EVIDENT CHANGE
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SDM® POLICY AND PROCEDURES MANUAL

Vermont Department for Children and Families

Family Services Division

August 2022

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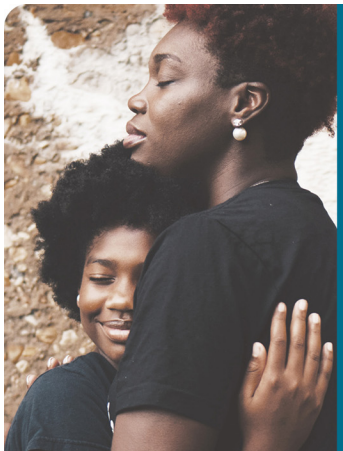


ABOUT EVIDENT CHANGE

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.

CONTENTS

CORE PRINCIPLES OF INTEGRATING THE SDM® SYSTEM INTO FAMILY ENGAGEMENT PRACTICE

ROLE

The SDM assessments guide the core set of information to be gathered at each phase of the assessment process, and each item on the assessment instrument helps determine the recommended response. The assessments are not interview guides. Gather information from the perspective of each family member, as well as from collateral sources, record review, and worker observations. Use the items on the instrument to focus areas of inquiry and the definitions to help assess a family's status in relationship to each item. Use the instrument's results to begin discussion with the family on the next steps.

INTERVIEWS

Use best social work practice to conduct interviews, including joining with the family, using open-ended questions, listening to the family's story, and using focus questions as needed to clarify key information related to decision making. Use the items and definitions to help focus the interviews. Focus questions ideally include techniques such as scaling questions, exception questions, etc.

ITEM RESPONSES

In most instances, the item response should reflect the family's perspective. At times, the family will present multiple perspectives and/or the worker's perspective will differ. Professional judgment is required to balance the various perspectives. Select the item response based on the perspective that is best supported by available evidence. If this response differs from that of one or more family members, sensitive handling of the situation can strengthen the relationship with the family. The worker should be respectful of the family's point of view, and narrative should reflect that the item response is not representative of everyone's perspective. Discussion with the family may help them see concerns that were not previously recognized. Discussion may also help the worker see the family in a different light and, as a result, lead to re-evaluation.

In summary, ***the worker should mark items appropriately when they are clearly supported by evidence****. If a family member disagrees, note their point of view in the "different perspectives" section of the assessment form or in the assessment narrative.* ***When the evidence is unclear and the worker cannot gain additional information, respond in the most protective manner.***

SDM® GENERAL DEFINITIONS

CAREGIVER

An adult in the household who is legally responsible for providing care and supervision for the child. Note that for SDM assessments, caregivers who are not household members are not included.

PRIMARY CAREGIVER

The primary caregiver is the adult living in the household who is legally obligated and entitled to provide for the safety and well-being of the child. When there are two such adult caregivers present, select the one who assumes more responsibility for child care than the other legal parent. If this does not resolve the question, the legally responsible adult who was a perpetrator or alleged perpetrator should be selected. For example, when a mother and a father reside in the same household and appear to equally share child care responsibilities and the mother is the perpetrator (or the alleged perpetrator), the mother should be selected. In circumstances where both parents are in the household, equally sharing child care responsibilities, and both have been identified as perpetrators or alleged perpetrators, the parent demonstrating the more severe behavior should be selected. Only one primary caregiver can be identified.

SECONDARY CAREGIVER/ADULT

The secondary caregiver/adult is the second caregiver (legally responsible adult), if any. If there is only one legally responsible adult, the secondary caregiver/adult may be any other adult living in the household who has routine responsibility for child care.

Note: An extended family member or unrelated adult living in the household can be considered as a secondary caregiver if there is only one legal parent in the home. Extended family or unrelated adults living in the home are never considered to be primary caregivers.

HOUSEHOLD MEMBER

SDM assessments are household based assessments. A household is defined as a group of people who have frequent contact with the child. A household member is defined as any individual, regardless of age, who resides in or spends substantial time in the home. This may include, but is not limited to, a non-resident parent who visits the home; relatives, significant others, and/or other individuals who stay overnight in the home; or an individual who routinely babysits in the home and/or otherwise assumes some degree of caregiving responsibility in the home for **any** child in that home.

WHICH HOUSEHOLD IS ASSESSED?

When a child's parents do not live together, the child may be a member of two households.

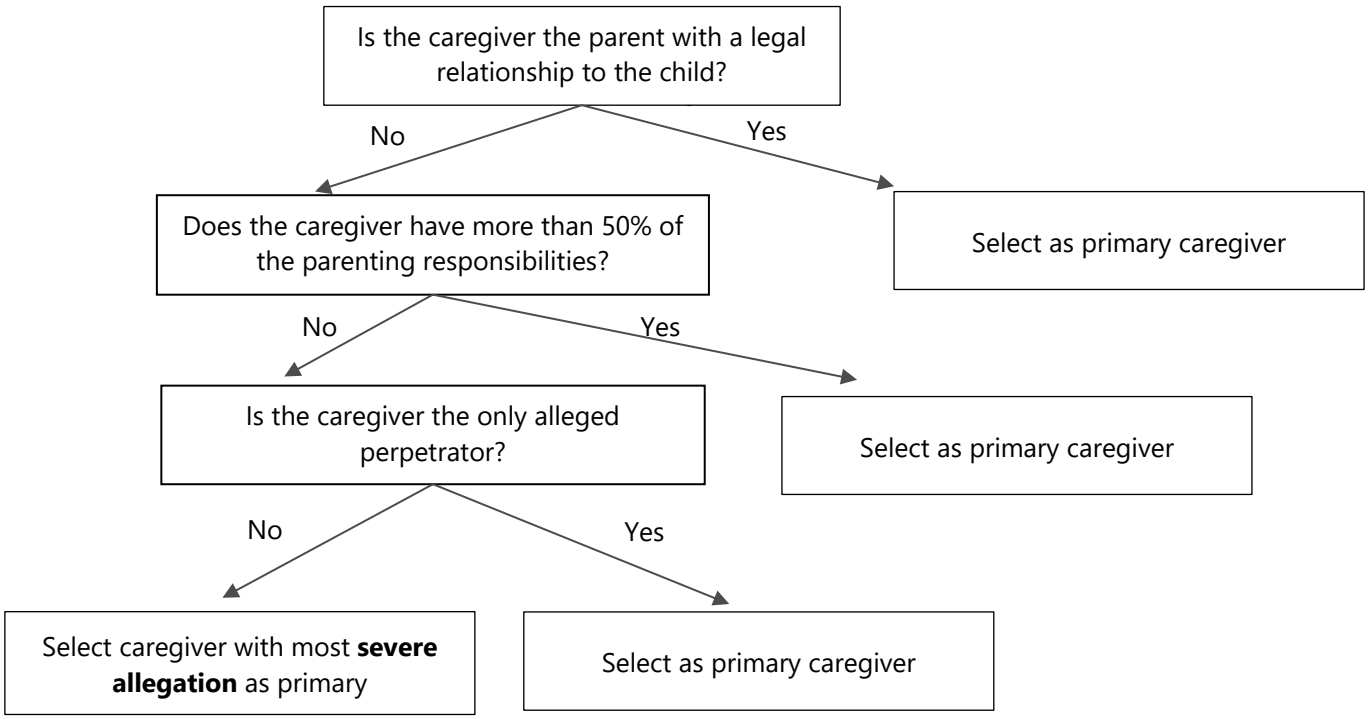
Always assess the household of the alleged perpetrator, which may or may not be the child's primary residence. If the alleged perpetrator is neither a caregiver nor a member of the child's household, SDM assessments are used only if there is a question about the caregiver's ability to protect. This does not require a separate accepted allegation of risk of harm.

Also assess under the following conditions.

- If the alleged perpetrator is a non-resident parent, assess the resident parent *if there is an allegation of failure to protect*.
- If a child is being removed from a resident parent, assess any non-resident parent identified *if they will receive child welfare services*.

CAREGIVER IDENTIFICATION CHART

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



FOR THE SAFETY ASSESSMENT

Assess all household members AND every adult who has access to the child. This may include non-household members.

SDM SAFETY ASSESSMENT

Vermont Department for Children and Families
Family Services Division

R: 05–22

Family Name: _____ **Family #:** _____

District: _____ **Intake # (if applicable):** _____

Type: ○ Initial ○ Change of circumstance ○ Investigation/family assessment closing/case closing

Date of Assessment: _____ **Household Members:** _____

WHO PROVIDED INFORMATION TO COMPLETE THE SAFETY ASSESSMENT?

☐ Primary caregiver: _____

☐ Secondary caregiver/adult (name): _____

☐ Others (names and roles; children's names can be included here):

☐ Consulted with non-resident parent

NAMES OF CHILDREN ASSESSED

(If more than six children are being assessed, add additional names and numbers on reverse side.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are there additional names on reverse? ○ Yes ○ No

SECTION 1: CONTEXT

FAMILY/HOUSEHOLD CULTURAL CONTEXT

How do the members of this family/household self-identify culturally, and how does it influence their parenting styles/techniques as it relates to the safety assessment?

FACTORS INFLUENCING CHILD VULNERABILITY

Conditions resulting in child's inability to protect self; mark all that apply to **any** child in the household.)

- ☐ Under age 6
- ☐ Significant diagnosed medical or mental disorder
- ☐ Isolated from objective adults
- ☐ Diminished developmental/cognitive capacity (e.g., developmental delay, nonverbal)
- ☐ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)

CAREGIVER CONTEXT

Complete this section only when there is evidence that one or more caregivers are experiencing any of the following factors. These are conditions/behaviors that contribute to greater difficulty for the family or make it complicated to create safety for a child, but which by themselves do not create a danger. These behaviors must be considered when assessing for and planning to mitigate the danger with a safety plan. Mark all that apply to the household.

☐ Substance abuse ☐ Mental health ☐ Physical condition ☐ Other (specify): _____

☐ Domestic violence ☐ Developmental/cognitive impairment

SECTION 2: DANGERS

Assess the household for each of the following dangers. Indicate whether currently available information results in reason to believe a danger is present by marking "yes" for any and all dangers present in the family's current situation and "no" for any of the dangers absent from the family's current situation, based on the information available at this time.

Review the definitions and mark all that apply, but do not mark more than one item for the same danger.

Yes No

○ ○ 1. Caregiver or other adult in the household caused serious physical harm to the child or the child is in imminent danger of serious harm, as indicated by:

- ☐ a. Serious injury or abuse to the child other than accidental.
- ☐ b. Caregiver fears they will maltreat the child.
- ☐ c. Threat to cause harm or retaliate against the child.
- ☐ d. Domestic violence is likely to injure child.
- ☐ e. Excessive discipline or physical force.
- ☐ f. Significant substance use.
  - ☐ 1. *Impairs ability to supervise, protect, or care for the child*.
  - ☐ 2. *Caregiver will likely be unable to care for the child*.
  - ☐ 3. *Caregiver's use of drugs and/or alcohol during pregnancy indicates that caregiver will likely be unable to care for the newborn*.

Describe caregiver behavior and impact on child that justifies selecting this item.

○ ○ 2. Child sexual abuse/exploitation is known or suspected, and the child's safety may be of immediate concern in the following circumstances. Indicate whether the suspected abuse was sexual abuse, sexual exploitation, or trafficking.

- ☐ a. *Sexual abuse*
- ☐ b. *Sexual exploitation*
- ☐ c. *Trafficking*

Describe caregiver behavior and impact on child that justifies selecting this item.

Yes No

○ ○ 3. Caregiver does not meet the child's immediate needs for supervision, food, clothing, shelter, and/or medical or mental health care.

☐ a. *Supervision*

☐ b. *Food, clothing, shelter*

☐ c. *Medical or mental health care*

Describe caregiver behavior and impact on child that justifies selecting this item.

○ ○ 4. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child, based on their age and developmental status.

Describe caregiver behavior and impact on child that justifies selecting this item.

○ ○ 5. Caregiver does not protect or is unable OR unwilling to protect the child from serious harm or risk of serious harm (includes physical or sexual abuse) by others (even though they may be trying); OR caregiver does not provide supervision necessary to protect the child, based on child's age and development. (Domestic violence behaviors should be captured under item #1.)

Describe caregiver behavior and impact on child that justifies selecting this item.

Yes No

○ ○ 6. Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury or the caregiver minimizes the harm to the child, AND the nature of the injury suggests that the child's safety may be of immediate concern.

Describe caregiver behavior and impact on child that justifies selecting this item.

○ ○ 7. The family refuses access to the child, or there is reason to believe that the family is about to flee with the child, or the family is keeping the child isolated from others to avoid the assessment.

Describe caregiver behavior and impact on child that justifies selecting this item.

○ ○ 8. Current circumstances, combined with information that the caregiver has severely maltreated a child in their care in the past, suggest that the child's safety may be in immediate danger. No Information is available to indicate the caregiver has taken steps to address the concerns. (*Do not mark if another item has been marked.)*

Describe caregiver behavior and impact on child that justifies selecting this item.

○ ○ 9. Other (specify): _____

Describe caregiver behavior and impact on child that justifies selecting this item.

SAFETY DECISION: IF NO DANGER IS PRESENT, MARK THE SAFETY DECISION BELOW.

○ **Safe.** No dangers 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/family assessment and the risk assessment as required or continue ongoing work.

Safety Assessment Discussion Box

In the narrative box, describe caregiver behaviors, their impact on the child, and what details informed the safety decision of "safe." Be brief but as specific as possible. Avoid labels and jargon.

SECTION 3: PROTECTIVE CAPACITIES AND PROTECTIVE ACTIONS

PROTECTIVE CAPACITIES

These are resources and coping skills/qualities in an individual or a family that increase the likelihood or ability to create safety for a child but in and of themselves do not fully address the danger.

PROTECTIVE ACTIONS

These are specific actions, taken by the caregiver, that directly address the danger and are demonstrated over time.

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

	PROTECTIVE CAPACITIES (Mark all that apply)	PROTECTIVE ACTIONS (Mark all that apply)
Caregiver problem solving	☐ At least one caregiver identifies and acknowledges the problem/danger(s) and suggests possible solutions.	☐ At least one caregiver articulates specific strategies that, in the past, have been at least partially successful in mitigating the identified danger(s), and the caregiver has used or could use these strategies in the current situation.

	PROTECTIVE CAPACITIES (Mark all that apply)	PROTECTIVE ACTIONS (Mark all that apply)
Caregiver safety network	☐ At least one caregiver has at least one supportive relationship with someone who is willing to be a part of their safety 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 dangers, including allowing caseworker(s) access to the child.	☐ At least one caregiver has a stable safety network whose members are aware of the danger(s), have been or are currently responding to the danger(s), and are willing to provide protection for the child.
Child problem solving	☐ At least one child is emotionally/ intellectually capable of acting to protect themself from a danger.	☐ At least one child, in the past or currently, acts in ways that protect themself from a danger.
Child safety network	☐ At least one child is aware of their safety network members and knows how to contact these individuals when needed.	☐ At least one child has successfully pursued support, in the past or currently, from a member of their safety network, and that person(s) was able to help address the danger and keep the child safe.
Other	☐ Other	☐ Other

SECTION 4: FAMILY PROTECTIVE INTERVENTIONS

If dangers have been identified in the household and after consideration of family culture, child vulnerabilities, caregiver context, protective capacities, and protective actions, it is determined that a safety plan will allow the child to be kept safe, the safety decision is "safe with plan." Mark the decision below. If a safety plan that would allow the child to remain safe in the custody of their caregivers cannot be created, go to Section 4.

SAFETY DECISION

○ **Safe with plan.** One or more dangers are present; however, the child can be kept safe with a short-term safety plan. Protective interventions have been initiated through a safety plan and the child can be kept safe as long as the safety plan interventions mitigate the dangers. Mark all 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. Use of tribal, religious, cultural, or other communal resources.

☐ 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 5: COURT PLACEMENT INTERVENTIONS

SAFETY DECISION

○ **Unsafe.** One or more dangers are present, and *DCF will take court action recommending out-of-home placement* because it is the only protective intervention possible for one or more children. Without court action/placement, one or more children will likely be in danger of immediate or serious harm because interventions 1–9 do not adequately ensure the child's safety.

Did any participant disagree with any item on the assessment?

○ No ○ Yes (if yes, describe below)

#	WHO	DIFFERENT POINT OF VIEW

FSD SAFETY PLAN: FRAMEWORK *(for addressing dangers identified on the safety assessment)*

Family Name: _____ Family#: _____ Date: ____/____/____

VERMONT
DEPARTMENT FOR CHILDREN & FAMILIES
FAMILY SERVICES DIVISION

DANGER/HARM
Details about the incident(s) that brought the family to DCF's attention. Pattern/history.

CONCERNS OF REPEATED DANGER/HARM
Risk to child(ren). Context of danger.

COMPLICATING FACTORS
Condition/behaviors that contribute to greater difficulty for the family. Risk factors.

GENOGRAM

SAFETY PLAN

SAFETY
Strengths demonstrated as protection over time. Pattern/history of exceptions.

STRENGTHS/PROTECTIVE CAPACITIES
Assets, resource and, capacities within the family, individual and community. Protective capacities.

FSD SAFETY PLAN: ACTIONS NEEDED

VERMONT
DEPARTMENT FOR CHILDREN & FAMILIES
FAMILY SERVICES DIVISION

Family name: _____ Family#:_____ Date: ____/___/_____

This plan will be reviewed on _____ or no more than 30 days from the safety plan's date.

What specific situation or action is causing the child to be unsafe or at risk?			
What's working well for the family? Who is in their network?			
What actions need to be taken right now to keep the child safe?	**ACTIONS TO BE TAKEN**	**BY WHO**	**BY WHEN**
Who will call DCF if the plan is not working?			

FSD SAFETY PLAN: SIGNATURE PAGE

VERMONT
DEPARTMENT FOR CHILDREN & FAMILIES
FAMILY SERVICES DIVISION

Family was given a completed: ☐Planning Framework ☐ Actions Needed ☐ Both

PARENTS/LEGAL GUARDIANS	
I UNDERSTAND this safety plan is voluntary and time limited and will be reviewed on_____. If the plan is not being followed, Family Services may seek help from the state's attorney to file a CHINS petition. This will mean the court may take action that could result in my child(ren) being removed from my care. If I am unable to follow this plan, I should contact my Family Services worker or the Child Protection Hotline at 1-800-649-5285 right away to develop a new plan.	
Print name Signature Date	Print name Signature Date
FAMILY SERVICES WORKER AND/ OR SUPERVISOR	
Print name Signature Date	Print name Signature Date
CHILDREN (SIGNATURES MAY NOT BE APPLICABLE)	**OTHER PARTICIPANTS**
Print name Signature Date	Print name Signature Date
Print name Signature Date	Print name Signature Date
WHO TO CALL IF THE PLAN IS NOT WORKING	
Assigned Family Services worker: Phone number:	Family Services Supervisor: Phone number:
After business hours, on weekends and on holidays, call the Vermont Child Protection Line at 1-800-649-5285. Instructions:	

SDM SAFETY ASSESSMENT DEFINITIONS

Vermont Department for Children and Families
Family Services Division

FAMILY/HOUSEHOLD CULTURAL CONTEXT

(How do the members of this family/household self-identify culturally, and how does it influence their parenting styles/techniques?) Inquire broadly about all aspects of the family's culture, including: race/ethnicity, sexual orientation, gender identity/expression, tribal affiliation, family roles, faith/spirituality, holiday traditions, and values. See appendix for further guidance.

FACTORS INFLUENCING CHILD VULNERABILITY

(Conditions resulting in child's inability to protect self; mark all that apply to **any** child in the household.)

- **Under age 6.** Any child in the household is under the age of 6. 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 themself 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).
- **Isolated from objective adults.** The child is isolated or less visible within the community (e.g., the family lives in an isolated community, or the child may not attend a public or private school or be routinely involved in other activities within the community).
- **Diminished developmental/cognitive capacity (e.g., developmental delay, nonverbal).** 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).

