SDM

The Structured Decision Making® System
for Child Welfare

Policy and Procedures Manual

April 2005
Updated March 2021



Virginia Department of Social Services

NCCD | Children's Research Center

CONTENTS

SDM® Intake Tool
Tool....1
SDM® Screening Assessment Definitions....7
SDM® Response Priority Definitions....15
Policy and Procedures....23

SDM® Safety Assessment
Assessment....26
Definitions....31
Policy and Procedures....40

SDM® Family Risk Assessment
Assessment....44
Definitions....47
Policy and Procedures....53
SDM® Contact Standards....56

SDM® Family Strengths and Needs Assessment/Review
Assessment....58
Caretaker Definitions....63
Child Definitions....69
Policy and Procedures....73

SDM® Family Risk Reassessment for CPS Cases
SDM® Reassessment Overview....75
Reassessment....76
Definitions....79
Policy and Procedures....82

SDM® Family Reunification Review
Review....85
Definitions....94
Policy and Procedures....104

APPENDIX
Kansas Milestone Chart

The NCCD Children's Research Center is a nonprofit social research organization and
a division of the National Council on Crime and Delinquency.

Structured Decision Making® and SDM® are
registered in the U.S. Patent and Trademark Office.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® INTAKE TOOL

r: 03/21

Case Name:_____ **Referral #:**_____ **Locality:** _____

FSS Name:_____ **Supervisor:**_____ **Referral Date:**_____

STEP 1: SCREENING ASSESSMENT

Section 1: Maltreatment Type

Physical Neglect
☐ Abandonment
☐ Inadequate supervision
☐ Inadequate basic care (clothing, shelter, personal hygiene, food, and/or malnutrition)
☐ Inadequate medical/dental or mental health care
☐ Non-organic failure to thrive attributed to physical neglect
☐ Other physical neglect

Provide detail:

Substance-Exposed Infant
☐ Fetal alcohol spectrum disorder
☐ Mother's controlled substance abuse during pregnancy
☐ Infant affected by controlled substance
☐ Withdrawal symptoms

Mental Abuse or Neglect
☐ Emotional or psychological abuse or neglect
☐ Verbal threat of serious/life-threatening physical harm toward a child
☐ Exposure to domestic violence
☐ Non-organic failure to thrive attributed to mental abuse or neglect

© 2021 by NCCD, All Rights Reserved

Physical Abuse

☐ Non-accidental or suspicious injury to a child by a caretaker
☐ Poisoning of a child by a caretaker
☐ Munchausen syndrome by proxy
☐ Caretaker action(s) indicates excessive force or force that would reasonably cause injury
☐ Exposure to drug-related activity
☐ Other physical abuse

Provide detail:

Sexual Abuse

☐ Sexual contact, exploitation, or trafficking
☐ Disclosure by a child
☐ Physical, behavioral, or suspicious indicators consistent with sexual abuse
☐ Other sexual abuse

Provide detail:

Section 2: Screening Decision

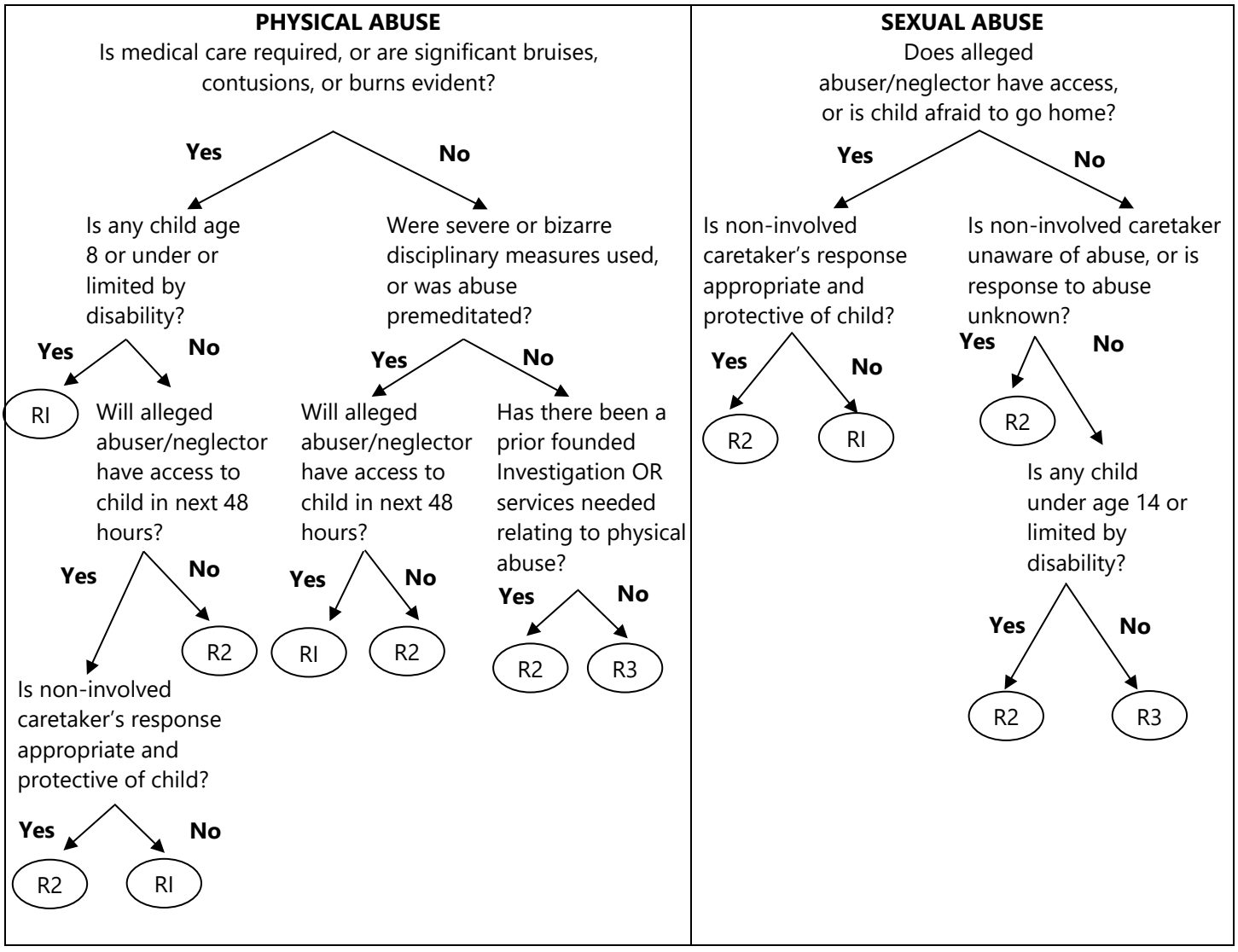
Validated as CA/N:

○ Yes *(Continue to Step 2, Response Priority)*
○ No *(Check all alternative actions. Do not complete Response Priority)*:
☐ Preventive service referral
☐ Law enforcement
☐ Information passed on to FSS
☐ Judicial referral
☐ Other: _____

© 2021 by NCCD, All Rights Reserved

STEP 2: RESPONSE PRIORITY

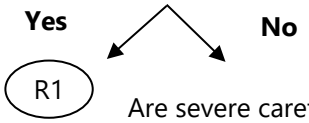
Section 1: Decision Trees



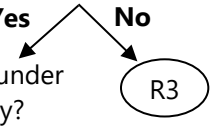
© 2021 by NCCD, All Rights Reserved

PHYSICAL NEGLECT

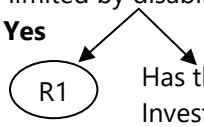
Is the living situation immediately dangerous; is any child currently left unsupervised who is age 8 or under or too disabled to care for self; does child appear seriously ill or injured and in need of immediate medical care; is caretaker not available and no provision for care has been made; or is the child currently alone with, or repeatedly left alone with, a non-related violent sex offender?



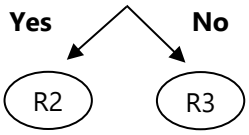
Are severe caretaker substance abuse, developmental disabilities, or mental illness issues present, AND no other appropriate caretaker is present?



Is any child age 8 or under or limited by disability?

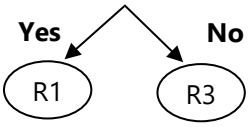


Has there been a prior founded Investigation OR services needed relating to maltreatment?



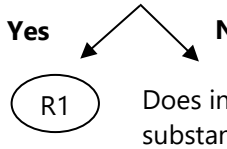
SUBSTANCE-EXPOSED INFANT

Is the substance-exposed infant under age 2?

