in imminent danger of serious harm. This may include cases where an active safety plan is present and the safety interventions are no longer able to mitigate safety threats.

Note: If the person alleged to be causing harm is the child/youth's parent/guardian/Indian custodian AND the child/youth is placed at a congregate care facility AND there is no allegation of harm by a facility caregiver, consider whether the safety assessment for family homes should be done instead of

the safety assessment for congregate care settings. Examples of times to do this include but are not limited to the following.

- An extended home visit in which the parent/guardian/Indian custodian caused harm and there is no indication that the facility failed to protect the child/youth when the alleged abuse/neglect occurred.
- A scheduled contact between the child/youth and their parent/guardian/Indian custodian off facility property during which the parent/guardian/Indian custodian caused harm, and there is no indication that the facility failed to protect the child/youth when the alleged abuse/neglect occurred.

Congregate care settings are defined here as any facility type outside of a home-based setting responsible for the placement and care of a dependent or ward child/youth. These include but are not limited to:

- Short-term residential therapeutic programs (STRTPs);
- Group homes, including enhanced behavioral support homes, minor-parent programs, and care for children under age 6;
- Transitional housing placement programs (THPP); and
- Transitional and temporary shelter care facilities.

Note: Juvenile detention facilities, child/youth homeless prevention centers, psychiatric hospitals or care facilities, and crisis nurseries are *not* included.

WHO

The assigned worker or probation officer who is responding to the referral.

WHEN

For a new referral, the safety assessment interviewing, planning, and decision-making *process* is completed during the initial face-to-face contact with the child/youth.

The safety assessment *form* should be completed within two working days after first contact. For a child/youth who has already been protectively placed in another setting by law enforcement or other means, and for whom no safety assessment has been completed, the worker will complete a safety assessment within two working days of the referral.

Update safety assessment: If a safety plan is initiated, there must be an updated safety assessment documented within 30 days.

DECISION

The safety assessment guides a structured assessment of whether any child/youth is in imminent danger of serious harm. This information guides the decision about whether the child/youth may remain in the placement with no intervention (safe), whether they may remain in the placement with safety interventions in place (safe with plan), or whether a placement change is required (unsafe).

APPROPRIATE COMPLETION

Workers should familiarize themselves with the items on the safety assessment and the accompanying definitions. Workers will notice that the items on the tool that are different for facility caregivers are items they are probably already assessing when they do these investigations. What distinguishes the SDM® tool is that it ensures that 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 their initial contact as they normally would—using good social work practice to collect information from the child/youth, facility, tribe (if applicable), and/or collateral sources. The SDM tool ensures that the specific items that comprise the safety assessment are assessed during the initial contact.

Note that for all assessment items, the worker should rely on the information available at the time of the assessment. If there is no evidence to select “yes” for an item, they should select “no.”

The decision logic for the safety assessment is:

- If no safety threats are selected, the only possible safety decision is “Safe: No safety threats were identified at this time.” No protective interventions need to be reviewed; the assessment is complete.
- If one or more safety threats are selected, the worker must determine whether a safety plan will mitigate the safety threat or whether the child/youth must be moved.
- If a safety plan can be developed with the facility, only interventions 1 through 8 can be selected, and the safety decision is “Safe with Plan: One or more safety threats are present; however, the child/youth can safely remain in the facility with a safety plan.” Protective interventions have been initiated through a safety plan, and the child/youth will remain in the facility as long as the safety interventions mitigate the safety threats. Placement change (intervention 10) should not be selected as an intervention if other interventions are selected.
- If a safety plan cannot be developed with the facility, then placement change (intervention 10) must be selected, and the safety decision must be “Unsafe: One or more safety threats are present, and placement change is the only protective intervention possible for the child/youth. Without a placement change, the child/youth will likely be in danger of imminent or serious harm.”

Complete all assessment header information as follows.

- Record the date of the safety assessment. The date of assessment is typically the date that the worker made initial face-to-face contact with the child/youth to assess safety, which may be different from the date that the tool is completed in WebSDM.
- Indicate whether the child/youth is or may be an Indian child/youth, as required by Welfare and Institutions Code (WIC) §224.2(a). When reason to believe exists, the investigating worker should contact all appropriate tribe(s) as soon as possible for further information gathering and decision making, as described in Manual of Policy and Procedures (MPP) 31-101.111 and 31-105.114. Contact with the tribe should not delay a decision about immediate safety for the child/youth; however, such contact is likely to create more possibilities for safety assessment and planning. Details of the contact/attempted contact with tribe(s), a summary of information, and the impact on assessment and decision making must be documented in CWS/CMS; and efforts to contact the tribe must continue through investigations as outlined in MPP 31-101.522.
- Enter the safety assessment type.
 - » **Initial.** Each referral should have one initial safety assessment, completed during the first face-to-face contact with the child/youth named in the referral. However, because this is a child-based assessment, if there are allegations involving two or more children/youth within a single referral, an initial safety assessment must be conducted on every child/youth.
 - » **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 a referral or case. A review/update includes a safety assessment completed on a second facility where there are no allegations.
- Enter the name of the child/youth assessed. In referrals where more than one child/youth is identified as being abused or neglected, a separate safety assessment is required for each child/youth.

The safety assessment consists of five sections.

SECTION 1: CONTEXT

This section includes a list of people who may have harmed the child/youth in the current report. It also covers child/youth vulnerabilities and facility vulnerabilities; each is a list of conditions that could make the child/youth more vulnerable to harm. A vulnerability does not automatically mean the child/youth is unsafe.

SECTION 2: SAFETY THREATS

This list of 11 safety threats (10 identified and defined and an "other") must be assessed by every worker in every case. They cover conditions that render a child/youth in danger of imminent, serious harm.

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. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the safety threats and accompanying definitions.

If the safety threat is present, based on available information, select “yes” for that item. If the safety threat is not present, select “no” for that item. Because not every conceivable safety threat can be anticipated or listed on a tool, the “other” category permits a worker to indicate that some other circumstance creates a safety threat.

SECTION 3: PROTECTIVE CAPACITIES

This section is completed only if one or more safety threats were identified. Select any of the listed protective capacities that are present for the child/youth and/or facility. Consider information from the referral; worker observations; interviews with child/youth, facility staff, and tribe (if applicable), and collaterals; and review of records. For “other,” consider any condition that exists and does not fit within one of the listed categories but may support protective interventions for the safety threats identified in Section 2.

SECTION 4: PROTECTIVE INTERVENTIONS

This section is completed only if one or more safety threats are identified and the worker has determined that a safety plan can be developed with the facility that will protect the child/youth in the facility while the investigation continues. When considering protective interventions, the child/youth should be included in understanding which interventions could help mitigate the safety threat(s).

A safety threat being present does not automatically mean that a child/youth must be moved from the facility. In many cases, it will be possible to initiate a temporary plan that will mitigate the safety threat(s) sufficiently so that the child/youth may remain in the facility while the investigation continues. When determining whether a safety plan can be developed, consider the relative severity of the safety threat(s), child/youth and facility protective capacities, the child/youth’s vulnerability, and the available protective interventions.

The protective intervention list contains general categories of interventions rather than specific programs. The worker should consider each category of interventions, determine whether an intervention in that category is available and sufficient to mitigate the safety threat(s), and determine whether there is reason to believe the facility will follow through with a planned intervention.

Simply because an intervention exists in the community or facility does not mean it should be used in a particular case. The worker may determine that even with an intervention, the child/youth would be unsafe; or the worker may determine that an intervention would be satisfactory but has reason to believe the facility would not follow through. The worker should keep in mind that while any single intervention may be insufficient to mitigate the safety threat(s), a combination of interventions may provide adequate safety for a safety plan to be successful.

Also keep in mind that the safety intervention is not the case plan—it is not intended to “solve” the facility’s problems or provide long-term answers. A safety plan permits a child/youth to remain in the facility for a short-term period by listing specific, timely actions that address the identified safety threats.

If one or more interventions will be implemented, select each category that will be used. If there is an intervention that will be implemented that does not fit in one of the categories, select safety intervention 8 and briefly describe the intervention. Safety intervention 9 is used only when the child/youth is unsafe and only a placement change can ensure safety.

Safety Decision

If there are no identified safety threats for this child/youth in the facility, the safety decision is “safe.” If a safety threat was identified, use the protective capacities to determine if ‘safe with plan’ or ‘unsafe’ is the final safety decision.

Safety Plan

Counties should each use their own safety plan form. The following must be included in any safety plan.

- Each safety threat that has been identified and a description of the conditions or behaviors in the facility that place the child/youth in imminent danger of serious harm. The worker should use language the child/youth and facility staff understand so it is clear to them what caused the worker to identify the threat.
- Detailed information for each planned safety intervention: What needs to happen to keep the child/youth safe? Explain how safety threat(s) will be mitigated. What will the facility do to keep the child/youth safe? What will other people outside the facility do? What will the child/youth do? This should include a written statement of actions or behaviors, to be taken by a responsible party, that will keep the child/youth safe in the current conditions.
- Who is participating in the plan, each participant’s role, a description of how the safety plan will be monitored (e.g., who is responsible for each intervention action), and the timeframe each intervention will remain in place.
- Signature lines for facility staff, the worker, and the worker’s supervisor. Include tribal representative’s signature in cases including an Indian child/youth.

A safety plan is required when safety decision is “safe with plan.”

The safety plan should be documented in the investigation contact and flagged with the appropriate special project code in CWS/CMS as specified in ACL 22-02.

The safety plan *must* be developed in partnership with and agreed to by the facility leadership and staff. The child/youth should be included in safety plan development to include their perspective of how interventions can mitigate the safety threat(s). Leave a copy with the facility and another with the child/youth.

Note: A facility firing or suspending the alleged perpetrator staff member is not sufficient in and of itself for a safety plan. The safety plan must include other action items as well; e.g., what the child/youth will

do if they become triggered by a similar event, what the facility will do to ensure the fired or suspended staff will not have access to the child/youth in the community.

If safety threats have not been resolved by the end of the investigation, the investigating worker will provide the safety plan to the ongoing services worker. The ongoing services worker will be responsible for maintaining the safety plan and all remaining interventions until the safety threat has been resolved.

Practice Guidance

Where it is known or there is reason to know that a child/youth is an Indian child/youth, safety plans should be developed in consultation with the tribe, with consideration given to the prevailing social and cultural standards and way of life of an Indian child/youth's tribe, as described in MPP 31-127.23. Consider having tribal resources, Indian community service agencies, and/or tribal representative participate in the safety plan and assist the family in addressing the identified safety threats.

SECTION 5: PLACEMENT CHANGE

This section is completed only when, after considering child/youth and facility protective capacities, the vulnerability of the child/youth, and the protective interventions that are available, the worker determines that placement change is the only intervention for protection of the child/youth. If the child/youth is an Indian child/youth or there is reason to know they are an Indian child/youth, the affiliated tribe(s) must be contacted if there is going to be a placement change.

If one or more safety threats are identified and the worker determines that protective interventions are unavailable, are insufficient, or may not be used, the final option is to indicate that the child/youth will be moved by selecting placement intervention 10.

Special consideration should be given to the impact of placement changes on children/youth. Placement changes can result in continued or additional trauma to the child/youth, and interventions should be initiated when possible.

SECTION 6: OTHER ACTIONS THAT MAY BE NEEDED

This section contains reminders to staff of other key activities that may be needed during the safety assessment process, including reporting other children/youth with child abuse and neglect concerns to the hotline at the county that placed that child/youth at that facility, contacting CCL if they have not been contacted, and contacting law enforcement if a cross-report is required. Collaboration with CCL and other parties involved is important to maintain transparency. Information sharing can benefit all parties involved and streamline decision making to best support the child/youth and facility involved.

PRACTICE CONSIDERATIONS

While safety is the prevailing concern of the first face-to-face contact, the manner of engaging the facility and child/youth will depend upon social work skills. Whenever possible, the worker should use a strengths-based approach in the initial contact while remaining observant for the presence or absence of safety threats. Most safety threats are salient and can be discerned without invasive questioning. Others are easier to assess when facility staff are candid, which is more likely when the worker approaches the facility with respect. If there are significant safety issues, the first face-to-face contact may be limited to assessing safety. At other times, the worker will also begin to gather additional clinical information along with information regarding risk, strengths, and needs.

For all cases in which the child/youth or parent/guardian/Indian custodian knows their tribe and membership status, the worker must contact the tribe to engage and work with the designated tribal representative or tribal family services department.

Resources for Indian children/youth vary depending on a tribe's resources and the location of the child/youth and family (rural versus urban, proximity to tribal resources, or proximity to urban Indian community resources). The child/youth's and/or parent/guardian/Indian custodian's tribe may provide resources through tribal family services or through a tribal consortium. Some urban areas have resources through Indian resource centers, Indian health clinics, Tribal Temporary Assistance for Needy Families (TANF), or Title VII Indian education programs (which may not be affiliated with a tribe). Some county child welfare agencies have a dedicated Indian specialist or specialty unit that serves Indian children/youth, who can assist with engagement and access to resources. They may also have current contact information to assist the child/youth in obtaining membership with their tribe. Many tribes have public websites that provide information about their ICWA or family service programs.

For children/youth of non-federally recognized tribes, the "Spirit of ICWA" expands the option and availability of culturally appropriate services to children/youth, which may include local Indian resource centers, tribal TANF, or Title VII Indian education programs. Resources such as the US Department of the Interior and the US Children's Bureau are available to assist the worker and caregivers in tracing Indian ancestry.

CHAPTER D:

SDM®

SUBSTITUTE

CARE

PROVIDER

SAFETY

ASSESSMENT

SDM® SUBSTITUTE CARE PROVIDER SAFETY ASSESSMENT

California Department of Social Services

r: 10/23

Primary SCP Name: _____ Referral Number: _____

Date of Referral: _____ Date of Assessment: _____

List any other related referrals:

Name(s) and age(s) of foster children in the household:

CSW Name: _____

SCP TYPE

- ☐ Foster
- ☐ Relative
- ☐ NREFM
- ☐ FFA
 - ☐ Small family home

SECTION 1: SAFETY THREATS

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

1. THE SCP 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:

- ☐ Yes (select all that apply)
 - ☐ Injury or abuse to the child other than accidental.
 - ☐ The SCP fears they will maltreat the child and/or requests the child's removal.
 - ☐ Threat to cause harm or retaliate against the child.
 - ☐ Domestic violence likely to injure child.
 - ☐ Excessive discipline or physical force.
- ☐ No

2. CHILD SEXUAL ABUSE IS SUSPECTED, AND CIRCUMSTANCES SUGGEST THAT THE CHILD'S SAFETY MAY BE OF IMMEDIATE CONCERN.

- ☐ Yes
- ☐ No

3. THE SCP DOES NOT MEET THE CHILD'S NEEDS FOR SUPERVISION, FOOD, CLOTHING, AND/OR MEDICAL OR MENTAL HEALTH CARE.

- ☐ Yes
- ☐ No

4. THE PHYSICAL LIVING CONDITIONS ARE HAZARDOUS AND IMMEDIATELY THREATENING TO THE HEALTH AND/OR SAFETY OF THE CHILD.

- ☐ Yes
- ☐ No

5. THE SCP ROUTINELY DESCRIBES THE CHILD IN NEGATIVE TERMS OR ACTS TOWARD THE CHILD IN NEGATIVE WAYS.

- ☐ Yes
- ☐ No

6. THE SCP FAILS TO PROTECT THE CHILD FROM HARM OR THREATENED HARM BY OTHERS. THIS MAY INCLUDE PHYSICAL ABUSE, SEXUAL ABUSE, NEGLECT, OR EMOTIONAL ABUSE.

- ☐ Yes
- ☐ No

7. THE SCP'S EXPLANATION FOR THE INJURY TO THE CHILD IS QUESTIONABLE OR INCONSISTENT WITH THE TYPE OF INJURY.

- ☐ Yes
- ☐ No

8. THE SCP HINDERS/REFUSES ACCESS TO THE CHILD.

- ☐ Yes
- ☐ No

9. CURRENT CIRCUMSTANCES, COMBINED WITH PRIOR REFERRALS OF ABUSE/NEGLECT AND/OR INCIDENT REPORTS, SUGGEST THAT THE CHILD'S SAFETY MAY BE OF IMMEDIATE CONCERN.

- ☐ Yes
- ☐ No

10. OTHER

Specify: _____

- ☐ Yes
- ☐ No

SAFETY DECISION: IF NO SAFETY THREATS ARE PRESENT, SELECT THE SAFETY DECISION BELOW.

- ☐ **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.

SECTION 1A: SUBSTITUTE CARE PROVIDER COMPLICATING BEHAVIORS

If yes is selected for any safety threats above, indicate whether any of the following behaviors are present. These are conditions that make it more difficult or complicated to create safety for a child, but do not by themselves constitute a safety threat. These factors must be considered when assessing for and planning to mitigate safety threats with a safety plan.

Select all that apply to the household.

- ☐ Developmental/cognitive impairment
- ☐ Domestic violence
- ☐ Mental health
- ☐ Physical condition
- ☐ Substance abuse
- ☐ Other (specify): _____

SECTION 2: IN-HOME PROTECTIVE INTERVENTIONS

SAFETY DECISION

- ☐ **Safe with plan.** One or more safety threats are present; however, the child can safely remain in the placement with a safety plan. In-home protective interventions have been initiated through a safety plan and the child will remain in the placement as long as the safety interventions mitigate the safety threats. Select all in-home interventions utilized in the safety plan.

Select all that apply:

- ☐ 1. Intervention or direct services by worker.
- ☐ 2. Use of family, neighbors, or other individuals in the community as safety resources.
- ☐ 3. Use of community agencies or services as safety resources.
- ☐ 4. Have the SCP appropriately protect the victim from the alleged perpetrator.
- ☐ 5. Have the alleged perpetrator leave the household, either voluntarily or in response to legal action.
- ☐ 6. Other (specify): _____

SECTION 3: PLACEMENT INTERVENTIONS

- ☐ 7. Removal from current placement is necessary because interventions 1–6 do not adequately ensure the child's safety.

SAFETY DECISION

- **Unsafe.** One or more safety threats are present, and removal from the SCP's household is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate harm.

If unsafe, document which foster children are being removed from placement and which foster children (if any) will not be removed from placement.

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Copy the appropriate individuals according to agency policy.

SDM® SUBSTITUTE CARE PROVIDER SAFETY ASSESSMENT DEFINITIONS

California Department of Social Services

GENERAL DEFINITIONS

FOSTER CHILD

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

LEGAL GUARDIAN

A person who has the legal authority and duty to care for a child.

SUBSTITUTE CARE PROVIDER (SCP)

A person providing out-of-home care to children, including approved relatives or non-related extended family members; and licensed foster homes, foster family homes, and/or small family homes.

SECTION 1. SAFETY THREATS

1. THE SCP 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.

The SCP fears they will maltreat the child and/or requests the child's removal.

Threat to cause harm or retaliate against the child.

Threat of action which could result in harm; or plans to retaliate against the child for CPS investigation.

Domestic violence likely to injure child.

There have been incidents of household violence that created a danger of physical injury to the child AND there is reason to believe that this may occur again (e.g., domestic violence perpetrator and victim are still involved in a relationship; a pattern of household violence continues to exist). For example:

- The child was in the arms of one person during a violent episode.
- A gun, knife, or other implement was involved.
- The child attempted to intervene or was near enough to violent altercation that he or she was in harm's way.

Excessive discipline or physical force.

The SCP used physical methods to discipline a child that resulted or could easily result in injury; OR the SCP injured or nearly injured a child by using physical force for reasons other than discipline; OR used corporal punishment; or the SCP has acted in a way that bears no resemblance to reasonable discipline.

2. 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 following:

- The child discloses sexual abuse either verbally or behaviorally by an SCP or others in the household (e.g., age-inappropriate, sexualized behavior toward self or others).
- Medical findings consistent with molestation.
- The SCP or others in household have been convicted, investigated, or accused of sexual misconduct with the child.
- Indications of poorly defined or questionable sexual boundaries between household members; and/or the SCP 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 or showering/bathing practices, exposure to nudity or sexually explicit materials, etc.
- Access to the child by possible or confirmed sexual abuse perpetrator exists.

3. THE SCP 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; or there is insufficient food in the home.
- The child is without warm clothing in cold weather.

- The SCP does not seek treatment for the child's medical/dental/vision condition(s) or does not follow prescribed treatment for such conditions. (For example, not providing insulin for a child with diabetes, not providing follow-up care for a wound that is infected, not providing care for a broken bone, or overmedicating a child with prescribed or unprescribed medication.)
- The child has special needs, such as being medically fragile, which the SCP does not or cannot meet.
- The child has serious emotional symptoms, lack of behavioral control, or psychosomatic symptoms (e.g., sleep/appetite disturbance) and the SCP will not/cannot seek or provide appropriate interventions.
- The SCP does not attend to the child to the extent that the child's need for care goes unnoticed or unmet (e.g., the SCP 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).
- The SCP leaves the child alone (time period varies with age and developmental stage).
- The SCP is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) or incapacitated (e.g., injured, ill).
- The SCP makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.

4. 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.
- Lack of water or utilities (heat, plumbing, electricity) and no alternate or safe provisions have been made.
- Open/broken/missing windows.
- 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 and other weapons are not locked.
- Unrestricted access to pool or other body of water.
- Blocked exits or unmarked exit routes.
- Missing or non-functioning smoke detectors.
- Ungated stairways.
- Unsafe sleeping arrangements.

5. THE SCP ROUTINELY DESCRIBES THE CHILD IN NEGATIVE TERMS OR ACTS TOWARD THE CHILD IN NEGATIVE WAYS.

- The SCP describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
- The SCP routinely curses and/or repeatedly puts the child down.
- The SCP scapegoats a particular child in the household.
- The SCP blames the child for a particular incident or household problems.
- The SCP treats the child in markedly different ways that may stigmatize the child.
- The SCP interferes with the child's identity, reunification, or adoption (e.g., interferes with visitation or communication with birth parent, makes negative comments about the child's birth/adoptive family).
- The SCP undermines the validity and value of, or participation in, cultural support activities that are important to the child's cultural identity.

6. THE SCP FAILS TO PROTECT THE CHILD FROM HARM OR THREATENED HARM BY OTHERS. THIS MAY INCLUDE PHYSICAL ABUSE, SEXUAL ABUSE, NEGLECT, OR EMOTIONAL ABUSE.

The SCP fails to protect the child from harm or threatened harm as a result of physical abuse, neglect, sexual abuse, or emotional abuse by other family members, other household members, or others having regular access to the child.

- The SCP does not provide the supervision necessary to protect the child from potential harm by others, based on the child's age or developmental stage.
- An individual(s) with known violent criminal behavior/history resides in the household, or is allowed by the SCP to have access to the child.
- The SCP regularly takes the child to dangerous locations where drugs are manufactured or regularly administered (e.g., meth labs or drug houses, or locations used for prostitution or pornography).