CAREGIVER CONTEXT

SUBSTANCE ABUSE

Caregiver has abused legal or illegal substances or alcoholic beverages in this incident to the extent that control of their actions was significantly impaired, or information is available that there has been past abuse of legal or illegal substances.

DOMESTIC VIOLENCE

Domestic violence perpetrators, in the context of the child welfare system, are parents and/or caregivers who engage in a pattern of coercive control against one or more intimate partners. This pattern of behavior may continue after the end of a relationship, or when the couple no longer lives together. Violence often escalates when the perpetrator's actions often directly involve, target, and impact family functioning and any children in the family. This can be evidenced by: a recent history of one or more physical assaults of one caregiver by an intimate partner in the household; or coercion, 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 a known history of mental health issues. Caregiver 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

One or both caregivers may have diminished capacity as a result of developmental delays or cognitive issues.

Physical condition

One or both caregivers has a physical condition that may impact their own functioning.

SECTION 1: DANGERS

1. Caregiver or other adult in the household caused serious physical harm to the child or the child is in imminent danger of serious harm, as indicated by the following.

a. *Serious injury or abuse to the child other than accidental*. The caregiver or other adult in the household caused serious injury, including but not limited to brain damage, skull or bone fracture, subdural/epidural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, or severe cuts;

AND

The child requires medical treatment, regardless of whether the caregiver sought medical treatment.

b. *Caregiver fears they will maltreat the child*. The caregiver or other adult in the household has reported credible fears that they will hurt the child in a way that would cause serious injury and/or requests placement.

c. *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.

d. *Domestic violence is likely to injure child*. There have been incidents of intimate partner violence that created danger of serious physical injury to the child

AND

There is reason to believe that this may occur again (e.g., a perpetrator pattern of violence continues to exist regardless of relationship status). *Examples include, but are not limited to, the following*.

- Child was in the arms of one person during a violent episode.
- A gun, knife, or other implement was involved.
- Child attempted to intervene or was near enough to the violent altercation that they were in harm's way.
- Child was previously injured in an incident where the perpetrator inflicted violence upon the non-offending caregiver (e.g., fractures, bruising, cuts, or burns) and there is violence occurring now.

e. *Excessive discipline or physical force*. The caregiver used physical methods to discipline a child that resulted or could easily result in serious injury, **OR** caregiver injured or nearly injured a child by using physical force for reasons other than discipline.

f. *Significant substance use*. Caregiver's current substance abuse seriously impairs their ability to supervise, protect, or care for the child.

1. *Impairs ability to supervise, protect, or care for the child*.
2. *Caregiver will likely be unable to care for the child*.
3. *Caregiver's use of drugs and/or alcohol during pregnancy indicates that caregiver will likely be unable to care for the newborn*.

- The above three sub items reference that the caregiver has abused legal or illegal substances or alcoholic beverages to the extent that control of their actions is significantly impaired. As a

result, the caregiver is unable or will likely be unable to care for the child, has harmed the child, or is likely to harm the child. **Examples include, but are not limited to, the following.**

- » Losing consciousness while caring for a child.
- » Being unaware of surroundings while caring for young children.
- » Driving while significantly impaired with children in any vehicle.
- » Being unaware of child's basic needs due to substance use.
- » Any caregiver is using illegal IV drugs.
- » The child is an infant and the mother's use of drugs and/or alcohol during pregnancy indicates caregiver will likely be unable to care for the child.

  a. There is **evidence** that the mother used alcohol or other drugs (prescribed or illegal drugs) during pregnancy;

  AND

  b. This has created **imminent danger** to the infant.

  - *Evidence* of drug use during pregnancy includes drugs found in the mother's or child's system, mother's self-report, mother's pregnancy diagnosed as high risk due to drug use, efforts on mother's part to avoid toxicology testing, withdrawal symptoms in mother or child, or pre-term labor due to drug use.
  - Indicators of *imminent danger* include the level of toxicity and/or type of drug present, diagnosis of infant as medically fragile due to drug exposure, or adverse effects on infant from introduction of drugs during pregnancy.

2. Child sexual abuse/exploitation is known or suspected, and the child's safety may be of immediate concern in the following circumstances. Indicate whether the suspected abuse was sexual abuse, sexual exploitation, or trafficking.

It is known or highly suspected that a caregiver sexually abused or exploited a household child.

- Sexual abuse or exploitation by a caregiver is indicated by one or more of the following.
  - » Disclosure that a caregiver engaged in sexual acts with the child.
  - » Disclosure that a known or suspected unnamed person engaged in sexual acts with the child AND caregiver cannot be ruled out.
  - » Medical findings are consistent with sexual abuse AND caregiver cannot be ruled out.
  - » Sexual act was witnessed by someone and is evidenced by photographs or other material, or a confession was made by the caregiver.
  - » Caregiver has forced or encouraged the child to engage in sexual performances or activities.
  - » Caregiver uses the child in a sexual way to gain advantage or profit.
- Sexual abuse by a caregiver may be highly suspected despite the absence of disclosure, medical findings, witnessed act, or other evidence. A single indicator, especially if isolated, is rarely sufficient to form a level of suspicion that a child is in imminent danger. Consider the extent to which each of the following are present.

    - » Child's behaviors strongly indicate sexual abuse (i.e., reactive sexual behavior toward self or others that is not appropriate for child's age and stage of development, and no other explanation is reasonable). See table in Appendix B.
    - » Caregiver's boundaries around nudity or exposure to sexual activity, content, or language are inappropriate for the child's developmental level; e.g., caregiver watches pornographic content with child present or frequently discusses sexual matters with child (other than developmentally indicated information).
- A caregiver who has a history of sexually abusing a child, and who has not successfully completed treatment, has access to child. Having a history includes criminal conviction or charges pending OR substantiated child sexual abuse history with any child protection agency OR being currently investigated for child sexual abuse.
- 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 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 (e.g., stripping) in return for a benefit—such as money, food, drugs, shelter, clothing, gifts, or other goods—or for financial or some other gain for a third party. The sexual conduct may include any direct sexual contact or performing any acts, sexual or nonsexual, for the sexual gratification of others. These acts constitute sexual exploitation regardless of whether they are live, filmed, or photographed.
    - » Commercial sexual exploitation of children/youth/young adults may include prostitution, pornography, trafficking for sexual purposes, and other forms of sexual exploitation. The youth is treated as a sexual object and as a commercial object. The sexual exploitation of the child may profit a much wider range of people than the immediate beneficiary of the transaction.

The child's safety may be of immediate concern in the following circumstances.

- There is not a non-offending caregiver, or the non-offending caregiver is unable or unwilling to be 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.
- Access to a child by a confirmed sexual abuse perpetrator exists.

3. Caregiver does not meet the child's immediate needs for supervision, food, clothing, shelter, and/or medical or mental health care. (*Do not check this item if you have already addressed this issue in item 1*.) Mark all subitems on the tool to specify the unmet needs identified.

The caregiver is unable, although may be trying, or unwilling to address critical areas of supervision, food, clothing, shelter, and/or medical and mental health care for the child;

AND

The child has been seriously harmed or is in imminent danger of being seriously harmed as a result. (Poverty alone is not a sufficient reason to mark this item.) *Examples include, but are not limited to, the following*.

- The child's nutritional needs are not met, resulting in danger to the child's health and/or safety, including malnutrition and morbid obesity.
- The child is without clothing appropriate to the weather. Consider the age of the child and whether clothing is the choice of the child or has been provided by the caregiver.
- 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, resulting in declining health status (e.g., not providing insulin for a child with diabetes, not providing follow-up care for a wound that is infected, or not providing care for a broken bone).

  Note: The pursuit of traditional or alternative practices rather than prescribed treatment is included here IF there is evidence that both the child's health status is declining **AND** the prescribed treatment would likely be effective.
- The child has exceptional needs, such as being diagnosed as medically fragile, which the caregiver does not or cannot meet, resulting in declining health status.
- The child is suicidal and/or is seriously self-harming **AND** the caregiver will not/cannot take protective action.
- The child shows effects of maltreatment, such as serious emotional symptoms, lack of behavioral control, or serious physical symptoms. This may include situations where a child exhibits severe anxiety (e.g., nightmares, insomnia, exhibits fear) related to situations associated with domestic violence perpetrator behavior.
- The caregiver is present but does not attend to the child to the extent that need for care goes unnoticed or unmet (e.g., child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).
- The caregiver leaves the child alone (time period varies with age and developmental stage) in circumstances that create opportunities for serious harm, e.g., child left unattended in vehicle.
- The caregiver is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) and there are no arrangements for the child that would ensure their safety.
- The caregiver makes inadequate and/or inappropriate babysitting or childcare arrangements, or demonstrates very poor planning for the child's care during absences, and these arrangements do not provide minimal safety for the child (e.g., temporary caregiver is intoxicated, has limited capacity, or for any reason is unable to meet child's needs).

4. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child, based on their age and developmental status.

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.

- 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, toxic mold, rat bites).
- Evidence of human or animal waste throughout living quarters.
- Guns and other weapons are not locked and not properly secured.
- Drug/methamphetamine pre-production and/or production in the home.
- Substances (including drugs, drug paraphernalia, or cleaning supplies) or objects within reach of child that may endanger their health and/or safety.
- Sleeping arrangements put infant at risk for suffocation.
- Imminent risk of fire.

5. Caregiver does not protect or is unable OR unwilling to protect the child from serious harm or risk of serious harm (includes physical or sexual abuse) by others (even though they may be trying); OR caregiver does not provide supervision necessary to protect the child, based on child's age and development. (*Domestic violence behaviors should be captured under danger #1 or #3.*)

The caregiver does not protect or is unable to protect the child from serious harm or threatened harm as a result of physical or sexual abuse or neglect by other family members, other household members, or others having regular access to the child. Include access by known sexual offenders if prior sexual abuse history is confirmed and caregiver knew about history but allowed access to child, or if caregiver did not know history previously, but upon learning information indicates that they are unable or unwilling to prevent future access.

OR

The caregiver does not provide supervision necessary to protect the child, based on the child's age and development. *Examples include, but are not limited to, 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 violent criminal behavior/history or sexual abuse resides in the home, or the caregiver allows them to have access to the child. Include regardless of 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 (not excluding their own home) where drugs are manufactured or regularly administered, or locations used for prostitution or pornography.

6. **Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury or the caregiver minimizes the harm to the child, 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, regardless of whether the caregiver sought medical treatment, 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.
- The caregiver's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury.
- The caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child.

7. **The family refuses access to the child, or there is reason to believe that the family is about to flee with the child, or the family is keeping the child isolated from others to avoid the investigation/assessment.**

This danger should only be identified when other dangers are near, but do not reach the threshold in the definitions and it is a Chapter 49 child safety intervention; 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. *Examples include, but are not limited to, the following*.

- 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 DCF investigation/assessment 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.

8. **Current circumstances, combined with information that the caregiver has severely maltreated a child in their care in the past, suggest that the child's safety may be in immediate danger. No Information is available to indicate the caregiver has taken steps to address the concerns. (Do not mark if another item regarding the same concern has been marked.)**

- Current immediate threats to child safety exist due to caregiver action or inaction that could seriously harm the child but currently does not meet any other danger indicator criteria;

  AND

- Related previous child maltreatment occurred that was severe and/or represents an unresolved pattern of maltreatment. Previous maltreatment includes any of the following.
  - » Prior child death, possibly as a result of abuse or neglect; e.g., a serious physical injury occurred in the home, and while it was substantiated with the perpetrator unknown, there was a reasonable amount of evidence to suggest it was one of the two caregivers who still reside in the home.
  - » Prior serious injury or abuse or near death of the child, other than accidental. The caregiver caused serious injury—defined as brain damage, skull or bone fracture, subdural or retinal hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe lacerations, symptoms related to starvation, strangulation, or shooting, or any other physical injury that was designated by a medical professional to have seriously impaired the health or well-being of the child and required medical treatment, regardless of whether the caregiver sought medical treatment.
  - » Prior patterns of serious abuse (as identified above) and/or neglect allegations (e.g., chronic neglect, torture, etc.) as defined in Policy 50.

Item 8-required text box instructions: Please describe current worrisome caregiver behaviors that could escalate to another danger item criteria and previous maltreatment.

9. **Other (specify).**

Circumstances or conditions that pose an immediate threat of serious harm to a child, which are not already described in dangers 1–8. The "other" category should be rarely used and workers should ensure the worry cannot fit under any other item definition.

If used, describe in the required text box the worrisome caregiver behavior and impact on the child that would meet a threshold for removal if marked and no safety plan can be developed.

SAFETY DECISION

Safe

No dangers 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/family assessment and the risk assessment as required, or continue ongoing work.

Safety Assessment Item Text Boxes

Please describe the specific caregiver behavior and impact on the child that met the definition criteria for selecting each item.

Safety Assessment Discussion Box

In the narrative box, describe all caregiver behaviors, their impact on the child, and what details informed the safety decision of "safe." Be brief but as specific as possible. Avoid labels and jargon.

For cases in which the child is determined to be **safe**, briefly describe the presence of safety—not just the absence of danger—by summarizing caregiver behaviors and what protective impact they have that makes the child safe.

SECTION 2: PROTECTIVE CAPACITIES AND PROTECTIVE ACTIONS

Protective capacities are resources and coping skills/qualities in an individual or a family that increase the likelihood or ability to create safety for a child but in and of themselves do not fully address the danger. These characteristics can be built upon for future planning and can 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 danger 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 they may be incorporated as part of the plan.

PROTECTIVE CAPACITIES

The following protective capacities should be assessed, considered, and built upon when creating a safety plan to mitigate the dangers. Mark all that apply to the household.

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

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

At least one caregiver has at least one supportive relationship with someone who is willing to be a part of their safety 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 safety network member is someone who cares about the child or family but may not, at this time, know what the danger 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 danger. This non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a danger to the safety of the child, and the non-offending caregiver may be willing to become part of a safety network and protect the child going forward.

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

In the current investigation or assessment, the caregiver allows DCF 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 themself from a danger.

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 dangers 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 safety 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 these 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 danger.

PROTECTIVE ACTIONS

The following actions should be assessed, considered, and built upon when creating a safety plan. Mark 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 danger(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 dangers in the past through their own actions or by using resources. The caregiver is able to describe both the current dangers and the strategies they are using to mitigate them currently.

At least one caregiver has a stable safety network whose members are aware of the danger(s), have been or are currently responding to the danger(s), and are 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 (including tribal ICWA programs, Indian organizations, and/or family members, which can include non-related tribal members) that provide support and meet a wide range of needs for the caregiver and/or the child. The caregiver has informed these network members of the dangers and they have assisted in the situation by providing protection to the child (e.g., members of the safety 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 themself from a danger.

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

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

When faced with one of the dangers, the child was able to seek help from and receive the necessary assistance from someone in the identified safety 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 dangers.

SECTION 3: FAMILY PROTECTIVE INTERVENTIONS

SAFETY DECISION

Safe with plan

One or more dangers are present; however, the child can be kept safe with a short-term safety plan. Protective interventions have been initiated through a safety plan and the child can be kept safe as long as the safety plan interventions mitigate the dangers. Mark all interventions used in the safety plan.

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

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

Actions taken or planned by the investigating worker or other DCF staff that specifically address one or more dangers. Examples include: 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. DOES NOT INCLUDE the investigation/family assessment 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: engaging a grandparent to assist with child care; agreement by a neighbor to serve as a safety

net for an older child; and/or commitment by a 12-step sponsor to meet with the caregiver daily and call the worker if the caregiver has used or missed a meeting;

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 respite time, such as overnight or for a few days—while the house gets cleaned up, while the caregiver goes through detox, to let tempers cool down, etc.

This is an immediate and/or contingency RESPITE in which the child spends a night or two with a relative or friend so that other parts of the plan can be put in place, or to provide a temporary relief valve within the plan. It is part of what will make it possible for the child to remain in their own home. It is not a placement.

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 dangers (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. Use of tribal, religious, cultural, or other communal resources.

This includes, but is not limited to, the following.

- Use of tribal resource center and education services.
- Refugee resettlement programs.
- Church or faith-based organizations.
- Local cultural center or cultural leaders.

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

A non-offending caregiver has acknowledged the dangers 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 dangers 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 DCF-initiated actions (file petition and child remains in the home). 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 danger that does not fit within items 1–8.

SECTION 4: COURT PLACEMENT INTERVENTIONS

SAFETY DECISION

Unsafe

One or more dangers are present, and *DCF will take court action recommending out-of-home placement* because it is the only protective intervention possible for one or more children. Without court action/placement, one or more children will likely be in danger of immediate or serious harm. *Court action where DCF recommends out-of-home placement is initiated because interventions 1–9 do not adequately ensure the child's safety*.

Safety Assessment Discussion Box

In the narrative box, describe caregiver behaviors, their impact on the child, and what details informed the safety decision of "safe with plan" or "unsafe." Be brief but as specific as possible. Avoid labels and jargon.

- For cases where the child is **safe with a plan**, the worker should briefly describe the reasons why the chosen interventions are likely to enhance safety. Actual plan details should be captured in the safety plan itself.
- For cases where the child is **unsafe**, the worker should explain why interventions explored were not possible and removal was necessary.

Safety Plan

The safety plan is required when:

- The safety decision is "safe with plan;" OR
- The safety decision is "unsafe," AND at least one child will remain in the home.

Safety Plan Review

A safety plan review is completed on or before the date identified by the investigator to determine whether the current safety plan should continue or should be modified, a new safety plan should be developed, or the safety plan is no longer needed.

- Any modification or new plan must be reviewed and discussed with the family.
- The worker should document in case notes any safety plan changes.
- The worker should complete a follow-up contact with the family to inform them when a safety plan ends.
- A case cannot be closed when there is an active safety plan.

SDM SAFETY ASSESSMENT PROCEDURES

Vermont Department for Children and Families
Family Services Division

PURPOSE

The SDM child safety assessment guides decisions about whether or not a child requires placement or a safety plan in order to remain safely at home.

SAFETY ASSESSMENT VERSUS RISK ASSESSMENT

It is important to keep in mind the difference between safety and risk when completing this form. The safety assessment differs from the risk assessment in that it assesses the child's **immediate danger or risk of harm** and the interventions currently needed to protect the child. In contrast, the risk assessment looks at the likelihood of any **future** system involvement.

WHICH CASES

All investigations and assessments.

Any open investigations/family assessments or cases in which changing circumstances require safety assessment due to:

- Changes in family circumstances, including:
  - Change in household composition/make-up;
  - New baby;
  - Moving house;
  - New criminal charge;
  - Significant change in health; and or
  - Non-accepted report follow-up on open case.
- Change in the ability of safety interventions to mitigate dangers.

WHO

Investigating/assessment social worker.

ONGOING CASE

Primary assigned worker.

WHICH HOUSEHOLD

Assess the household of the caregiver who is the subject of the investigation or family assessment.

If the alleged perpetrator is part of the child's household, assess that household.

If the alleged perpetrator is not a member of the child's household, do *not* complete a safety assessment for the household of the alleged perpetrator; instead, complete a safety assessment for the household of the caregiver of the child.

If the abuse or neglect involved more than one household, assess each household where the alleged abuse or neglect occurred.

If the non-offending caregiver is being considered to care for the child full time, do not complete safety and risk assessments on their household, since there are no allegations. Instead, assess the parental capacity to care for the child and refer to any needed community services.

WHEN

Safety is assessed **throughout** the life of the case. For a new investigation/family assessment the safety assessment *process* should be completed within 24 hours 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.