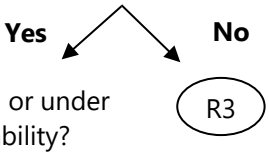


MENTAL ABUSE OR NEGLECT

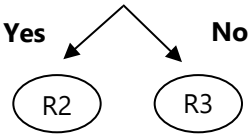
Is caretaker's behavior toward child extreme, severe, or bizarre; or does child's behavior put self at risk and caretaker does not respond appropriately?



Does information show observable and substantial impairment in child's ability to function in a developmentally appropriate manner?



Is any child age 8 or under or limited by disability?



Section 2: Overrides

Policy Override
Shall increase to R1 whenever:

☐ a. Family is about to flee or has a history of fleeing;
☐ b. Forensic Investigation would be compromised if Investigation/Family Assessment is delayed;
☐ c. Law enforcement is requesting immediate response;
☐ d. Child victim is under age 2; or
☐ e. Allegation is exposure to drug-related activity and involves a meth lab.

May decrease by one priority level whenever:

☐ a. Child is in alternate safe environment; or
☐ b. A substantial period of time has passed since the incident occurred.

© 2021 by NCCD, All Rights Reserved

Discretionary Override *(requires supervisor approval)***:**
☐ Increase
☐ Decrease

Reason: _____

FINAL ASSIGNED RESPONSE TIME
R1 = as soon as possible within 24 hours
R2 = as soon as possible within 48 hours
R3 = as soon as possible within 40 work hours

STEP 3: DIFFERENTIAL RESPONSE DECISION
Select either Investigation or Assessment, and select all applicable reasons within column.

○ Investigation

Mandatory Investigation reasons (if one or more apply, MUST be assigned as Investigation):
☐ Sexual abuse
☐ Child fatality
☐ Serious injury per 18.2-371.1
☐ Child taken into custody due to child abuse/neglect (CA/N)
☐ Child taken into custody due to Safe Haven
☐ Child taken into custody by physician or law enforcement
☐ Out-of-Family
☐ Third valid report within 12 months
☐ Child has been left alone in the same dwelling with a person to whom the child is not related by blood or marriage and who has been convicted of an offense against a minor for which registration is required as a violent sexual offender per 9.1-902

Suggested Investigation reasons:

Physical Abuse
☐ Injury is serious, but less serious than 18.2-371.1
☐ Injury requires medical evaluation, treatment, or hospitalization

Mental Abuse or Neglect
☐ Serious distress or impairment of child
☐ Emotional needs not met or severely threatened

Physical Neglect
☐ Serious injury or illness due to lack of supervision
☐ Injury or threat of injury due to weapons in home
☐ Non-organic failure to thrive of infant at imminent risk of severe harm
☐ Abandonment

☐ Other: _____

© 2021 by NCCD, All Rights Reserved

○ **Assessment**

☐ No Mandatory Investigation Circumstances Are Present (must be selected if Assessment is selected)
Note: Select for all valid substance-exposed infant reports, in which that is the only allegation

Suggested Assessment Reasons:

Physical Abuse
☐ No injury, or injury that does not require medical treatment

Mental Abuse or Neglect
☐ Minor distress or impairment
☐ Emotional needs sporadically met and behavioral indicators of impact
☐ Exposed to domestic violence but no immediate threat of harm

Physical Neglect
☐ Lack of supervision but child not in danger at time of report
☐ Inattention to safety results in no or minor injuries

☐ Other: _____

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® SCREENING ASSESSMENT DEFINITIONS

STEP 1: SCREENING ASSESSMENT

Section 1: Maltreatment Type

Physical Neglect occurs when a parent or other person responsible for a child's care neglects or refuses to provide care necessary for the child's health; when a child is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian, or other person standing in loco parentis; when parent(s) or other person(s) responsible for the child's care abandons the child.

Abandonment: Conduct or actions by the caretaker implying a disregard of caretaking activities including extreme lack of interest or commitment to the child, or leaving the child without a caretaker and without making proper arrangements for the care of the child.

This may include a caretaker disregarding their caretaker duties, obligations, and responsibilities by failing to make reasonable efforts to locate the child when the child has run away and/or is missing. Reasonable efforts include but are not limited to contacting local law enforcement to make a report that the child has run away and/or is missing.