7. THE SCP'S EXPLANATION FOR AN INJURY TO THE CHILD IS QUESTIONABLE OR INCONSISTENT WITH THE TYPE OF INJURY.

Factors to consider include the age of the child, location of the injury, exceptional needs of the child, or chronicity of injuries.

- Medical evaluation indicates injury is consistent with abuse; the SCP denies, or attributes injury to accidental causes.
- OR
- There was a suspicious injury that did not require medical treatment but was located on an infant, or for older children, on the torso, face, or head; covered multiple parts of the body; appeared to be caused by an object; or is in different stages of healing.

AND one of the following is true:

- The SCP's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury.
- OR
- The SCP denies abuse or attributes injury to accidental causes;
- OR
- The SCP's description of the injury or its cause minimizes the extent of harm to the child.

8. THE SCP HINDERS/REFUSES ACCESS TO THE CHILD.

- The SCP currently refuses or hinders access to the child and there has been a complaint of abuse and/or neglect.
- The SCP keeps the child at home, away from peers, school, and other outsiders for extended periods of time, for purposes of avoiding investigation.
- The SCP intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

9. CURRENT CIRCUMSTANCES, COMBINED WITH PRIOR REFERRALS OF ABUSE/NEGLECT AND/OR INCIDENT REPORTS, SUGGEST THAT THE CHILD'S SAFETY MAY BE OF IMMEDIATE CONCERN.

There must be both current concerns AND related previous referrals/incidents that represent an emerging or unresolved pattern. Previous incidents may include any of the following:

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

10. OTHER (Specify):

Circumstances or conditions that pose an immediate threat of serious harm to a child, which are not already described in safety threats 1–9.

SECTION 1A: SUBSTITUTE CARE PROVIDER COMPLICATING BEHAVIORS

SUBSTANCE ABUSE

The SCP has abused legal or illegal substances or alcoholic beverages in this incident to the extent that control of their actions or ***caregiving*** abilities is significantly impaired, or information is available that ***past abuse of legal or illegal substances has impaired the SCP's caregiving capabilities in the past.***

DOMESTIC VIOLENCE

There are indications of a recent history of one or more physical assaults between intimate members of the household, or threats/intimidation or harassment that are known as a result of self-report or other credible report by a family or other household member, friend, other collateral contacts, and/or police reports.

MENTAL HEALTH

The SCP appears to be mentally ill at the time of this incident or has a known history of mental health issues ***that have or could have impacted care of children***. The SCP may have a past diagnosis, hospitalization(s), or referrals for observation that are known as a result of self-report or other credible report by a family or other household member, friend, other collateral contacts, and/or police reports.

DEVELOPMENTAL/COGNITIVE IMPAIRMENT

The SCP may have diminished capacity as a result of developmental delays or cognitive issues ***that may impact their ability to provide care and supervision of children***.

PHYSICAL CONDITION

The SCP has a physical condition that impacts care and protection of the child in the household.

OTHER (Specify)

Other caregiver complicating behaviors that make it more difficult or complicated to create safety for a child that must be considered when assessing for and planning to mitigate safety threats with a safety plan.

SECTION 2. IN-HOME PROTECTIVE INTERVENTIONS

SAFE WITH PLAN

One or more safety threats are present; however, the child can safely remain in home with a safety plan. In-home protective interventions have been initiated through a safety plan and the child will remain in the home as long as the safety interventions mitigate the safety threats. Select all in-home interventions used in the safety plan.

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes. Follow county policies whenever applying any of the safety interventions.

1. INTERVENTION OR DIRECT SERVICES BY WORKER.

Actions taken or planned by the investigating worker or other CPS staff that specifically address one or more safety threats. Examples include providing information about nonviolent disciplinary methods, the child's development needs, or parenting practices; providing emergency material aid such as food; planning return visits to the home to check on progress; providing information on obtaining restraining orders; and providing definitions of child abuse laws and informing involved parties of consequences of violating these laws. DOES NOT INCLUDE the investigation itself, or services provided to respond to family needs that do not directly affect safety.

2. USE OF FAMILY, NEIGHBORS, OR OTHER INDIVIDUALS IN THE COMMUNITY AS SAFETY RESOURCES.

Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbors, or other individuals to mitigate safety concerns; agreement by a neighbor or relative to serve as a safety net for the child.

3. USE OF COMMUNITY AGENCIES OR SERVICES AS SAFETY RESOURCES.

Involving community-based organizations, faith-related organizations, or other agencies in activities to address safety concerns. DOES NOT INCLUDE long term therapy or treatment or being put on a waiting list for services.

4. HAVE THE SCP APPROPRIATELY PROTECT THE VICTIM FROM THE ALLEGED PERPETRATOR.

The SCP has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator.

5. HAVE THE ALLEGED PERPETRATOR LEAVE THE HOUSEHOLD, EITHER VOLUNTARILY OR IN RESPONSE TO LEGAL ACTION.

Removal of the alleged perpetrator. Examples include arrest of alleged perpetrator, "kicking out" alleged perpetrator who has no legal right to residence, or perpetrator agrees to leave.

6. OTHER (Specify).

The family or worker identifies a unique intervention for an identified safety concern that does not fit within items 1–5.

7. REMOVAL FROM CURRENT PLACEMENT IS NECESSARY BECAUSE INTERVENTIONS 1–6 DO NOT ADEQUATELY ENSURE THE CHILD’S SAFETY.

One or more children will be removed from the current placement to an alternative placement resource.

SDM® SUBSTITUTE CARE PROVIDER SAFETY ASSESSMENT POLICY AND PROCEDURES

California Department of Social Services

WHICH CASES

All investigations of alleged abuse/neglect by an SCP, including:

- Licensed foster homes;
- Non-related extended family members (NREFM);
- Approved relative homes;
- Certified foster family agencies (FFA);
- Small family homes;
- Adoptive parents if the adoption has not yet been finalized; or
- Legal guardians, when a dependency case is still open (i.e., the department has protective responsibility for the child).

Excludes group homes, institutions, and residential treatment facilities.

WHEN

As part of the investigation, prior to leaving the child in the home—documented within two working days of the first face-to-face contact with the alleged child victim. If needed, a subsequent SCP safety assessment may be completed to assess changes in safety during the investigation.

WHO

The investigating social worker.

DECISION

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

APPROPRIATE COMPLETION

Workers should familiarize themselves with the items that are 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 SDM safety assessment for child protective service investigations.

Use of the safety assessment ensures that every worker is assessing the same items in each investigation of abuse/neglect by an SCP, 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 their initial contact as they normally would, using good social work practice to collect information from the child, SCP, and/or collateral sources. The SDM system ensures that the specific items that comprise the safety assessment are assessed at some time during the initial contact.

Enter the name of the primary SCP and record the type of home being assessed. List the referral names and numbers of any related referrals for other foster children in the home. Complete one assessment per referral.

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 that the worker made initial face-to-face contact with the child(ren) to assess safety. This may be different than the date that the form is being completed in WebSDM.

The safety assessment consists of four sections:

SECTION 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 an SCP. 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, there is something other than the listed categories 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 expected that not all facts about a case can be known immediately. Some information is inaccessible, and some may be 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, select "yes" for that item. If the safety threat is not present, select "no" for 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 select "other" and briefly describe the threat.

If no safety threats are identified, the safety decision is “safe.”

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. The SDM assessment guides the worker to leave the child in the placement for the present.

SECTION 1A: SUBSTITUTE CARE PROVIDER COMPLICATING BEHAVIORS

This section is completed only when there are safety threats identified as present in the household. If “yes” is selected for any of the safety threats and there is evidence that one or more caregivers are experiencing substance abuse, mental health concerns, domestic violence, or cognitive/developmental or physical health concerns, indicate all that apply. These are conditions which make it more difficult or complicated to create safety for a child, but do not by themselves constitute a safety threat. These behaviors must be considered when assessing for and planning to mitigate safety threats. Select all that apply to the household.

SECTION 2: IN-HOME PROTECTIVE 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 SCP’s home. In many cases, it will be possible to initiate a temporary plan that will mitigate the safety threat(s) sufficiently so that the child may remain in the placement 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 an intervention in that category is available and sufficient to mitigate the safety threat(s), and whether there is reason to believe the SCP 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 SCP would not follow through. The worker should keep in mind that while any single intervention may be insufficient to mitigate the safety threat(s), 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 safety plan permits a child to remain in the placement 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 SCP’s home.

If one or more interventions will be implemented, select each category that will be used. If there is an intervention that will be implemented that does not fit in one of the categories, select item 6 and briefly describe the intervention. Safety intervention 7 is used only when it is determined that no interventions that would allow the current placement to continue are available or appropriate to mitigate safety threats.

Safe With Plan

One or more safety threats are present; however, the child can safely remain in the placement with a safety plan.

Select this safety decision if one or more safety threats are identified and the worker is able to identify sufficient protective interventions that lead the worker to believe that the child may remain in the home for the present time.

Safety Plan

Individual counties should use their own safety plan form. The following must be included in any safety plan:

1. Each safety threat that has been identified and a description of the conditions or behaviors in the home that place any child at imminent threat of serious harm. The worker should use language the family understands so it is clear to them what caused the worker to identify the threat.
2. Detailed information for each planned safety intervention. What needs to happen to keep the child safe? Explain how safety threat(s) will be mitigated. What will the family do to keep the child safe? What will other people outside the family do? This should include a written statement of actions or behaviors to be taken by a responsible party, which will keep the child safe in the current conditions.
3. Who is participating in the plan, the role of each participant, and information that describes how the safety plan will be monitored (e.g., who is responsible for each intervention action) and the timeframe during which each intervention will remain in place.
4. Signature lines for family members, the worker, and their supervisor.

A SAFETY PLAN IS REQUIRED WHEN SAFETY DECISION IS "SAFE WITH PLAN."

Note: The safety plan should be documented in CWS/CMS.

The safety plan MUST be completed with the SCP, and a copy should be left with the family.

SECTION 3: PLACEMENT INTERVENTIONS

Unsafe

One or more safety threats are present, and removal from the SCP's household is the only protective intervention possible for one or more children.

The worker has determined that the child cannot be safely kept in the home, even after considering a complete range of interventions. It is possible that the worker will determine that interventions make it possible for one child to remain in the home while another must be removed. Select this safety decision if ANY child is removed from the home.

If one or more children are moved to another placement, list the names of foster children who are being removed from the home and the names of any foster children who were not removed from the home.

CHAPTER E:

SDM® FAMILY

RISK

ASSESSMENT

SDM® FAMILY RISK ASSESSMENT

California Department of Social Services

r: 10/23

Referral Name: _____ Referral Number: _____

Date Completed: _____ County: _____

Worker Name: _____ Worker ID Number: _____

PRIOR INVESTIGATIONS

1. PRIOR NEGLECT INVESTIGATIONS

Answers	Neglect	Abuse
<input type="radio"/> a. No prior neglect investigations	0	0
<input type="radio"/> b. One prior neglect investigation	0	1
<input type="radio"/> c. Two prior neglect investigations	1	1
<input type="radio"/> d. Three or more prior neglect investigations	2	1

2. PRIOR ABUSE INVESTIGATIONS

Answers	Neglect	Abuse
<input type="radio"/> a. No prior abuse investigations	0	0
<input type="radio"/> b. One prior abuse investigation	1	0
<input type="radio"/> c. Two prior abuse investigations	1	1
<input type="radio"/> d. Three or more prior abuse investigations	1	2

3. HOUSEHOLD HAS PREVIOUS OR CURRENT OPEN ONGOING CPS CASE (VOLUNTARY/COURT ORDERED)

Answers	Neglect	Abuse
<input type="radio"/> a. No	0	0
<input type="radio"/> b. Yes, but not open at the time of this referral	1	1
<input type="radio"/> c. Yes, household has open CPS case at the time of this referral	2	2

4. PRIOR PHYSICAL INJURY TO A CHILD RESULTING FROM CHILD ABUSE/NEGLECT OR PRIOR SUBSTANTIATED PHYSICAL ABUSE OF A CHILD

Answers	Neglect	Abuse
<input type="radio"/> a. None/not applicable	0	0
<input type="radio"/> b. One or more apply (<i>select all applicable</i>)		
<input type="checkbox"/> Prior physical injury to a child resulting from child abuse/neglect	0	1
<input type="checkbox"/> Prior substantiated physical abuse of a child		

CURRENT INVESTIGATION

5. CURRENT REPORT MALTREATMENT TYPE

Select all applicable

Answers	Neglect	Abuse
<input type="checkbox"/> a. Neglect	1	0
<input type="checkbox"/> b. Physical and/or emotional abuse	0	1
<input type="checkbox"/> c. None of the above	0	0

6. NUMBER OF CHILDREN INVOLVED IN THE CHILD ABUSE/NEGLECT INCIDENT

Answers	Neglect	Abuse
<input type="radio"/> a. One, two, or three	0	0
<input type="radio"/> b. Four or more	1	1

7. PRIMARY CAREGIVER ASSESSMENT OF THE INCIDENT

Answers	Neglect	Abuse
<input type="radio"/> a. Caregiver does not blame the child	0	0
<input type="radio"/> b. Caregiver blames the child	0	1

FAMILY CHARACTERISTICS

8. AGE OF YOUNGEST CHILD IN THE HOME

Answers	Neglect	Abuse
<input type="radio"/> a. 2 years or older	0	0
<input type="radio"/> b. Under 2	1	0

9. CHARACTERISTICS OF CHILDREN IN THE HOUSEHOLD

Answers	Neglect	Abuse
<input type="radio"/> a. Not applicable	0	0
<input type="radio"/> b. One or more present (<i>select all applicable</i>)	Not Scored	Not Scored
<input type="checkbox"/> Mental health or behavioral problems	1*	1*
<input type="checkbox"/> Developmental disability	0 or 1*	0 or 1*
<input type="checkbox"/> Learning disability	0 or 1*	0 or 1*
<input type="checkbox"/> Physical disability	0 or 1*	0
<input type="checkbox"/> Medically fragile or failure to thrive	0 or 1*	0

*The first item selected will add one point for this column, any additional selections will not result in further points added.

10. HOUSING

Answers	Neglect	Abuse
<input type="radio"/> a. Household has physically safe housing	0	0
<input type="radio"/> b. One or more apply (<i>select all applicable</i>)		
<input type="checkbox"/> Physically unsafe; OR	1	0
<input type="checkbox"/> Family homeless		

11. INCIDENTS OF DOMESTIC VIOLENCE IN THE HOUSEHOLD IN THE PAST YEAR

Answers	Neglect	Abuse
<input type="radio"/> a. None or one incident of domestic violence	0	0
<input type="radio"/> b. Two or more incidents of domestic violence	0	1

12. PRIMARY CAREGIVER DISCIPLINARY PRACTICES

Answers	Neglect	Abuse
<input type="radio"/> a. Employs appropriate discipline	0	0
<input type="radio"/> b. Employs excessive/inappropriate discipline	0	1

13. PRIMARY OR SECONDARY CAREGIVER HISTORY OF ABUSE OR NEGLECT AS A CHILD

Answers	Neglect	Abuse
<input type="radio"/> a. No history of abuse or neglect for either caregiver	0	0
<input type="radio"/> b. One or both caregivers have a history of abuse or neglect as a child	1	1

14. PRIMARY OR SECONDARY CAREGIVER MENTAL HEALTH

Answers	Neglect	Abuse
<input type="radio"/> a. No past or current mental health problem	0	0
<input type="radio"/> b. Past or current mental health problem (<i>select all applicable</i>)	1	1
<input type="checkbox"/> During the past 12 months	Not Scored	Not Scored
<input type="checkbox"/> Prior to the last 12 months	Not Scored	Not Scored

15. PRIMARY OR SECONDARY CAREGIVER ALCOHOL AND/OR DRUG USE

Answers	Neglect	Abuse
<input type="radio"/> a. No past or current alcohol/drug use that interferes with family functioning	0	0
<input type="radio"/> b. Past or current alcohol/drug use that interferes with family functioning (<i>select all applicable</i>)	1	1
<input type="checkbox"/> Alcohol (if yes, indicate) <input type="checkbox"/> Last 12 months and/or <input type="checkbox"/> Prior to the last 12 months	Not Scored	Not Scored
<input type="checkbox"/> Drugs (if yes, indicate) <input type="checkbox"/> Last 12 months and/or <input type="checkbox"/> Prior to the last 12 months	Not Scored	Not Scored

16. PRIMARY OR SECONDARY CAREGIVER CRIMINAL ARREST HISTORY

Answers	Neglect	Abuse
<input type="radio"/> a. No caregiver has prior criminal arrests	0	0
<input type="radio"/> b. Either caregiver has one or more criminal arrests	1	0

TOTAL

	Neglect	Abuse
Total Score		

SCORED RISK LEVEL

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

NEGLECT SCORE	ABUSE SCORE	SCORED RISK LEVEL
<input type="radio"/> 0–2	<input type="radio"/> 0–1	<input type="radio"/> Low
<input type="radio"/> 3–5	<input type="radio"/> 2–4	<input type="radio"/> Moderate
<input type="radio"/> 6–8	<input type="radio"/> 5–7	<input type="radio"/> High
<input type="radio"/> 9 +	<input type="radio"/> 8 +	<input type="radio"/> Very high

OVERRIDES

POLICY OVERRIDES

Select yes or no for each question. Select yes if a condition shown below is applicable in this case. If **any** condition is applicable, override the final risk level to **very high**. (This is automated in WebSDM.)

1. Sexual abuse case AND the perpetrator is likely to have access to the child.

- ☐ Yes
- ☐ No

2. Non-accidental injury to a child under age 2.

- ☐ Yes
- ☐ No

3. Severe non-accidental injury.

- ☐ Yes
- ☐ No

4. Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).

- ☐ Yes
- ☐ No

Is a policy override needed?

- ☐ Yes. If yes, increase risk to Very High
- ☐ No

DISCRETIONARY OVERRIDE

Is a discretionary override needed?

- ☐ Yes. If yes, increase risk by one level: ☐ Moderate ☐ High ☐ Very High
- ☐ No

Discretionary override reason: _____

Supervisor Review/Approval: _____

FINAL RISK LEVEL

Select final level assigned

- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ Very high

RECOMMENDED DECISION

FINAL RISK LEVEL	SAFE	SAFE WITH PLAN	UNSAFE
Low/Moderate	Close	Open	Open
High/Very High	Refer to services or open	Open	Open

PLANNED ACTION

Indicate what action you plan to take after completing the risk assessment.

- ☐ Close without any intervention
- ☐ Refer to services as primary intervention
 - ☐ Universal prevention services
 - ☐ Specialist prevention services or community agency: _____
 - ☐ Substance use
 - ☐ In-home parenting
 - ☐ Mental health
 - ☐ Domestic violence
 - ☐ Other: _____
 - ☐ Differential response program
- ☐ Open for child welfare services case
 - ☐ Family Maintenance (voluntary in-home)
 - ☐ Family Maintenance (court-ordered in-home)
 - ☐ Out of home (select only for households with unmitigated safety threats)
 - ☐ Other: _____

If recommended decision and planned action do not match, explain why.

SUPPLEMENTAL RISK ITEMS

Note: These items should be recorded but are not scored. Answer yes or no to each item.

1. EITHER CAREGIVER DEMONSTRATES DIFFICULTY ACCEPTING ONE OR MORE CHILDREN'S GENDER IDENTITY OR SEXUAL ORIENTATION.

- ☐ a. No
- ☐ b. Yes

2. ALLEGED PERPETRATOR IS AN UNMARRIED PARTNER OF THE PRIMARY CAREGIVER.

- ☐ a. No
- ☐ b. Yes

3. ANOTHER NON-RELATED ADULT IN THE HOUSEHOLD PROVIDES UNSUPERVISED CHILD CARE TO A CHILD UNDER THE AGE OF 3.

- ☐ a. Not applicable
- ☐ b. No
- ☐ c. Yes. If yes, answer the following:

3a. Is the other non-related adult in the household employed?

- ☐ No
- ☐ Yes

4. EITHER CAREGIVER IS ISOLATED IN THE COMMUNITY.

- ☐ a. No
- ☐ b. Yes

5. CAREGIVER HAS PROVIDED SAFE AND STABLE HOUSING FOR AT LEAST THE PAST 12 MONTHS.

- ☐ a. No
- ☐ b. Yes

SDM® FAMILY RISK ASSESSMENT DEFINITIONS

California Department of Social Services

PRIOR INVESTIGATIONS

1. PRIOR NEGLECT INVESTIGATIONS

Identify whether there are prior investigations where neglect was alleged, substantiated, inconclusive, or unfounded. If there are prior investigations for neglect, identify the number of priors. Neglect includes severe and general neglect, exploitation (excluding sexual exploitation), and caregiver being absent/incapacitated, regardless of whether there were also abuse allegations in the investigation.

Do not include referrals that were not assigned for investigation.

Where possible, neglect history from other county or state jurisdictions should be included. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

For differential response referrals, include Paths 2 and 3.

Consider all adults in the household and count prior investigations for which they were alleged to be perpetrators (assign the highest score that applies).

- a. Choose "a" if there were no investigations for any type of neglect prior to the current investigation.
- b. Choose "b" if there was one investigation, substantiated or not, for any type of neglect prior to the current investigation.
- c. Choose "c" if there were two investigations, substantiated or not, for any type of neglect prior to the current investigation.
- d. Choose "d" if there were three or more investigations, substantiated or not, for any type of neglect prior to the current investigation.

2. PRIOR ABUSE INVESTIGATIONS

Identify whether there are prior investigations where abuse was alleged, substantiated, inconclusive, or unfounded. If there are prior investigations for abuse, identify the number of priors. Abuse includes physical abuse, emotional abuse, or sexual abuse/exploitation, regardless of whether there were any neglect allegations in the investigation.

Do not include referrals that were not assigned for investigation.

Where possible, history from other county or state jurisdictions should be included. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

For differential response referrals, include Paths 2 and 3.

Consider all adults in the household and count prior investigations for which they were alleged to be perpetrators (assign the highest score that applies).

- a. Choose "a" if there were no investigations for any type of abuse prior to the current investigation.
- b. Choose "b" if there was one investigation, substantiated or not, for any type of abuse prior to the current investigation.
- c. Choose "c" if there were two investigations, substantiated or not, for any type of abuse prior to the current investigation.
- d. Choose "d" if there were three or more investigations, substantiated or not, for any type of abuse prior to the current investigation.

3. HOUSEHOLD HAS PREVIOUS OR CURRENT OPEN ONGOING CPS CASE (VOLUNTARY/COURT ORDERED)

Identify whether the household has previously had or currently has an open case as a result of a prior investigation. Service history includes voluntary or court-ordered family services or Family Preservation Services but does not include delinquency services. Select the highest-scoring applicable response.