DOCUMENTATION

The safety assessment form should be completed within one working day 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 one working day of the investigation/family assessment.
- For open investigations/family assessment or cases in which changing circumstances prompt a new safety assessment, the safety assessment *process* should be completed immediately. The safety assessment *form* should be completed within one working day.
- If a safety plan was initiated, there must be an updated safety assessment documenting that the dangers have been resolved. If dangers remain unresolved, a case should be opened. (If the child is no longer living in the household that has unresolved dangers, and that parent refuses services, the case may be closed.)

- A safety assessment must be done prior to closing a case. A case will not be closed if dangers in the household are present if the children are residing in the home. In the event that the children are placed outside of the home with a long-term arrangement, then the case can be closed with a safety decision of "unsafe."

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 plan interventions in place (safe with plan), or court action is taken and child 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 describe areas they are probably already assessing. The SDM model ensures that the specific items that comprise the safety assessment are assessed at some time during the initial contact with a family. What distinguishes SDM is that it ensures that every worker is assessing the same items, defined the same way 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 best social work practices to collect information from the child, caregiver, and/or collateral sources. The tool is meant to be a prompt for critically thinking about caregiver behaviors that impact child safety, but is not to be used in front of the family as an interview guide.

Assign each allegation or concern about the family to the item definition that best fits that behavior. Mark only one danger item for the same concerning behavior. Do not mark more than one danger for the same concerning behavior, to avoid duplication.

The decision logic for the safety assessment follows.

- If no dangers are marked, the only possible safety decision is "Safe: No dangers were identified at this time." No family interventions or court placement interventions need to be reviewed; the assessment is complete.
- If one or more dangers are marked, the worker must determine whether a safety plan will mitigate the danger or whether court action must be taken and the child must be protectively placed.
- If a safety plan can be developed with the caregivers, only interventions 1 through 9 can be marked and the safety decision is "Safe with plan: One or more dangers are present; however, the child can be kept safe with a short-term safety plan." Protective interventions have been initiated through a safety plan and the child can be kept safe as long as the safety plan interventions mitigate the dangers.

If a safety plan cannot be developed with the caregivers, then the safety decision must be "Unsafe: One or more dangers 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." **Court action where DCF recommends out-of-home placement is initiated because interventions 1–9 do not adequately ensure the child's safety.**

Complete all assessment header information as indicated below.

- **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.
- Enter the type of safety assessment.
  - » *Initial*. Each investigation/family assessment 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 investigation/family assessment, there may be two initial safety assessments.
  - » *Change of circumstance*. After the initial assessment, any additional safety assessment is most likely a review/update as a result of a change in household circumstances and/or caregiver context, unless the safety assessment is being completed when an investigation, family assessment, or case is being closed.
  - – Examples of change in household circumstances include, but are not limited to: birth of a baby, new household members, a person leaves the household, the household moves, or there is a change in the capability of safety interventions to mitigate dangers.
  - » *Investigation/family assessment closing*. This is a specialized review/update that is completed when considering closing an investigation/family assessment without promoting it to a case when a danger has been documented at some point during the investigation.
  - » *Case closing*. This is a specialized review/update that is completed when considering closing a case.
- **Enter the name of the household assessed.** In investigation/family assessments 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 mark 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), mark "no."
- **Indicate (mark) 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 MAJOR SECTIONS: CONTEXT, DANGERS, PROTECTIVE CAPACITIES AND PROTECTIVE ACTIONS, FAMILY PROTECTIVE INTERVENTIONS, AND COURT PLACEMENT INTERVENTIONS.

Family Cultural Context and Factors Influencing Child Vulnerability sections shape the lens through which danger definitions are applied by the worker.

SECTION 1: CONTEXT

This section should be completed only when 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/behaviors that contribute to greater difficulty for the family, which make it more difficult or complicated to create safety for a child, but do not by themselves constitute a danger. These behaviors must be considered when assessing for and planning to mitigate danger. Mark all that apply to the household.

SECTION 2: DANGERS

This is a list of nine critical dangers (eight identified and defined and an "other") that must be assessed by every worker in every case. These dangers cover the kinds of conditions that, if they exist, would render a child in danger of immediate, serious harm or risk of 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. Some information is inaccessible, and some is deliberately hidden from the worker. Based on reasonable efforts to obtain the information necessary to respond to each item, review each of the dangers and accompanying definitions.

For each item, consider the most vulnerable child. If the danger is present, based on available information, mark that item "yes." If the danger is not present, mark that item "no." Because not every conceivable danger can be anticipated or listed on a form, the "other" category permits a worker to indicate that some other circumstance creates a danger. If there are circumstances that the worker determines to be a danger, and these circumstances are not described by one of the existing items, the worker should mark "other" and briefly describe the danger. "**Other" should be rarely used and workers should ensure the worry cannot fit under any other item definition. A narrative justification for all selected items must be included in the text boxes provided.**

SAFETY DECISION

If there are no identified dangers in the household, the safety decision is "safe." Mark "Safe" and the safety assessment is completed.

SECTION 3: PROTECTIVE CAPACITIES AND PROTECTIVE ACTIONS

This section should be completed only if one or more dangers were identified. Mark any of the listed protective capacities that are present for any child/caregiver. Consider information from the investigation/family assessment; 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 dangers identified in Section 1.

SECTION 4: FAMILY PROTECTIVE INTERVENTIONS

This section should be completed only if one or more dangers 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 dangers 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 danger(s) sufficiently so that the child may remain in the home or temporarily stay with relatives/friends so a plan can be put in place while the investigation continues. When determining whether a safety plan can be developed, consider the relative severity of the danger(s), any complicating behaviors by the caregiver that may impact safety planning, household strengths and protective actions, the vulnerability of the child, and the safety plan interventions that are available.

The family 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 danger(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 danger(s), a combination of interventions may provide adequate safety.

Also keep in mind that the family protective interventions defined in the safety plan are not the case plan—they are 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 danger.

If one or more interventions will be implemented, mark each category that will be used. If there is an intervention that will be implemented that does not fit in one of the categories, mark line 9 and briefly describe the intervention.

SAFETY PLAN

The following behavioral descriptions must be included in any safety plan.

- **What is the specific situation or action that causes the child to be unsafe?** What is causing the current danger(s) to the child? Describe the conditions or behaviors in the home that place any child at imminent threat of serious harm. Use language the family understands so it is clear to them what caused the worker to identify the danger.
- **What is working well for the family and who is in their safety network*?*** List actions of protection and any strengths of the caregivers and family members that can be built upon to enhance future safety. List all identified network members (combination of family, friends, and professionals) and their roles in supporting the family.
- **What actions need to be taken by whom right now to keep the child safe?** Explain how each of the dangers listed will be mitigated. What will the family do to keep the child safe? This includes a written statement of an action or behavior taken by the responsible party, which keeps the child safe in the current conditions. If appropriate, it is suggested that the worker and family discuss a contingency plan in case the original plan to keep the child safe unexpectedly changes, due to unforeseen circumstances.
    - » Who will take action and assume responsibility for the actions needed to keep the child safe? The individual assigned this responsibility must be present and acknowledge their understanding of keeping the child safe. Actions to keep the child safe should not be assigned to individuals who were not present (either in person or on the phone) for the safety planning discussion.
- **Timeframe for completing the actions.** When do the responsible parties' tasks need to be accomplished? For how long must the intervention continue? Discuss with the family when and how the worker will follow up to ensure that actions to keep the child safe are being followed. Who will call the department if they are worried about the plan failing? When will the plan be reviewed?
- **Signatures of family members, the worker, and their supervisor.** The safety plan must be signed by the caregiver(s) and all family members who are taking action to keep the child safe from the identified danger(s). Signing the safety plan is acknowledgment by all parties that they understand the purpose of the safety plan and the roles and responsibilities of each individual in carrying out the tasks in the safety plan. Workers should ensure that they have thoroughly explained the safety plan tasks to the family and that the family understands their role. A supervisor or manager will review the safety plan within 24 hours to ensure all dangers have been addressed appropriately by the family and the safety network.

Safety planning process requirements include the following.

- The safety plan must include at least one safe adult. This adult CANNOT be the alleged perpetrator.
- The safety plan should be reviewed at least every 30 days, or sooner as needed.
- The responsibility of providing for the child's safety should be transferred back to the caregiver, replacing formal and agency-provided supports with the family's informal supports as the caregiver's ability is developed or better understood.

- Each safety plan should be feasible and effective, meaning that the worker has confidence it will be completed as planned and that it will successfully provide for the child's safety.
- Each safety plan should also employ the skills of the caregiver and family.

  Note: The safety plan details will be documented in the narrative in the case record. The safety plan MUST be completed with the family. A copy should be left with the family and with anyone outside the family who is participating in the plan. The plan must be signed by everyone involved in the safety plan to indicate that they understand and agree to their roles and responsibilities in implementing the plan.
- If dangers have not been resolved by the end of the investigation, the safety plan will be provided to the ongoing worker and all remaining interventions will be incorporated into the ongoing case plan.

Safety Plan Review

Each safety plan should be reviewed with the family and their safety network on or about the review date to ensure the plan is still working. Any modification to the existing safety plan or new plan must be reviewed and discussed with the family. The worker should leave a copy of any new plan with the family and any safety plan participants and set a subsequent review date.

SECTION 5: COURT PLACEMENT INTERVENTIONS

This section should only be completed when, after considering complicating behaviors that may impact safety planning, household strengths and protective actions, the vulnerability of the child, and the family protective interventions that are available, the worker determines that court placement is the only intervention possible to protect the child.

If one or more dangers are identified and the worker determines that family protective interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will be placed in out-of-home care as a result of court action.

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 dangers. Most dangers 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 identified local state-recognized tribal partners.

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). 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 http://www.doi.gov/tribes/trace-ancestry.cfm and http://www.bia.gov/cs/groups/public/documents/text/idc002656.pdf.

IDEAS FOR PURSUING UNDECIDED DANGER ITEMS

Note: The fact that an area of questioning or observing is mentioned below does not confer the legal authority to pursue it. Be sure to know the legal issues in your jurisdiction. If needed, seek legal consultation. This table is meant to provide examples and general guidance and is not a comprehensive list of assessment questions or observations.

DANGER ITEM	HOT	WARM	COOL
Serious physical harm	• Observe injury, check for other injuries • Medical reports, medical opinion, medical exam • Forensic interview of child victim, all caregivers, all witnesses (coordinate with law enforcement)	• Ask questions about reacting to particularly stressful situations • Ask questions about beliefs regarding discipline • Ask the child about injuries to self or siblings • "Tell me how that happened."	• Observe for visible injuries and implements used for discipline • During interviews, listen for spontaneous reports about injuries or dangerous discipline techniques • Ask general questions about discipline
Sexual abuse	• Forensic interview (coordinate with law enforcement) • Medical exam if needed • Ask detailed questions about non-offending caregiver's beliefs and willingness to protect child • Ask child about their own perceptions of safety • Determine the location of alleged perpetrator and their ability to access child	• Ask the child age-appropriate, non-leading questions about touching, grooming behaviors • Ask caregiver about changes in child's behaviors, sexualized behaviors, contact with persons of concern	• During interviews, listen for spontaneous reports about sexual touch, sexual behavior, discomfort/fear related to a specific person, etc. • Ask general questions about whether there is anyone who makes the child uncomfortable, any worries, anything the child would like help with
Emotional harm	• Elicit specific details about frequency of incidents, child's reaction to incidents • Elicit specific details about child's emotional status (how long, how severe, behavioral indicators) • Ask about child suicidal/self-harming behaviors	• Ask questions about caregiver's view of child and their behavior towards child • Ask questions about child's emotional/behavioral status	• During interview, listen for spontaneous reports about the caregiver's behavior towards child and child's emotional status • Observe child for indicators of severe emotional distress

DANGER ITEM	HOT	WARM	COOL
Positive toxicology on infant	• Medical reports, medical opinion • Obtain a thorough history of the mother's substance use during pregnancy • Obtain professional advice on the likelihood of continued alcohol/drug use • Ask detailed questions about mother's care of/relationship with infant • Ask detailed questions about plans for care of infant		
Immediate needs unmet[1]	• Ask detailed questions (of child, caregiver, others) about the presence or absence of a specific need • Ask detailed questions about efforts to meet this need in the recent past • Ask detailed questions about plans to meet the need in the immediate future • Ask detailed questions about the unmet need's impact on the child (may require a medical and/or mental health professional's input)	• Ask questions about how caregiver is meeting child needs[2] • Ask child about their experience specific to the concern[3]	• During interviews, listen for spontaneous reports[4] • Observe for indicators of unmet needs[5]

[1] See the Basic Needs in Detail appendix on page 41 for a more detailed description of each type of need.

[2] ibid

[3] ibid

[4] ibid

[5] ibid

DANGER ITEM	HOT	WARM	COOL
Hazardous living conditions	• Ask detailed questions about how long the condition has existed • Ask detailed questions about efforts to resolve the condition • Ask detailed questions about efforts to protect child from the condition • Ask detailed questions about injuries/illnesses to any household member as a result of the condition • Create detailed plans with family for resolving the condition • Assess how the child could be harmed as a result of the condition and the likelihood of that happening (e.g., child will likely sustain a very minor injury; a severe injury could result but it is highly unlikely; or a severe injury is likely)	• For interviews outside the home, follow up on any spontaneous statements or observed illness or injury with general questions (e.g., "How did you get so many bug bites?") • For interviews outside the home where history has raised the item to middle priority, ask about whether prior concerns are present now (e.g., "What is it like inside your house now? What would I see if I walked in your front door?") • For in-home interviews, ask to see operation of the utility in question (e.g., turn on lights, look for stopped-up sinks or inoperable toilets) • To follow up on the observed potential hazard, ask about how long it has been that way, whether anyone has been injured, and how caregiver is protecting child from hazard	• For interviews outside the home, listen for spontaneous reports of hazardous conditions or harm resulting from hazardous conditions • For interviews outside the home, observe for signs of illness or injury resulting from hazards • When in the home, observe for hazards and functioning utilities
Unable to protect	• Ask detailed questions about caregiver's knowledge of harm/potential harm to child • Ask detailed questions about caregiver's recent protective behaviors • Ask detailed questions about caregiver's plans for protecting child in the immediate future and capacity to carry out these plans	• Ask child about who helps keep them safe • Ask child what they would do if left alone and various situations emerged • Ask child how the caregiver responded when child informed caregiver of the harm • Ask caregiver about their plans for protecting child	• During interviews, listen for spontaneous reports about harm by a third party • Ask general questions about child's perception of safety, who keeps them safe, and whether there are any times they feel unsafe • If there is no report or concern of child being harmed by someone other than the caregiver, no further inquiry is needed

DANGER ITEM	HOT	WARM	COOL
Questionable explanation	• In individual interviews, gather each witness's detailed account of the incident (including child and alleged perpetrator; coordinate with law enforcement if needed) • Obtain at least one medical opinion about cause and potential for injury to have been caused as reported • May require physical evidence (generally handled by law enforcement, but be aware of the need to avoid contamination of evidence)	• Ask child and caregiver general questions about how the injury occurred • Make observations about plausibility of explanation and/or conflicting accounts	If there is no injury/illness, no further inquiry is needed
Refuses access/likely to flee	• Verify specific location of child • Determine whether access is being refused entirely or if agreeable arrangements can be made to see the child • If access is refused, consult legal authority • Ask detailed questions about where caregiver will be/how caregiver can be reached and verify answers • In some instances, immediate protective order and security plan may be needed (e.g., threat to remove very ill child from hospital against medical advice) • Ask child whether someone has asked them to tell worker anything or to not tell something	• Ask questions about where family members can be reached in the next several days • If indicators of impending flight or refusal of access were observed, ask for explanation • For child, ask "What do you think [mommy/daddy] want you to tell me today?"	• Able to complete interviews as needed • During interviews, listen for spontaneous statements suggesting flight or intent to avoid further access • Observe for indicators that family may be preparing to leave • Observe whether child acts reluctant to talk or over-eager to talk. Is child describing things in a way that is uncharacteristic of their other speech, or with details/vocabulary that are unusual for child's age/development stage?

SAFETY ITEM	HOT	WARM	COOL
Caregiver Context			
Caregiver substance use	• It is NOT necessary to have a diagnosis of substance abuse • Observe level of incapacity (e.g., balance, speech, judgment, volatility) • Establish child's age/developmental status/maturity/vulnerability to determine their self-care ability while caregiver is under the influence • If caregiver is not obviously under the influence during interview: » Detailed questions about use: what is used, how often, how much » Detailed questions about incidents during intoxication in which child was injured or unattended » Pattern of use and whether there are plans to use in the near future	• For historical information, ask caregiver how they have been doing since last contact, if there is any treatment they have completed or support groups they are attending, or any substance use • Ask child how caregiver has been and whether child is concerned that use has resumed • To follow up on observed signs of intoxication or use, state observation and ask caregiver's explanation • If use is established but safety is uncertain, ask about its effect on child and child's location during use	• During interviews, listen for spontaneous reports • For young children, listen for knowledge of caregiver's substance use or related behavior • Observe caregiver for signs of intoxication • Observe residence for signs of drug/alcohol abuse
Caregiver mental health, developmental/ cognitive ability	• Ask questions about specific existing diagnosis/assessment (who, when, what, prescribed treatment) • Ask questions about existing treatment/safety plan and the extent to which it is being followed • Ask questions about impact on child	• Ask caregiver to describe their understanding of pertinent caregiving responsibilities • Ask caregiver and/or child to describe typical day (who does what, etc.) • Ask caregiver about how they are coping	• During interview, listen for caregiver content suggesting lack of understanding about basic caregiving responsibilities, loss of touch with reality, mention of incapacitating depression, etc. • During interview, watch for affect or behavior that might indicate poor mental health or cognitive deficits • Observe for unmet child needs
Domestic violence Note: If there is any indication of domestic violence, interview caregivers separately.	• Ask detailed questions about violent incidents/threats, including frequency, severity, injuries, use of weapons • Location/involvement of the child • Impact on child (What does child do when it happens? After it happens?) • Police record checks	• Ask questions about how decisions are made/conflict is handled • Ask questions about freedom (e.g., can one caregiver go out, make phone calls, spend money without fear?) • Ask questions about how caregiver is getting along with partner • "Do you ever feel afraid of your partner? • "Have you ever been hit in anger?"	• During interviews, listen for spontaneous reports of violence and/or power/control disparities in caregiver relationship • Observe signs of violent behavior, such as damage to walls or doors, or injuries on caregiver

BASIC NEEDS IN DETAIL

BASIC NEED	HOT	WARM	COOL
Food	• Medical opinion/diagnosis • Presence/absence of food in home • Size and appearance of child • Ask detailed questions of the child related to recent food intake and feelings of hunger • Ask detailed questions of the caregiver related to recent feeding, availability of food, ability to secure food • In some instances, ask about beliefs regarding feeding	• Ask child about food likes/dislikes; what they have eaten in the last day; who fixes meals; whether child is hungry (if so, have them describe more to distinguish from normal hunger) • Ask caregiver to talk about typical meals, whether it is easy or hard to provide enough food for family • Ask to see refrigerator and cupboards	• During interviews, listen for spontaneous reports of going without food or food being withheld • Does child appear strikingly underweight, listless, or have other signs of possible malnutrition or failure to thrive?
Supervision	• Establish age/developmental status/maturity/special needs of child: How capable is child of self-supervision? • Ask detailed questions about recent times child was alone: How long? Under what circumstances? Include whether child is currently home alone. • Ask detailed questions about caregiver's plans to provide supervision in the immediate future: Who will watch child when caregiver is away? What do we know about that person? • Interview caregiver, child, and perhaps others about any incidents that occurred while child was alone, such as accidents and poor judgment/decisions. Note: Same type of question applies if the concern is that caregiver is present but inattentive.	• Ask questions about whether child is ever home alone (or unsupervised in other circumstances) and if so, for how long • Observe extent to which caregiver attends to child during interview • Ask child who is known to be alone occasionally how they would handle various situations and how safe they feel	• During interviews, listen for spontaneous reports • Was young child home alone on arrival?

BASIC NEED	HOT	WARM	COOL
Clothing	• Medical opinion regarding existing or potential hypothermia, frostbite, sunburn, sunstroke, etc. • Determine why certain clothing was worn (e.g., child may be diagnosed with frostbite, but caregiver provided gloves to child in the morning and child lost them)	• Ask whether child has more appropriate clothing	• During interviews, listen for spontaneous reports of dangerously inappropriate clothing • During interview, is child's clothing appropriate for the weather?
Medical	• Medical consultation regarding child's condition. May require second opinion. Be specific about the following: » What will happen if treatment is not provided (include timeframes) » What treatment would accomplish, if provided » Details of prior attempts to get treatment to child • Ask caregiver about their understanding of child's condition and treatment plan options	• Ask caregiver about how they are addressing child's medical need, and whether there are any difficulties accessing health care or following prescribed treatment plan • Ask child about trips to doctor, medicines taken, how caregiver helps them with illness/injury/condition	• During interviews, listen for spontaneous reports of missed medical appointments, untreated medical conditions, and/or treatment plans that are not being followed • Observe for general wellness—does child appear ill, or does condition appear untreated?
Mental health	• Determine acuity and severity of mental health situation (e.g., is child psychotic? Does child have a suicide plan? Does child's depression result in them not getting to school?) • Determine specific efforts caregiver has made to provide treatment/support. Was caregiver aware? • Determine caregiver's plans to provide treatment in the immediate future • If child is suicidal, determine plan to provide safety	• Ask child age-appropriate questions about their mental health • Ask caregiver about child's mood, symptoms of mental health issues • Ask caregiver about any barriers to getting help/support for child	• During interviews, listen for spontaneous reports of missed mental health appointments, suicide threats that were not responded to, psychotropic medication that is not being provided, etc. • Observe child for affect and behavioral indicators of mental health concerns

REFERENCE

Bragg, H. L. (2003). *Child protection in families experiencing domestic violence*. Washington, DC: US Department of Health and Social Services, Office on Child Abuse and Neglect. Available at http://www.childwelfare.gov/pubs/usermanuals/domesticviolence/domesticviolence.pdf

DANGER ITEMS: RULED OUT, RESOLVED, CONTROLLED, OR DISCOVERED?

	DESCRIPTION	NEW SAFETY ASSESSMENT?
Ruled out	New information supports that the danger was never there in the first place.	Yes
Resolved	Danger was present initially but is no longer present AND family no longer relies on external intervention to maintain safety.	Yes
Controlled	• Danger remains but is being controlled by interventions in the safety plan; OR • Danger is temporarily resolved, but continued intervention is required to prevent imminent reappearance of danger.	No
Discovered	A danger that was not previously marked is now confirmed as being present.	Yes

PROTECTIVE CAPACITY INTERVIEW IDEAS

PROTECTIVE CAPACITIES	
PROTECTIVE CAPACITY (GENERAL TITLE)	**QUESTION AND OBSERVATION IDEAS**
Child	• How has [child] avoided being hurt before? • Does [child] know how to call 911? • Does child seem calm or distressed? Developmentally on target? How large is child? Any disability?
Caregiver able and willing to participate in creating and carrying out plan	• What do you think you could do to protect child from [danger]? • What steps have you taken already to protect child?
Willing/able to use resources	• Would you be willing to accept help from [resource] to protect [child]? • Have you already asked for help? From whom?
Supportive relationships	• Who could help you right now? Is there someone you'd like to call to come over right now to help us plan? What do you think they could do to help? • Who could get together with us tomorrow (or the next day) to come up with a plan? What do you think they could do to help? • If [friend/relative] offered to help, would that be okay with you?
Healthy relationship with child	• Observe interactions. • Listen for how caregiver describes child. • Ask child about their relationship with caregiver. NOTE: If this is the only protective capacity, it may not be sufficient for a plan.
Provides for basic needs	• What would you say [child] needs right now to be safe? • How far are you willing to go to meet [child's] needs? • Observe quality of shelter, food, and clothing. NOTE: Cannot be present as protective capacity if danger items #3 or 4 are marked.
Problem solving	• Have you ever been in a situation like this before? How did you solve it?
Self-control	• Listen for statements such as "I will do whatever it takes to protect [child]." Listen for caregiver's willingness to sacrifice convenience and/or self-interest, if needed. • Observe caregiver for ability to reach a place of calm. Caregiver may remain angry, but is able to channel anger in nonviolent ways.
Community resources	• If safety plan depends on resources in the community, worker should provide information if known, about appropriate resources. Also ask family if they are aware of resources.

SAFETY PLAN IDEAS AND MONITORING

SAFETY ITEM (GENERAL TITLE)	SAFETY PLAN IDEAS
Serious physical harm	• Alleged perpetrator is arrested • Alleged perpetrator agrees to remain outside the home until investigation concludes • Non-offending caregiver will not let alleged perpetrator into house until investigation concludes • Child will remain in hospital • Caregiver agrees to not use corporal punishment for the next 30 days • Non-offending caregiver will obtain a temporary restraining order against alleged perpetrator
Positive toxicology on infant	• Another caregiver moves in or assumes primary responsibility • Caregiver agrees to not use substance(s) and/or provide alternative care if using them • Caregiver agrees to detox
Immediate needs unmet	(*Refer to next four rows for more detailed descriptions of each type of need.*)
Food	• Worker provides groceries • Worker assists family in applying for emergency food stamps • Worker provides information on food pantries • [Relatives/friends] provide money or food • Caregiver provides meals for child (define meal based on child's age)
Clothing	• Worker provides voucher for necessary clothing • Worker provides information on clothing resources • Caregiver ensures that child is dressed for weather • Caregiver ensures that child has clean clothes • Worker provides voucher for laundromat • [Relative/friend] allows family to wash clothes in their machine for next two weeks
Medical	• Caregiver makes and keeps appointment • Caregiver fills prescription and provides medicine to child • Caregiver follows medical recommendations while investigation continues • Worker assists family in applying for benefits, e.g., medical, SSI • Hospital/provider agrees to let family have service and arrange payment plan • [Agency] provides medicine/medical equipment
Mental health	• Caregiver will remove guns from home • Caregiver will stay with child at all times • [Relatives/friends] will help caregiver provide 24-hour observation of child • Caregiver will obtain/provide prescribed medication • Caregiver will take child for immediate mental health evaluation • Caregiver will allow child to begin/resume therapy with [provider]

SAFETY ITEM (GENERAL TITLE)	SAFETY PLAN IDEAS
Hazardous living conditions	• Child will stay with [approved relative] until hazard is removed • Family will stay with [friend/relative] until hazard is removed • Family will stay in homeless shelter until hazard is removed • Worker will help advocate for landlord to remove hazard • Agency will assist in removing hazard • [Relatives/friends] will help remove hazard • Caregiver will remove hazard
Unable to protect	• Caregiver will not let alleged perpetrator into house or have any contact with child until investigation concludes • [Relative/friend] will be available for non-offending caregiver to call if tempted to allow alleged perpetrator back home • Caregiver arranges supervision • Caregiver agrees to not leave house unless there is supervision • Worker provides information on affordable child care
Questionable explanation	• Alleged perpetrator is arrested • Alleged perpetrator agrees to remain outside the home until investigation concludes • Non-suspected caregiver will not let alleged perpetrator into house until investigation concludes • [Relative/friend] will stay in the home and be with child at all times until investigation concludes
No access/flee	• Caregiver will permit worker to see child • Child will attend school every day • [Relative/friend] will stay in the home and be with child at all times until investigation concludes • Caregiver will provide names and contact information for at least three employers/teachers/pastors/friends/relatives to worker, and worker will confirm identities and willingness to provide new phone/address for family • Caregiver will sign a release of information with [DMV, probation agent, etc.] so that worker can obtain new contact information if family moves • No one will attempt to influence child's statements
Current circumstances AND previous patterns of severe abuse/neglect	• Prior death of a child as a result of caregiver's or other household member's maltreatment or neglect • Prior serious injury or abuse to the child other than accidental: The caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural/epidural hemorrhage or hematoma, serious bruising or soft tissue damage, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts; impairment of any organ; or fatality

SAFETY ITEM (GENERAL TITLE)	SAFETY PLAN IDEAS
Caregiver Context	
Caregiver substance use	• Using caregiver will go to detox • Using caregiver will stay with [relative/friend] until clean/sober • Using caregiver will not be responsible for child care while under the influence • Non-using caregiver will provide all child care and will protect child from the using caregiver • [Relative/friend] will stay in home until using caregiver is clean/sober and will provide all child care • Child has a safe place to go if caregiver begins using substances [neighbor/friend]
Caregiver mental health, cognitive ability	• Caregiver will have immediate mental health evaluation • Caregiver will resume prescribed medication • Non-affected caregiver will provide all child care and will be with child at all times while child is not in school • [Relative/friend] will stay in home and provide [all or specific] child care while investigation continues • Public health nurse will provide instructions for caregiver and caregiver will follow
Domestic violence	Excellent resource for developing a safety plan for a domestic violence victim: http://www.aardvarc.org/dv/plan.shtml • Victim caregiver will go to shelter with children • Victim caregiver will go to [relative/friend] with children • Victim caregiver will develop and implement a safety plan for domestic violence • Alleged perpetrator is arrested • Alleged perpetrator will remain out of the home while investigation continues • Caregivers ensure that children are out of the home or in safe location in the home if caregivers begin to argue • Child (if older) will not intervene if parents begin to fight (may leave home and go to neighbor's house/call 911.)

MONITORING	
ISSUE	**MONITORING IDEAS**
Monitoring	• Worker will check on child [daily/weekly/at least twice] • Worker will call [collateral contact] to confirm that… • [Collateral contact] will call worker if caregiver is not following plan • Child will have worker's number plus a 24/7 number and can call any time

SDM RISK ASSESSMENT

Vermont Department for Children and Families
Family Services Division

R: 03–17

Family Name: _____

Intake # _____ **MIS #:** _____ **District:** _____

Child Safety Intervention Type: ○ Ch. 49 Investigation (CI) ○ Ch.49 Assessment (CA) ○ CHINS (B) (CJ)

Date: _____ **Worker:** _____

Household Members: _____

Who provided information to complete the risk assessment?

☐ Primary caregiver: _____

☐ Secondary caregiver/adult (name): _____

☐ Consulted with non-resident parent

☐ Others (names and roles; children's names can be included here):

Family/Household Cultural Context

How do the members of this family/household self-identify culturally, and how does it influence their parenting styles/techniques as it relates to the risk assessment?

SECTION 1: NEGLECT/ABUSE INDEX

	Risk of Future Neglect Score	Risk of Future Abuse Score
R1. Current accepted report for child safety intervention		
○ a. Neglect or risk of harm	1	0
○ b. Physical abuse, sexual abuse, or emotional maltreatment	0	1
○ c. Both A and B	1	1
○ d. CHINS (B)	0	0
Evidence of why item meets definition:		
R2. Prior Chapter 49 assessments/investigations or CHINS (B) involving any adult currently living in the household		
○ a. No	0	0
○ b. Yes	1	0
Evidence of why item meets definition:		
R2a. Prior Chapter 49 assessment/investigation for neglect/risk of harm or CHINS (B)		
☐ a. None	0	0
☐ b. One	1	0
☐ c. Two	1	0
☐ d. Three or more	2	0
R2b. Prior Chapter 49 assessment/investigation for physical abuse, sexual abuse, or emotional maltreatment		
☐ a. None	0	0
☐ b. One	0	1
☐ c. Two or more	0	2
R3. Prior ongoing child protection case and/or custody (do not include CHINS [C] or [D])		
○ a. No	0	0
○ b. Yes	1	1
Evidence of why item meets definition:		

	Risk of Future Neglect Score	Risk of Future Abuse Score
R4. Number of alleged child victims involved in the current accepted report		
○ a. One, two, or three	0	0
○ b. Four or more	1	0
Evidence of why item meets definition:		
R5. Prior injury to any child resulting from child abuse/neglect		
○ a. No	0	0
○ b. Yes	0	1
Evidence of why item meets definition:		
R6. Age of youngest child in the home		
○ a. 2 or older	0	0
○ b. Younger than 2	1	0
Evidence of why item meets definition:		
R7. Current or historic characteristics of children in household (mark all that apply)		
☐ a. Does not exhibit any of the following	0	0
☐ b. Medically fragile or failure to thrive	1	0
☐ c. Positive toxicology screen at birth	1	0
☐ d. Developmental, physical, or learning disability	1	0
☐ i. Developmental or learning disability	0	1
☐ ii. Physical disability	0	0
☐ e. Child or youth in conflict with law/delinquent behavior	0	1
☐ f. Mental health or behavioral issue	0	1
Evidence of why item meets definition:		
R8. Primary caregiver's assessment of incident (mark all that apply)		
☐ a. Does not blame child or justify maltreatment	0	0
☐ b. Blames child	0	1
☐ c. Justifies maltreatment of child	0	2
Evidence of why item meets definition:		
R9. Primary caregiver provides physical care consistent with child's needs		
○ a. Yes	0	0
○ b. No	1	0
Evidence of why item meets definition:		

	Risk of Future Neglect Score	Risk of Future Abuse Score
R10. Housing (mark all that apply)		
☐ a. Safe and stable residence or long-term shelter	0	0
☐ b. Current housing is physically unsafe	1	0
☐ c. No shelter or about to be evicted	2	0
Evidence of why item meets definition:		
R11. Violence involving caregivers and/or another adult in the household in the past year		
○ a. No	0	0
○ b. Yes	0	2
Evidence of why item meets definition:		
R12. Primary caregiver characteristics (mark all that apply)		
☐ a. Does not exhibit any of the following	0	0
☐ b. Provides insufficient emotional/psychological support	0	1
☐ c. Employs excessive/inappropriate discipline	0	1
☐ d. Over controlling	0	1
Evidence of why item meets definition:		
R13. Primary caregiver has a historic or current alcohol and/or drug issue interfering with individual and family functioning		
☐ a. No	0	0
☐ b. Alcohol (mark all that apply)	1	0
☐ Within the last 12 months		
☐ Prior to the last 12 months		
☐ c. Drugs (mark all that apply)	1	0
☐ Within the last 12 months		
☐ Prior to the last 12 months		
Evidence of why item meets definition:		
R14. Primary caregiver has a historic or current mental health issue interfering with individual and family functioning		
○ a. No	0	0
○ b. Yes (mark all that apply)	1	0
☐ Within the last 12 months		
☐ Prior to the last 12 months		
Evidence of why item meets definition:		

	Risk of Future Neglect Score	Risk of Future Abuse Score
R15. Primary caregiver has a history of abuse or neglect as a child		
○ a. No	0	0
○ b. Yes	0	1
Evidence of why item meets definition:		
R16. Secondary caregiver has a historic or current alcohol and/or drug issue interfering with individual and family functioning		
○ a. No secondary caregiver	0	0
○ b. No	0	0
○ c. Yes	0	1
Alcohol (mark all that apply)		
☐ Within the last 12 months		
☐ Prior to the last 12 months		
Drugs (mark all that apply)		
☐ Within the last 12 months		
☐ Prior to the last 12 months		
Evidence of why item meets definition:		
R17. Secondary caregiver characteristics		
☐ Not applicable; no secondary caregiver		
a. Secondary caregiver has a historic or current mental health issue	0	0
○ Yes ○ No		
b. Secondary caregiver has a history of abuse or neglect as a child	0	0
○ Yes ○ No		
Evidence of why item meets definition:		
R18. Primary or secondary caregiver criminal charge history (mark all that apply)		
☐ a. Neither caregiver has prior criminal charges	0	0
☐ b. Either caregiver has one or more criminal charges in the past five years	0	0
Time since most recent charge: _____ ○ Months ○Years		
☐ c. Either caregiver has one or more criminal charges more than five years ago	0	0
Time since most recent charge: _____ ○ Months ○Years		
Evidence of why item meets definition:		

	Risk of Future Neglect Score	Risk of Future Abuse Score
R19. Number of serious incidents between adults in the household in the past year		
○ a. None	0	0
○ b. One between (mark all that apply): ☐ Intimate partners ☐ Other adults	0	0
○ c. Two or more between (mark all that apply): ☐ Intimate partners ☐ Other adults	0	0
Evidence of why item meets definition:		
TOTAL RISK SCORE		

SECTION 2: SCORING

SCORED RISK LEVEL

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

OVERRIDES

Select an override code. If there are no overrides, select "No overrides apply;" risk level will remain the same. If there is a policy override, select the appropriate override; the risk level will be overridden to "very high." If there is a discretionary override, the risk level will be overridden up by one level, and a reason must be entered in the box provided.

○ **No overrides apply**

○ **Policy overrides**

- ☐ Sexual abuse case AND the perpetrator is likely to have access to the child victim.
- ☐ Non-accidental injury to a child under age 2.
- ☐ Severe non-accidental injury.
- ☐ Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

○ **Discretionary Override:** Increases risk level by one

Discretionary override reason:

Supervisor approval of discretionary override (if yes, include name or signature below): ○ Yes ○ No

Supervisor name/signature: _____ Date:_____

FINAL RISK LEVEL

Final Risk Level: ○ Low ○ Moderate ○ High ○ Very High

RISK CLASSIFICATION	INVESTIGATION FINDING: VALIDATED AND NOT VALIDATED	MARK RECOMMENDED ACTION
Very High	Open for ongoing services	○
High	Open for ongoing services	○
Moderate	Close*	○
Low	Close*	○

*Low-risk and moderate-risk cases should be opened if the most recent safety assessment finding was "safe with a plan" or "unsafe."

Action

Enter the action taken (opened as a case or not opened as a case). If the recommended action differs from the action taken, provide an explanation in accordance with Policy 52. District director approval is required.

○ Open (note whether ☐ new or ☐ continuing services offered)

○ Do not open

If the recommended action and the action taken do not match, explain why. If a case is not opening due to family refusal, indicate what the family's plan is to mitigate risks and prevent future Division involvement. Please include a list of the family's formal and informal supports.

District director approval of recommended action override (if yes, include name or signature below):

○ Yes

○ No

Director name/signature: _____ Date: _____

SDM RISK ASSESSMENT DEFINITIONS

Vermont Department for Children and Families
Family Services Division

FAMILY/HOUSEHOLD CULTURAL CONTEXT

How do the members of this family/household self-identify culturally, and how does it influence their parenting styles/techniques? Inquire broadly about all aspects of the family's culture, including race/ethnicity, sexual orientation, gender identity/expression, tribal affiliation, family roles, faith/spirituality, holiday traditions, and values. See appendix for further guidance.

R1. Current accepted report for child safety intervention

Determine whether the current accepted report for child safety intervention is for neglect or risk of harm, abuse, or CHINS (B). Abuse includes physical abuse, emotional maltreatment, or sexual abuse.

For a definition of child in need of care or supervision (CHINS), see 33 VSA § 5102(3).

a. Mark "a" for neglect or risk of harm.
b. Mark "b" for physical abuse, sexual abuse, or emotional maltreatment.
c. Mark "c" in each column if both abuse and neglect are included in the current accepted report.
d. Mark "d" if the accepted report is a CHINS (B) assessment.

R2. Prior Chapter 49 investigations/assessments or CHINS (B) involving any adult currently living in the household

Count all prior reports (including those from other states) that resulted in an in-person response and that involved any adult member of the current household as an alleged perpetrator. Count regardless of whether the report was substantiated.

Do not count:

- CHINS (C) or (D);
- Prior reports in which allegations were perpetrated by an adult who does not currently live in the household;
- Prior reports in which children in the home were identified as perpetrators; or
- Reports that were not accepted for in-person response.

R2a. Prior Chapter 49 assessment/investigation for neglect/risk of harm or CHINS (B)

Indicate the number of accepted reports for prior neglect/risk of harm, regardless of the number of abuse reports.