- a. Choose "a" if the household has not had an open CPS case prior to this investigation.
- b. Choose "b" if the household has previously had an open CPS case and that case is not open at the time of this investigation.
- c. Choose "c" if the household has a currently open CPS case at the time of this investigation that began prior to this investigation.

4. PRIOR PHYSICAL INJURY TO A CHILD RESULTING FROM CHILD ABUSE/NEGLECT OR PRIOR SUBSTANTIATED PHYSICAL ABUSE OF A CHILD

Identify whether a child has sustained a physical injury resulting from abuse and/or neglect by a current or former adult member of the household. Also identify whether any adult living in the household (caregiver or not) previously injured a child in an incident of abuse or neglect.

Injury sustained as a result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn.

- a. Choose "a" if no child has sustained a physical injury resulting from abuse and/or neglect prior to this investigation OR no current adult household member has caused such an injury OR there is no prior substantiated physical abuse to a child involving a current household member as a perpetrator, regardless of whether the child is a prior or current household member.
- b. Choose "b" if a child sustained a physical injury resulting from abuse and/or neglect prior to this investigation that was not previously known to the agency, based on credible information from the child, caregivers, or others.

OR

Choose "b" if there was prior substantiated physical abuse of a child involving a current household member as a perpetrator, regardless of whether the child is a prior or current household member.

CURRENT INVESTIGATION

5. CURRENT REPORT MALTREATMENT TYPE (*SELECT ALL APPLICABLE*)

Identify whether the current report is for neglect, physical/emotional abuse, or both. This includes referred allegations or allegations made during the course of the investigation.

- a. Choose "a" if the current report is for neglect.
- b. Choose "b" if the current report is for physical and/or emotional abuse.
- c. Choose "c" if the report does not include the above or is for sexual abuse/exploitation only.

6. NUMBER OF CHILDREN INVOLVED IN THE CHILD ABUSE/NEGLECT INCIDENT

Identify the number of children less than 18 years of age for whom abuse or neglect was alleged or substantiated in the current investigation. If any child is removed as a result of the current investigation, count the child as residing in the home.

- a. Choose "a" if there are one, two, or three children in the household.
- b. Choose "b" if there are four or more children in the household.

7. PRIMARY CAREGIVER ASSESSMENT OF THE INCIDENT

Identify whether the primary caregiver is supportive of the child in this incident or blames the child for the incident.

Blaming the child for the incident refers to the caregiver's statement that the maltreatment incident occurred because of the child's action or inaction (e.g., claiming that the child seduced them or the child deserved beating because they misbehaved).

- a. Choose "a" if the primary caregiver does not blame the child for the incident.

- b. Choose “b” if the primary caregiver does blame the child for the incident.

FAMILY CHARACTERISTICS

8. AGE OF YOUNGEST CHILD IN THE HOME

Identify the current age of the youngest child presently in the household where the maltreatment incident reportedly occurred. If a child is removed as a result of the current investigation, count the child as residing in the home.

- a. Choose “a” if all children in the household are 2 years of age or older.
- b. Choose “b” if any child in the household is younger than 2 years old.

9. CHARACTERISTICS OF CHILDREN IN THE HOUSEHOLD

Identify whether any child in the household has a developmental, learning, and/or physical disability; is diagnosed as medically fragile or failure to thrive; or has mental health and/or behavioral issues. Base identification on credible information from a caregiver that a child has been diagnosed, statements from a physician or mental health professional, or review of records.

- a. Choose “a” if no child in the household exhibits the characteristics listed in “b.”
- b. Choose “b” if any child in the household exhibits characteristics listed below and select all types present. Select all types that apply for any child in the household:

Mental health or behavioral problems

Any child in the household has mental health or behavioral problems not related to a physical or developmental disability. This could be indicated by a diagnosis made by a mental health professional in an area that impacts daily functioning, receiving mental health treatment, attendance in a special classroom because of behavioral problems, or if the child is currently taking prescribed psychoactive medications.

Developmental disability

A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

Learning disability

Child has an individualized education plan (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 or failure to thrive

- *"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 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 an ongoing threat to their continued well-being. Examples include a child who requires a trach-vent for breathing or a g-tube for eating.
- *Failure to thrive:* A diagnosis of failure to thrive by a physician.

10. HOUSING

Identify the family's current housing status.

- a. Choose "a" if the family has housing that is physically safe.
- b. Choose "b" if either of the following applies (select all applicable).
 - The family has housing, but the current housing situation is physically unsafe to the extent that it does not meet the health or safety needs of the child (e.g., exposed wiring, inoperable heat or plumbing, roach/rat infestations, human/animal waste on floors, rotting food).

OR

- The family is homeless or was about to be evicted at the time the investigation began or the family becomes homeless/receives an eviction notice by the time the risk assessment is completed. Consider as "homeless" people who are living in a shelter and those living on a short-term basis with relatives or friends.

11. INCIDENTS OF DOMESTIC VIOLENCE IN THE HOUSEHOLD IN THE PAST YEAR

Identify whether there has been domestic violence in the household in the past year. Identification may be based on a credible report from the caregiver(s), police reports, or other records.

- a. Choose "a" if, in the previous year, there has been one domestic violence incident or no domestic violence has occurred in the household.
- b. Choose "b" if in the previous year, there have been two or more physical assaults or multiple periods of intimidation/threats/harassment in the household between caregivers or between a caregiver and another adult.

12. PRIMARY CAREGIVER DISCIPLINARY PRACTICES

Identify the disciplinary practices of the primary caregiver of the child in the household.

- a. Choose "a" if the primary caregiver employs appropriate discipline.
- b. Choose "b" if the primary caregiver employs excessive/inappropriate discipline. Include excessively harsh physical or emotional disciplinary practices that caused or threatened harm to the child and/or were inappropriate given the child's age or development. Do not choose "b" if the actions of the caregiver that have caused harm or injury bear no resemblance to discipline.

Examples of excessive/inappropriate discipline include but are not limited to locking the child in a closet or basement, holding the child's hand over fire, hitting the child with dangerous implements, or depriving a young child of physical and/or social activity for extended periods.

13. PRIMARY OR SECONDARY CAREGIVER HISTORY OF ABUSE OR NEGLECT AS A CHILD

Identify whether either caregiver was maltreated as a child. Maltreatment includes neglect or physical, sexual, or emotional abuse.

- a. Choose "a" if there are no credible statements by the primary or secondary caregiver or others, or state records of past allegations, that indicate either caregiver was maltreated as a child.
- b. Choose "b" if credible statements by the primary or secondary caregiver or others, or state records of past allegations, indicate that either caregiver was maltreated as a child.

14. PRIMARY OR SECONDARY CAREGIVER MENTAL HEALTH

Identify the primary and secondary (if present) caregivers' mental health statuses.

- a. Choose "a" if the primary and secondary (if present) caregivers do not have past or current mental health problems.
- b. Choose "b" if credible and/or verifiable statements by the primary and/or secondary caregiver or others indicate that the primary and/or secondary caregiver:

- Has been diagnosed as having a significant mental health disorder that impacts daily functioning, as determined by a mental health professional; OR
- Has had repeated referrals for mental health/psychological evaluations; OR
- Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

If “b,” indicate whether the identified mental health problem is current (present in the last 12 months) and/or was present prior to the last 12 months before this referral.

15. PRIMARY OR SECONDARY CAREGIVER ALCOHOL AND/OR DRUG USE

Identify the primary and secondary (if present) caregivers’ alcohol and/or drug use, both current and historical, and whether it interferes or has interfered with family functioning.

- Choose “a” if the primary or secondary caregiver does not have and never has had a drug or alcohol problem that interferes with family functioning.
- Choose “b” if the primary or secondary caregiver has past or current alcohol and/or drug use that interferes with their or the family’s functioning. Such interference is evidenced by:
 - Substance use that affects or affected employment, criminal involvement, or marital or family relationships; and/or that affects or affected caregiver’s ability to provide protection, supervision, and care for the child;
 - An arrest in the past two years for driving under the influence (DUI) or refusing breathalyzer testing;
 - Self-report of a problem;
 - Treatment received currently or in the past;
 - Multiple positive urine samples;
 - Health/medical problems resulting from substance use and/or abuse; or
 - The child’s diagnosis with fetal alcohol syndrome or exposure, or the child’s positive toxicology screen at birth and the primary caregiver was the birth parent.

If “b,” indicate whether the identified substance use problem is current (present in the last 12 months) and/or was present prior to the last 12 months before this referral.

16. PRIMARY OR SECONDARY CAREGIVER CRIMINAL ARREST HISTORY

Indicate whether either the primary or secondary caregiver has a criminal arrest history prior to the current complaint as either an adult or a juvenile. This includes DUIs but excludes all other traffic offenses.

Information may be located in the case narrative material, reports from other agencies, self-report, etc. Also review any police reports in the file for this information.

- a. Choose “a” if neither caregiver has criminal arrests prior to this complaint.
- b. Choose “b” if either caregiver has one or more criminal arrests prior to the current complaint.

OVERRIDES

POLICY OVERRIDES

Select yes if a condition listed below is applicable in this case. If any condition is applicable, override the final risk level to very high.

1. Sexual abuse case AND the perpetrator is likely to have access to the child.

One or more of the children in this household are or have been victims of sexual abuse AND the perpetrator is likely to have unmanaged access.

2. Non-accidental injury to a child under age 2.

Any child under 2 years old in the household has any kind of physical injury resulting from the actions or inactions of a caregiver.

3. Severe non-accidental injury.

Severe non-accidental injury includes, for example, 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 action or inaction resulted in the death of a child due to abuse or neglect (previous 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. Select this override if this condition has ever existed within the household.

DISCRETIONARY OVERRIDE

A discretionary override is used by the ongoing worker whenever the worker believes that the risk score does not accurately portray the household’s actual risk level. The worker may only increase the risk

level. If the worker applies a discretionary override, the reason should be specified and the final risk level should be selected.

SUPPLEMENTAL RISK ITEMS

1. EITHER CAREGIVER DEMONSTRATES DIFFICULTY ACCEPTING ONE OR MORE CHILDREN'S GENDER IDENTITY OR SEXUAL ORIENTATION.

Identify whether either caregiver in the household indicates a lack of acceptance of a child's gender identity or sexual orientation. A lack of acceptance may be indicated by verbal statements (calling names, derogatory statements, etc.); actions (physical aggression, kicking the child out, etc.); or a lack of caregiver support, such as a failure to acknowledge the child's gender identity or sexual orientation.

- a. Choose "No" if neither caregiver demonstrates difficulty.
- b. Choose "Yes" if either caregiver demonstrates difficulty.

2. ALLEGED PERPETRATOR IS AN UNMARRIED PARTNER OF THE PRIMARY CAREGIVER.

Identify whether an alleged perpetrator in this incident is an unmarried partner of the primary caregiver in the household. The primary caregiver may or may not also be an alleged perpetrator.

- a. Choose "No" if an alleged perpetrator is not an unmarried partner.
- b. Choose "Yes" if an alleged perpetrator is an unmarried partner.

3. ANOTHER NON-RELATED ADULT IN THE HOUSEHOLD PROVIDES UNSUPERVISED CHILD CARE TO A CHILD UNDER THE AGE OF 3.

Identify whether another unrelated adult in the household (stepparent, significant other, or roommate) provides unsupervised child care to any child in the household who is younger than 3.

- a. Choose "No" if a stepparent, significant other, or roommate in the household does not provide unsupervised care for a child younger than 3.
- b. Choose "Yes" if a stepparent, significant other, or roommate in the household does provide unsupervised care for a child younger than 3.
- c. Choose "N/A" (not applicable) if there is only a primary caregiver in the household.

3a. Is the other non-related adult in the household employed?

Identify whether the other adult in the household (stepparent, significant other, or roommate) is employed or not.

- a. Choose "No" if the other adult in the household (stepparent, significant other, or roommate) providing unsupervised care to a child in the household younger than 3 is not employed.
- b. Choose "Yes" if the other adult in the household (stepparent, significant other, or roommate) providing unsupervised care to a child in the household younger than 3 is employed.
- c. Choose "N/A" if there is only a primary caregiver in the household.

4. EITHER CAREGIVER IS ISOLATED IN THE COMMUNITY.

Identify whether either caregiver in the household is isolated in the community, as evidenced by lack of communication with others, a lack of meaningful relationships, or a lack of access to community resources.

- a. Choose "No" if both caregivers have relationships in the community for support.
- b. Choose "Yes" if either caregiver is isolated in the community.

5. CAREGIVER HAS PROVIDED SAFE AND STABLE HOUSING FOR AT LEAST THE PAST 12 MONTHS.

Identify whether the caregiver has provided safe and stable housing for the last 12 months as evidenced by housing that is physically safe for the child.

- a. Choose "No" if the family has had frequent moves or if there are environmental conditions that pose a threat to the child.
- b. Choose "Yes" if the family has had safe and stable housing.

SDM® FAMILY RISK ASSESSMENT POLICY AND PROCEDURES

California Department of Social Services

The SDM family risk assessment classifies families into low-, moderate-, high-, or very high-risk categories according to the likelihood of future child protective services (CPS) involvement for alleged child abuse or neglect. By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will come to the attention of child protection for allegations of maltreatment to a child within the next 12 to 24 months.

The difference between risk levels is substantial. Families classified as high risk have significantly higher rates of subsequent referral and substantiation than families classified as low risk, and families classified as high risk are more often involved in abuse or neglect incidents that require more intensive agency involvement (e.g., child removal).

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

The current risk assessment is based on research on investigations with substantiated or inconclusive allegations of abuse or neglect. It examines the relationships between family characteristics and the outcomes of subsequent CPS referrals, investigations, substantiations, and placements. The tool does not predict recurrence but simply assesses whether a family shares characteristics with other families who are more or less likely to have subsequent CPS involvement.

WHICH CASES

Required for all substantiated and inconclusive referrals; also recommended to be completed on unfounded referrals.

A risk assessment should not be completed for the following in-person responses.

- An incident involving *only* a third-party perpetrator of sexual exploitation with no allegations regarding the caregiver.
- An investigation of child fatality suspected to be a result of abuse or neglect AND there are no remaining minor children in the household.
- A referral regarding allegations in an out-of-home care setting.
- New assigned referrals on open cases. Instead, complete relevant risk reassessment if applicable.

WHO

The social worker who is responding to the referral.

WHEN

After the safety assessment has been completed and the worker has reached a conclusion regarding the allegation AND prior to the decision to promote to a case or close without continuing services. This is no later than 30 days from the first face-to-face contact.

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 baseline risk assessment within 30 days of identifying that parent. (Note: This risk assessment is completed within a *case* in WebSDM.)

DECISION

The SDM risk level identifies the likelihood that a household will be involved with child protective services for alleged child abuse or neglect. When considered alongside the SDM safety assessment, the risk level can guide the decision of which families may benefit most from post-investigation services.

RECOMMENDED DECISION

FINAL RISK LEVEL	SAFE	SAFE WITH PLAN	UNSAFE
Low/Moderate	Close	Open	Open
High/Very High	Refer to services or open	Open	Open

PLANNED ACTION

Close without intervention

Safe families that have a low or moderate risk level should not be considered for formal child welfare intervention. These families may benefit from increased connection to natural support networks and community prevention services (e.g., heat, food pantry, TANF, SNAP).

Refer to services as primary intervention

Intervention for families in this group may include a referral to any of the following.

- Universal prevention services.

- Referral to a specialist agency or community agency as needed, based on specific family needs. Specialized services may include substance use services, in-home parenting supports, mental health supports, domestic violence services, or other targeted community-based services such as medical care or kinship navigation.
- Differential response programs such as Path 2 services provided by community agencies working in partnership with CWS to provide an alternative response.

Open for child welfare services case

Intervention for families in this group involves opening a child welfare services case, including the following.

- Family Maintenance services supporting in-home child welfare interventions including both voluntary and court-ordered.
- Out-of-home intervention. Select this intervention only for households with unmitigated safety threats.

APPROPRIATE COMPLETION

The risk assessment is completed based on conditions that exist at the time the incident is reported and investigated as well as 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 a member of two households and there are allegations on both households, complete a risk assessment on both households.
- Complete a second risk assessment for non-custodial parents who will receive reunification services.

SCORING INDIVIDUAL ITEMS

Workers should familiarize themselves with the items that are included on the risk assessment and the accompanying definitions for those items. A score for each assessment item is derived from the worker's observation of the characteristics the item describes during interviews with household members (child, caregivers, and others) and collaterals; worker observations; reports and case records; or other reliable sources. 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 their assessment of the family, through use of the definitions.

After all risk items are scored, the score is totaled and indicates the corresponding risk levels for both subsequent neglect and subsequent abuse. Next, the scored risk level is determined; it is the higher between the abuse and the neglect risk levels.

OVERRIDES

After completing the risk assessment, the worker considers whether reasons to override the scored risk level are present. There are two types of overrides. Overrides must be reviewed and approved by a supervisor.

Policy Overrides

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. Consider each of the four policy override reasons and select yes or no as appropriate for each policy override.

Discretionary Override

A discretionary override is used by the worker to increase the risk level in any case in which the worker believes that the scored risk level determined 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. When used, a discretionary override increases the scored risk level by one level (e.g., from low to moderate OR moderate to high, but NOT from low to high). Discretionary overrides require a written description of the reasons to increase the risk level and 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), and the discretionary risk level.

PLANNED ACTION

WebSDM will display the recommended response based on the scored risk level and the most recent safety decision on the allegation household. Enter the true planned action. If the recommended response differs from the planned action, provide an explanation and obtain supervisory approval.

SUPPLEMENTAL RISK ITEMS

These are items that are answered for each investigation in which a risk assessment is completed. The purpose of the supplemental risk items is to gather information in areas that are thought to have a relationship to subsequent harm. The supplemental risk items are used in validation of the risk assessment, which occurs every five to seven years. Use the definitions to answer the items and gather the information for the answers in the same way as the risk assessment items.

CHAPTER F: SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT

SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT

California Department of Social Services

r: 10/23

Case Name: _____ Case Number: _____

Date Completed: _____ County: _____

Worker Name: _____ Worker ID Number: _____

Household Name: _____

Primary Caregiver Name: _____

Secondary Caregiver Name: _____

Answer all questions below for primary and secondary caregiver if applicable.

SECTION 1: CAREGIVER STRENGTHS AND NEEDS ASSESSMENT

RACE

Select all that apply

Primary	Secondary	Race
<input type="checkbox"/>	<input type="checkbox"/>	African American/Black
<input type="checkbox"/>	<input type="checkbox"/>	American Indian/Alaska Native
<input type="checkbox"/>	<input type="checkbox"/>	Asian/Pacific Islander
<input type="checkbox"/>	<input type="checkbox"/>	Latino/a
<input type="checkbox"/>	<input type="checkbox"/>	Multiracial
<input type="checkbox"/>	<input type="checkbox"/>	White

☐ Other: _____

ETHNICITY

--

TRIBAL AFFILIATION

Primary	Secondary	Tribal Affiliation
<input type="checkbox"/>	<input type="checkbox"/>	Yes
<input type="checkbox"/>	<input type="checkbox"/>	No
<input type="checkbox"/>	<input type="checkbox"/>	Parent not available
<input type="checkbox"/>	<input type="checkbox"/>	Parent unsure

If "Yes" is selected, provide tribe name: _____

Federally Recognized

- ☐ Yes
☐ No

SEXUAL ORIENTATION

Primary	Secondary	Sexual Orientation
<input type="checkbox"/>	<input type="checkbox"/>	Heterosexual
<input type="checkbox"/>	<input type="checkbox"/>	Gay
<input type="checkbox"/>	<input type="checkbox"/>	Lesbian
<input type="checkbox"/>	<input type="checkbox"/>	Bisexual
<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Not discussed

GENDER IDENTITY/EXPRESSION

Primary	Secondary	Sexual Orientation
<input type="checkbox"/>	<input type="checkbox"/>	Female
<input type="checkbox"/>	<input type="checkbox"/>	Male
<input type="checkbox"/>	<input type="checkbox"/>	Transgender
<input type="checkbox"/>	<input type="checkbox"/>	Other

RELIGIOUS/SPIRITUAL AFFILIATION

OTHER CULTURAL IDENTITY IMPORTANT TO CAREGIVER

e.g., immigration status, disability status

A. HOUSEHOLD CONTEXT

Answer all the following items for both primary and secondary caregiver (if applicable).

The caregiver’s perspective of culture and cultural identity:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Consider how the family’s culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence or shape parenting and caregiving. Are there contacts or services within this culture that can be mobilized in the case plan to enhance safety now or over time?

B. CAREGIVER DOMAINS

Indicate whether the caregiver’s behaviors in each domain (a) actively help create safety, permanency, or well-being for the child/youth/young adult; (b) are neither a strength nor a barrier for child/youth/young adult safety, permanency, or well-being; (c) make it difficult to create long-term safety, permanency, or well-being (i.e., are a barrier); or (d) directly contribute to a safety threat.

Always select the highest priority that applies, e.g., if caregiver actions fit definitions “c” and “d,” select “d.”

Domains and behaviors identified as “d” 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 “d.”

SN1. Resource Management/Basic Needs

The caregiver’s resources and management of resources:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN2. Physical Health

The caregiver’s physical health:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN3. Parenting Practices

The caregiver’s parenting practices:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are a barrier to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN4. Social Support System

The caregiver's social support system:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively helps create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Is a barrier to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN5. Household and Family Relationships

The caregiver's relationships with other adult household members:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN6. Domestic Violence

The caregiver's intimate relationships:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN7. Substance Use

The caregiver's actions regarding substance use:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN8. Mental Health

The caregiver's mental health:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN9. Prior Adverse Experiences/Trauma

The caregiver's response to prior adverse experiences/trauma:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN10. Cognitive/Developmental Abilities

The caregiver's developmental and cognitive abilities:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

SN11. Other Identified Caregiver Strength or Need (not covered in SN1–SN10)

☐ Not applicable

An additional need or strength has been identified that:

Primary	Secondary	Answers
<input type="radio"/>	<input type="checkbox"/>	a. Actively help create safety, permanency, and child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	c. Are barriers to safety, permanency, or child/youth/young adult well-being.
<input type="radio"/>	<input type="checkbox"/>	d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Provide description of behaviors.

[illegible]

C. PRIORITY NEEDS AND STRENGTHS

Enter the item number and domain name of all of the most serious needs ("d"s first, then "c"s) from items SN1 – SN11. Describe if the need is for the primary caregiver, the secondary caregiver (if applicable) or for both. Then identify which needs are a priority for closure. Domains identified with a "d" should always be a priority. The family's priority needs should all be included in the family case plan.

Needs

SCORE (d's then c's)	DOMAIN NAME	CAREGIVER	PRIORITY FOR CLOSURE? (required if score is d)
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No

Strengths

Enter the item number and domain name of all of the family's strengths ("a" answers) from items SN1 – SN11. Describe if the strength is for the primary caregiver, the secondary caregiver (if applicable) or for both. These family strengths can be used to address the priority needs identified above. Determine if this strength should be included in the family case plan.