If, during a CHINS (B) assessment, the worker identified additional circumstances that required a Chapter 49 assessment or investigation AND those allegations resulted in another accepted report, do not count the CHINS (B) as a prior assessment.

R2b. Prior Chapter 49 assessment/investigation for physical abuse, sexual abuse, or emotional maltreatment

Indicate the number of accepted reports for physical abuse, sexual abuse, and/or emotional maltreatment, regardless of the number of neglect reports from Vermont Family Services Division (FSD) or child protective services in any other state.

If, during a CHINS (B) assessment, the worker identifies additional circumstances that require a Chapter 49 assessment or investigation AND those allegations result in another accepted report, count ONLY the Chapter 49 assessment or investigation as a prior incident.

R3. Prior ongoing child protection case and/or custody (do not include CHINS [C] or [D])

Includes cases that were opened as a result of neglect, risk of harm, physical abuse, sexual abuse, or emotional maltreatment by an adult currently in the household or CHINS (B). Do not include CHINS (C) or (D).

a. Mark "a" if no adult in the household has ever been involved in an ongoing case or custody.
b. Mark "b" if any adult within the current household was previously in a caregiving role and received ongoing services from Vermont Family Services Division (FSD) or child protective services in any other state. This includes but is not limited to:
    - Court-ordered services (FSD custody, conditional custody orders); and
    - Ongoing non-court-involved family support case.

R4. Number of alleged child victims involved in the current accepted report

Count each child under the age of 18 who is involved in the incident and lives in the household, even if they temporarily reside elsewhere (e.g., foster care, residential program, boarding school, regular visitation with non-resident parent, etc.) but is regularly part of the household.

a. Mark "a" if there are one, two, or three children involved in the child abuse/neglect (CA/N) incident, including CHINS (B).
b. Mark "b" if there are four or more children involved in the CA/N incident, including CHINS (B).

R5. Prior injury to any child resulting from child abuse/neglect

a. Mark "a" if there were no prior injuries to any child resulting from CA/N by an adult member of the current household.

b. Mark "b" if any adult member of the *current* household has previously caused an injury to any child as a result of CA/N prior to the current report. 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. Sexual abuse should be included as an injury. Score regardless of whether the prior abuse-related injury was reported as abuse at the time, based on any credible information from the child, caregivers, or others.

R6. Age of youngest child in the home

Consider the youngest child in the household. If a child is removed during the current investigation or assessment, count the child as residing in the home.

a. Mark "a" if the youngest child is age 2 or older.

b. Mark "b" if the youngest child in the household is younger than 2 years old.

R7. Current or historic characteristics of children in household (mark all that apply)

Identify whether any child in the household is diagnosed as medically fragile or failure to thrive; had a positive toxicology screen at birth; has a developmental, learning, and/or physical disability; is in conflict with the law/behaves delinquently; 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. See definitions below.

a. Mark "a" if no child in the household exhibits the characteristics below.

b. *Medically fragile or failure to thrive*. "Medically fragile" describes a child who meets **ALL** of the following criteria:

- Has any condition diagnosed by a physician that can become unstable and change abruptly, resulting in a life-threatening situation; **AND**
- Requires daily, ongoing medical treatments and monitoring by appropriately trained personnel, which may include caregivers or other family members; **AND**
- Requires the routine use of life-sustaining medication or a medical device/assistive technology to compensate for the loss of usefulness of a bodily function needed to participate in activities of daily living.
- 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.

c. *Positive toxicology screen at birth*. Confirmation that as a newborn, the child:

- Had a positive toxicology screen for **illegal substances or prescription medication not prescribed** to the patient or administered by a physician; OR

- Was deemed by a medical professional to have Neonatal Abstinence Syndrome through NAS scoring as the result of maternal use of illegal substances or non-prescribed prescription medication; OR
- Was deemed by a medical professional to have fetal alcohol spectrum disorder (FASD).

d. *Developmental, physical, or learning disability*. Any child in the household has a developmental, physical, or learning disability that has been diagnosed by a professional as evidenced by caregiver's or other person's credible statement of such a diagnosis, medical/school records, and/or professional's statement. Do not include ADHD/ADD; will be included under mental health or behavioral issue.
   - *Developmental disability*: A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include developmental disability, autism spectrum disorders, and cerebral palsy.
   - *Learning disability*: Child has an individualized education plan (IEP), or other formal plans, that document a learning problem such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral issues. Also include a child who was diagnosed with a learning disability by a physician or mental health professional and is eligible for an IEP but does not yet have one or is in preschool.
   - *Physical disability*: A severe, acute, or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include, but are not limited to, paralysis, amputation, and blindness.

e. *Child or youth in conflict with law/delinquent behavior*. Any child in the household has been involved with the juvenile/criminal justice system. Offending or antisocial behavior not brought to court attention but that creates stress within the household should also be marked "yes," such as child who runs away or is habitually truant.

f. *Mental health or behavioral issue*. Any child in the household has mental health or behavioral problems not related to a physical or developmental disability (includes ADHD/ADD). 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 the child is currently taking prescribed psychoactive medications.

R8. Primary caregiver's assessment of incident (mark all that apply)

a. Mark "a" if neither b nor c applies.

b. Mark "b" if the primary caregiver blames the child for the current situation. Blaming refers to caregiver's statement that the situation occurred because of the child's action or inaction (e.g., claiming that the child seduced them or that the child deserved a beating because they misbehaved).

c. Mark "c" if the primary caregiver justifies maltreatment of the child. Justifying refers to the caregiver's statement that their action or inaction that resulted in harm to the child was appropriate (e.g., claiming that such abuse or neglect is acceptable because the caregiver was raised the same way).

R9. Primary caregiver provides physical care consistent with child's needs

a. Mark "a" if the physical care provided meets the child's needs to the extent that the child has not been harmed and their well-being is maintained. Consider the child's age/developmental status when scoring this item.

b. Mark "b" if physical care of the child (age-appropriate feeding, clothing, shelter, hygiene, and medical care) threatens the child's well-being or results in harm to the child. E*xamples include, but are not limited to, the following*.

- Failure to obtain medical/dental care for severe or chronic illness.
- Repeated failure to provide the child with weather-appropriate clothing.
- Poisonous substances or dangerous objects lying within reach of a small child.
- The child wears extremely soiled clothes for extended periods of time.
- The child's poor hygiene results in a medical condition.

R10. Housing (mark all that apply)

Note: A family may be homeless but physically safe, physically unsafe but not homeless, or homeless AND unsafe.

a. Mark "a" if the family has a stable residence (including long-term shelter) that meets the child's health and safety needs.

b. Mark "b" if the family has housing but the housing situation is physically unsafe to the extent that it does not meet the child's health or safety needs (e.g., exposed wiring, roach/rat infestations, human/animal waste on floors, rotting food).

c. Mark "c" if the family is homeless or about to be evicted when the investigation begins. Do not score if the family is/was in a long-term shelter.

R11. Violence involving caregivers and/or another adult in the household in the past year

a. Mark "a" if "b" does not apply.

b. Mark "b" if in the previous 12 months, there have been two or more physical assaults or periods of intimidation/threats/harassment involving caregivers or a caregiver and another adult.

R12. Primary caregiver characteristics (mark all that apply)

a. Mark "a" if the primary caregiver does not exhibit the characteristics below.

b. Mark "b" if the primary caregiver provides insufficient emotional/psychological support to the child, such as persistently berating/belittling/demeaning the child or depriving the child of affection or emotional support.

c. Mark "c" if the primary caregiver employs excessive/inappropriate discipline, defined as disciplinary practices that caused or threatened harm to a child because they were excessively harsh physically or emotionally, and/or dangerous given the child's age or development. *Examples include, but are not limited to, the following*.

- Hitting, kicking, biting, or punching the child.
- Locking the child in a room, closet, or attic.
- Hitting the child with dangerous objects.
- Isolating the child from physical and/or social activity for extended periods.

d. Mark "d" if the primary caregiver is over controlling, as indicated by controlling, abusive, overly restrictive, or over reactive rules.

R13. Primary caregiver has a historic or current alcohol and/or drug issue interfering with individual and family functioning

Identify the primary caregivers' alcohol and/or drug use, both current and historical, **AND** whether it interferes or has interfered with family functioning.

a. Mark "a" if the primary caregiver does not have and never has had a drug or alcohol use issue that interferes with family functioning.

b. Mark "b" if the primary caregiver has a past or current alcohol issue that interferes with their and the family's functioning. Indicate whether the alcohol use occurred within the most recent 12 months, more than 12 months ago, or both.

c. Mark "c" if the primary caregiver has a past or current drug issue that interferes with their and the family's functioning. Indicate whether the drug use occurred within the most recent 12 months, more than 12 months ago, or both. Interference, as referenced for items b and c, can be evidenced by, but is not limited to:
   - Substance use that affects or affected employment, criminal involvement, or marital or family relationships and that affects or affected the 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 is diagnosed with fetal alcohol syndrome or exposure, or the child had a positive toxicology screen at birth and the primary caregiver was the birth parent.

R14. Primary caregiver has a historic or current mental health issue interfering with individual and family functioning

a. Mark "a" if the primary caregiver has no known history of a mental health concern that interfered with individual and family functioning.

b. Mark "b" if credible and/or verifiable statements by the primary caregiver or others indicate that the primary 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/services; OR
- Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

Indicate whether the mental health concern existed within the most recent 12 months, more than 12 months ago, or both.

R15. Primary caregiver has a history of abuse or neglect as a child

a. Mark "a" if the primary caregiver's childhood did not include experiences that would be considered abusive or neglectful.

b. Mark "b" if verifiable/credible statements by the primary caregiver or others and/or past records indicate that the primary caregiver was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse).

R16. Secondary caregiver has a historic or current alcohol and/or drug issue interfering with individual and family functioning

Identify the secondary caregivers' alcohol and/or drug use, both current and historical, and whether it interferes or has interfered with family functioning.

a. Mark "a" if there is no secondary caregiver.

b. Mark "b" if the secondary caregiver does not have and never has had a drug or alcohol issue that interferes with family functioning.

c. Mark "c" if the secondary caregiver has a past or current alcohol and/or drug use issue that interferes with their and the family's functioning. Such interference can be evidenced by but is not limited to:
   - Substance use that affects or affected employment, criminal involvement, or marital or family relationships and/or that affects or affected the caregiver's ability to provide protection, supervision, and care for the child;
   - A DUI arrest in the past two years or arrest for 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 is diagnosed with fetal alcohol syndrome or exposure, or the child had a positive toxicology screen at birth and the secondary caregiver was the birth parent.

Indicate drug and/or alcohol use and indicate whether the drug/alcohol use existed within the most recent 12 months, longer than 12 months ago, or both.

R17. Secondary caregiver characteristics

a. Mark "a" if any credible and/or verifiable statements by the secondary caregiver or others indicate that the 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/services; OR
   - Was recommended for treatment/hospitalization or treated/hospitalized for emotional problems.

b. Mark "b" if the secondary caregiver was maltreated as a child. Consider any maltreatment history known to the agency and/or credible statements by the secondary caregiver or others. Include situations that would be considered abuse or neglect by current standards, even if the situation was not considered to be abuse or neglect at the time.

R18. Primary or secondary caregiver criminal charge history (mark all that apply)

Indicate whether either the primary or secondary caregiver has a criminal charge 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. Do not include criminal arrests with no charges.

a. Mark "a" if neither caregiver has prior criminal charges.
b. Mark "b" if the primary and/or secondary caregiver had one or more criminal charges in the past five years. Indicate the months or years since the most recent charge.
c. Mark "c" if the primary and/or secondary caregiver had one or more criminal charges more than five years ago. Indicate the months or years since the most recent charge.

R19. Number of serious incidents between adults in the household in the past year

Serious incidents include those resulting in serious physical harm and/or involving the use of a weapon, which includes use of any type of weapon or object or any other means to inflict or attempt to inflict injury on the victim. Examples include murder/attempted murder or strangulation.

a. Mark "a" if neither caregiver had a serious incident of violence.
b. Mark "b" if there was one serious incident of violence. Indicate whether the incident was between intimate partners and/or other adults.
c. Mark "c" if there were two or more serious incidents of violence. Indicate whether the incident was between intimate partners and/or other adults.

SDM RISK ASSESSMENT PROCEDURES

Vermont Department for Children and Families
Family Services Division

PURPOSE

The risk assessment estimates the probability of future maltreatment in the household. The higher the risk, the more important it is to engage the family in services to prevent future harm.

WHICH CASES

All new Chapter 49 investigations and assessments and CHINS (B) assessments, regardless of determination.

WHEN

Once during the investigation/assessment, before making a decision about ongoing services.

WHO

The worker assigned to the investigation/assessment.

DECISIONS

Responses to each item lead to a risk classification of low, moderate, high, or very high.

- High- and very high-risk cases should be opened for ongoing services.
  - » Use engagement skills to interest the family in services.
  - » If a family refuses, workers should consult with their supervisor about whether there is a need to complete another safety assessment.
  - » If unable to provide ongoing services because the family refuses and there will be no court order, consider connecting the family to community services. Document the reason that ongoing services were not provided on the risk assessment and in the appropriate section of FSDNet.

- Low- and moderate-risk cases should **not** be opened for ongoing services unless there is an unresolved danger. Referrals to community services to meet the family's needs may be appropriate. If ongoing services are provided to low- or moderate-risk families, document the reason in the appropriate section of FSDNet.

APPROPRIATE COMPLETION

SECTION 1: NEGLECT/ABUSE INDEX

When scoring individual items, workers should familiarize themselves with the items on the risk assessment and the items' definitions. 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, through use of the definitions, based on their assessment of the family.

Continue to gather information from the report, family perspectives, perspectives of collateral sources, and personal observations. Mark each item according to the **definition**. Each assessment item must be rated before the assessment is complete. Each response option has a point value.

SECTION 2: SCORING

Scored Risk Level

- Add the scores for each neglect item and enter the total at the bottom of the column.
- Add the scores for each abuse item and enter the total at the bottom of the column.
- In the scoring section, select the risk level for neglect and the risk level for abuse that corresponds with the column score.
- The scored risk level is the higher of the two.

Policy Overrides

Policy overrides are conditions that present very serious situations that will be served as if the risk level is very high, regardless of actual scored risk level.

- If one or more of the policy override conditions are present, mark.
- The family will be considered to be at very high risk.

Discretionary Overrides

If the worker, in consultation with the supervisor determines that there are situations that were not measured within the actuarial items that substantially affect the probability of future harm, the worker may apply a discretionary override.

Risk level may be overridden up by one level. For example: Though the scored risk level was moderate, the mother is experiencing extraordinarily high stress, that stress directly resulted in a current incident of maltreatment, and that stress is expected to continue for several months. **In rare instances, the district director may determine that a high or very high risk score will not lead to opening a case per policy 52. In general, exceptions may be considered when the family has a very strong and active safety network that is aware of potential danger and agrees to take action if necessary AND/OR is actively engaged with community services to address any needs.**

It is important to remember that families have a choice about engaging in ongoing services if their family is deemed safe. If a family is not interested in working with DCF to reduce risk of future involvement beyond the child safety intervention, confirm that there have been no changes in circumstances which would warrant a new safety assessment,* offer a safe closure meeting to coordinate natural supports and service providers, and close. (See below for safe closure meeting guidance.)

If a family refuses services when there is a danger present, seek court involvement to ensure safety (either through a conditional custody order or custody). The identified danger should be described in the affidavit, along with efforts made to create a safety plan and offer services to mitigate the danger. If the deputy state's attorney refuses to file the petition, seek support from the assistant attorney general.

In any situation in which a family is high or very high risk and refusing services, consider consulting with the child safety manager for the purpose of shared decision making and clear documentation.

*Circumstances that may lead to a new safety assessment needing to be completed:

- Lack of engagement that indicates an unwillingness to protect
- New household member
- Deterioration of condition of the home
- More than 60 days since the last safety assessment

Facts That Support Items

In the text field, briefly describe the facts, in behavioral detail, that justify why each item is marked as it is. Bullet points are acceptable.

SAFE CASE CLOSURE GUIDANCE

A **safe closure meeting** includes caregivers, network members, service providers, and children/youth when appropriate. It can be held virtually, in person, or a combination of both. The purpose of a safe closure meeting is to support the family and their supports in the creation of a plan to mitigate risks and prevent future Division involvement. The meeting should address what the family identifies as risks and barriers, as well as risk items identified on the risk assessment, and it should include a concrete plan for who will do what to support the family going forward. Safe closure meetings should be documented in case notes.

Examples may include, but are not limited to, the following.

- Dates and transportation plan for upcoming appointments
- Support with barriers to education (e.g., someone to attend school meetings with caregiver)
- Scheduling and facilitating team meetings when needed
- What network members can do if they are worried

This meeting can take any form to fit the family's needs, such as addressing the Three Ws or holding a team meeting. Keep in mind that the Division does not close cases with a safety plan in place, and the purpose of the safe closure meeting is to support the family in creating its own plan, not to create an expectation that the family is beholden to an FSD-driven case plan beyond the closing of the case.

SDM REUNIFICATION ASSESSMENT

Vermont Department for Children and Families
Family Services Division

R: 04–17

Family Name: _____ **MIS #:** _____

District: _____

Primary Caregiver: _____

Secondary Caregiver: _____ **Date:** _____

Household Members: _____

Reunification Assessment: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

○ **Child in custody (CC)** ○ **Out-of-home conditional custody order (CCO)**

Who provided information to complete the reunification assessment?

☐ Primary caregiver: _____

☐ Secondary caregiver: _____

☐ Consulted with non-resident parent

☐ Others (names and roles; children's names can be included here):

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

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are there additional names on reverse? ○ Yes ○ No

Family/Household Cultural Context

How do the members of this family/household self-identify culturally, and how does it influence their parenting styles/techniques as it relates to the reunification assessment?

To be completed for each household to which a child may be returned.

SECTION 1: REUNIFICATION RISK REASSESSMENT

Score

R1. Final risk level on *most recent* child safety intervention related to the household of the reunification caretaker/subject of the CHINS petition (do not use risk level from previous reunification assessments or risk reassessments)

- ○ a. Low 0
- ○ b. Moderate 3
- ○ c. High 4
- ○ d. Very high ..... 5 _____

R2. Has there been a new substantiation since the initial risk assessment or last reunification assessment for the household of the reunification caretaker/subject of the CHINS petition?

- ○ a. No 0
- ○ b. Yes ..... 2 _____

Score

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.)***

P	S		
○	○	a. Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged in maintaining objectives	−2
○	○	b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives	−1
○	○	c. Minimally demonstrates new skills and behaviors consistent with case plan objectives and/or has been inconsistently engaged in achieving the objectives specified in the case plan	0
○	○	d. Does not demonstrate new skills and behaviors consistent with case plan objectives and/or refuses engagement	4
	○	No secondary caregiver	

Describe caregiver behaviors and skills:

TOTAL SCORE

REUNIFICATION RISK LEVEL

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

OVERRIDES

During current period

○ **No overrides apply**

○ **Policy overrides:** Indicate if any of the following are true in the current review period. Incident may be current or historic. Behavior change status is current.

☐ 1. Sexual abuse; perpetrator has access to child and has not successfully addressed the offending behavior.

☐ 2. Non-accidental physical injury to an infant, and caregiver has not successfully addressed the offending behavior.

☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment, and caregiver has not successfully addressed the offending behavior.

☐ 4. Death of a sibling as a result of abuse or neglect in the household, and caregiver has not successfully addressed the offending behavior.

○ **Discretionary override:** Reunification risk level may be adjusted up or down one level.