SCORE (d's then c's)	DOMAIN NAME	CAREGIVER	INCLUDE IN FAMILY CASE PLAN?
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Primary <input type="radio"/> Secondary <input type="radio"/> Both	<input type="radio"/> Yes <input type="radio"/> No

SECTION 2: CHILD/YOUTH/YOUNG ADULT STRENGTHS AND NEEDS ASSESSMENT

Repeat this section for each child/youth/young adult in the family.

Name of child/youth/young adult: _____

RACE

Select all that apply.

- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian/Pacific Islander
- ☐ Latino/a
- ☐ Multiracial
- ☐ White
- ☐ Other

ETHNICITY

TRIBAL AFFILIATION

- ☐ Yes. Provide tribal name: _____
- ☐ No
- ☐ Parent not available
- ☐ Parent unsure

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/YOUTH/YOUNG ADULT

e.g., immigration status, disability status

A. HOUSEHOLD CONTEXT

The child/youth/young adult's perspective of culture, cultural identity, norms, and past/current experiences of discrimination:

- ☐ a. Help them create safety, permanency, and well-being for themselves.
- ☐ b. Have no effect on their safety, permanency, or well-being.
- ☐ c. Make it difficult for them to experience long-term safety, permanency, or well-being.
- ☐ d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Consider how the child/youth/young adult's culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence them. Are there contacts or services within this culture that can be mobilized in the case plan?

B. CHILD/YOUTH/YOUNG ADULT DOMAINS

Indicate whether the behaviors of the child/youth/young adult in each domain (a) actively help create safety, permanency, or well-being for themselves; (b) are neither a strength nor a barrier for their safety, permanency, or well-being; (c) make it difficult to create long-term safety, permanency, or well-being (i.e., are a barrier); or (d) directly contribute to a safety threat.

Always select the highest priority that applies, e.g., if child/youth/young adult actions fit definitions "c" and "d," select "d."

Domains and behaviors identified as "d" 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 "d".

CSN1. Emotional/Behavioral Health

- ☐ a. The child/youth/young adult's emotional/behavioral health contributes to their safety.
- ☐ b. The child/youth/young adult does not have an emotional/behavioral concern OR the child/youth/young adult has an emotional/behavioral health concern, but no additional intervention is needed.
- ☐ c. The child/youth/young adult has an emotional/behavioral health concern, AND it is an ongoing unmet need.
- ☐ d. The child/youth/young adult has an emotional/behavioral health concern that directly contributes to danger to the child/youth/young adult.

CSN2. Trauma

- ☐ a. The child/youth/young adult's response to prior trauma contributes to their safety.
- ☐ b. The child/youth/young adult has not experienced trauma OR the child/youth/young adult has experienced trauma but no additional intervention is needed.
- ☐ c. The child/youth/young adult's response to prior trauma is a concern AND it is an ongoing unmet need.
- ☐ d. The child/youth/young adult's response to prior trauma is a concern that directly contributes to danger to the child/youth/young adult.

CSN3. Child Development

- ☐ a. The child/youth/young adult's development is advanced.
- ☐ b. The child/youth/young adult's development is age-appropriate.
- ☐ c. The child/youth/young adult's development is limited.
- ☐ d. The child/youth/young adult's development is severely limited. If "d" is selected, also answer:
Has a regional center referral been completed?
 - ☐ Yes
 - ☐ No

CSN4. Education

- ☐ a. The child/youth/young adult has outstanding academic achievement.
- ☐ b. The child/youth/young adult has satisfactory academic achievement OR the child/youth/young adult is not of school age.
- ☐ c. The child/youth/young adult has academic difficulty.
- ☐ d. The child/youth/young adult has severe academic difficulty.

Also indicate all that apply:

- ☐ The child/youth/young adult has an individualized education plan.
- ☐ The child/youth/young adult has an educational surrogate parent.
- ☐ The child/youth/young adult needs an educational surrogate parent.
- ☐ The child/youth/young adult is required by law to attend school but is not attending.

CSN5. Social Relationships

- ☐ a. The child/youth/young adult has strong social relationships.
- ☐ b. The child/youth/young adult has adequate social relationships.
- ☐ c. The child/youth/young adult has limited social relationships.
- ☐ d. The child/youth/young adult has poor social relationships.

CSN6. Family Relationships

- ☐ a. The child/youth/young adult's relationships within their family contribute to their safety.
- ☐ b. The child/youth/young adult's relationships within their family do not impact their safety.
- ☐ c. The child/youth/young adult's relationships within their family interfere with long-term safety.
- ☐ d. The child/youth/young adult's relationships within their family contribute to danger of serious physical or emotional harm to the child/youth/young adult.

CSN7. Physical Health/Disability

- ☐ The child/youth/young adult's immunizations are current.
- ☐ a. The child/youth/young adult has no health care needs or disabilities.
- ☐ b. The child/youth/young adult has minor health problems or disabilities that are being addressed with minimal intervention and/or medication.
- ☐ c. The child/youth/young adult has health care needs or disabilities that require routine interventions.
- ☐ d. The child/youth/young adult has serious health/disability needs that require ongoing treatment and interventions by professionals or trained caregivers AND/OR the child/youth/young adult has an unmet medical need.

CSN8. Alcohol/Drugs

- a. The child/youth/young adult actively chooses an alcohol- and drug-free lifestyle.
- b. The child/youth/young adult does not use or experiment with alcohol/drugs.
- c. The child/youth/young adult's alcohol and/or other drug use results in disruptive behavior and conflict.
- d. The child/youth/young adult's chronic alcohol and/or other drug use results in severe disruption of functioning.

CSN9. Delinquency

- a. The child/youth/young adult has no delinquent behavior. There is no indication of delinquent history or behavior.
- b. The child/youth/young adult has no delinquent behavior in the past two years.
- c. The child/youth/young adult is/has engaged in delinquent behavior and may have been arrested or placed on probation in the past two years.
- d. The child/youth/young adult is or has been involved in any violent, or repeated nonviolent, delinquent behavior. If selected, also indicate if:
 - ☐ The child/youth/young adult has been adjudicated a WIC Section 602 ward.
 - ☐ The child/youth/young adult is in need of a WIC Section 241.1 hearing.

CSN10. Relationship With Substitute Care Provider (if child/youth/young adult is in care)

- Not applicable; child/youth/young adult is not in care. If selected go to CSN11.
- a. The child/youth/young adult has developed a strong attachment to at least one substitute care provider.
- b. The child/youth/young adult has no conflicts with the substitute care provider.
- c. The child/youth/young adult has some conflicts with the substitute care provider that have resulted or may result in the child/youth/young adult feeling unsafe or unaccepted in the placement; however, with support, these issues can be mitigated.
- d. The child/youth/young adult has serious conflicts with one or more members of the current substitute care provider's household.

CSN11. Independent Living (if age 15.5 or older)

- ☐ Not applicable. If selected, go to CSN12.
- ☐ a. The youth/young adult is prepared to function as an adult.
- ☐ b. The youth/young adult is making progress toward being prepared for adulthood.
- ☐ c. The youth/young adult is attempting to prepare for adulthood but lacks the confidence, emotional maturity, and/or sufficient skills to live independently.
- ☐ d. The youth/young adult is not prepared or is refusing to prepare for adulthood.

For youth/young adult age 15.5 and older, select all that apply to preparation for adulthood.

- ☐ The youth/young adult is receiving assistance from a regional center.
- ☐ The 15.5-year-old assessment has been completed.
- ☐ For youth/young adults age 16 or older, a referral to formal services and a credit check application have been completed.
- ☐ For youth/young adults age 17 and older, an independent living plan has been completed.
 - ☐ A 90-Day Transition Meeting has been held.
 - ☐ An Emancipation Conference has been held.
 - ☐ The youth/young adult is participating in the extension foster care program (AB 12).

CSN12. Other Identified Child/Youth/Young Adult Strength or Need (not covered in CSN1-CSN11)

- ☐ Not applicable. If selected, go to prioritization below.
- ☐ a. Actively helps them create safety, permanency and well-being for themselves.
- ☐ b. Is not a strength or a barrier for safety, permanency and well-being.
- ☐ c. Is a barrier to their safety, permanency and well-being.
- ☐ d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Provide description of behaviors:

C. PRIORITY NEEDS AND STRENGTHS

Enter the item number, domain name and description of all of the most serious needs ("d"s first, then "c"s) from items CSN1–CSN12 for each child/youth/young adult.

Domains identified with a "d" should always be a priority and should all be included in the family case plan.

SCORE (d's, then c's)	DOMAIN NAME AND DESCRIPTION

Enter the item number and domain name of all the family's strengths ("a" answers) from items CSN1 – CSN12.

These child/youth/young adult strengths can be used to address the priority needs identified above. Determine if this strength should be included in the family case plan.

SCORE (a's)	DOMAIN NAME	INCLUDE IN FAMILY CASE PLAN?
		<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Yes <input type="radio"/> No
		<input type="radio"/> Yes <input type="radio"/> No

SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT (FOR CAREGIVERS & CHILDREN)

DEFINITIONS

California Department of Social Services

SECTION 1: CAREGIVER STRENGTHS AND NEEDS ASSESSMENT

A. HOUSEHOLD CONTEXT

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 a family member's race (African American/Black, American Indian/Alaska Native, Asian/Pacific Islander, Latino/a, multiracial, White, other), ethnicity, tribal affiliation, sexual orientation (heterosexual, gay, lesbian, bisexual), gender identity/expression (female, male, transgender, other), religious/spiritual affiliation, disability, or other social identity that reflects the family's unique characteristics.*

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 nonmainstream culture and may refer to the mainstream culture.

Connecting culture, identity, and caregiving/parenting

Consider how the family's culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence or shape parenting and caregiving.

In particular, consider:

- How the caregiver identifies themselves (see culture and cultural identity above);
- 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 childrearing? How do all of the above influence or shape the caregiver's actions with their children?

The caregiver's perspective of culture and cultural identity

a. Actively helps create safety, permanency, and child/youth/young adult well-being.

The caregiver draws upon their culture to respond to challenges in ways that create safety for the child/youth/young adult.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

The caregiver is connected to a culture and/or identifies with a culture and this has no impact on child/youth/young adult safety.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being.

The caregiver is connected to a culture and/or identifies with a culture in ways that cause struggles for the child/youth/young adult, such as mild to moderate conflict with the caregiver over culture/cultural identity or disrupted relationships with the child/youth/young adult based on cultural differences.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

The caregiver is connected to a culture and/or identifies with a culture in ways that cause danger for the child/youth/young adult, such as physically or emotionally harming the child/youth/young adult over differences in culture/cultural identity.

B. CAREGIVER DOMAINS

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, permanency, and well-being of a child/youth/young adult. 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/youth/young adult's safety.

SN1. Resource Management/Basic Needs

Consider the caregiver's management of available financial resources to meet basic care needs related to the child/youth/young adult's health and safety.

The caregiver's resources and management of resources:

a. Actively help create safety, permanency, and child/youth/young adult well-being.

The caregiver has a history of consistently providing adequate housing, food, and clothing. The caregiver has the ability to problem solve and proactively seek resources to meet the family's ongoing needs.

b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.

The caregiver has adequate housing, food, and clothing. The caregiver adequately and/or successfully manages available resources to meet basic care needs related to health and safety.

OR

The caregiver may have limited/no income, but they are able to secure assistance independently (e.g., use of food pantries, Temporary Assistance to Needy Families, Supplemental Nutrition Assistance Program/food stamps, etc.) that will be sufficient for the long term (e.g., caregiver has a plan for the next six months).

c. Are barriers to safety, permanency, or child/youth/young adult well-being.

- The caregiver provides housing, but it is in poor repair due to inadequate utilities or housekeeping.
- Caregiver may have limited/no income, and they are unable to secure assistance independently (e.g., food pantry) OR has been able to secure only short-term assistance (e.g., motel vouchers, limited-time food pantry, etc.)
- Food and/or clothing may sometimes not meet child/youth/young adult's basic needs.
- The family may be homeless; however, there is no evidence of harm or threat of harm to the child/youth/young adult.
- The caregiver does not adequately manage available resources, which results in difficulty providing for basic care needs related to health and safety (e.g., getting to necessary medical appointments, purchasing needed medications, providing supervision). However, this condition is not chronic, and the child/youth/young adult has not experienced harm or threat of harm.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Considering the age and vulnerability of the child/youth/young adult, resource conditions exist in the household that have already caused illness or injury to family members, or are immediately likely to cause illness or injury, such as:

- Inoperable plumbing, heating, or wiring, causing an imminent threat of harm to the child/youth/young adult;
- No food, food is spoiled, or family members are malnourished;

- Child/youth/young adult chronically presents with clothing that is unclean, not appropriate for weather conditions, or in poor repair to the extent that the child/youth/young adult experiences physical harm (e.g., rash from soiled clothing, frostbite from inappropriate clothing);
- Family is homeless, which results in harm or threat of harm to the child/youth/young adult; or

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/youth/young adult's basic needs unmet while using resources for other priorities.

SN2. Physical Health

When assessing, consider both the diagnosed or suspected condition AND the impact that such conditions have on the caregiver's ability to adequately parent and protect the child/youth/young adult. The condition itself does not necessitate the selection of "d."

The caregiver's physical health:

a. Actively helps create safety, permanency, and child/youth/young adult well-being.

The caregiver has no current health concerns that affect family functioning. The caregiver proactively seeks preventive health care for themselves and the family. The caregiver promotes a healthy lifestyle, including nutrition, physical activity, and recreational activities that promote overall health and well-being.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

The caregiver has no current health concerns that affect family functioning. The caregiver accesses regular health resources for self-care (e.g., medical/dental), or caregiver is in good health and is physically able to meet most of the child/youth/young adult's needs. Caregiver may have a medical condition, but they are consistently able to meet the child/youth/young adult's needs (e.g., caregiver with mild or well-controlled lupus who is able to participate in most of the child/youth/young adult's activities, and child/youth/young adult is not experiencing a sense of loss).

c. Is a barrier to safety, permanency, or child/youth/young adult well-being.

Examples of caregiver conditions include but are not limited to the following:

- The caregiver has health concerns or conditions that affect family functioning and/or family resources; or

- Caregiver may occasionally struggle to meet child/youth/young adult's needs because of health limitations (e.g., chronic medical condition, physical disability), and child/youth/young adult's needs are sometimes unmet.

Caregiver conditions have not resulted in serious harm to child/youth/young adult and are not likely to result in serious harm, but the child/youth/young adult experiences some adverse impact.

Examples of impact on the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may occasionally worry or feel stress about caregiver's health, but such worry does not interfere with their participation in school or community life (e.g., caregiver has chronic diabetes that is not well-managed and the caregiver's related mood variations have some nonsignificant impact on the child/youth/young adult; caregiver's lupus makes it impossible for them to participate fully in child/youth/young adult's activities, and child/youth/young adult feels sad).
- Child/youth/young adult may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.
- Child/youth/young adult's basic needs may sometimes be unmet due to caregiver incapacity, but the child/youth/young adult has not experienced injury and is not likely to experience serious harm.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Examples of caregiver conditions include but are not limited to the following:

- The caregiver has serious/chronic or potentially life-threatening health problem(s) or condition(s) that affect the caregiver's ability to care for and/or protect the child/youth/young adult.
- The caregiver has one or more health conditions that limit the caregiver's ability to meet the child/youth/young adult's needs to the extent that a child/youth/young adult has already experienced significant physical/emotional harm or is likely to.

Examples of threats of serious harm to the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may spend substantial time worrying about the caregiver's health, to the extent that the child/youth/young adult is not engaging in play or is struggling in school.
- Child/youth/young adult may assume parenting responsibilities for self or siblings in ways that interfere with development or functioning.
- Child/youth/young adult 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 child/youth/young adult).

Caregiver cannot meet child/youth/young adult's needs for food, shelter, or supervision (e.g., caregiver has severe lupus and has been unable to feed infant, and infant has been diagnosed with failure to thrive, or there have been so many missed feedings that infant would likely develop failure to thrive;

caregiver has diabetes that is not well-managed and sometimes becomes unable to notice or respond to child/youth/young adult needs).

SN3. Parenting Practices

Parenting practices include knowledge, skills, and abilities demonstrated by the parent or caregiver.

Note: Safe and appropriate parenting may be demonstrated differently in different cultures. For example, in some cultures, overt displays of affection or a parent who engages in physical play with the child/youth/young adult may be frowned upon. This should not be interpreted as inappropriate parenting unless there is evidence that this behavior is harmful to the child/youth/young adult.

The caregiver's parenting practices:

a. Actively help create safety, permanency, and child/youth/young adult well-being.

The caregiver displays exceptional parenting patterns that are age-appropriate for the child/youth/young adult in the areas of expectations, discipline, communication, protection, and nurturing. The caregiver has the basic knowledge and skills to provide care. Examples of such parenting include but are not limited to the following:

- Caregiver recognizes and expresses hope for the child/youth/young adult's abilities/strengths.
- Caregiver has the ability to recognize and respond to the child/youth/young adult's cues.
- Caregiver has an understanding of age- and developmentally appropriate expectations for the child/youth/young adult and promotes and encourages activities such as (but not limited to):
- Developmental play groups;
- Occupational/physical therapy or other developmental services; or
- School-, church-, or community-based activities appropriate for the child/youth/young adult's age.
- The caregiver spends quality time with the child/youth/young adult and supports the child/youth/young adult when they are upset.

b. Are not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

The caregiver displays adequate parenting patterns that are age-appropriate for the child/youth/young adult in the areas of expectations, discipline, communication, protection, and nurturing. The caregiver has the basic knowledge and skills to provide care. Examples of such parenting include but are not limited to the following:

- When the child/youth/young adult errs, caregiver provides nonviolent intervention. Interventions and communication of expectations may not be perfectly consistent, but, at a minimum, they are

generally effective in helping the child/youth/young adult understand limits and self-regulate behavior (as age-appropriate).

- Child/youth/young adult is growing to have a developmentally appropriate sense of behavioral expectations and is learning to manage their behavior well.
- Caregiver provides adequately for child/youth/young adult's basic needs.
- Minimally, caregiver periodically spends time with child/youth/young adult, supports child/youth/young adult when child/youth/young adult is upset, and lets child/youth/young adult know that they are loved and valued.

c. Are a barrier to safety, permanency, or child/youth/young adult well-being.

Examples of such parenting include but are not limited to the following:

- Caregiver seldom sets limits or expectations for the child/youth/young adult in advance or sets limits/expectations that are somewhat outside of the range of child/youth/young adult's potential; and/or when child/youth/young adult errs, caregiver often fails to respond at all or responds by blaming child/youth/young adult, calling child/youth/young adult names, using physical discipline that does not injure, etc.
- Caregiver frequently fails to meet some of child/youth/young adult's basic needs, often because caregiver did not notice or was unaware of the child/youth/young adult's need. Child/youth/young adult experiences so much worry over basic needs that they are developing symptoms such as lack of concentration, difficulty sleeping, hoarding, or stealing food.
- Caregiver seldom expresses love or value for the child/youth/young adult. Child/youth/young adult may worry about their place in the life of the caregiver and/or may frequently experience self-doubt. However, child/youth/young adult is able to function on a daily basis in developmentally expected ways.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Examples of such parenting practices include but are not limited to the following:

- Caregiver is unable or unwilling to protect the child/youth/young adult from harm by another.
- Caregiver sets no limits/expectations or sets limits/expectations that are far beyond the range of child/youth/young adult's potential, and when child/youth/young adult errs, caregiver intervenes with physical or verbal violence, resulting in serious physical or emotional harm to the child/youth/young adult.
- Caregiver has not set limits/expectations for the child/youth/young adult to the extent that the child/youth/young adult has no sense of commonly acceptable behavior and no ability to manage their own behavior; child/youth/young adult has already or is likely to engage in delinquent behaviors.
- Caregiver is unaware of the child/youth/young adult's needs to the extent that the child/youth/young adult has become seriously ill or injured due to unmet basic needs.

- Caregiver rarely, if ever, expresses love or value for the child/youth/young adult AND the child/youth/young adult is showing signs of emotional harm. Symptoms of emotional harm to the child/youth/young adult include but are not limited to: fear of the caregiver, nightmares, aggression toward siblings/peers, anxiety, unusual protective behaviors toward siblings, thumb sucking (and other indicators of developmental regression), and *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnoses related to experiences of caregiver behavior.

SN4. Social Support System

A social support system is a network of individuals (other than intimate partners or members of the household) or organizations (e.g., religious organizations, community organizations, professional providers) who provide or share concrete support (e.g., financial help, transportation, babysitting) or emotional support (e.g., listening, advice). Contact may include in-person or other means, including social media.

The caregiver's social support system:

a. Actively helps create safety, permanency, and child/youth/young adult well-being.

The caregiver has frequent contact with an extensive mutual support system. A mutual support system means that the caregiver is able to engage in providing support to members of their support network and is able to access support from members when needed.

AND

This contributes to child/youth/young adult safety in that many people work together to create safety for the child/youth/young adult.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

The caregiver has a sufficient social support system and is able to get concrete or emotional support when needed.

OR

The caregiver is able to maintain child/youth/young adult safety despite lack of social support.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being.

At times, the caregiver needs concrete or emotional support and their social support system is not able to provide what the caregiver needs. As a result, the child/youth/young adult experiences some

isolation or unmet needs; however, this has not created danger for the child/youth/young adult. This may include:

- Lack of a sufficient social support system;
- Not using the support that is available; and/or
- The support provided either contributes to child/youth/young adult distress or adversely impairs the caregiver's ability to create long-term safety.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

The caregiver is unable to resolve conditions that create danger for the child/youth/young adult because of limits in the ability of their social support network to help in ways that would keep the child/youth/young adult safe. This may include the following:

- No one is able to help provide concrete support that is needed, and this has contributed to danger (e.g., needed medical care for child/youth/young adult is not sought due to lack of transportation).
- The caregiver's lack of support contributes to the caregiver's experience of being overwhelmed and as a result, the caregiver cannot meet the needs of the child/youth/young adult, which has resulted in danger (e.g., caregiver cannot get respite care and as a result either leaves child/youth/young adult unattended in a dangerous situation or stays with child/youth/young adult but loses control and hurts child/youth/young adult).
- Involvement of the social support system directly creates danger for the child/youth/young adult (e.g., while providing concrete support, system member encourages caregiver to use drugs).

SN5. Household and Family Relationships

Include relationships between caregiver and other adults in the household, including intimate relationships, but do not rate presence or absence of physical violence or intimidating/controlling behaviors in this item.

The caregiver's relationships with other adult household members:

a. Actively help create safety, permanency, and child/youth/young adult well-being.

Caregiver and other adult household members have and demonstrate healthy interpersonal relationships, including communication, shared agreements, mutual respect, empathy, and safe conflict resolution.

b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.

Caregiver and other household members have relationships that do not adversely affect child/youth/young adult.

c. Are barriers to safety, permanency, or child/youth/young adult well-being.

Caregiver and other household members or child/youth/young adult's other parent experience conflict to the extent that child/youth/young adult is aware of and troubled by conflict.

OR

Child/youth/young adult is confused and/or upset by frequent introduction of new intimate partners of the caregiver.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Conflict among adult household members is so persistent and severe that child/youth/young adult's needs are unmet to the extent that the child/youth/young adult has been seriously harmed or is in danger of being seriously harmed.

OR

Caregiver allows individuals who are violent or sexual toward the child/youth/young adult to be part of the household.

OR

Caregiver's relationship with child/youth/young adult's other parent(s) continues to involve child/youth/young adult in conflict to the extent that child/youth/young adult is seriously emotionally harmed and/or caused to experience repeated medical/legal examinations due to repeated unfounded allegations against the other parent.

SN6. Domestic Violence

Household violence means physical violence or a pattern of threats/intimidation or controlling behavior between the caregiver and any adult household member, including intimate relationships. This does not include violence between a caregiver and a minor child/youth/young adult.

The caregiver's intimate relationships:

a. Actively help create safety, permanency, and child/youth/young adult well-being.

The caregiver consistently responds nonviolently to situations involving conflict and frustration and works with other adults in the household to make choices.

AND

This contributes to safety for the child/youth/young adult by effectively protecting the child/youth/young adult from violence and teaching/demonstrating nonviolence to the child/youth/young adult.

The caregiver may have a history of violent relationships, but they had developed new patterns of behavior and consciously chooses relationships that are not violent.

b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.

The caregiver is not currently in and has not been in a relationship that includes violence, threats/intimidation, or controlling behavior.

OR

The caregiver is or has been in a relationship that includes a minimal degree of violence, threats/intimidation, or controlling behavior, but the child/youth/young adult is unaware and/or untroubled AND has not experienced harm.

Violence that has resulted in injury to a caregiver or involved use of a weapon cannot be rated "b" even if the child/youth/young adult is unaware or reports being unaffected.

c. Are barriers to safety, permanency, or child/youth/young adult well-being.

The caregiver is in or has been in a relationship characterized by violence or a pattern of threats/intimidation or controlling behavior, and the child/youth/young adult is aware of and troubled by this.

OR

The violence, threats/intimidation, or controlling behavior is ongoing and increasing in frequency or severity.

OR

The caregiver has ended a violent relationship but has not developed behaviors to prevent repeating being either a victim or an aggressor.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

The caregiver is in or has recently left a relationship characterized by severe household violence and the child/youth/young adult has been seriously hurt, physically or emotionally, by the violence.

OR

The caregiver remains in a violent relationship and at least one partner is unwilling to address the violence.

SN7. Substance Use

Include alcohol, other illegal drugs, and prescription drugs that are not used according to prescription.

The caregiver's actions regarding substance use:

a. Actively help create safety, permanency, and child/youth/young adult well-being.

The caregiver has no history of substance abuse (whether or not caregiver uses alcohol or legal drugs)
OR the caregiver may have a history of substance abuse but is in recovery to the extent that they help support the recovery of others;

AND

The caregiver, by words and actions, actively promotes a healthy, addiction-free lifestyle and environment for their children.

b. Are not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

The caregiver has no history of substance abuse (whether or not caregiver uses alcohol or legal drugs)
OR has a history of substance abuse but is in recovery and able to maintain recovery without formal support (may continue to participate in self-help groups);

HOWEVER

Alcohol and drug use or history of use does not negatively affect parenting or the caregiver's ability to maintain child/youth/young adult safety.

c. Are a barrier to safety, permanency, or child/youth/young adult well-being.

The caregiver's alcohol or drug use results in behaviors that impede their ability to meet the child/youth/young adult's basic needs (food, clothing, shelter, supervision, and hygiene) or emotional well-being on a consistent basis and/or have contributed to a current, nondangerous incident;

OR

The caregiver is in recovery from drug or alcohol abuse and requires minimal to moderate continuing support to preserve child/youth/young adult safety, e.g., caregiver remains in day treatment or other outpatient intervention;

HOWEVER

Caregiver's alcohol or drug use has not resulted in serious harm to the child/youth/young adult (e.g., malnutrition, homelessness, physical harm due to insufficient supervision).

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

The caregiver's use of alcohol or drugs results in behaviors that consistently impede their ability to meet the child/youth/young adult's basic needs to the extent that the child/youth/young adult has been seriously harmed by abuse or neglect, or serious harm is imminent.

OR

Caregiver is just beginning recovery and needs intensive support to preserve child/youth/young adult safety, e.g., caregiver is in detox or inpatient treatment or residential setting to support recovery.

AND

- Caregiver is physically or attentively absent to the extent that child/youth/young adult is in danger.
- When caregiver is under the influence of alcohol or drugs, they forget to feed the child/youth/young adult to the extent that the child/youth/young adult has experienced growth disruption, malnutrition, or dehydration.
- When caregiver is under the influence of alcohol or drugs, they become violent toward or near the child/youth/young adult.

SN8. Mental Health

Mental health includes a diagnosed condition (which is not automatically a need) and also 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/youth/young adult. Similarly, a caregiver with

exceptional coping skills may be able to parent and protect the child/youth/young adult through extraordinarily stressful family conditions.

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 the caregiver's ability to parent and protect the child/youth/young adult.

The caregiver's mental health:

a. Actively helps create safety, permanency, and child/youth/young adult well-being.

The caregiver demonstrates the ability to cope with adversity, crises, and long-term problems in a constructive manner. The caregiver demonstrates realistic, logical judgment and demonstrates emotional responses that are consistent with circumstances. Caregiver understands their own emotional needs and is effectively meeting them in ways that do not interfere with ability to provide care. Caregiver demonstrates ability to think about what the child/youth/young adult needs, and caregiver has/acquires the knowledge needed to respond to child/youth/young adult's needs most of the time.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

Caregiver may struggle from time to time, but caregiver is always able to manage sufficiently so that child/youth/young adult does not experience significant stress, worry, or unmet needs. For example, caregiver may experience some depression or anxiety, but they are managing through medication, therapy, or self-help so that while child/youth/young adult may be aware, child/youth/young adult is not significantly worried and the caregiver's condition does not interfere with caregiving.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being.

Examples of caregiver behavior include but are not limited to the following:

- Caregiver displays periodic mental health symptoms, including but not limited to depression, low self-esteem, or apathy. The caregiver has occasional difficulty dealing with situational stress, crises, or problems.
- While caregiver may have moments of being overwhelmed and temporarily distracted from the child/youth/young adult's needs, the caregiver is able to rally and continue.

Examples of impact on the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may occasionally worry about how caregiver is coping, but such worry does not interfere with their participation in school or community life.
- Child/youth/young adult may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.

- Child/youth/young adult may have a periodic sense of loss/grief when caregiver is not available.
- Child/youth/young adult's basic needs may sometimes be unmet due to caregiver incapacity, but the child/youth/young adult has not experienced injury and is not likely to experience serious harm.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Examples of caregiver behaviors or conditions include but are not limited to the following:

- The caregiver displays chronic, severe mental health 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 and shelter.
- Caregiver has been repeatedly hospitalized for mental health concerns.

Examples of threats of serious harm to the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may spend substantial time worrying about how the caregiver is coping, to the extent that the child/youth/young adult is not engaging in play or is struggling in school.
- Child/youth/young adult may assume parenting responsibilities for self or siblings in ways that are interfering with development or functioning.
- Child/youth/young adult is falling significantly behind developmentally due to prolonged caregiver unavailability/absence.
- Caregiver could not meet child/youth/young adult's needs for food, shelter, or supervision to the extent that it was dangerous.

SN9. Prior Adverse Experiences/Trauma

Trauma may occur when a person has experienced, witnessed, or been confronted with an event(s) of actual or threatened death or serious injury, a threat of serious physical harm to themselves or others, or emotional abuse. Trauma may be caused by many experiences, e.g., serious physical harm; sexual abuse; bullying; domestic violence; natural disasters; and long-term exposure to extreme poverty, neglect, or verbal abuse.

The caregiver's response to prior adverse experiences/trauma:

a. Actively helps create safety, permanency, and child/youth/young adult well-being.

Caregiver has not experienced trauma OR the caregiver has a prior experience of trauma, but that prior trauma provides the caregiver with additional skills to improve daily functioning.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

The caregiver may or may not have a prior history of trauma; however, any traumatic experiences do not impact care for the child/youth/young adult (either because there is no impact on the caregiver's functioning or because the caregiver has learned to manage the impact on their functioning effectively).

c. Is a barrier to safety, permanency, or child/youth/young adult well-being.

Caregiver has experienced trauma AND the caregiver's response involved intense fear, helplessness, or horror, which sometimes impairs functioning and sometimes causes distress, but not harm, to the child/youth/young adult. The caregiver has learned some strategies to manage these responses, and the caregiver sometimes uses them.

Caregiver sometimes experiences intrusive, distressing recollections of the event, including images, thoughts, or perceptions; has distressing dreams of the event; or acts or feels like the traumatic event is recurring, BUT caregiver has learned some skills and interventions to manage these thoughts and caregiver sometimes uses them.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Caregiver has experienced trauma AND the caregiver's response involved intense fear, helplessness, or horror, causing impaired functioning and significant distress/harm for the child/youth/young adult. For example, the caregiver has not accessed services and/or cannot use coping strategies or has not received intervention to help manage their responses, AND this has resulted in significant harm to the child/youth/young adult. Caregiver may deny the traumatic experience or how it affects them or the child/youth/young adult.

SN10. Cognitive/Developmental Abilities

Include diagnosed or suspected cognitive conditions, including developmental disabilities, traumatic brain injury, or dementia/Alzheimer's disease. When assessing, consider both the diagnosed or suspected condition AND the impact that such conditions have on the caregiver's ability to adequately parent and protect the child/youth/young adult. The condition itself does not necessitate the selection of "d."

The caregiver's developmental and cognitive abilities:

a. Actively help create safety, permanency, and child/youth/young adult well-being.

Caregiver demonstrates ability to think about what child/youth/young adult needs and has or acquires the knowledge needed to respond to child/youth/young adult's needs. Caregiver has demonstrated creative thinking to overcome challenges and has created child/youth/young adult safety as a result.

b. Are not strengths or barriers for safety, permanency, or child/youth/young adult well-being.

Caregiver has no cognitive limitations;

OR

Caregiver may struggle to understand some aspects of parenting knowledge but has always been able to work out solutions that meet the child/youth/young adult's needs. Caregiver may struggle from time to time, but they are always able to manage sufficiently so that the child/youth/young adult does not experience significant stress, worry, or unmet needs. For example, the caregiver may have some cognitive limitations, but they are able to meet the child/youth/young adult's basic needs with the assistance of family or other non-agency-provided help.

c. Are barriers to safety, permanency, or child/youth/young adult well-being.

Examples of caregiver behavior include but are not limited to the following:

- Caregiver has some difficulty understanding essential child/youth/young adult care information. Caregiver's difficulty understanding makes it harder to parent effectively and/or has some adverse impact on the child/youth/young adult, but has never resulted in serious harm AND is not likely to result in serious harm.
- Caregiver requires additional efforts to acquire knowledge, such as repetition, creating visual cues, or other approaches, and with these approaches, caregiver is able to acquire necessary information.

Examples of impact on the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may occasionally worry about how caregiver is coping, but such worry does not interfere with participation in school or community life.
- Child/youth/young adult may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.
- Child/youth/young adult's basic needs may sometimes be unmet due to caregiver incapacity, but the child/youth/young adult has not experienced injury and is not likely to experience serious harm.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

Examples of parental behaviors or conditions include but are not limited to the following:

- Caregiver has significant difficulty understanding fundamental parenting information, such as how much to feed and how often, how to decide when a child/youth/young adult needs medical care, or whether it is reasonable to expect a 6-month-old to be fully potty-trained. Despite numerous efforts to help the caregiver understand vital information, they do not appear to comprehend and cannot apply information to parenting tasks.

Examples of threats of serious harm to the child/youth/young adult include but are not limited to the following:

- Child/youth/young adult may spend substantial time worrying about how the caregiver is coping, to the extent that the child/youth/young adult is not engaging in play or is struggling in school.
- Child/youth/young adult may assume parenting responsibilities for self or siblings in ways that are interfering with development or functioning. Child/youth/young adult is falling significantly behind developmentally due to prolonged caregiver unavailability/absence.
- Caregiver cannot meet child/youth/young adult's needs for food, shelter, or supervision.

SN11. Other Identified Caregiver Strength or Need (not covered in SN1–SN10)

Select "not applicable" if the caregiver does not have any strengths or needs that are relevant for case planning, beyond those captured in the domains above.

OR

An additional need or strength has been identified that:

a. Actively helps create safety, permanency, and child/youth/young adult well-being.

A caregiver 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 areas of need.

b. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

A caregiver has an area of strength or need that is not included in other domains, but this area is not relevant for case planning.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being.

A caregiver's need has a moderate to significant impact on family functioning but has not resulted in harm or threat of harm to the child/youth/young adult. The family perceives that they would benefit from services and support that address the need.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

A caregiver has a need that has a serious impact on family functioning, placing the child/youth/young adult at imminent threat of serious harm.

SECTION 2: CHILD/YOUTH/YOUNG ADULT STRENGTHS AND NEEDS ASSESSMENT

A. HOUSEHOLD CONTEXT

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 a family member's race (African American/Black, American Indian/Alaska Native, Asian/Pacific Islander, Latino/a, multiracial, White, other), ethnicity, tribal affiliation, sexual orientation (heterosexual, gay, lesbian, bisexual), gender identity/expression (female, male, transgender, other), religious/spiritual affiliation, disability, or other social identity that reflects the family's unique characteristics.*

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 a family member 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.

Connecting Culture and Identity

Consider how the family's culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence or shape the child/youth/young adult's perspective.

In particular, consider:

- How the child/youth/young adult identifies themselves (see culture and cultural identity above);
- Any historical experiences of oppression/discrimination that are important or relevant to this child/youth/young adult;
- Any current experiences of oppression/discrimination this child/youth/young adult might be experiencing; and
- Any coping skills, strengths, and survival skills this child/youth/young adult has developed or demonstrated in facing oppression/discrimination.

How do all of the above influence or shape the child/youth/young adult?

The child/youth/young adult's perspective of culture, cultural identity, norms, and past/current experiences of discrimination:

a. Help them create safety, permanency, and well-being for themselves.

The child/youth/young adult draws upon their culture to respond to challenges in ways that create safety for the child/youth/young adult.

b. Have no effect on their safety, permanency, or well-being.

The child/youth/young adult is connected to a culture and/or identifies with a culture and this has no impact on their safety.

c. Make it difficult for them to experience long-term safety, permanency, or well-being.

The child/youth/young adult is connected to a culture and/or identifies with a culture in ways that cause struggles, such as mild to moderate conflict with the caregiver over culture/cultural identity or disrupted relationships with the caregiver based on cultural differences.

d. Contribute to imminent danger of serious physical or emotional harm to the child/youth/young adult.

The child/youth/young adult is connected to a culture and/or identifies with a culture in ways that cause danger for the child/youth/young adult, such as physically or emotionally harming themselves over differences in culture/cultural identity.

B. CHILD/YOUTH/YOUNG ADULT DOMAINS

CSN1. Emotional/Behavioral Health

a. The child/youth/young adult's emotional/behavioral health contributes to their safety.

The child/youth/young adult displays coping skills/responses at or above the developmentally expected ability in dealing with crises, disappointment, and daily challenges and contributes to their own safety.

The child/youth/young adult routinely manages their own behavior at or above developmentally expected ability.

The child/youth/young adult is developing a sense of acceptable social norms valued by their family and/or community, and the child/youth/young adult is able to weigh the positives and negatives of conforming to or deviating from such norms.

b. The child/youth/young adult does not have an emotional/behavioral concern OR the child/youth/young adult has an emotional/behavioral health concern, but no additional intervention is needed.

The child/youth/young adult's coping skills/responses do not interfere with school, family, or community functioning. The child/youth/young adult is able to develop and maintain trusting relationships. The child/youth/young adult may be able to identify the need for, seek, and accept guidance. The child/youth/young adult may demonstrate some situationally related depression, anxiety, or withdrawal symptoms. However, the child/youth/young adult maintains situationally appropriate emotional control.

OR

The child/youth/young adult has emotional or behavioral health concerns that are being effectively managed through a treatment program that does not require additional caregiver support (e.g., child/youth/young adult receives limited in-school support and is not on medication).

c. The child/youth/young adult has an emotional/behavioral health concern, AND it is an ongoing unmet need.

The child/youth/young adult must display one of the following:

- Periodic mental health symptoms (e.g., depression, somatic complaints, antisocial behavior, hostile behavior, apathy). OR
- Some difficulties dealing with situational stress, crises, or problems. AND one of the following must also be true.
- This is interfering with the child/youth/young adult's sense of well-being, development, and/or ability to form relationships. OR
- The child/youth/young adult's emotional or behavioral health condition is being managed through a treatment program that requires minimal to moderate caregiver support.

d. The child/youth/young adult has an emotional/behavioral health concern that directly contributes to danger to the child/youth/young adult.

The child/youth/young adult must display one of the following:

- Functioning in one or more areas is severely impaired due to chronic/severe mental health symptoms. OR
- Behavior is/may be harmful to self or others, including self-injury, extreme risk-taking, persistent violence toward others, inappropriate sexual behaviors, cruelty to animals, running away, curfew violations, stealing, inappropriate use of social media (e.g., sexting, cyberbullying), defiant behaviors, truancy, or fire-setting.

AND one of the following must be true.

- The child/youth/young adult is in danger of serious harm to self or others. OR
- The child/youth/young adult's emotional or behavioral condition is being managed through a treatment program that requires extensive caregiver support and/or frequent crisis intervention.

CSN2. Trauma

Trauma may occur when a person has experienced, witnessed, or been confronted with an event(s) of actual or threatened death or serious injury, or a threat of serious physical harm to themselves or others.

Trauma may be caused by many experiences, e.g., serious physical harm; sexual abuse; bullying; domestic violence; natural disasters; and long-term exposure to extreme poverty, neglect, or verbal abuse.

a. The child/youth/young adult's response to prior trauma contributes to their safety.

The child/youth/young adult has a prior experience of trauma, but that prior trauma provides the child/youth/young adult with additional skills to improve daily functioning.

b. The child/youth/young adult has not experienced trauma OR the child/youth/young adult has experienced trauma but no additional intervention is needed.

The child/youth/young adult may or may not have a prior history of trauma; however, any traumatic experiences do not impact care for the child/youth/young adult, either because there is no impact on the child/youth/young adult's functioning or because the child/youth/young adult has learned to manage the impact on their functioning effectively.

c. The child/youth/young adult's response to prior trauma is a concern AND it is an ongoing unmet need.

The child/youth/young adult has experienced trauma AND the child/youth/young adult's response involved intense fear, helplessness, or horror that sometimes impairs their functioning and sometimes causes distress. They do not have long-term indicators of permanent harm/distress but could learn to manage the impacts of trauma on their functioning, or they begin to learn to apply some strategies to manage these responses and sometimes use them.

d. The child/youth/young adult's response to prior trauma is a concern that directly contributes to danger to the child/youth/young adult.

The child/youth/young adult has experienced trauma AND the child/youth/young adult's response involved intense fear, helplessness, or horror, causing impaired functioning and significant distress/harm for the child/youth/young adult. For example, the child/youth/young adult has not accessed services, cannot use coping strategies, and/or has not received intervention to help manage their responses, AND this has resulted in significant harm to the child/youth/young adult. The child/youth/young adult may deny the traumatic experience or how it is affecting them.

CSN3. Child Development

For a chart of average development by age, consult the [Physical and Cognitive Developmental Milestones](#).

a. The child/youth/young adult's development is advanced.

The child/youth/young adult's physical and cognitive skills are above their chronological age level.

b. The child/youth/young adult's development is age-appropriate.

The child/youth/young adult's physical and cognitive skills are consistent with their chronological age level.

c. The child/youth/young adult's development is limited.

The child/youth/young adult does not exhibit most physical and cognitive skills expected for their chronological age level.

d. The child/youth/young adult's development is severely limited.

Most of the child/youth/young adult's physical and cognitive skills are two or more age or developmental levels behind chronological age expectations. If "d" is selected, also indicate whether a regional center referral has been completed.

CSN4. Education

a. The child/youth/young adult has outstanding academic achievement.

The child/youth/young adult is working above grade level and/or is exceeding the expectations of the specific educational plan.

b. The child/youth/young adult has satisfactory academic achievement OR the child/youth/young adult is not of school age.

The child/youth/young adult is working at grade level and/or is meeting the expectations of the specific educational plan, or the child/youth/young adult is not of school age.

c. The child/youth/young adult has academic difficulty.

The child/youth/young adult is working below grade level in at least one, but not more than half, of their academic subject areas, and/or the child/youth/young adult is struggling to meet the goals of the existing educational plan. The existing educational plan may need modification.

d. The child/youth/young adult has severe academic difficulty.

The child/youth/young adult is working below grade level in more than half of their academic subject areas, and/or the child/youth/young adult is not meeting the goals of the existing educational plan. The existing educational plan needs modification.

CSN5. Social Relationships

When considering adult relationships, consider the child/youth/young adult's relationships with adults who are not immediate family members or foster family members. This domain would include coaches, neighbors, child welfare workers, club leaders, teachers, mentors, etc. Specify in the narrative who these adults are.

When considering peer relationships, consider the child/youth/young adult's relationships with other children in school and the community. Exclude relationships with siblings.

a. The child/youth/young adult has strong social relationships.

The child/youth/young adult enjoys and participates in a variety of constructive, age-appropriate social activities. The child/youth/young adult enjoys reciprocal, positive relationships with others.

b. The child/youth/young adult has adequate social relationships.

The child/youth/young adult demonstrates adequate social skills. The child/youth/young adult maintains stable relationships with others; occasional conflicts are minor and easily resolved.

c. The child/youth/young adult has limited social relationships.

The child/youth/young adult demonstrates inconsistent social skills and has limited positive interactions with others. Conflicts are more frequent and serious, and the child/youth/young adult may be unable to resolve them.

d. The child/youth/young adult has poor social relationships.

The child/youth/young adult has poor social skills, as demonstrated by frequent conflictual relationships or exclusive interactions with negative or exploitative peers, or the child/youth/young adult is isolated and lacks a support system.

CSN6. Family Relationships

For children in voluntary or court-ordered placement, score the child/youth/young adult's family of origin, not their placement family.

a. The child/youth/young adult's relationships within their family contribute to their safety.