Supervisor approval of discretionary override (if yes, include name or signature below):

○ Yes

○ No

Supervisor name/signature: _____ Date: _____

FINAL REUNIFICATION RISK LEVEL

Final risk level: ○ Low ○ Moderate ○ High ○ Very high

SECTION 2: FAMILY TIME EVALUATION

Evaluate the caregiver's success with the planned frequency of family time, as well as the quality of family time. Base your evaluation on direct observation whenever possible, supplemented by observation of the child, reports by foster parents or alternate caregivers, etc.

CAREGIVER'S SUCCESS WITH FAMILY TIME		
FAMILY TIME FREQUENCY	QUALITY OF FACE-TO-FACE FAMILY TIME	
	STRONG/ADEQUATE	LIMITED/HARMFUL
Totally		
Routinely		
Sporadically		
Rare or Never		

Shaded cells indicate acceptable family time.

Indicate available family time and actual family time:

OVERRIDES

○ Policy: Override to unacceptable; family time is being supported and/or monitored for safety.

○ Discretionary (reason): _____

IF RISK LEVEL IS LOW OR MODERATE AND FAMILY TIME IS ACCEPTABLE, CONTINUE TO SECTION C, REUNIFICATION SAFETY ASSESSMENT.

IF RISK LEVEL IS HIGH OR VERY HIGH AND/OR FAMILY TIME IS UNACCEPTABLE, GO TO SECTION D, PLACEMENT/PERMANENCY PLAN GUIDELINES. DO NOT COMPLETE SECTION C.

SECTION 3: REUNIFICATION SAFETY ASSESSMENT

DANGERS

1. **Are any dangers identified on the safety assessment that resulted in the child's removal still present?**

   ○ a. No. (List the initial danger(s) below and describe how they were addressed after the child's removal.)

   ○ b. Yes. (List and describe the currently existing danger(s) below.)

   Describe:

   1a. If yes, are there one or more protective interventions that can and will be incorporated into the case plan to address the danger(s)?

   ○ No; there are no protective interventions available and appropriate to address the danger(s) if the child were to be reunified at this time.

   ○ Yes; one or more protective interventions have been identified to address the danger(s) and allow reunification to proceed with a safety plan in place.

   Describe:

2. **Have any new dangers been identified since the child's removal OR are there any other circumstances or conditions present in the reunification household that, if the child were returned home, would present an immediate risk of serious harm?**

   ○ a. No

   ○ b. Yes

   Describe:

2a. If yes, are there one or more protective interventions that can and will be incorporated into the case plan to address these dangers?

○ No; there are no protective interventions available and appropriate to address the dangers if the child were reunified at this time.

○ Yes; one or more protective interventions have been identified to address the dangers and allow reunification to proceed with a safety plan in place.

Describe:

REUNIFICATION SAFETY DECISION

Identify the reunification safety decision by selecting the appropriate option below. Take into account all dangers, protective interventions, and any other information known about the case. Select only one option.

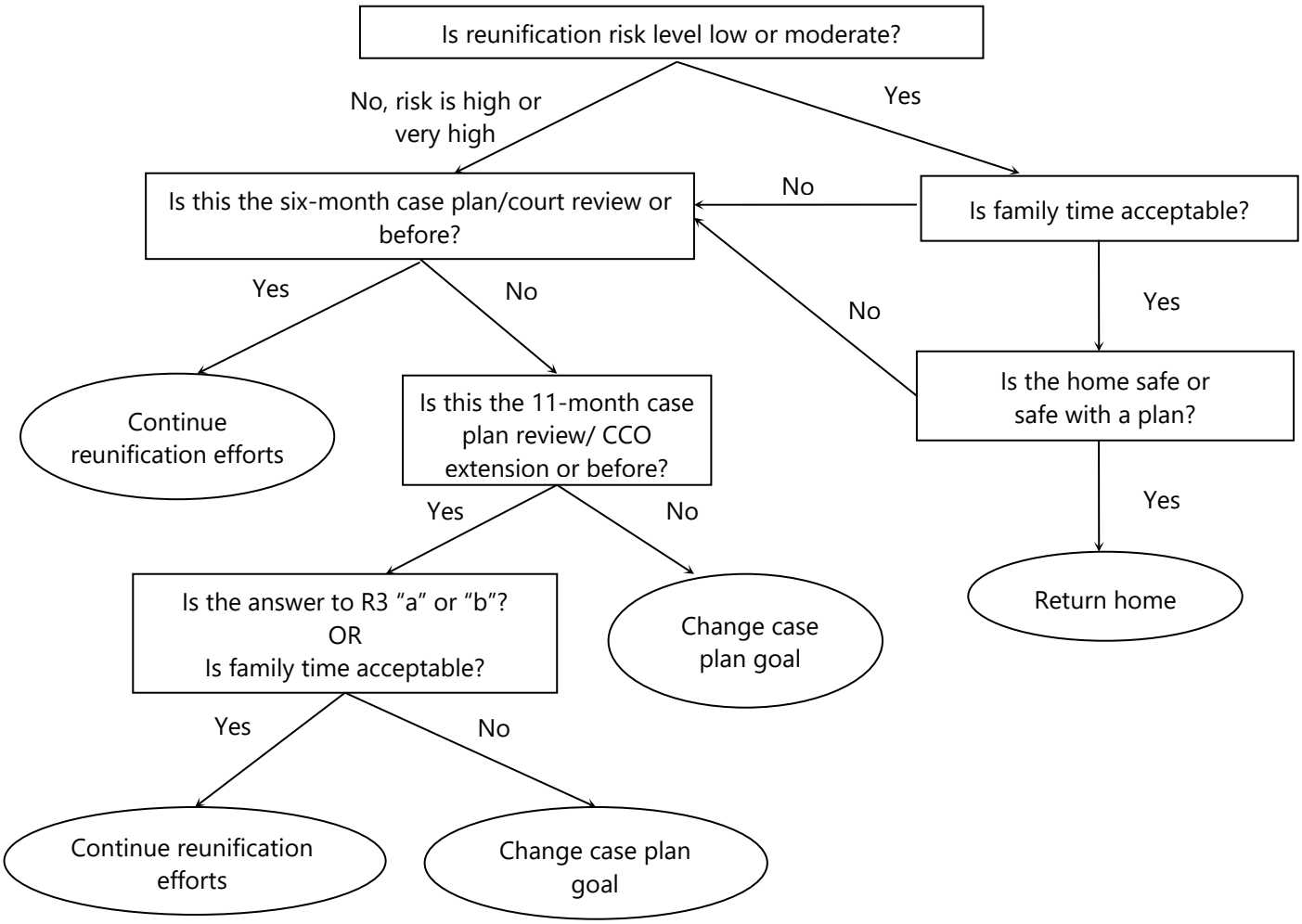
○ **Safe.** No dangers were identified at this time and all prior dangers have been resolved. Based on currently available information, there are no children likely to be in immediate danger or at risk of serious harm upon return home.

○ **Safe with plan.** One or more dangers are present, and protective interventions have been planned or taken. Based on these interventions, the child would be safe with a safety plan in place upon return home. SAFETY PLAN REQUIRED.

○ **Unsafe**. One or more dangers are present, and *DCF will take court action recommending continued out-of-home placement* because it is the only protective intervention possible for one or more children. Without continued placement, one or more children will likely be in immediate danger or at risk of serious harm.

SECTION 4: PLACEMENT/PERMANENCY PLAN GUIDELINES

Complete for each child receiving ongoing services towards family reunification and enter the results in Section E, Recommendation Summary. Consult with your supervisor and appropriate reunification policies 68, 122, and 125 and Vermont statutes. Consider options in light of the child's age and vulnerability.



OVERRIDES

○ **No overrides apply**

○ **Policy overrides**

☐ 1. Child has been in placement 15 of the last 22 months (change to "Change case plan goal").

☐ 2. The tree leads to "Change case plan goal" and it is the 12-month hearing or before, BUT there is a probability of reunification within six months (change to "Continue reunification efforts").

☐ 3. The tree leads to "Continue reunification efforts," but conditions exist to recommend a change to the case plan goal (change to "Change case plan goal").

Specify: _____

○ **Discretionary override (reason):**

Change recommendation to:

○ Return home

○ Continue reunification efforts

○ Change case plan goal

Supervisor Name/Signature: _____ Date: _____

SECTION 5: RECOMMENDATION SUMMARY

If recommendation is the same for all children, enter "all" under child # and complete row 1 only.

CHILD #	RECOMMENDATION		
	RETURN HOME	CONTINUE REUNIFICATION EFFORTS	CHANGE CASE PLAN GOAL
1.			
2.			
3.			
4.			

SECTION 6: SIBLING GROUP

If at least one child has a recommendation of "Change case plan goal" 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. They will be considered individually.

○ Yes. The recommendation for all children will be "Change case plan goal."

If the decision is to return all children home and more than 30 days have passed since reunification assessment completion, complete another safety assessment to document the plan for any children for whom dangers were identified.

SDM REUNIFICATION ASSESSMENT DEFINITIONS

Vermont Department for Children and Families
Family Services Division

FAMILY/HOUSEHOLD CULTURAL CONTEXT

How do the members of this family/household self-identify culturally, and how does it influence their parenting styles/techniques? Inquire broadly about all aspects of the family's culture, including race/ethnicity, sexual orientation, gender identity/expression, tribal affiliation, family roles, faith/spirituality, holiday traditions, and values. See appendix for further guidance.

SECTION 1: REUNIFICATION RISK REASSESSMENT

R1. Final risk level on <u>most recent</u> child safety intervention related to the household of the reunification caretaker/subject of the CHINS petition (do not use risk level from previous reunification assessments or risk reassessments)

The baseline for all reunification risk reassessments is the SDM risk assessment risk level from the most recent child safety intervention (investigation/assessment). This is often what led to the child's removal from the home. If there has been a child safety intervention since the child came into custody, indicate the most recent risk level.

R2. Has there been a new substantiation since the initial risk assessment or last reunification assessment for the household of the reunification caretaker/subject of the CHINS petition?

Consider only the period of time since the initial risk assessment (if this is the first reunification assessment) or the most recent reunification assessment. If there has been a new substantiation during this time period, select "yes." If not, select "no."

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 the caregiver is actively engaged in achieving the case plan objectives specified in the case plan and is demonstrating the skills/behaviors that will enable the caregiver to create and maintain safety for the child (e.g., ability to address substance use/abuse and manage treatment; 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 partner).

Vermont has a statutory requirement that all case plans must include a statement of family changes needed to correct the problems that necessitated DCF's intervention, with timetables for accomplishing the changes.[6]

If there are two caregivers, rate progress for each. If progress differs between caregivers, score 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 in maintaining 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 achieving 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. The caregiver's 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 for one or more children.

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.

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[6]. 33 V.S.A. § 5316(b)(5).

Policy Overrides

Indicate whether a policy override condition exists. Incident may be current or historic. Behavior change status is current. 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 addressed the offending behavior*. 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 has not successfully addressed the sexually offending behavior.

2. *Non-accidental physical injury to an infant, and caregiver has not successfully addressed the offending behavior*. An infant in the household has a physical injury resulting from the actions or inactions of a caregiver, and the caregiver has not successfully addressed the offending behavior.

3. *Serious non-accidental physical injury requiring hospital or medical treatment, and caregiver has not successfully addressed the offending behavior*. Any child in the household has a serious physical injury resulting from the action or inaction of the caregiver. "Serious physical injury" is 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. *Death of a sibling as a result of abuse or neglect in the household, and caregiver has not successfully addressed the offending behavior*. Any child in the household has died as a result of actions or inactions by the caregiver. This child fatality may have occurred prior to the current case.

Discretionary Override

A discretionary override is used by the ongoing worker whenever the worker believes that the risk score does not accurately 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 in the text box and the final reunification risk level should be marked.

SECTION 2: FAMILY TIME EVALUATION

FAMILY TIME FREQUENCY—COMPLIANCE WITH FAMILY TIME CASE PLAN

Divide the total number of completed family time visits by the number of planned family times. Family times that are appreciably shortened by late arrival/early departure are considered missed. Do not count family time as missed if it was not the caregiver's fault (e.g., foster parent failed to make the child available, transportation that the agency was required to provide did not occur).

$$\frac{\text{Actual family time}}{\text{Available family time}} = \text{Family time frequency}$$

Totally: Caregiver regularly attends family time or calls in advance to reschedule (90% to 100% compliance).

Routinely: Caregiver misses family time occasionally and rarely requests to reschedule (65% to 89% compliance).

Sporadically: Caregiver misses or reschedules many scheduled family time opportunities (26% to 64% compliance).

Rare or Never: Caregiver does not attend, or attends 25% or fewer, of the allowed family time opportunities (0% to 25% compliance).

Quality of Face-to-Face Family Time

The evaluation of family time quality should be based on the worker's direct observation whenever possible, supplemented by observation of child, reports of foster parents or alternate caregivers, etc.

QUALITY OF FACE-TO-FACE FAMILY TIME	
Strong/Adequate	**Caregiver** • 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 interest in school, other child activities, medical appointments, etc. Note: Family time may have progressed to include time that is not supported or monitored, but this progression is not required in order to score the quality of family time as adequate/strong.

QUALITY OF FACE-TO-FACE FAMILY TIME	
Limited/Harmful	**Caregiver** • 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 the individual supporting or monitoring family time. • May not be focused on child during parenting time and/or conducts self inappropriately during time (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 family time toward unmonitored and/or extended family time, or has had significant family time setbacks that have required increasing monitoring and support due to worries for the child's safety.

OVERRIDES

Policy

Override to unacceptable; family time is being monitored and supported for safety. The agency has determined that reunification will not be considered if there is a requirement that all family time be monitored/supported for the child's safety.

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 family time was strong, and 64% of family time sessions were completed; all missed family time sessions were due to documented medical emergencies).

SECTION 3: REUNIFICATION SAFETY ASSESSMENT

DANGERS

Prior to assessing current safety, the worker should review the safety assessment that led to removal.

1. **Are any dangers identified on the safety assessment that resulted in the child's removal still present?**

Identify whether the danger(s) that resulted in the child's removal have been resolved. Review the original safety assessment, list the initial danger(s), and describe how the initial danger(s) 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 family time.

1a. If yes, are there one or more protective interventions that can and will be incorporated into the case plan to address the danger(s)?

Identify whether any protective interventions are available and appropriate to address any identified dangers. Review the definitions (provided elsewhere in this manual) of dangers and protective interventions.

2. **Have any new danger(s) been identified since the child's removal OR are there any other circumstances or conditions present in the reunification household that, if the child were returned home, would present an immediate risk of serious harm?**

Identify whether any new danger(s) have emerged during the review period. Review the SDM definitions. If any new dangers are identified that would pose an immediate threat of serious harm to a child if they were reunified, describe the conditions and circumstances. Be behaviorally specific and avoid jargon.

2a. If yes, are there one or more protective interventions that can and will be incorporated into the case plan to address these dangers?

Identify whether any protective interventions are available and appropriate to address any newly identified danger(s). Use the danger and protective intervention definitions (provided elsewhere in this manual) to determine whether there are any new dangers.

REUNIFICATION SAFETY DECISION

1. **Safe.** No dangers were identified at this time and all prior dangers have been resolved. Based on currently available information, there are no children likely to be in immediate danger or at risk of serious harm upon return home.

2. **Safe with plan.** One or more dangers are present, and protective interventions have been planned or taken. Based on these interventions, the child would be safe with a safety plan in place upon return home. SAFETY PLAN REQUIRED.

3. **Unsafe.** One or more dangers are present, and *DCF will take court action recommending continued out-of-home placement* because it is the only protective intervention possible for one or more children. Without continued placement, one or more children will likely be in immediate danger or at risk of serious harm.

SDM REUNIFICATION ASSESSMENT PROCEDURES

Vermont Department for Children and Families
Family Services Division

The purpose of the reunification assessment is to structure critical case management decisions for children in placement who have a reunification goal by:

1. Routinely monitoring critical case factors that affect goal achievement;
2. Helping to structure the case review process; and
3. Expediting permanency for children in substitute care.

WHICH CASES

All ongoing cases in which at least one child is in out-of-home placement with a goal of return home. If more than one household is receiving ongoing services for reunification, complete one assessment on each household.

WHO

The ongoing worker.

WHEN

Vermont policy 122 requires a case plan review at least every six months. Each review process should begin with a SDM reunification assessment to inform the recommendations made. It should be completed:

- No more than 30 calendar days prior to completing each case plan or recommending reunification or a change in the permanency planning goal; or
- Sooner, if there are new circumstances or new information that would affect safety status and/or risk level.

DECISION

The reunification assessment guides the decision of whether to:

1. Return a child to the removal household or to another household with a legal right to placement (non-removal household)[7] where there are historical or current concerns about the household regarding safety and risk;
2. Maintain out-of-home placement; or
3. Change the case plan goal and implement a permanency alternative.

APPROPRIATE COMPLETION

Following the principles of family-centered practice, the reunification assessment is completed in conjunction with each identified household and begins after a child is removed. The case plan should be shared with the family at the beginning so that they understand what is expected. The reunification assessment form should be shared with the family at the same time so that they understand exactly what will be used to evaluate reunification potential and the threshold they must reach. The three key factors that should be discussed are the final reunification risk level, the quantity and quality of family time, and safety considerations.

Workers should explain three key factors to the family.

1. Inform the family of their original risk level and explain that this will serve as the baseline for the reunification assessment (unless a new report is accepted, in which case the new risk level will be used). Explain that a new substantiation or failure to progress toward case plan goals would increase their risk level, and that progress toward case plan goals will reduce their risk level.
2. Explain that both the quantity and quality of their family time will be considered and that they must attend **a minimum of** 65% of family time opportunities and have at least adequate quality (provide the definition for adequate quality).
3. Provide information on the reunification safety assessment and explain that the family must either demonstrate that no dangers are present, or have a plan in place to address any identified dangers. If everything else would permit reunification, the final consideration is safety.

SECTION 1: REUNIFICATION RISK REASSESSMENT

Select the reunification risk level that corresponds to the total score.

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[7] **Removal household** is that household from which the child was removed or—if that designation is unclear due to joint custody—the household where the most serious maltreatment occurred. **Non-removal households** are those with legal rights to the child.

Overrides

Consider only the period of time since the initial risk assessment (if this is the first reunification assessment) or the most recent reunification assessment.

- *Policy overrides*. Indicate whether a policy override condition exists. The presence of one or more policy override conditions increases risk to very high.
- *Discretionary override*. A discretionary override is proposed by the ongoing 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. 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 in the text box and the final reunification risk level should be marked. Supervisor approval is required.

SECTION 2: FAMILY TIME EVALUATION

- **Determine face-to-face family time frequency.** Determine the number of face-to-face family time occurrences and divide by the number of family time opportunities scheduled for each caregiver. Do not count family time that did not occur for reasons not attributable to the caregiver (e.g., foster parent failed to make child available, transportation that the agency was required to provide did not occur).

$$\frac{\text{Actual family time}}{\text{Available family time}} = \text{Family time frequency}$$

- **Determine face-to-face family time quality.** Consider multiple sources of information, including your own direct observations and reports from people such as the caregiver, child, foster parent, case aide, and/or family time coach.

On the matrix, locate the row corresponding to the household's family time quality and the column corresponding to the household's family time frequency. Where the row and column intersect, place the name or initials of each child. If this mark appears in the shaded area, the household is considered to have acceptable family time. If the mark appears outside of the shaded area, family time is considered unacceptable.

If family time frequency and quality were identical for all children in the family, indicate that the matrix applies to all children. If family time varied among children, identify each child's results on the matrix using each child's name or initials. If family time varied among caregivers, identify each caregiver's results on the matrix using each caregiver's name or initials.