The child/youth/young adult experiences positive interactions with family members and has a sense of belonging within the family. The family defines roles, has clear boundaries, and supports the child/youth/young adult's growth and development.

b. The child/youth/young adult's relationships within their family do not impact their safety.

The child/youth/young adult experiences positive interactions with family members and feels safe and secure in the family, despite some unresolved family conflicts.

c. The child/youth/young adult's relationships within their family interfere with long-term safety.

Stress/discord within the family interferes with the child/youth/young adult's sense of safety and security. The family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own.

d. The child/youth/young adult's relationships within their family contribute to danger of serious physical or emotional harm to the child/youth/young adult.

Chronic family stress, conflict, or violence severely impedes the child/youth/young adult'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. Physical Health/Disability

Physical health means physical well-being, which includes dental and vision care. Also indicate whether the child/youth/young adult's immunizations are current.

a. The child/youth/young adult has no health care needs or disabilities.

The child/youth/young adult demonstrates good health and hygiene care, involving awareness of nutrition and exercise. The child/youth/young adult receives routine preventive and medical/dental/vision care and immunization.

b. The child/youth/young adult has minor health problems or disabilities that are being addressed with minimal intervention and/or medication.

The child/youth/young adult has adequate health. Minimal interventions are those that typically require no formal training (e.g., oral medications).

c. The child/youth/young adult has health care needs or disabilities that require routine interventions.

The child/youth/young adult has 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).

d. The child/youth/young adult has serious health/disability needs that require ongoing treatment and interventions by professionals or trained caregivers AND/OR the child/youth/young adult has an unmet medical need.

Those who provide treatment/interventions have received substantial instruction (e.g., central line feeding, paraplegic care, or wound dressing changes).

CSN8. Alcohol/Drugs

Drugs include illegal substances as well as misuse of prescription and over-the-counter medications, inhalants, synthetic drugs, incense when used for intoxicating properties, etc.

a. The child/youth/young adult actively chooses an alcohol- and drug-free lifestyle.

The child/youth/young adult does not use alcohol or other drugs and is aware of consequences of use. The child/youth/young adult avoids peer relations/social activities involving alcohol and other drugs, and/or chooses not to use substances despite peer pressure/opportunities to do so.

b. The child/youth/young adult does not use or experiment with alcohol/drugs.

The child/youth/young adult does not use alcohol or other drugs. The child/youth/young adult may have experimented with alcohol or other drugs, but there is no indication of sustained use. The child/youth/young adult has no demonstrated history or current problems related to substance use.

c. The child/youth/young adult's alcohol and/or other drug use results in disruptive behavior and conflict.

This conflict may occur in school/community/family/work relationships. Use may have broadened to include multiple drugs.

d. The child/youth/young adult's chronic alcohol and/or other drug use results in severe disruption of functioning.

Disruption of functioning may be indicated by the loss of relationships or jobs, school suspension/expulsion/drop-out, problems with the law, and/or physical harm to self or others. The child/youth/young adult may require medical intervention to detoxify.

CSN9. Delinquency

Delinquent behavior includes any action that would constitute a crime. Consider this domain to include both offenses for which the child/youth/young adult has been arrested/charged and those which have not yet come to the attention of law enforcement.

a. The child/youth/young adult has no delinquent behavior. There is no indication of delinquent history or behavior.

The child/youth/young adult may be involved in community service and/or crime prevention programs and takes a stance against crime.

b. The child/youth/young adult has no criminal behavior in the past two years.

There is a history of delinquent behavior but the child/youth/young adult has successfully completed probation, and there has been no criminal behavior in the past two years.

c. The child/youth/young adult is/has engaged in delinquent behavior and may have been arrested or placed on probation in the past two years.

The child/youth/young adult may have been arrested or placed on probation within the past two years.

d. The child/youth/young adult is or has been involved in any violent, or repeated nonviolent, delinquent behavior.

This behavior has or may have resulted in consequences such as arrests, incarcerations, or probation. Violent behavior includes aggressive behavior in any form that has resulted or is likely to result in an injury to another person. Repeated nonviolent delinquent behavior includes situations where a youth has more than one contact for delinquent behavior, but none of the contacts included violent behavior, as defined above.

CSN10. Relationship With Substitute Care Provider (if child/youth/young adult is in care)

Consider the wishes and feelings of the child/youth/young adult as appropriate. Indicate whether the wishes and feelings of the child/youth/young adult assist in the development of strengths or create struggles for the child/youth/young adult.

When assessing this item, keep in mind that the child/youth/young adult may have different relationships with adults and with children in the home. Please consider both when documenting strengths and struggles.

Not applicable; child/youth/young adult is not in care.

a. The child/youth/young adult has developed a healthy attachment to at least one substitute care provider.

The child/youth/young adult has developed a nurturing/supportive relationship with at least one substitute care provider. There is positive interaction/attachment between the child/youth/young adult and caregiver or others in the caregiver's household; the child/youth/young adult is supported and has a sense of belonging.

b. The child/youth/young adult has no conflicts with the substitute care provider.

Adequate relationships exist with all family members. Interactions between the child/youth/young adult and substitute care provider (and others in the caregiver's household) are generally positive; age-appropriate attachments exist despite some problems.

c. The child/youth/young adult has some conflicts with the substitute care provider that have resulted or may result in the child/youth/young adult feeling unsafe or unaccepted in the placement; however, with support, these issues can be mitigated.

The child/youth/young adult has limited relationships with the substitute care provider and family members. Problems limit positive interactions and appropriate attachments with one or more members of the substitute care provider's household.

d. The child/youth/young adult has serious conflicts with one or more members of the current substitute care provider's household.

There are significant problems/conflict in the placement. Chronic problems severely interfere with the child/youth/young adult's interactions and attachments with one or more members of the substitute care provider's household.

CSN11. Independent Living (if age 15.5 or older)

Includes:

- Financial knowledge (e.g., 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 (e.g., hygiene, laundry, housekeeping, grocery shopping, cooking, basic health care, etc.).

a. The youth/young adult is prepared to function as an adult.

The youth/young adult has demonstrated and practiced skills necessary for independent living and is prepared.

b. The youth/young adult is making progress toward being prepared for adulthood.

The youth/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 youth/young adult is aware that they are not fully prepared but is making progress. Youth/young adult is participating in formal or informal independent living services.

c. The youth/young adult is attempting to prepare for adulthood but lacks the confidence, emotional maturity, and/or sufficient skills to live independently.

The youth/young adult may have developed only some or none of the skills necessary for independent living. The youth/young adult may be fully confident of their ability to live independently, contrary to their actual skills/abilities (e.g., youth/young adult may be delaying completion of tasks to receive an extension; youth/young adult may lack a support system to provide advice after aging out).

d. The youth/young adult is not prepared or is refusing to prepare for adulthood.

The youth/young adult is actively not participating in plans for preparation for adulthood or is unable to prepare in key areas that may include but are not limited to the following:

- Youth/young adult has sex offense charges and is ineligible for federal housing programs.
- Youth/young adult is in an out-of-state facility where independent living planning is impeded.
- Youth/young adult has developmental delays that impede independent functioning.

For youth/young adults age 15.5 and older, check all that apply to preparation for adulthood.

- The youth/young adult is receiving assistance from a regional center.
- The 15.5-year-old assessment has been completed.
- For youth/young adults age 16 or older, a referral to formal services and a credit check application have been completed.
- For youth/young adults age 17 and older, an independent living plan has been completed.
- A 90-Day Transition Meeting has been held.
- An Emancipation Conference has been held.
- The youth/young adult is participating in the extension foster care program (AB 12).

CSN12. Other Identified Child/Youth/Young Adult Strength or Need (not covered in CSN1 – CSN11)

Select “not applicable” if the caregiver does not have any strengths or needs that are relevant for case planning, beyond those captured in the domains above.

OR

An additional need or strength has been identified that:

a. Actively helps them create safety, permanency, and well-being for themselves.

A child/youth/young adult 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.

b. Is not a strength or barrier for their safety, permanency, or well-being.

A child/youth/young adult has an area of strength or need that is not included in other domains, but this area is not relevant for case planning.

c. Is a barrier to their safety, permanency, or well-being.

A child/youth/young adult has a need that has a moderate impact on family functioning. The family perceives that they would benefit from services and support that address the need.

d. Contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

A child/youth/young adult has a serious need that has a significant impact on family functioning.

SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT (FOR CAREGIVERS & CHILDREN) POLICY AND PROCEDURES

California Department of Social Services

The family strengths and needs assessment (FSNA) is used to evaluate the presenting strengths and barriers that caregivers encounter when trying to provide safety, permanency, and well-being for their children. This assessment is used with caregivers to collaboratively identify critical family needs that should be addressed in the case plan. This tool is used to systematically identify critical family needs that underlie safety in the family and risk of subsequent harm, and it helps plan effective interventions with the family. The FSNA serves several purposes:

- It ensures that all social workers consistently consider each family's strengths and needs in an objective format when assessing the need for interventions that improve child/youth outcomes.
- It provides a guide to support collaborative assessment for development of case plans by workers, supervisors, and family members that assists in identifying key areas of need and strengths and resources that can be used to increase child/youth safety.
- The initial strengths and needs assessment, when followed by periodic reassessments, permits family members, social workers, family support workers, and their supervisors to assess changes in family functioning together and thus assess the effects of their work together over time during the case plan service period.
- In the aggregate, needs assessment data provide management with information on the problems families face. These profiles can then be used to develop resources to meet family needs.

WHICH CASES

Every referral that is promoted to a case.

May be used when a referral will be closed and a detailed service referral will be made, which may benefit from the completion of an FSNA.

The child assessment portion is completed for each child who will be included in the case plan and for whom a case is established in the child welfare services case management system (CWS/CMS).

WHO

The social worker who is responsible for developing the initial case plan in conjunction with the family.

WHEN

INITIAL

Prior to initial case plan

REVIEW

Voluntary

Within 30 days prior to case plan

Court

Within 65 days prior to case plan

DECISION

Identifies the priority needs of caregivers and all needs of children that must be addressed in the case plan. Goals, objectives, and interventions in a case plan should relate to one or more of the priority needs.

Identifies a family's priority areas of strength, which should be incorporated into the case plan to the greatest extent possible, as a means to address identified needs.

APPROPRIATE COMPLETION

Workers should familiarize themselves with the 11 caregiver domains and the 12 child domains of the FSNA and the corresponding definitions. Workers will notice that the domains are areas that they began to look at in the assessments prior to the FSNA, with the difference that the responses to these items lead to specific case planning goals and objectives.

Once a worker is familiar with the domains that must be assessed to complete the FSNA, the worker should conduct their family assessment as they normally would—using good social work practice to collect information from the child, caregiver, and/or collateral sources.

Each of the domains in the assessment represents a significant area of family functioning that may support or impede a family's ability to maintain the safety, permanency, 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 safety of the child/youth/young adult.

For each domain, there are four possible responses:

a. This is a strength response where the behavior actively helps create safety, permanency, and child/youth/young adult well-being.

b. This is an "average" or adequate functioning response. Is not a strength or barrier for safety, permanency, or child/youth/young adult well-being.

This response is also used to score children who are too young to assess in some categories. A caregiver/child with a response of "b" has not achieved the exceptional skills or resources reflected by a response of "a" and may experience a degree of stress or struggle common to daily functioning, but is generally functioning well in the area. These responses are considered as potential strengths, with the exception of children who are scored "b" in some categories because they are too young to assess. For example, an infant may be scored "b" for delinquency because they are too young to be assessed in this area, but it should not be selected as a strength for case planning purposes.

c. Is a barrier to safety, permanency, or child/youth/young adult well-being. A response in this area may be a barrier to achieving child safety, permanency, or well-being but does not actively contribute to a threat to a child's safety.

d. A response in this category represents an area that actively contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult.

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

SN1 TO SN11 AND CSN1 TO CSN12

Determine the appropriate response for each domain and check the item in the space provided. Note that:

- CSN1 to CSN10 relate to children in the family/household.
- CSN10 is only answered for a child in placement and addresses the child's relationship to their substitute care provider.

- CSN11 is only answered for a young person who is at least 15.5 years old and addresses independent living issues.
- SN11 and CSN12 are used when a caregiver or child, respectively, has a unique strength, barrier, or critical need that contributes to imminent danger that is not covered in other domains and is relevant to case planning. If an individual has a strength, select "a." If an individual has an area of strength or need that is not covered in other domains but it is not relevant for case planning, select "b." If an individual has a need, select "c" or "d," depending on the severity of the need. Use the comment box to briefly describe "a," "c," or "d" responses.

PRIORITY NEEDS AND STRENGTHS FOR CAREGIVERS AND CHILDREN

To identify priority strengths and needs for caregivers, consider ratings for domains SN1 through SN11 in Section 1 (caregiver) of the FSNA. All identified child needs must be considered in the family case plan.

All domains identified as "d" (contributes to imminent danger of serious physical or emotional harm to the child/youth/young adult) should have a danger statement created about them and be addressed both by a safety plan and by the case plan. These are priorities for case closure.

All items entered as "c" (a barrier to safety, permanency, or child/youth/young adult well-being) should be strongly considered for the case plan but may not be required to be fully resolved for case closure.

All items entered as "a" should be considered as potential resources and aids when addressing domains identified as "d" and "c."

For needs, enter the domain number and title for all domains assessed as a contributor to imminent danger ("d") first and then all domains assessed as a barrier ("c"). A domain may be a priority need for one or both caregivers. Identify whether the assessment of each domain is for the primary caregiver, secondary caregiver, or both (P, S, or B).

For priority strengths, enter the domain number and title of all domains with an assessment of "a" (actively helps create safety, permanency, and child/youth/young adult well-being). Only items with an "a" may be identified as priority strengths. Look across both caregivers to identify strengths. A domain may be a priority strength for one or both caregivers. Select "P" if it is a strength for only the primary caregiver, "S" if it is a strength for only the secondary caregiver, and "B" if it is a strength for both the primary and secondary caregivers.

Note: A domain may be a priority need for one caregiver and a priority strength for another caregiver.

CASE PLAN

A family case plan is to be written with behaviorally specific goals and objectives that consider and incorporate the caregiver's priority strengths in addressing the caregiver's priority needs. The family case plan is also to include service referrals that address the child's needs and take into consideration

the child's strengths. It is the caregiver's responsibility to ensure that the child's needs are met through appropriate service provision. If a child is in protective placement, and the caregiver is unable to meet the child's needs, the agency must meet the child's needs.

PRACTICE CONSIDERATIONS

Completion of the FSNA requires gathering information from all family members and collaterals, and performing a review of records. The assessment may be completed or modified during the course of family team meetings. The worker must be aware of culturally specific interpretation of appearances and must engage the family in culturally appropriate ways to make an accurate assessment. Where it is difficult to distinguish between responses, additional assessment may be helpful (i.e., psychological, developmental, substance use assessments), particularly if the difference between one rating and another is likely to impact the selection of priority needs.

The FSNA identifies priority AREAS to address in the case plan. Once those areas are identified, the worker may benefit from additional assessment within those areas to identify specific objectives, services, and activities most appropriate for this family. The family's history of service utilization and willingness to change in these areas should be considered. Case plan objectives should be behaviorally specific-and measurable. If there was a safety plan in place, any continuing safety intervention requirements should now be incorporated into the case plan.

Once completed, the initial assessment and the resulting case plan can be used as a foundation for ongoing conversations and periodic (monthly) assessment between the social workers and family members about progress in identified areas of need and use of identified strengths and resources to increase child/youth/young adult safety, permanency, and well-being. This ongoing assessment process, documented in the case record during the service period, then serves to inform formal reassessment tools.

For children in out-of-home care, the case plan will also include information regarding visitation. While SDM does not guide the decision concerning visitation in the initial case plan, the worker is encouraged to consider the safety threats that led to removal, the risk level, and the specific needs of parent and child.

PHYSICAL AND COGNITIVE DEVELOPMENTAL MILESTONES

AGE LEVEL	PHYSICAL SKILLS	COGNITIVE SKILLS
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, in 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 9 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. Fifty percent drink from cup by themselves.	Imitates speech sounds. Correctly uses mama/dada. Understands simple command ("give it to me"). Beginning sense of humor.
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. Fifty percent 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." Fifty percent imitate household tasks.
15 to 18 months	Runs stiffly. Walks backwards. Attempts to kick. Climbs on furniture. Crude page turning. Most use spoon well. Fifty percent can help in little household tasks. Most can take off pieces of clothing.	Vocabulary of about 10 words. Uses words with gestures. Fifty percent 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.

AGE LEVEL	PHYSICAL SKILLS	COGNITIVE SKILLS
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.
2 Years	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. 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?"
3 Years	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.
4 to 5 Years	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.
6 to 11 Years	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.
12 to 17 Years	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, Columbus, OH (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.

CHAPTER G:

SDM®

REUNIFICATION

ASSESSMENT

SDM® REUNIFICATION ASSESSMENT

California Department of Social Services

r: 10/23

Case Name: _____ Case Number: _____

Date Completed: _____ Household Assessed: _____

Assessment Number: _____

To be completed for each household to which a child may be returned (e.g., father's home, mother's home).

A. REUNIFICATION RISK REASSESSMENT

R1. RISK LEVEL ON MOST RECENT REFERRAL (NOT REUNIFICATION RISK LEVEL OR RISK REASSESSMENT)

Answer	Score
<input type="radio"/> a. Low	0
<input type="radio"/> b. Moderate	3
<input type="radio"/> c. High	4
<input type="radio"/> d. Very High	5

R2. HAS THERE BEEN A NEW SUBSTANTIATION SINCE THE INITIAL RISK ASSESSMENT OR LAST REUNIFICATION ASSESSMENT?

Answer	Score
<input type="radio"/> a. No	0
<input type="radio"/> b. Yes	2

R3. CAREGIVER'S PROGRESS WITH CASE PLAN OBJECTIVES (AS INDICATED BY BEHAVIORAL CHANGE)

(Compliance with/attendance of services is not sufficient to indicate behavioral change.)

Select for primary and secondary caregiver if applicable.

Primary	Secondary	Answer	Score
<input type="radio"/>	<input type="checkbox"/>	a. Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged to maintain objectives	-2
<input type="radio"/>	<input type="checkbox"/>	b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives	-1
<input type="radio"/>	<input type="checkbox"/>	c. Minimally demonstrates new skills and behaviors consistent with case plan objectives and/or has been inconsistently engaged in obtaining the objectives specified in the case plan	0
<input type="radio"/>	<input type="checkbox"/>	d. Does not demonstrate new skills and behaviors consistent with case plan objectives and/or refuses engagement	4

TOTAL: _____

REUNIFICATION RISK LEVEL

Assign the risk level based on the following chart.

SCORE	RISK LEVEL
-2 to 1	<input type="radio"/> Low
2-3	<input type="radio"/> Moderate
4-5	<input type="radio"/> High
6+	<input type="radio"/> Very High

OVERRIDES

Policy Overrides

(Increases risk level to very high): **Indicate whether any of the following are true in the current review period.**

1. *Sexual abuse; perpetrator has access to child and has not successfully completed treatment.*

- ☐ Yes
- ☐ No

2. *Non-accidental physical injury to an infant, and caregiver has not successfully completed treatment.*

- ☐ Yes
- ☐ No

3. *Serious non-accidental physical injury requiring hospital or medical treatment, and caregiver has not successfully completed treatment.*

- ☐ Yes
- ☐ No

4. *Death of a sibling as a result of abuse or neglect in the household, and caregiver has not successfully completed treatment.*

- ☐ Yes
- ☐ No

Discretionary Override

Risk level may be adjusted up or down one level. Override Risk Level:

- ☐ Lower
- ☐ Higher

Requires reason:

Supervisor's approval: _____

FINAL REUNIFICATION RISK LEVEL

- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ Very High

B. VISITATION PLAN EVALUATION

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.

VISITATION FREQUENCY

- ☐ Totally (acceptable)
- ☐ Routine (acceptable)
- ☐ Sporadic
- ☐ Rarely or never

VISITATION QUALITY

- ☐ Strong (acceptable)
- ☐ Adequate (acceptable)
- ☐ Limited
- ☐ Destructive
- ☐ No visitation

OVERRIDE

- ☐ No override
- ☐ Policy: Visitation is supervised for safety. Describe reason for continued supervision:

- ☐ Discretionary (reason):

IF RISK LEVEL IS LOW OR MODERATE AND CAREGIVER HAS ATTAINED AN ACCEPTABLE LEVEL OF COMPLIANCE WITH VISITATION PLAN (VISITATION FREQUENCY MUST BE TOTALLY OR ROUTINE, AND VISITATION QUALITY MUST BE STRONG OR ADEQUATE), CONTINUE TO SECTION C, REUNIFICATION SAFETY ASSESSMENT.

IF RISK LEVEL IS HIGH OR VERY HIGH OR VISITATION IS UNACCEPTABLE, GO TO SECTION D, PLACEMENT/PERMANENCY PLAN GUIDELINES. DO NOT COMPLETE SECTION C.

C. REUNIFICATION SAFETY ASSESSMENT

SAFETY THREATS

1. Are any safety threats identified on the safety assessment that resulted in the child's removal still present?

- ☐ No; list the initial safety threats and describe below how the initial safety threat(s) was ameliorated or mitigated after the child's removal.
- ☐ Yes; list and describe safety threat(s) as it currently exists.

Describe details:

If yes, is there a safety intervention that can and will be incorporated into the case plan to mitigate these safety threats?

- ☐ No; there are no safety interventions available and appropriate to mitigate safety concerns if the child were to be reunified at this time.
- ☐ Yes; one or more safety interventions have been identified to mitigate safety concerns and allow reunification to proceed with an in-home safety plan in place.

Describe details:

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 danger of serious harm?

- ☐ No
- ☐ Yes

Describe details:

If yes, is there a safety intervention(s) that can and will be incorporated into the case plan to mitigate these safety threats?

- ☐ No; there are no safety interventions available and appropriate to mitigate safety concerns if the child were reunified at this time.
- ☐ Yes; one or more safety interventions have been identified to mitigate safety concerns and allow reunification to proceed with an in-home safety plan in place.

Describe details:

SAFETY DECISION

Identify the safety decision by selecting 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.

- ☐ **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.
- ☐ **Safe with plan.** One or more safety threats are present, and protective safety interventions have been planned or taken. Based on safety interventions, the child would be safe with a safety plan in place upon their return home. SAFETY PLAN REQUIRED.
- ☐ **Unsafe.** One or more safety threats are present, and continued placement is the only protective 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 one of the following trees for each child receiving family reunification services (FR), depending on whether they are over or under age 3, and enter the results in Section E. Complete for each child. Consult with supervisor and appropriate statutes and regulations.

DECISION TREE FOR CHILDREN UNDER AGE 3 AT TIME OF REMOVAL

1. Is the reunification risk level low or moderate?

- ☐ No. Go to question 2.
- ☐ Yes. Go to question 4.

2. Is this the six-month hearing or before?

- ☐ No. RECOMMENDATION: Pursue permanency alternative. Proceed to overrides below.
- ☐ Yes. Go to question 3.

3. Is the answer to question R3 above "a" or "b," or is visitation acceptable?

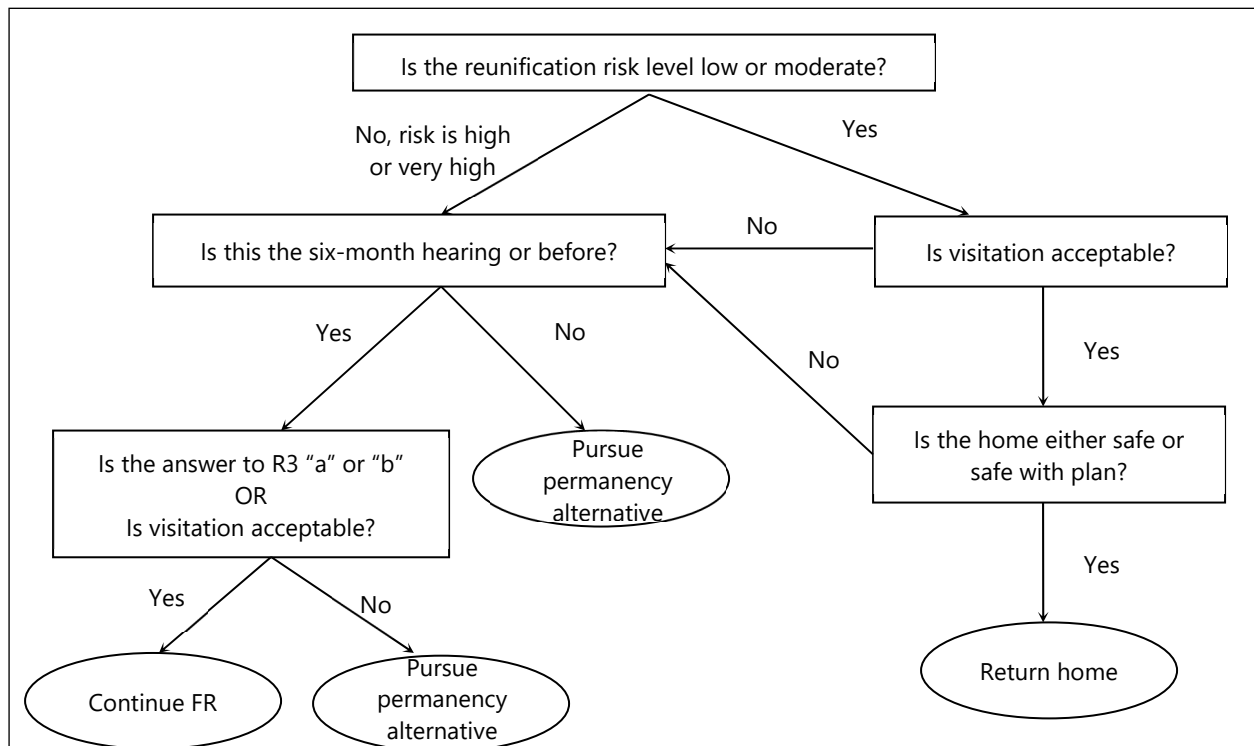
- ☐ No. RECOMMENDATION: Pursue permanency alternative. Proceed to overrides below.
- ☐ Yes. RECOMMENDATION: Continue FR services. Proceed to overrides below.

4. Is visitation acceptable?

- ☐ No. Go to question 2.
- ☐ Yes. Go to question 5.

5. Is the home SAFE or SAFE WITH PLAN?

- ☐ No. Go to question 2.
- ☐ Yes. RECOMMENDATION: Return Home.



DECISION TREE FOR CHILDREN AGE 3 OR OLDER AT TIME OF REMOVAL

1. Is the reunification risk level low or moderate?

- ☐ No. Go to question 2.
- ☐ Yes. Go to question 5.

2. Is this the six-month hearing or before?

- ☐ No. Go to question 3.
- ☐ Yes. RECOMMENDATION: Continue FR services.

3. Is this the 12-month hearing or before?

- ☐ No. RECOMMENDATION: Pursue permanency alternative. Proceed to overrides below.
- ☐ Yes. Go to question 4.

4. Is the answer to question R3 above “a” or “b” OR is visitation acceptable?

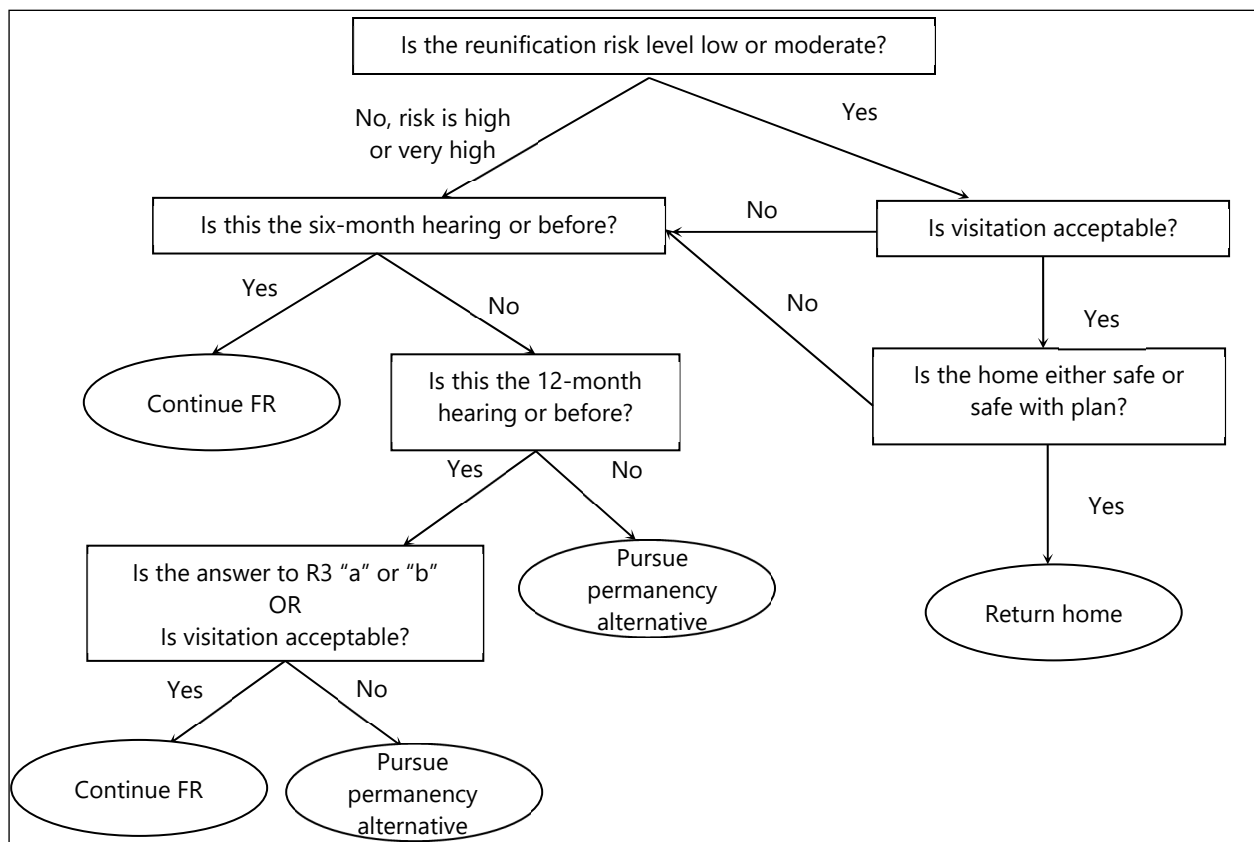
- ☐ No. RECOMMENDATION: Pursue permanency alternative. Proceed to overrides below.
- ☐ Yes. RECOMMENDATION: Continue FR services. Proceed to overrides below.

5. Is visitation acceptable?

- ☐ No. Go to question 2.
- ☐ Yes. Go to question 6.

6. Is the home SAFE or SAFE WITH PLAN?

- ☐ No, home is UNSAFE. Go to question 2.
- ☐ Yes. RECOMMENDATION: Return home.



OVERRIDES

- ☐ No override
- ☐ Policy override (pick one):
 - ☐ The tree leads to "Continue FR," but any of the following policy conditions exist (Change recommendation to "Pursue Permanency Alternative.")
 - ☐ The child has been in placement for 15 of the last 22 months.
 - ☐ The child was removed under WIC § 300 (g) (abandonment) and whereabouts of the caregiver are still unknown.
 - ☐ The caregiver has failed to contact and visit the child.
 - ☐ The caregiver has been convicted of a felony indicating parental unfitness based on WIC § 366.21 (e).
 - ☐ The tree leads to "Pursue permanency alternative," and it is the six-month hearing or before BUT there is a probability of reunification within six months. (Change recommendation to "Continue FR."
- ☐ Discretionary override, change recommendation to:
 - ☐ Return home
 - ☐ Continue FR
 - ☐ Pursue permanency alternative

If any override selected, describe rationale:

E. RECOMMENDATION SUMMARY

For each child, document if the recommendation was to return home, continue FR services, or pursue permanency alternative. If pursuing permanency alternative, also document recommended permanent alternatives.

CHILD NAME	RECOMMENDATION: RETURN HOME	RECOMMENDATION: CONTINUE FR SERVICES	RECOMMENDATION: PURSUE PERMANENCY ALTERNATIVE
1.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

F. SIBLING GROUP

If at least one child under the age of 3 at the time of removal has a recommendation of "Pursue permanency alternative" and at least one other child has any other recommendation, will all children be considered a sibling group when making the final permanency plan recommendation?

- ☐ No
- ☐ Yes. The recommendation for all children will be "Pursue permanency alternative."

If the decision is to return any children home, complete a safety assessment to document the plan for any children for whom safety threats were identified.

SDM® REUNIFICATION ASSESSMENT

DEFINITIONS

California Department of Social Services

A. REUNIFICATION RISK REASSESSMENT

R1. RISK LEVEL ON MOST RECENT REFERRAL (NOT REUNIFICATION RISK LEVEL OR RISK REASSESSMENT)

Identify and record the final risk level from the risk assessment completed for the most recent investigation. (This would normally be the assessment just prior to the start of family reunification services.) If an initial risk assessment was not completed on the referral that led to case opening or a subsequent assigned referral, score "c" (high risk) as the initial risk level for the household.

Do not use a prior risk reassessment or reunification assessment risk level.

R2. HAS THERE BEEN A NEW SUBSTANTIATED INVESTIGATION SINCE THE INITIAL RISK ASSESSMENT OR THE LAST REUNIFICATION ASSESSMENT?

Identify whether there has been a new substantiated investigation since either the initial risk assessment that led to case opening or, if at least one reunification assessment has been completed, the most recent reunification assessment.

- a. Choose "a" if there has not been a substantiated investigation in the review period.
- b. Choose "b" if there has been at least one substantiated investigation.

R3. CAREGIVER'S PROGRESS WITH CASE PLAN OBJECTIVES (AS INDICATED BY BEHAVIORAL CHANGE)

(Compliance with/attendance of services is not sufficient to indicate behavioral change.)

Identify whether a caregiver is actively engaged in achieving the case plan objectives specified in the case plan and is demonstrating the skills/behaviors (e.g., ability to manage substance use/abuse; ability to resolve conflict constructively and respectfully; using age-appropriate, nonphysical discipline in conjunction with appropriate boundary setting; developing a mutually supportive relationship with partner) that will enable the caregiver to create and maintain safety for the child.

If there are two caregivers, rate progress for each. If progress differs between caregivers, score based on the caregiver demonstrating the least amount of participation/progress.

a. Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged to maintain objectives.

Choose “a” if the caregiver is regularly demonstrating all behavioral changes identified in the case plan objectives and is able to create long-term safety for children in the household. The caregiver is actively engaged in activities to maintain the objectives.

b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives.

Choose “b” if the caregiver is demonstrating some new skills and behavioral changes consistent with case plan objectives and is actively engaged in achieving the objectives, but is not regularly demonstrating the behaviors necessary to create long-term safety in all areas.

c. Minimally demonstrates new skills and behaviors consistent with case plan objectives and/or has been inconsistently engaged in obtaining the objectives specified in the case plan.

Choose “c” if the caregiver is demonstrating minor behavioral change consistent with family case plan outcomes but has made little progress toward changing their behavior and is not actively engaged in achieving the objectives. Caregiver behavior continues to make it difficult to create safety or may contribute to immediate danger of serious harm.

d. Does not demonstrate new skills and behaviors consistent with case plan objectives and/or refuses engagement.

Choose “d” if the caregiver has not demonstrated behavioral change consistent with family service plan objectives. The caregiver refuses services, sporadically follows the case plan, or has not demonstrated the necessary skills/behaviors due to a failure or inability to participate. The caregiver is unable to create or maintain safety, and their behavior is likely to contribute to immediate danger of serious harm.

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 assessment, consider the period since the initial risk assessment. If this is *not* the initial reunification assessment, consider the period since the last reunification assessment. 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.

1. Sexual abuse; perpetrator has access to child and has not successfully completed treatment.

One or more of the children in this household is or has been a victim of sexual abuse. The perpetrator is likely to have unmanaged access to the victim and the perpetrator has not completed treatment.

2. Non-accidental injury to an infant, and caregiver has not successfully completed treatment.

An infant in the household has a physical injury resulting from the actions or inactions of a caregiver, and the caregiver has been referred to treatment but has not yet completed the treatment.

3. Serious non-accidental physical injury requiring hospital or medical treatment, and caregiver has not successfully completed treatment.

Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, or severe cuts, AND the child requires medical treatment. The caregiver has been referred for treatment but has not yet completed the treatment.

4. Death of a sibling as a result of abuse or neglect in the household, and caregiver has not successfully completed treatment.

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. The caregiver has been referred for treatment but has not yet completed the treatment.

Discretionary Override

A discretionary override is used by the assigned worker whenever the worker believes that the risk score does not accurately portray the household's actual risk level. Unlike the initial risk assessment, in which the worker could only increase the risk level, the reunification assessment permits the worker to increase or decrease the risk level by one level. The reason a worker may now decrease the risk level is that after a minimum of six months, the worker has acquired significant knowledge of the household. If the worker applies a discretionary override, the reason should be specified and the final reunification risk level should be selected.

B. VISITATION PLAN EVALUATION

VISITATION FREQUENCY—COMPLIANCE WITH VISITATION PLAN

Divide the total number of completed visits by the number of planned visits. Visits that are appreciably shortened by late arrival/early departure are considered missed. Do not count visits as missed or planned that did not occur for reasons not attributable to the household (e.g., foster parent failed to make the child available, transportation that the agency was required to provide did not occur).

Visitation frequency is calculated by dividing available visits by actual visits.

$$\frac{\text{Actual visits}}{\text{Available visits}} = \text{Visitation frequency}$$

Total

Caregiver regularly attends visits or calls in advance to reschedule (90% to 100% compliance).

Routine

Caregiver misses visits occasionally and rarely requests to reschedule visits (65% to 89% compliance).

Sporadic

Caregiver misses or reschedules many scheduled visits (26% to 64% compliance).

Rare or Never

Caregiver does not visit or attends 25% or fewer of the allowed visits (0% to 25% compliance).

QUALITY OF FACE-TO-FACE VISIT

Quality of visit is based on the worker's direct observation whenever possible, supplemented by observation of child, reports of foster parents, etc.

STRONG/ ADEQUATE	<p>Caregiver</p> <ul style="list-style-type: none"> • Consistently demonstrates acts of protection and supportive behaviors toward the child that are consistent with case plan objectives. • Often reinforces appropriate roles and boundaries for child (e.g., caregiver preserves parent-child relationship or takes on adult roles and responsibilities). • Demonstrates an ability to recognize child's behaviors and cues; generally responds appropriately to behaviors and cues. • Identifies the child's physical and emotional needs; responds adequately to these needs. • Demonstrates effective limit-setting and discipline strategies. • Demonstrates a focus on the child during visits; shows empathy to child. • Demonstrates interest in school, other child activities, medical appointments, etc. • Demonstrates behaviors that prioritize the child's needs over their own. <p>Note: Visitation may have progressed to include unsupervised and/or extended visits, but progression to extended visits is not required in order to score the quality of visits as adequate/strong.</p>
LIMITED/ DESTRUCTIVE	<p>Caregiver</p> <ul style="list-style-type: none"> • May not demonstrate acts of protection and supportive behaviors toward the child that are consistent with case plan objectives. • 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. • 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. • 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. • 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. • May have ignored redirection by supervising worker. • May not be focused on child during parenting time and/or conducts self inappropriately during visit (e.g., arriving for parenting time while substance-impaired, reinforcing "parentification" of child, knowingly making false promises to child, cursing at/violently arguing with worker in presence of child). • Has not been successful in progressing visitation toward unsupervised and/or extended visits, or has had significant visitation setbacks that have required increasing supervision due to safety concerns for the child. • Does not demonstrate behaviors that prioritize the child's needs over their own.

OVERRIDES

Policy

Visitation is supervised for safety. The agency has determined that reunification will not be considered if there is a requirement that all visits be supervised for the child's safety. Do not apply this override if supervised visits are still in place solely due to court delays and the child is otherwise safe during visits.

Discretionary

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 visits was strong, and 64% of visits were completed; all missed visits were due to documented medical emergencies).

C. REUNIFICATION SAFETY ASSESSMENT

SAFETY THREATS³

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 threats that resulted in the child’s removal have been resolved. Review the original safety assessment, list the initial safety threats, and describe how the initial safety threats were resolved OR, if not resolved, what the current circumstances are that would pose an immediate threat of harm if the child were to be reunified.

Consider how safe the child would be if they were to be 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.

If yes, is there a safety intervention that can and will be incorporated into the case plan to mitigate these safety threats?

Identify whether any safety interventions are available and appropriate to mitigate any identified safety threats. Use the definitions provided in WebSDM to review both 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 danger of serious harm?

Identify whether any new safety threats have emerged during the review period. Review the safety threat definitions provided in WebSDM. If any new safety threats are identified that would pose an

³ Workers can review the [SDM Safety Assessment Definitions](#) section to help think about safety threats while considering these questions.

immediate threat of serious harm to a child if they were reunified, describe the conditions and circumstances.

If yes, is there a safety intervention(s) that can and will be incorporated into the case plan to mitigate these safety threats?

Identify whether any safety interventions are available and appropriate to mitigate any newly identified safety threats. Use the safety threat and safety intervention definitions provided in WebSDM to determine whether there are any new safety threats.

SAFETY DECISION

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.

Safe With Plan

One or more safety threats are present, and protective safety interventions have been planned or taken. Based on safety interventions, the child would be safe with an in-home safety plan upon their return home. SAFETY PLAN REQUIRED.

Unsafe

One or more safety threats are present, and continued placement is the only protective 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

OVERRIDES

Consider whether any overrides are applicable. If no overrides apply, select "No overrides applicable (policy or discretionary)." If an override will be applied, indicate whether it is a policy or a discretionary override and select the specific reason.

Policy

For all children

The tree leads to "Continue FR," but policy conditions exist to recommend ending reunification services: Change to "Pursue Permanency Alternative."

- Child has been in placement for 15 of the last 22 months.
- The child was removed under WIC § 300 (g) (abandonment) and whereabouts of the caregiver are still unknown.
- The caregiver has failed to contact and visit the child.
- The caregiver has been convicted of a felony indicating parental unfitness based on WIC § 366.21 (e).

For children under age 3 at time of most recent removal

The tree leads to "Pursue permanency alternative" and it is the **six-month hearing** or before, BUT there is a probability of reunification within six months (change to "Continue FR"). There is a probability of reunification within six months, based on the requirements of California Welfare and Institutions Code (WIC) § 366.21 (g) (1) (A–C).

- The caregiver has consistently and regularly contacted and visited the child.
- The caregiver has made substantial progress in resolving problems that led to the child's removal from home.
- The caregiver has demonstrated the capacity and ability to both complete the objectives of their treatment plan and provide for the child's safety, protection, physical and emotional well-being, and special needs.

For children ages 3 and over at time of most recent removal

The tree leads to "Pursue permanency alternative" and it is the **12-month hearing** or before, BUT there is a probability of reunification within six months (change to "Continue FR"). There is a probability of reunification within six months, based on the requirements of California Welfare and Institutions Code (WIC) § 366.21 (g) (1) (A–C).

- The caregiver has consistently and regularly contacted and visited the child.
- The caregiver has made substantial progress in resolving problems that led to the child's removal from home.
- The caregiver has demonstrated the capacity and ability to both complete the objectives of their treatment plan and provide for the child's safety, protection, physical and emotional well-being, and special needs.

Discretionary

Unique considerations exist that warrant an alternative decision. If yes, indicate the permanency plan goal that is being recommended (return home, continue FR, pursue permanency alternative).

E. RECOMMENDATION SUMMARY

The SDM recommendation summary is designed to record worker decisions. In addition to the SDM reunification assessment, the worker should consider all relevant Division 31 regulations and Welfare and Institution Code statutes and should consult with their supervisor.

For each child being assessed, record the final recommendation.

F. SIBLING GROUP

This section applies only if at least one child under the age of 3 at the time of removal was recommended for pursuing a permanency alternative, and at least one other child has any other recommendation.

Select "yes" if all siblings will be considered as a group. Select "no" if siblings will be assessed individually.

If yes, the recommendation for all children will be "pursue permanency alternative."

SDM® REUNIFICATION ASSESSMENT POLICY AND PROCEDURES

California Department of Social Services

The purpose of the reunification assessment is to help assess whether children in placement who have a reunification goal should:

1. Be returned home to the removal household or another household with a legal right to placement; or
2. Be maintained in placement while reunification services continue; or
3. Have a permanency alternative established as their case plan goal.

Research indicates that children are less likely to suffer subsequent harm and re-enter care when the three sections of the reunification assessment are satisfied.

WHICH CASES

All ongoing cases in which at least one child is in placement with a goal of return home. If more than one household is receiving reunification services, complete one assessment on each household.

WHO

The assigned worker.

WHEN

At a minimum, every six months from point of removal. If adequate time has passed to demonstrate progress on the case plan, it is recommended to complete this assessment every 90 days.

The reunification assessment should be completed sooner in the following circumstances.

- Prior to any court hearing at which the permanency goal or progress toward case plan goals is being reviewed.
- At any time a child is being considered for return home (e.g., formal case consultation, change of circumstances affecting ability to plan for safety in home).

If inadequate time has passed to show progress on the case plan but circumstances related to household safety have changed, use the SDM safety assessment to reassess for a safe return home.