Overrides

- *Policy: Override to unacceptable; family time is being supported and/or monitored for safety*. The agency has determined that reunification will not be considered if there is a requirement that all family time be supported/monitored for the child's safety.
- *Discretionary Override*. A worker may determine that unusual circumstances exist that warrant changing an acceptable response to an unacceptable response or vice versa. The reason for this change must be documented and supervisor approval is required (e.g., quality of family time was strong, and 64% of family time was completed; all missed family time was due to documented medical emergencies). For example, in two-caregiver households, if there is limited family time quality by the secondary caregiver **AND** the secondary caregiver is not the person who harmed the child and will not be a major caregiver, then a discretionary override may be considered.

SECTION 3: REUNIFICATION SAFETY ASSESSMENT

Prior to assessing the current safety, the worker should review the safety assessment that led to removal. Consider how safe the child would be if 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 family time. In the narrative, be brief but as specific as possible. Avoid labels and jargon.

Complete the reunification safety assessment section. If any dangers are present that can be addressed with a safety plan containing protective interventions, ensure the safety plan meets the following requirements.

- The safety plan must include at least one safe adult. This adult CANNOT be the alleged perpetrator.
- The safety plan should be reviewed at least every 30 days, or sooner as needed.
- The responsibility of providing for the child's safety should be transferred back to the caregiver, replacing formal and agency-provided supports with the family's informal supports as the caregiver's ability is developed or better understood.
- Each safety plan should be feasible and effective, meaning that the worker has confidence it will be completed as planned and that it will successfully provide for the child's safety.
- Each safety plan should also employ the skills of the caregiver and family.

  Note: The safety plan details will be documented in the narrative in the case record. The safety plan must be completed WITH the family. A copy should be left with the family and with anyone outside the family who is participating in the plan. The plan must be signed by everyone involved in the safety plan to indicate that they understand and agree to their roles and responsibilities in implementing the plan.

Note: The safety plan should be documented on the Vermont Safety Plan Form.

Safety Plan Review

Each safety plan should be reviewed with the family and their safety network on or about the review date to ensure the plan is still working. Any modification to the existing safety plan or new plan must be reviewed and discussed with the family. The worker should leave a copy of any new plan with the family and any safety plan participants and set a subsequent review date.

SECTION 4: PLACEMENT/PERMANENCY PLAN GUIDELINES

After completing the reunification risk reassessment, family time evaluation, and reunification safety assessment (if indicated), review the decision tree. Begin at the top of the tree. Continue following the pathway until a final decision point is reached. Consider options in the context of the child's age and vulnerability. The possible decisions are:

- Return home
- Continue reunification efforts
- Change case plan goal

Overrides

Consider whether any overrides are applicable. If no overrides apply, mark "No override applicable (policy or discretionary)." If an override will be applied, indicate whether it is a policy or a discretionary override. Mark the specific reason or recommendation.

Policy

- Child has been in placement for 15 of the last 22 months (change to "Change case plan goal").
- The tree leads to "Change case plan goal" and it is the 12-month hearing or before, BUT there is a probability of reunification within six months (change to "Continue reunification efforts"). Note: There is a likelihood of reunification within six months when:
  - » The caregiver has consistently and regularly contacted and had acceptable family time with the child;
  - » The caregiver demonstrated significant behavioral change and addressed the danger that led to the child's removal; AND
  - » The caregiver has demonstrated the capacity and ability both to complete the case plan objectives and to provide for the child's safety and well-being.
- The tree leads to "Continue reunification efforts," but conditions exist to recommend a change to the case plan goal (change to "Change case plan goal"). Conditions exist to recommend termination. For example, the caregiver has failed to contact and have family time with the child.

Discretionary

Unique considerations exist that warrant an alternative decision. If yes, indicate the permanency plan goal that is being recommended (return home, continue reunification efforts, or change case plan goal). Supervisor approval is required.

SECTION 5: RECOMMENDATION SUMMARY

The SDM recommendation summary is designed to document worker decisions. For each child being assessed, record the final recommendation and provide a specific rationale.

SECTION 6: SIBLING GROUP

Select "yes" if all siblings will be considered as a group and change the case plan goal for all.

Select "no" if siblings will be assessed individually.

SDM RISK REASSESSMENT

Vermont Department for Children and Families
Family Services Division

R: 07–16

Family Name: _____

MIS #: _____ **District:** _____

Assessment # (mark): ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 **Date:** _____

Worker: _____

Household Members: _____

Who provided information to complete the risk reassessment?

☐ Primary caregiver: _____

☐ Secondary caregiver/adult (name): _____

☐ Consulted with non-resident parent

☐ Others (names and roles; children's names can be included here):

FAMILY/HOUSEHOLD CULTURAL CONTEXT

How do the members of this family/household self-identify culturally, and how does it influence their parenting styles/techniques as it relates to the risk reassessment?

R1. Number of Chapter 49 assessments/investigations of abuse/neglect or CHINS (B) by an adult currently living in the household PRIOR to the Chapter 49 assessment/investigation or CHINS (B) that led to this case Score

- ○ a. None 0
- ○ b. One 1
- ○ c. Two or more ..... 2 _____

Evidence of why item meets definition:

R2. Prior ongoing child protection case and/or custody (do not include CHINS [C] a or [D])

- ○ a. No prior ongoing case/custody 0
- ○ b. One or more prior open for ongoing case/custody ..... 1 _____

Evidence of why item meets definition:

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

- ○ a. No 0
- ○ b. Yes ..... 1 _____

Evidence of why item meets definition:

R4. Child characteristics (mark all that apply)

- ☐ a. Does not exhibit any of the following 0
- ☐ b. Medically fragile or failure to thrive 1
- ☐ c. Developmental or learning disability 1
- ☐ d. Physical disability ..... 1 _____

Evidence of why item meets definition:

CURRENT REVIEW PERIOD

R5. New accepted Chapter 49 reports

- ○ a. No accepted Chapter 49 reports of abuse or neglect during review period required an in-person response 0
- ○ b. One or more Chapter 49 investigations/assessments of abuse or neglect by a household member during review period ..... 2 _____

Evidence of why item meets definition:

R6. Substance abuse (mark one)

- ○ a. No history of substance abuse issue that interferes with individual and family functioning 0
- ○ b. One or more caregivers have a history of substance abuse, but there is no current issue that requires treatment 0
- ○ c. Substance abuse issue is being addressed 0
- ○ d. Substance abuse issue interferes with individual or family functioning and is not being addressed ..... 1 _____

Evidence of why item meets definition:

R7. Adult relationships

- ○ a. No problems with adult relationships 0
- ○ b. No violence, but harmful, tumultuous adult relationships 1
- ○ c. Current household violence ..... 2 _____
  - ☐ Intimate partner
  - ☐ Other

Evidence of why item meets definition:

R8. Primary caregiver provides physical care consistent with child's needs

○ a. Yes 0

○ b. No ..... 1 _____

Evidence of why item meets definition:

R9. Housing (mark all that apply; score will be based on the highest response marked)

☐ a. Family had a safe and stable residence during entire review period (includes long-term shelter) 0

☐ b. Housing was physically unsafe at some point during review period 1

☐ c. Homeless at some point during review period ..... 2 _____

Evidence of why item meets definition:

R10. Primary caregiver's mental health (mark one)

○ a. No history of mental health issue that interferes with individual and family functioning 0

○ b. Primary caregiver has a historical mental health issue but has been symptom free for at least 12 months and does not require formal individual treatment 0

○ c. Mental health issue is being addressed by active engagement in treatment 0

○ d. Mental health issue interferes with individual and family functioning and is not being addressed ..... 1 _____

Evidence of why item meets definition:

R11. Caregiver's progress with case plan objectives (mark one)

- ○ a. Demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged in activities to maintain objectives 0
- ○ b. Demonstrates some new skills and behaviors consistent with family case plan objectives and is actively engaged in activities to achieve objectives 0
- ○ c. Minimally demonstrates new skills and behaviors consistent with family case plan objectives and/or has been inconsistently engaged in activities to achieve objectives 0
- ○ d. Does not demonstrate new skills and behaviors consistent with family case plan objectives and/or refuses engagement ..... 0 _____

Describe caregiver behaviors and skills:

TOTAL SCORE _____

SCORED RISK LEVEL

Score	Scored Risk Level
○ 0–2	○ Low
○ 3–5	○ Moderate
○ 6–8	○ High
○ 9+	○ Very High

OVERRIDES

Select an override code. If there are no overrides, select "No overrides apply;" risk level will remain the same. If there is a policy override, select the appropriate override; the risk level will be overridden to "very high." If there is a discretionary override, the risk level will be overridden up or down by one level, per Policy 69, and a reason must be entered in the box provided.

○ **No overrides apply**

○ **Policy overrides**

- ☐ Sexual abuse case AND the perpetrator is likely to have access to the child victim.
- ☐ Non-accidental injury to a child under age 2.
- ☐ Severe non-accidental injury.
- ☐ Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

○ **Discretionary override:** Select override level: ☐ Low ☐ Moderate ☐ High ☐ Very High

Discretionary override reason:

Supervisor approval of discretionary override (if yes, include name or signature below): ○ Yes ○ No

Supervisor name/signature: _____ Date: _____

FINAL RISK LEVEL

Final risk level: ○ Low ○ Moderate ○ High ○ Very High

Facts that support risk items:

Did any participant disagree with any item on the assessment?

○ No ○ Yes (If yes, describe below.)

#	WHO	DIFFERENT POINT OF VIEW

SDM RISK REASSESSMENT DEFINITIONS

Vermont Department for Children and Families
Family Services Division

FAMILY/HOUSEHOLD CULTURAL CONTEXT

How do the members of this family/household self-identify culturally, and how does it influence their parenting styles/techniques? Inquire broadly about all aspects of the family's culture, including race/ethnicity, sexual orientation, gender identity/expression, tribal affiliation, family roles, faith/spirituality, holiday traditions, and values. See appendix for further guidance.

R1. Number of Chapter 49 assessments/investigations of abuse/neglect or CHINS (B) by an adult currently living in the household PRIOR to the Chapter 49 assessment/investigation or CHINS (B) that led to this case

Count all Chapter 49 assessments/investigations for abuse or neglect or CHINS (B) assessments by a current adult household member PRIOR to the Chapter 49 assessment/investigation or CHINS (B) that resulted in the current ongoing case. Count regardless of whether the report was substantiated. Do not count prior reports in which allegations were perpetrated by an adult who does not currently live in the household. Do not count prior reports in which children in the home were identified as perpetrators of abuse/neglect, prior reports that were not accepted or that were found to be false reports, or reports received AFTER the current period of ongoing case management began.

For a definition of child in need of care or supervision (CHINS), see 33 VSA § 5102(3).

a. Mark "a" if there were no prior Chapter 49 assessments/investigations or CHINS (B) assessments related to abuse or neglect.
b. Mark "b" if there was one prior Chapter 49 assessment/investigation or CHINS (B) assessment.
c. Mark "c" if there were two or more prior Chapter 49 assessments/investigations or CHINS (B) assessments.

R2. Prior ongoing child protection case and/or custody (do not include CHINS [C] or [D])

a. Mark "a" if the household has never been involved with the agency for an ongoing case or custody as a result of a Chapter 49 assessment/investigation or CHINS (B).
b. Mark "b" if the household was previously open for at least one ongoing case or custody or is currently open for an ongoing case or custody as a result of a Chapter 49 assessment/investigation or CHINS (B). Do not include cases and/or custody that were the result of CHINS (C) or (D).

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

a. Mark "a" if the primary caregiver's childhood did not include experiences that would be considered abusive or neglectful.

b. Mark "b" if verifiable/credible statements by the primary caregiver or others and/or past records indicate that the primary caregiver was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse).

R4. Child characteristics (mark all that apply)

Identify whether any child in the household is diagnosed as medically fragile or failure to thrive, or has a developmental, learning, and/or significant physical disability. 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. Mark "a" if no child in the household exhibits the characteristics listed below.

b. *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.

c. *Developmental or learning disability*.

- *Developmental disability*: A severe, chronic condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include developmental disability, autism spectrum disorders, and cerebral palsy.
- *Learning disability*: Child has an individualized education plans (IEPs) 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.

d. *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.

CURRENT REVIEW PERIOD

R5. New accepted Chapter 49 reports

a. Mark "a" if there were no reports of abuse or neglect during the review period requiring an investigation/assessment.

b. Mark "b" if at least one new accepted report for abuse or neglect involving an adult household member resulted in a Chapter 49 assessment/investigation **during the current review period**.

R6. Substance abuse (mark one)

Legal, non-abusive prescription drug use should not be included.

Indicate whether either caregiver has a past or current alcohol/drug abuse issue that interferes with their and the family's functioning and indicate whether the problem is being addressed. If both caregivers have a past or current alcohol/drug abuse issue that interferes with their and the family's functioning, rate the caregiver with the more problematic behavior.

Examples of a caregiver not addressing the problem since the last assessment/reassessment may include any of the following.

- Substance use that affects or affected employment, criminal involvement, or marital or family relationships; and/or that affects or affected the 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.
- Caregiver denies or minimizes prior treatment.
- Self-report of a problem or relapse.
- Multiple positive urine samples.
- Health/medical problems resulting from substance use and/or abuse.
- 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. Mark "a" if no caregiver has or ever has had a substance abuse problem that interferes with individual and family functioning.
b. Mark "b" if the caregiver has been diagnosed with a substance abuse problem but has been in stable recovery for at least 12 months and this information has been verified. The caregiver does not require formal treatment but may still participate in support or 12-step groups.
c. Mark "c" if one or more caregivers have a current substance abuse problem AND are actively engaged in treatment. Indications of being "actively engaged" may include confirmation of being in treatment, providing the division with signed releases, and having a plan of how to address relapse and recovery needs. The alcohol/drug abuse problem does not interfere with the caregiver's parental abilities.
d. Mark "d" if one or more caregivers have a current alcohol/drug abuse problem that interferes with the caregiver's and the family's functioning, and they are not addressing the problem OR if substance abuse or relapse occurred during the last review period and impacts the caregiver's parental abilities.

R7. Adult relationships

Score based on the current status of adult relationships in the household.

a. Mark "a" if there are no problems observed.
b. Mark "b" if there are harmful/tumultuous adult relationships that interfere with household functioning or care of the child (but not at the level of household violence).
c. Mark "c" if household violence is present. Since the most recent assessment, the household has had physical assault(s) or periods of intimidation/threats/harassment involving caregivers or a caregiver and another adult.

R8. Primary caregiver provides physical care consistent with child's needs

a. Mark a" if the physical care provided meets the child's needs to the extent that the child has not been harmed and their well-being is maintained. Consider the child's age/developmental status when scoring this item.
b. Mark "b" if inconsistent physical care of the child (age-appropriate feeding, clothing, shelter, hygiene, and medical care) threatens the child's well-being or results in harm to the child. Needs may be considered unmet even when the situation is outside of the parent/caregiver's control. *Examples include, but are not limited to, the following*.
    - Failure to obtain medical care/dental care for severe or chronic illness.
    - Repeated failure to provide the child with weather-appropriate clothing.
    - Poisonous substances or dangerous objects lying within reach of a small child.
    - The child is wearing extremely soiled clothes for extended periods of time.
    - The child's hygiene is so poor that it results in a medical condition.

R9. Housing (mark all that apply; score will be based on the highest response marked)

a. Mark "a" if during the entire current review period, the family has maintained a **safe and stable** residence that is free of hazards. Include long-term shelter.
b. Mark "b" if on at least one day during the review period, housing was physically unsafe to the extent that it did not meet the health or safety needs of the child (e.g., exposed wiring, roach/rat infestations, human/animal waste on floors, or rotting food). If the family was also homeless for at least one night during the review period, mark "c."
c. Mark "c" if on at least one night during the review period, the family was evicted or had no residence and slept in a car, on the street, or at a shelter. Do not score if the family was in a long-term shelter.

R10. Primary caregiver's mental health (mark one)

a. Mark "a" if the primary caregiver has never had a mental health problem that interferes with family functioning.

b. Mark "b" if the primary caregiver has been diagnosed with a mental health problem but has been symptom free for at least 12 months and does not require formal treatment. Caregiver may still participate in support groups or use maintenance doses of psychotropic medication.
c. Mark "c" if the primary caregiver has been diagnosed with a mental health problem and is actively engaged in treatment.
d. Mark "d" if the primary caregiver has a current mental health problem that interferes with the caregiver's or the family's functioning and they are not addressing the problem.

R11. Caregiver's progress with case plan objectives (mark one)

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 FSDNet case plan that identifies 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. Mark "a" if the caregiver regularly demonstrates all behavioral changes identified in the case plan objectives and is able to create long-term safety for the child in the household. The caregiver is actively engaged in activities to maintain the objectives.
b. Mark "b" if the caregiver demonstrates some new skills and behavioral changes consistent with case plan objectives and is actively engaged in achieving the objectives, but they do not regularly demonstrate the behaviors necessary to create long-term safety in all areas.
c. Mark "c" if the caregiver demonstrates 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. Mark "d" if the caregiver has not demonstrated behavioral change consistent with family case 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.

SDM RISK REASSESSMENT PROCEDURES

Vermont Department for Children and Families
Family Services Division

PURPOSE

The risk reassessment uses a selection of some of the strongest actuarial risk items plus progress toward case plan goals to arrive at an estimate of the likelihood of future system involvement after services have been provided for a period of time. It is used to guide decisions about whether to continue ongoing services or to close the case.

WHICH CASES

All ongoing cases where all children are in the home.

WHEN

Every 90 days.

WHO

The ongoing worker.

DECISIONS

- Cases that are reassessed as low or moderate risk should be closed unless there are unresolved dangers. A safety reassessment should be completed to determine safety status prior to closure. If closing a case, referrals to community services should be made to address continuing service needs. If continuing services are provided to low- or moderate-risk families, document the reason in the appropriate section of FSDNet.
- Cases that are reassessed as high or very high risk should remain open for services. Use engagement skills to interest the family in continuing services.
- If a family refuses to work with the Division, complete a new safety assessment to ensure that there are no active dangers and hold a safe closure meeting with caregivers, children (if appropriate), and both formal and informal supports. Ask the family to identify a plan to mitigate their likelihood of future Division involvement. Document this plan in case notes, and identify network members who

will support the family with this plan (see the section SDM Risk Assessment Procedures, Safe Case Closure Guidance).

- If dangers are identified on the safety assessment and the family continues to refuse, the danger should be described in an affidavit—along with efforts made to safety plan and offer services to mitigate the danger—and presented to the state's attorney in writing. If the state's attorney refuses to file the petition, seek support from the assistant attorney general.
- If the family refuses a safe closure meeting, document efforts and consider connecting the family to community supports.

ADDITIONAL CONSIDERATIONS

Only one household can be assessed on each form. Family constellation may change over time. Use the current family constellation to determine who is included in the household being assessed and whether a second household must be assessed.

Risk Items

There is only one set of items on the risk reassessment. Based on progress during the review period (including family perspectives, perspectives of collateral sources, and your observations), mark each item according to the *definition*. Each item must be rated before the assessment is complete. There is a point value for each response option. Enter the point value for the response on the line.

Scoring

Add the scores for each item and enter the total at the bottom of the column. In the "Scored Risk Level" section, select the risk level that corresponds with the column score.

Overrides

Policy Overrides

Policy overrides are applicable for very serious situations that will be served as if the risk level is very high, regardless of actual scored risk level.

- If one or more of the policy override conditions are present **at this time**, mark it. The override condition must be current.
- The family will be considered to be at very high risk.

Discretionary Overrides

If the worker, in consultation with the supervisor, determines that there are situations that were not measured within the actuarial items and that substantially affect the likelihood of future harm, the worker may apply a discretionary override (change of one level in either direction) per Policy 69.

Facts That Support Items

In the text field, briefly describe the facts in behavioral detail that justify why you marked each item as you did. Bullet points are acceptable.

Different Point of View

If the way an item (risk item or override) is marked or not marked does not reflect a shared understanding of all family members and the worker, use this space to explain the alternate point(s) of view.