DECISION

The reunification assessment guides the decision to:

1. Return a child to the removal household⁴ or to another household with a legal right to placement (non-removal household);
2. Continue FR services; or
3. Pursue permanency alternative.

APPROPRIATE COMPLETION

Following the principles of family-centered practice, the reunification assessment is completed in conjunction with each appropriate household and begins when a case is first opened. The case plan should be informed by the structure and criteria in this assessment and 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 family members understand exactly what will be used to evaluate reunification potential and the threshold they must reach. Specifically:

- Inform the family of their original risk level, and explain that this will serve as the baseline for the reunification assessment (unless a new referral is received, in which case the new risk level will be used).
- Explain that a new substantiated investigation or failure to progress toward case plan goals will increase their risk level, and that progress toward case plan goals will reduce their risk level.
- Explain that both the quantity and quality of their visitation with the child will be considered, and that they must attend at least 65% of their visits and those visits must have at least adequate quality (provide the definition for adequate quality).
- Provide information on the reunification safety assessment and explain that if everything else would permit reunification, the final consideration is safety. They must demonstrate that the safety threats that led to placement have either been mitigated or can be controlled by a safety plan, and that either no safety threats are currently present or there is a safety plan in place to address any identified safety threats.

For each household participating in reunification services, using the definitions and instructions, complete the following.

³Removal household is that household from which the child was removed, or, if due to joint custody that designation is unclear, then the household where the most serious maltreatment occurred. Non-removal households are those households other than the removal household with legal rights to the child (father's home, mother's home).

A. REUNIFICATION RISK REASSESSMENT

Complete all risk items using the definitions, determine the scored risk level, consider overrides, and determine the final risk level.

B. VISITATION PLAN EVALUATION

Complete the visitation plan evaluation for each child in the household based upon the participation of the caregiver demonstrating the least progress, using the definitions, and consider overrides for each child. It is recommended that efforts be made to behaviorally describe visitation quality within the family's case plan relevant to the specific safety threats, risk factors, and underlying family functioning that account for the children being in out-of-home care.

C. REUNIFICATION SAFETY ASSESSMENT

Complete the safety assessment if required by the results of the reunification risk reassessment and visitation plan evaluation. Risk must be either low or moderate and visitation must be acceptable. Consider how the safety threats that led to removal have been mitigated; whether additional safety threats have been identified since removal and if so, whether those threats have been mitigated; or if current safety threats can be controlled in home through a safety plan. Note that safety threat items that should be assessed when considering any new threat in the home are the same as on the original safety assessment.

D. PLACEMENT/PERMANENCY PLAN GUIDELINES

After completing the reunification risk reassessment, visitation plan evaluation, and reunification safety assessment (if indicated), select the appropriate decision tree, based on the child's age at the time of removal.

Begin at the top of the tree. Proceed to the left if the reunification risk level is high or very high, and to the right if the reunification risk level is low or moderate.

Continue following the pathway answering all questions until a recommendation is reached. Recommendations are:

- Return home;
- Continue FR services; and
- Pursue permanency alternative.

OVERRIDES

Consider whether any overrides are applicable, using the definitions. If no overrides apply, select "No overrides applicable (policy or discretionary)." If an override will be applied, indicate whether it is a policy or a discretionary override and select the specific reason. Provide explanation where required.

CHAPTER H: SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES

SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES

California Department of Social Services

r:10/23

Case Name: _____ Case Number: _____

Date Completed: _____ County: _____

Worker Name: _____ Worker ID Number: _____

The first four items are scored based on conditions that were present at the time of the referral that resulted in the case opening. Unless new information has been learned about those conditions, these should be scored the same as on the initial risk assessment.

R1. NUMBER OF PRIOR NEGLECT OR ABUSE CPS INVESTIGATIONS

Answers	Score
<input type="radio"/> a. None	0
<input type="radio"/> b. One or two	1
<input type="radio"/> c. Three or more	2

R2. HOUSEHOLD HAS PREVIOUSLY HAD AN OPEN CPS CASE (VOLUNTARY/COURT ORDERED)

Answers	Score
<input type="radio"/> a. No	0
<input type="radio"/> b. Yes	1

R3. PRIMARY CAREGIVER HAS A HISTORY OF ABUSE AND/OR NEGLECT AS A CHILD

Answers	Score
<input type="radio"/> a. No	0
<input type="radio"/> b. Yes	1

R4. CHARACTERISTICS OF CHILDREN IN THE HOUSEHOLD

Answers	Score
<input type="radio"/> a. Not applicable	0
<input type="radio"/> b. One or more present (<i>select all applicable for any child</i>) <ul style="list-style-type: none"> <input type="checkbox"/> Developmental disability <input type="checkbox"/> Learning disability <input type="checkbox"/> Physical disability <input type="checkbox"/> Medically fragile or failure to thrive 	1

The following case observations pertain to the period since the last assessment/reassessment.

R5. NEW INVESTIGATION OF ABUSE OR NEGLECT SINCE THE INITIAL RISK ASSESSMENT OR THE LAST REASSESSMENT

Answers	Score
<input type="radio"/> a. No	0
<input type="radio"/> b. Yes	2

R6. PRIMARY/SECONDARY CAREGIVER ALCOHOL AND/OR DRUG USE SINCE THE LAST ASSESSMENT/REASSESSMENT

Select one for each caregiver

Primary	Secondary	Answers	Score
<input type="radio"/>	<input type="checkbox"/>	a. No history of alcohol or drug abuse	0
<input type="radio"/>	<input type="checkbox"/>	b. No current alcohol or drug abuse; no intervention needed	0
<input type="radio"/>	<input type="checkbox"/>	c. Yes, alcohol or drug abuse; problem is being addressed	0
<input type="radio"/>	<input type="checkbox"/>	d. Yes, alcohol or drug abuse; problem is <u>not</u> being addressed	1

R7. ADULT RELATIONSHIPS IN THE HOME

Answers	Score
<input type="radio"/> a. None applicable	0
<input type="radio"/> b. Yes (select all that apply) <input type="checkbox"/> Harmful/tumultuous relationships <input type="checkbox"/> Domestic violence	1

R8. PRIMARY CAREGIVER MENTAL HEALTH SINCE THE LAST ASSESSMENT/REASSESSMENT

Answers	Score
<input type="radio"/> a. No history of mental health problem	0
<input type="radio"/> b. No current mental health problem; no intervention needed	0
<input type="radio"/> c. Yes, mental health problem; problem is being addressed	0
<input type="radio"/> d. Yes, mental health problem; problem is <u>not</u> being addressed	1

R9. PRIMARY CAREGIVER PROVIDES PHYSICAL CARE OF THE CHILD THAT IS:

Answers	Score
<input type="radio"/> a. Consistent with child needs	0
<input type="radio"/> b. Not consistent with child needs	1

R10. CAREGIVER'S PROGRESS WITH CASE PLAN OBJECTIVES (AS INDICATED BY BEHAVIORAL CHANGE)

Score for each caregiver. Score based on the caregiver demonstrating the least progress

Primary	Secondary	Answers	Score
<input type="radio"/>	<input type="checkbox"/>	a. Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged to maintain objectives	0
<input type="radio"/>	<input type="checkbox"/>	b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives	0
<input type="radio"/>	<input type="checkbox"/>	c. Minimally demonstrates new skills and behaviors consistent with case plan objectives and/or has been inconsistently engaged in obtaining the objectives specified in the case plan	0
<input type="radio"/>	<input type="checkbox"/>	d. Does not demonstrate new skills and behaviors consistent with case plan objectives and/or refuses engagement	1

TOTAL: _____

SCORED RISK LEVEL

Assign the family's risk level based on the following chart.

SCORE	RISK LEVEL
0–1	<input type="radio"/> Low
2–4	<input type="radio"/> Moderate
5–7	<input type="radio"/> High
8+	<input type="radio"/> Very High

OVERRIDES

POLICY OVERRIDES

Select yes if condition is applicable in the current review period. If any condition is applicable, override final risk level to very high.

1. Sexual abuse case AND the perpetrator is likely to have access to the child.

- ☐ Yes
- ☐ No

2. Non-accidental injury to a child under age 2.

- ☐ Yes
- ☐ No

3. Severe non-accidental injury.

- ☐ Yes
- ☐ No

4. Caregiver action or inaction resulted in death of a child due to abuse or neglect.

- ☐ Yes
- ☐ No

Is a policy override needed?

- ☐ Yes
- ☐ No

DISCRETIONARY OVERRIDE

Is a discretionary override needed? Risk level may be overridden one level higher or lower.

- ☐ Yes. If yes, select override risk level, and indicate the reason:
☐ Low ☐ Moderate ☐ High ☐ Very High
- ☐ No

Reason:

FINAL RISK LEVEL

Select final level assigned.

- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ Very High

RECOMMENDED DECISION

FINAL RISK LEVEL	RECOMMENDATION
<input type="radio"/> Low	Close (unless there are unresolved safety threats)
<input type="radio"/> Moderate	Close (unless there are unresolved safety threats)
<input type="radio"/> High	Continue Services
<input type="radio"/> Very High	Continue Services

PLANNED ACTION

- ☐ Continue Services
- ☐ Close. **Note: A closing safety assessment is required.**

If recommended decision and planned action do not match, explain why.

SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES DEFINITIONS

California Department of Social Services

R1. NUMBER OF PRIOR NEGLECT OR ABUSE CPS INVESTIGATIONS

Identify the number of assigned physical abuse, sexual abuse, emotional abuse, and neglect investigations prior to the investigation resulting in the current case, regardless of whether the allegations were substantiated, inconclusive, or unfounded.

Do not include referrals that were not assigned for investigation or investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect.

- a. Choose "a" if there were no prior assigned investigations.
- b. Choose "b" if there were one or two prior assigned investigations.
- c. Choose "c" if there were three or more prior assigned investigations.

R2. HOUSEHOLD HAS PREVIOUSLY HAD AN OPEN CPS CASE (VOLUNTARY/COURT-ORDERED)

Identify whether the household has had an open CPS case prior to the investigation resulting in the current case. This applies to the household that has been investigated and opened in the current case.

Service history includes voluntary or court-ordered family services, but not delinquency services.

- a. Choose "a" if the household has not had a prior open CPS case.
- b. Choose "b" if the household has one or more prior open CPS cases.

R3. PRIMARY CAREGIVER HAS A HISTORY OF ABUSE AND/OR NEGLECT AS A CHILD

Identify whether the primary caregiver was a victim of child abuse/neglect as a child. Are there credible statements by the primary caregiver or others and/or documentation that indicate the primary caregiver was maltreated as a child? (Maltreatment includes neglect or physical, sexual, or emotional abuse.)

- a. Choose "a" if the primary caregiver was not maltreated as a child.
- b. Choose "b" if the primary caregiver was maltreated as a child.

R4. CHARACTERISTICS OF CHILDREN IN THE HOUSEHOLD

Identify whether any child in the household has a developmental, learning, and/or physical disability, or is diagnosed as medically fragile or failure to thrive. Base identification on credible information from a caregiver that a child has been diagnosed, statements from a physician or mental health professional, or review of records.

- a. Choose "a" if no child in the household exhibits characteristics listed below.
- b. Choose "b" if any child in the household exhibits characteristics listed below and select all types present.

DEVELOPMENTAL DISABILITY

A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

LEARNING DISABILITY

Child has an individualized education plan (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 OR FAILURE TO THRIVE

"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 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 an ongoing threat to their continued well-being. Examples include a child who requires a trach-vent for breathing or a g-tube for eating.

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 OF ABUSE OR NEGLECT SINCE THE INITIAL RISK ASSESSMENT OR THE LAST REASSESSMENT

Identify whether there was at least one investigation involving a caregiver in the household that was initiated since the initial risk assessment or last reassessment. This includes open or completed investigations, regardless of the investigation's conclusion, that have been initiated since the initial assessment or last reassessment. Do not include duplicate referrals.

R6. PRIMARY/SECONDARY CAREGIVER ALCOHOL AND/OR DRUG USE SINCE THE LAST ASSESSMENT/REASSESSMENT

Identify alcohol/drug use by the caregiver(s) during the review period, whether there is a current problem that interferes with caregiver functioning or family functioning, and if so, how the caregiver(s) has addressed the problem during the review period.

Non-abusive use of legal prescription drugs or over-the-counter medications should not be identified as an issue.

If both caregivers have a substance abuse problem, rate the more negative behavior of the two caregivers.

Not addressing the problem since the last assessment/reassessment includes:

- Substance use that affects or affected employment, criminal involvement, or marital or family relationships; and/or that affects or affected caregiver's 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;
 - Treatment received currently or in the past;
 - Multiple positive urine samples;
 - Health/medical problems resulting from substance use and/or abuse; or
 - The child's diagnosis with fetal alcohol syndrome or exposure, or the child's positive toxicology screen at birth and the primary caregiver was the birth parent.
- a. Choose "a" if there is no history of alcohol or drug abuse.
 - b. Choose "b" if there is a history of alcohol or drug abuse that is not current and did not require intervention during the review period.

- c. Choose "c" if there is alcohol or drug abuse, and the problem is being addressed.
- d. Choose "d" if there is alcohol or drug abuse, and the problem is not being addressed.

R7. ADULT RELATIONSHIPS IN THE HOME

Identify the current status of adult relationships in the household.

- a. Choose "a" if not applicable or there are no problems observed.
- b. Choose "b" if there are harmful/tumultuous adult relationships or domestic violence.

HARMFUL/TUMULTUOUS RELATIONSHIPS

There are adult relationships in the household that are harmful to domestic functioning or to the care the child receives (but not at the level of domestic violence). Internal or external stressors are present, and the household is experiencing increased disruption of positive interactions, coupled with lack of cooperation and/or emotional or verbal abuse.

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 MENTAL HEALTH SINCE THE LAST ASSESSMENT/REASSESSMENT

Determine the primary caregiver's current mental health status. Does the caregiver have a current diagnosis of a significant mental health problem that impacts daily functioning, as determined by a mental health clinician, and if so, is the problem being addressed?

Not addressing the problem includes a caregiver who during the review period:

- Has a mental health condition that affects or affected the caregiver's employment, criminal involvement, or marital or family relationships; or that affects or affected their ability to provide protection, supervision, and care for the child;
- Has had referrals for mental health/psychological evaluations; or
- Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

- a. Choose "a" if the primary caregiver does not have a current or past mental health problem.
- b. Choose "b" if there is a history of mental health problems, but within the last year, there is no mental health problem that requires intervention.
- c. Choose "c" if there is a mental health problem, and the problem is being addressed.
- d. Choose "d" if there is a mental health problem, and the problem is not being addressed.

R9. PRIMARY CAREGIVER PROVIDES PHYSICAL CARE OF THE CHILD THAT IS:

Determine whether the child's physical care is consistent with the child's needs (age-appropriate feeding, clothing, shelter, hygiene, and medical care). Physical care that is not consistent with the child's needs threatens the child's well-being or results in harm to the child. Examples of physical care that is not consistent with child need include but are not limited to:

- Repeated failure to obtain physician-recommended immunizations;
 - Failure to obtain medical care for severe or chronic illness;
 - Repeated failure to provide the child with weather-appropriate clothing;
 - Persistent rat or roach infestations;
 - Inadequate or inoperative plumbing or heating;
 - Poisonous substances or dangerous objects lying within reach of small child;
 - The child wears filthy clothes for extended periods of time; or
 - The child is not being bathed on a regular basis, resulting in dirt caked on skin and hair and a strong odor.
- a. Choose "a" if physical care is consistent with child needs.
 - b. Choose "b" if physical care is not consistent with child needs.

R10. CAREGIVER'S PROGRESS WITH CASE PLAN OBJECTIVES (AS INDICATED BY BEHAVIORAL CHANGE)

Compliance with/attendance of services is not sufficient to indicate behavioral change.

Identify whether a caregiver is actively engaged in achieving the case plan objectives specified in the case plan and is demonstrating skills/behaviors that will enable the caregiver to create, and maintain, safety for the child (e.g., ability to manage substance use/abuse; ability to resolve conflict constructively and respectfully; using age-appropriate, non-physical discipline in conjunction with appropriate boundary setting; developing a mutually supportive relationship with a partner).

"Case plan objectives" specifically refers to the service objective type in the CWS/CMS case plan, identifying the changes in caregiver behavior necessary to create and maintain safety.

If there are two caregivers, rate progress for each. If progress differs between caregivers, score the item based on the caregiver who is demonstrating the least amount of participation/progress.

A. DEMONSTRATES NEW SKILLS AND BEHAVIORS CONSISTENT WITH ALL FAMILY CASE PLAN OBJECTIVES AND IS ACTIVELY ENGAGED TO MAINTAIN OBJECTIVES.

Choose "a" if the caregiver is regularly demonstrating all behavioral changes identified in the case plan objectives and is able to create long-term safety for children in the household. The caregiver is actively engaged in activities to maintain the objectives.

B. DEMONSTRATES SOME NEW SKILLS AND BEHAVIORS CONSISTENT WITH FAMILY CASE PLAN OBJECTIVES AND IS ACTIVELY ENGAGED IN ACTIVITIES TO ACHIEVE OBJECTIVES.

Choose "b" if the caregiver is demonstrating some new skills and behavioral change consistent with case plan objectives and is actively engaged in achieving the objectives, but is not regularly demonstrating the behaviors necessary to create long-term safety in all areas.

C. MINIMALLY DEMONSTRATES NEW SKILLS AND BEHAVIORS CONSISTENT WITH CASE PLAN OBJECTIVES AND/OR HAS BEEN INCONSISTENTLY ENGAGED IN OBTAINING THE OBJECTIVES SPECIFIED IN THE CASE PLAN.

Choose "c" if the caregiver is demonstrating minor behavioral change consistent with family case plan outcomes but has made little progress toward changing their behavior and is not actively engaged in achieving the objectives. Caregiver behavior continues to make it difficult to create safety or may contribute to immediate danger of serious harm.

D. DOES NOT DEMONSTRATE NEW SKILLS AND BEHAVIORS CONSISTENT WITH CASE PLAN OBJECTIVES AND/OR REFUSES ENGAGEMENT.

Choose "d" if the caregiver has not demonstrated behavioral change consistent with family service plan objectives. The caregiver refuses services, sporadically follows the case plan, or has not demonstrated the necessary skills/behaviors due to a failure or inability to participate. The caregiver is unable to create or maintain safety or their behavior is likely to contribute to immediate danger of serious harm.

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 risk reassessment, consider the period since the initial risk assessment. If this is not the initial risk reassessment, consider the period since the last risk reassessment. Discretionary overrides require supervisory approval.

POLICY OVERRIDES

Indicate whether a policy override condition exists. Consider only the most recent review period. Presence of one or more mandatory override conditions increases the risk level to very high.

1. Sexual abuse case AND the perpetrator is likely to have access to the child.

One or more of the children in this household are or have been victims of sexual abuse AND the perpetrator is likely to have unmanaged access.

2. Non-accidental injury to a child under age 2.

Any child under 2 years old in the household has any kind of physical injury resulting from the actions or inactions of a caregiver.

3. Severe non-accidental injury.

Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, or severe cuts, AND the child requires medical treatment.

4. Caregiver action or inaction resulted in death of a child due to abuse or neglect.

Any child in the household has died as a result of actions or inactions by the caregiver. This child fatality may have occurred prior to the current case.

DISCRETIONARY OVERRIDE

A discretionary override is used by the assigned worker whenever the worker believes that the risk score does not accurately portray the household'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 level. The reason a worker may now decrease the risk level is that after a minimum of six months, the worker has acquired significant knowledge of the household. If the worker applies a discretionary override, the reason should be specified and the final risk level should be selected.

SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES POLICIES AND PROCEDURES

California Department of Social Services

The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently to allow a case to be closed, or whether the risk level remains high and services should continue. This is accomplished through evaluating whether **behaviors and actions** of the family has changed as a result of the case plan.

The family risk reassessment combines items from the original risk assessment with additional items that evaluate a family's progress toward case 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 uses a single index.

WHICH CASES

All open cases in which all children remain in the home, or cases in which all children have been returned home and family maintenance services will be provided.

WHO

The case-carrying worker.

WHEN

Prior to each Division 31–required review, which occurs at least once every six months, regardless of court hearing dates or case plan updates in addition to the following guidance, and any recommendation to close the case or continue services. To ensure that current SDM assessments are available, they should be completed:

VOLUNTARY CASES

- No more than 30 calendar days prior to completing each case plan.
- No more than 30 calendar days prior to recommending case closure.

INVOLUNTARY CASES

- No more than 65 calendar days prior to completing each case plan.
- No more than 65 calendar days prior to recommending case closure.

ALL CASES

Should 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 close a case.

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

APPROPRIATE COMPLETION

SCORING INDIVIDUAL ITEMS

Workers should familiarize themselves with the items that are included on the risk reassessment and the accompanying definitions for those items. A score for each item is derived from the worker's observation of the characteristics it describes during interviews with household members (child, caregivers, and others) and collaterals; worker observations; reports and case records; or other reliable sources concerning progress in demonstrating behavioral change and meeting case plan objectives. 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 their assessment of the family.

Using the definitions for the risk reassessment, complete all items on the risk reassessment and consider whether any override reasons are present.

Risk items R1–R4: The first four items on the risk reassessment generally are scored the same way as the first four items on the initial risk assessment, unless new information has become available about conditions that existed at the time of the initial risk assessment. Review the initial risk assessment to determine the scores and consider all information currently available.

Risk items R5–R10: These items are scored based ONLY on observations since the most recent assessment or reassessment.

When all items are scored, total the scores to determine the scored risk level following the instructions on the form.

OVERRIDE

Consider both policy and discretionary overrides. If any are present, then determine the final risk level. If no overrides are present, then the scored and final risk level are the same.

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 have occurred since the initial risk assessment or the last reassessment. If one or more policy override conditions exist, select “yes” for each reason for the override and select “very high” for the final risk level. Policy overrides require supervisory review.

Discretionary Override

A discretionary override is used by the ongoing 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 a minimum of six months, the worker has acquired significant knowledge of the family. If a discretionary override applies, select “yes,” indicate the reason, and select the override risk level. Discretionary overrides require supervisory approval. The worker then indicates the final risk level.

DISPOSITION

WebSDM will display the recommended response based on the risk-based case open/close guide. Enter the actual case disposition (continuing the case or closing the case). If the recommended response differs from the actual disposition, provide an explanation.

PRACTICE CONSIDERATIONS

Case workers should explain to the family, at the start of the service period, the structure and process for conducting the reassessment, and should link the reassessment process to the developed case plan.

Case workers should use formal and informal family engagement strategies during monthly in-person contacts or periodically scheduled family meetings to gather information about change over time, which should be documented in the case record. This aggregate information can then form the basis for scoring the formal reassessment.

Use of formal engagement strategies, such as family team meetings to conduct the formal reassessment and develop an updated case plan or engage in planning for case closure, is highly recommended.