APPENDIX: PRACTICE GUIDANCE FOR ASSESSING CULTURAL CONTEXT

This practice guidance is divided into three primary sections:

- Preparing to Work With Families
- Family Engagement
- Case Planning, Services, and Documentation

INTRODUCTION & OVERVIEW

All families have multiple identity domains (no one is only one identity) and unique cultures that shape child rearing and family functioning, and they provide valuable context to better assess and plan with families. Family members may identify with multiple cultures, and 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 person with a disability or a person with a substance use disorder than to identify based on their race or ethnicity. Past or current experiences of discrimination or oppression in any identity domain may shape behaviors, parenting, and caregiving.

This is a guide for assessing a family's cultural context in practice, both when assessing safety and throughout a case, to learn how culture shapes and influences beliefs and values about child development and parenting norms and strategies. Attention to the cultural context of *every* family is critical to the development of an individualized and strength-based response. This guide is a tool to increase understanding of the value and relevance of cultural context and to provide strategies for applying this understanding to casework and decision making regarding child safety and well-being.

Asking families about their culture is not meant to be intrusive or done exclusively for data-gathering purposes. A family's race, culture, and background are essential parts of who they are and how they see, experience, and are seen by the world. Over time, we should strive to move from surface-level conversations with families to deeper conversations about cultural beliefs and values.

When workers with the Vermont Department for Children and Families (DCF) set the tone of the relationship and engage families in dialogue about their culture from the start, they can build the trust necessary for ongoing casework. Examining the intersections of different cultures through an equity lens can help workers more accurately identify a family's protective capacities and actions and determine the appropriate threshold for dangers in the context of the family and community.

As a reminder, cultural domains to explore include race, ethnicity, sexual orientation, gender identity and expression, immigration status, socioeconomic status, faith/spirituality/religion, education, military status, ability status, family history of addiction and mental health, medical background, personality type of each family member, child developmental milestones, parenting norms in family of origin, etc.

STEP 1: PREPARING TO WORK WITH FAMILIES

Understand Your Own Biases

- Be mindful of your own beliefs, values, cultural norms, and gaps in knowledge. Start with looking across race, then the other identities.
- Recognize the limits of your understanding about particular cultural groups.
- Be willing to seek information and advice. Use local or online resources at your disposal. Examples include multicultural liaisons or cultural brokers within communities, AALV, U.S. Committee for Refugees and Immigrants (USCRI), Vermont Refugee Resettlement Program, and the Multicultural Youth Program. See FSD's Racial Equity SharePoint Page for training and events, articles, videos, books, podcasts, and other online resources.
  - » The Vermont Commission on Women has developed a comprehensive list of racial justice organizations within Vermont.
  - » The Vermont Network has developed a list of anti-racism resources.
  - » A BIPOC business directory exists for the state of Vermont.
- Everyone holds positive, negative, conscious, and unconscious biases about various cultural groups that can play out in relationships and in work with children and families. Being aware of and preparing in advance for these biases can improve interactions and reduce miscommunications with families.
- Remember to stay focused on assessment of imminent danger of serious harm, not complicating factors. For example, avoid unintentionally criminalizing poverty and parenting norms/values that differ from personal experiences.

Research and Reflection

- Nationally, the child welfare field has moved from acknowledging the problem of systemic racial and ethnic disproportionality and disparity to formulating and implementing solutions. Many social work policies and practices were constructed from a bias that privileges the White, middle class, heterosexist norms and expectations of parents and families in the United States. This has resulted in harm for families involved with the system and led to a distrust of child protective services by certain communities.
  - » What might this family be most worried will happen if they tell you their truth?
- Prior to interviews, try to find out what differences between you and the family exist and learn any common cultural beliefs and practices relating to parenting and child protection within the family's cultural community. See CPS Potential Differences handout for reference.
  - » Identify the cultural variables you already have fluency with.
  - » Notice which cultural/identity differences that make you feel uncomfortable or that you are less knowledgeable of.
- Work with your supervisor to identify the cultures with which you have minimal or no experience or exposure. Then brainstorm good questions you can ask to learn more before the first interview with

the family. Beginning with the understanding that every family values and believes things based on many facets of their cultural context, approach the first interaction with a family with the goal of:

  - » Listening to the family's story while holding both your desire to understand and your expertise to assess safety, and do so within the family's context by knowing your racial and other cultural biases;
  - » Being prepared to use strong inquiry skills;
  - » Preparing to set a positive and open tone that builds a bridge across any difference; and
  - » Using this difference as an asset for planning and decision-making.
- If family members are immigrants or refugees, contact local support agencies to learn more about the family's country of origin, including its ethnic demography, religion, and migration to and settlement in the United States experience of state-based or interpersonal trauma.
- Contact other agency or community workers who can share knowledge about family engagement across cultural difference while ensuring the family's confidentiality. Speaking with multiple sources where possible will provide a broader understanding. While general knowledge of particular subgroups is important, we must remember that families are not one-dimensional.
- *Sexual Orientation/Gender Identity*. Research tells us that certain youth experience differential treatment as a result of their sexual orientation, gender identity, and expression (SOGIE). Current child welfare best practices state that collecting SOGIE is an important first step to better understanding the lives, experiences, and unique challenges of lesbian, gay, bisexual, transgender, two spirit, queer, questioning, intersex, asexual, pansexual, polysexual (abbreviated to LGBTQ) and gender nonconforming youth in the child welfare system. While we want to gather this information, there are ways to do it that both respect the youth and offer validation and support. Youth whose sexual/romantic identity, gender identity, or gender expression does not conform to heteronormative or cisgender roles experience discrimination and invalidation; Family Services Policy 76 provides guidance on how best to support LGBTQ youth. Outright Vermont is the division's close partner in consultations and this work with youth and families.

Prepare to Engage

- Remember that the family is the expert about themselves and the most important source of understanding the ways that their culture influences their functioning, decision making and assessment of safety and well-being. Also remember that with such high populations of people identifying with majority culture (e.g. White, heterosexual, cisgender, able-bodied), it is likely that many families have not had to think much about their culture, which may make this question more difficult to answer. It is good to think of questions that help you elicit information that is relevant to the purpose of the assessment: Examples include bedtime routines, how families express joy, anger or sadness, how they eat meals, their beliefs about discipline and health. When you talk about culture through actions, expressions, and activities, families may be able to provide you with more information.
- Be prepared to acknowledge and name the differences between yourself and the family aloud, this includes the power differential.
- Seek to understand the family's perspective about their lives and their decision making. Ask "how" rather than "why" when trying to understand culture.

- Come from a place of cultural humility and be the one to lead the conversation into an experience of transparency and willingness to tolerate any discomfort you may have discussing topics with a family.
- Prepare solution-focused questions to engage each family member and network member to learn as much as you can about their culture and self-identity. (See Step 2.)
    - » For individuals who are part of a LGBTQ community, ask what they would like to keep confidential. For example, a youth may not have come out to their parents yet and prefer to do so themselves when they feel ready. Start by using your pronouns every time you meet at family, not just when you think someone may be part of a LGBTQ community.
- Conversations and engagement about families' cultures should happen consistently throughout the life of the case. Families will share more details over time as trust builds. Each worker can build upon the information gathered by the previous one.
- If family members do not speak English or their proficiency in English is limited, workers must utilize interpretive services to communicate with the family. The requirement to utilize interpretation and translation services applies to every aspect of the department's engagement and work with families (any type of involvement or open case). See AHS's Limited English Proficiency (LEP) SharePoint Page for information about the contracted services available to staff and families.

STEP 2: FAMILY ENGAGEMENT

Pre-Interview

- If you are aware of the primary spoken language and dialect of the family, it can be helpful for family services workers to invest time in finding the right interpreter for the family. Considerations and sensitivities may include differences in regional dialects, connections to elders within a community, worries about confidentiality, and conflicts of interest. Therefore, FSD needs to take these things into consideration when arranging for interpreter services. Work with the contractor/agency to consider these factors.
- When possible, use the same interpreter every time you meet. Allow the family to determine if the translator would be in person or by phone.
- Use the tools available to you, such as the eco-map, Circles of Safety and Support and genogram to understand how family members define their support network and community of peers. This is a valuable piece of information for ongoing assessment and planning.
- Ask the family if they would like to invite anyone from their family group/network, church, community of peers, to attend (e.g., tribal elder, faith leader, cultural community representative).

During the Interview or the First Conversation With the Family

- Use clear, plain language. Avoid acronyms, long sentences, informal English phrases and nuances, and professional jargon. Understand that some words may not have a perfect translation or meaning across languages.

- Name and acknowledge the differences between you and the family and share your commitments. For example:
  - "DCF has a legal obligation to assess safety, and we want to do that in partnership with your family in a way that you understand and that you feel I understand you. I recognize this can feel scary and threatening to you and your family because DCF has power that at times can involve the court system. DCF involvement can push you to do things that may not be easy to do and make decisions that may feel bad to you."
  - "But I honestly want to hear what you need and want to acknowledge we have the same goal—that your child is safe. I want to work with you to keep your family together and get any resources and support you may need to do this."
  - "I am committed to being transparent about my work with you and your family and to making sure you have a say in what happens. I am also committed to learning about your family's culture and how that shapes how you run your household and raise your kids."
- Pay attention to family members' cues. If the family seems uncomfortable discussing aspects of their culture for fear of judgment, family network dynamics related to information-sharing or perhaps domestic violence, or confusion, break the conversation down into smaller parts, being clear about the concern at hand and what the specific options are to resolve it. Understand there can be a stigma across cultures about mental health and wellness, where mental health challenges can be viewed negatively within the culture. Allow the family time and space to share more about themselves and their day-to-day life; the family is the expert on their story, and taking the time to understand them allows them to know that you care about them. If you make a misstep or need to do repair work, be direct and apologize, explaining that you did not know that you should not have done whatever it was.
- Pay attention to your surroundings for cultural norms. Some examples include:
  - If you are visiting a home and see a family's shoes outside, as long as you feel safe doing so, you should remove your shoes when entering out of respect.
  - The offering of food and drinks during home visits may be a norm in some cultures. Accepting beverages or food usually signals that you are comfortable and builds relationships.
  - In some cultures, making eye contact may be seen as disrespectful and cause a family to close off and not listen or engage. Community resources and cultural brokers can help with this if you have time to ask in advance.
  - When it comes to obtaining signatures on documents, in some cultures women will decline to sign things like releases because the male head of household is the one who signs.
- Create a **safe space for youth** by taking the time to ask where they would like to meet and what would help them to be more comfortable participating in this process. Allow time for them to ask questions that will help to build the bridge of communication. Enter conversations with all youth with a statement that conveys openness and awareness for youth to self-identify and to disclose their SOGIE. Pay attention to both process and content for yourself and the youth. For yourself: Be aware of your nonverbal reactions, especially if a youth discloses something different from what you anticipated. Your reaction can shift the dynamics of the conversation. For the youth: Be aware of their nonverbals as they share information. For example: The youth may say that they are doing great and want to stay in a home, but their nonverbal cues could signal the opposite.

- Ask how each person self-identifies. Show respect by calling them by their preferred names and pronouns and by pronouncing their names accurately. Best practice is to use their name or they/them pronouns until you know their preferred language. Here is an example: "Hey there, I am Jill. I generally like to be called Jill rather than Ms. Richard and definitely not Mrs. Richard, though sometimes I am called Mrs. Richard because that's what feels best to others. I can be flexible but certainly prefer Jill. You will also see from my email that I prefer the pronouns she/her—this is something that's important for me to share because I want everyone to know that I don't want to make any assumptions about how you identify and what's important to you. I want to learn more about you as we work together. Not just about your pronouns, of course, but about all different parts of you and your life. As we discuss what led to our meeting, I will try to understand more about you and what is important to you. I will also share a bit about me when it seems important so we can develop a good working relationship. Is this okay with you?
- Here are sample questions that could be used or adapted for all family members.
  - » What name would you like me to call you? I go by _____.
  - » What are your pronouns? Mine are _____.
  - » How do you identify racially and ethnically? I identify as _____.
  - » Another option: Do you feel comfortable telling me how you identify racially and ethnically?
  - » What is your primary language, and what language do you feel most comfortable speaking and reading? My primary language is _____ and I also speak _____.
- Stay curious and explain that you will ask multiple questions, even when it seems obvious, to better understand their unique family cultural context and how it connects to **household functioning and parenting practices**.
  - » How would you describe parenting practices or norms that are important to you?
  - » Are they connected to your family history in a way that you want me to know about? How do they show up in your day-to-day life?
  - » When you were growing up, what did your family value most? What things were important to you as a family? As an individual?
  - » Are there any other aspects of your family's values and norms that you think would help me better understand where you're coming from?
- Be prepared to articulate the connections between their cultural values, norms, and activities and the impact on their child's safety and well-being. For example, when a family talks about protecting privacy and you assess that there is a multigenerational culture of secrecy, explain that when families can learn to trust other people, they can feel less isolated and more supported to make behavioral changes that will increase child safety.
- Summarize what you learned from the family and ask whether you got it right.

STEP 3: CASE PLANNING, SERVICES, AND DOCUMENTATION

We have conversations about how families culturally identify and how their cultural beliefs/values impact their parenting norms and child safety so that workers can use the information to inform their planning processes.

General Considerations for Culturally Informed Planning

- Adopt a supportive role where possible and provide assistance in the form of concrete, culturally relevant services as quickly as possible, whenever possible.
- Ask families what has worked or not worked for them in the past and, if appropriate, their preferences for any actions they can take to increase safety.
- Include behavior-detailed action steps to mitigate safety threats on the plan, not just a list of services (which go on the case plan) or vague expectations. Think of the small details of *how* the parent will demonstrate the actions in daily parenting activities in ways that are culturally specific and relevant—and how network members can support them. Families will struggle if asked to conform to dominant cultural expectations outside of their own; allow them to explore action steps that promote change and healing that they relate to and connect with.
- Facilitate a conversation to help families identify their safety networks using the Circles of Safety and Support.
- Include the family's network members in the plan to provide emotional support and monitoring functions.
- Ensure that a child's identity is not documented anywhere that will be shared with others without their permission, including on the safety or case plan. Similarly, if the youth would like specific names or pronouns to be used, be sure to consistently use these verbally and in writing to model and convey respect.

Considerations Specific to Out-of-Home Planning

- When out of home care is necessary, work diligently within the family and their community to identify an alternative caregiver. See Family Services Policy 91 (Kinship Care & Collaboration With Relatives) for additional information and policy guidance.
- Consider whether the foster care application, licensing regulations, or other pertinent documents need to be translated into another language.
- Some sections of the foster care application may not be applicable to applicants who do not speak English or their proficiency in English is limited, and support may be offered during the completion of the application. FSD staff are permitted to assist these individuals with completing the application packet (i.e., partnering with an interpreter to read the questions and documenting the individual's responses for them, excluding the required signatures).
- Be aware that a foster care licensing variance may be used to facilitate placement with relatives, kin, or fictive kin, or a placement that would keep a child connected to their culture, tribe, language, traditions, or background.
- Ask the parent about their child's identity and what they would like shared with the caregiver.
- Also ask the child about their identity, what they would like shared with the caregiver, and what information about themselves they would like to remain confidential. Unless provided with explicit permission to share and document gender identity information about a youth, ensure that their identity is not documented anywhere that will be shared with others.

- Policy requires Initial Caregiver Meeting and Shared Parenting Meetings for the caregiver and parent to meet. This is an opportunity for the caregiver to better understand what the child needs to remain connected to their culture while in care. Share information with individuals who are supporting family time about the family's culture and the importance of using that context when providing feedback to the Division. See Family Services Policy 124 (Family Time [Parent/Child Contact]) for additional information and policy guidance. *Provide an interpreter for the family when the language of the alternative caregiver is different from the parent and vice versa*.
- Ask the caregiver to share insight about their family culture. The child will have cross-cultural experiences at this point even if, for example, the foster family is within the same race.
- Arrange family time/visitation that is culturally responsive and allows the family to engage in rituals, traditional gatherings, and celebrations. When the family time plan is developed, indicate holidays, celebrations, or traditions that family time should be planned around. Ensure the caregivers are agreeable and able to accommodate these needs. With the family's permission, reach out to cultural leaders or organizations in the community to learn more about the family's culture of origin to ensure that contact between the child and their cultural community remains a priority (e.g., child can attend faith-based services with a relative; has regular sibling visits; can participate in birthdays, traditional holidays, or the annual family reunion).
- Help the foster family learn about the family's culture. Ensure they are committed to upholding the values and supporting the child's cultural, ethnic, and racial identities and create a plan to support cultural disconnects/gaps (e.g., clothing, hair, attending traditional events, "the talk" about being a Black youth walking on the street or pulled over by police, etc.). For example, if the child comes from a family that is atheist and is placed with a family who participates in faith-based activities, create a plan that allows the child and family to respectfully coexist without the child being defined as "non-compliant" or "oppositional."

Workers must summarize these discussions and what they learned (rather than guessing or assuming) and share how an understanding of the family's values and norms are incorporated into assessment and planning throughout the life of a case. Tips for behaviorally detailed documentation include the following.

- If the family speaks a language with no written form (e.g., Mai-Mai), plan for turnaround time on translation and audio or video recordings of the safety plan, case plan, or any other traditionally written document.
- Include the questions asked during interviews with parents, network members, and collaterals.
- Write how the family culturally identifies in each domain inquired about. Never guess an aspect of a family's culture (country of origin, ethnicity, race, religion, etc.).
- When documenting in the safety assessment cultural context box, summarize the connections between the family's various cultural beliefs and values and their parenting norms and behaviors. For example: Mom identifies racially as White; ethnically, she is Irish and French. She states that she grew up in a strict fundamentalist Christian home, went to church weekly, and was physically disciplined as a child with a wooden spoon that often left marks on her behind. Her parents always said, "The Bible says spare the rod, spoil the child." She feels that she turned out fine, and so she has continued using the same discipline with her own children.

- When making referrals for the family, consider the match between the community provider and the individual (for adults and children/youth). Consider whether there are specialties needed when matching individuals with a clinician or therapist (i.e., they may need expertise on childhood trauma or substance use disorders, but also a lens on the needs of people of color and/or LGBTQ communities). If such resources do not exist locally or in small communities, consider whether online therapy or online peer support groups could offer a safer, simpler way to find culturally responsive, social justice-oriented support.
- Be explicit about how a safety plan or case plan was made to be culturally responsive.
  - » The family relies on their congregational church pastor for counseling and advice when struggling with poverty and the father's drinking. The pastor agreed to be part of the family's safety network and will be part of the safety plan.
  - » Tommy, age 15, identifies as genderqueer and pansexual and uses they/them pronouns. Tommy sees their gender as fluid but often identifies as more female than male. Tommy's pansexuality means that they are attracted to other people regardless of their sex or gender identity. Tommy has told their mom about this; mom agrees to use Tommy's pronouns and to respect their choice to date whomever they choose without criticism.
  - » Mom identifies as Buddhist and prefers Eastern medicine practices. She has always counted on her Reiki practitioner to help her maintain sobriety, so going to Reiki at least once every two weeks is now included in her case plan activities.
  - » Kimberly's foster parents agree to support her cultural connections to her Abenaki Tribal culture by transporting her to Western Abenaki language classes and the Nulheganaki celebration.
- Document how a caregiver is attending to the child's cultural identity and helping them to remain connected. For example: The foster parents attend Mass on Sundays and have given Levi the option to attend Shabbat with a Jewish family friend either on Friday night or Saturday morning. When the foster family is in Mass, Levi has a babysitter or stays with the family's neighbor. Levi's parents have expressed gratitude that they are not forcing him to attend Mass with them and that he can maintain his Jewish faith and traditions.
- What is written in the action plan should be linked to why the case is open and why the case cannot yet safely close. There may be identified issues the family could benefit from working on, but we should not have an action plan around them if they are not preventing safe case closure. Action steps should be revisited if the appropriate services do not exist within communities to meet families' needs.