Inadequate supervision: The child has been left in the care of an inadequate caretaker or in a situation requiring judgment or actions greater than the child's level of maturity, physical condition, and/or mental abilities would reasonably dictate.

OR;

Caretaker provides minimal care or supervision such that the child is placed in jeopardy of sexual or other exploitation, physical injury, or that results in status offenses, criminal acts by the child, or alcohol or drug abuse.

OR;

Caretaker allows, encourages, or engages in sex trafficking of the child.

Examples may include but are not limited to the following.

- Caretaker ignored/disregarded pertinent information about either the child's behavior history or self-management abilities.
- Exposure to an incident of domestic violence. *Note*: *Consider physical abuse or mental abuse/neglect that may be the result of exposure to domestic violence.*

© 2021 by NCCD, All Rights Reserved

- Caretaker locks the child in or out, or expels the child from the home.

- Caretaker fails to protect the child from abuse/neglect and/or allows continued access to the child by someone the caretaker knows has previously maltreated the child.

- Caretaker leaves the child alone in the same dwelling with a person not related by blood or marriage who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to § 9.1-902.

- Caretaker is physically and/or mentally incapacitated, or caretaker's use of substances severely limits performing of childcare tasks.

Inadequate basic care (clothing, shelter, personal hygiene, food, and/or malnutrition):
Note: Family poverty and lack of outside resources in and of themselves may not be justification for selection of this item. Consider providing appropriate services to the family.

- *Inadequate clothing*—Failure to provide appropriate and sufficient clothing for environmental conditions, or failure to provide articles of proper fit that do not restrict physical growth and normal activity.

- *Inadequate shelter*—Failure to provide protection from the weather and observable environmental hazards in and around the home that have the potential for injury or illness.

- *Inadequate personal hygiene*—Failure to provide the appropriate facilities for personal cleanliness to the extent that illness, disease, or social ostracism has occurred or may occur. In the case of a young child, the caretaker must not only provide such facilities but also make use of them for the child.

- *Inadequate food*—Failure to provide and ensure an acceptable quality and quantity of diet to the extent that illness, disease, developmental delay, or impairment has occurred or may result.

- *Malnutrition*—Chronic lack of necessary or proper nutrition in the body caused by inadequate food, lack of food, or insufficient amounts of vitamins or minerals. This condition requires a medical diagnosis.

Inadequate medical/dental or mental health care: The failure by the caretaker to obtain and/or follow through with a complete regimen of medical, mental, or dental care for a condition that if untreated could result in illness or developmental delays.

Examples may include but are not limited to the following.

© 2021 by NCCD, All Rights Reserved

- Caretaker is failing to seek, obtain, or follow through with medical attention for a specific moderate-to-serious medical or dental injury, illness, or condition for a child, including failure to use prescribed drugs (consider medication, medical condition, adverse effect, injury to self or other). Include emergency treatment, necessary care or treatment, and necessary dental care or treatment.

- Caretaker is failing to seek, obtain or follow through with mental health services and intervention for a child in need of treatment or evaluation (includes suicide threats or attempts, severe emotional disorders, exhibiting behaviors dangerous to self or others, etc.).

Non-organic failure to thrive attributed to physical neglect: Failure to thrive occurs as a syndrome of infancy and early childhood that is characterized by growth failure and signs of severe malnutrition.

To select this item, it must be reported by a health care professional with reasonable suspicion that the condition is due to non-organic factors.

Other physical neglect: If the child has suffered a type of physical neglect that is not one of the above specified types, the CPS worker may document the type as "Other physical neglect" and specifically describe the type of physical neglect.

"Other physical neglect" may be selected when circumstances or conditions are present that are likely to result in failure to meet the child's basic needs in the near future to the extent that the child's health or safety is endangered.

Substance-Exposed Infant
Select this item when a health care professional reports any of the following.

Fetal alcohol spectrum disorder: An infant has fetal alcohol spectrum disorder (FASD). Including diagnosis of FASD up to age 5.

Mother's controlled substance abuse during pregnancy: An infant has an illness, disease, or condition attributable to mother's controlled substance abuse during pregnancy.

Infant affected by controlled substance: An infant is affected by controlled substances.

Withdrawal symptoms: An infant is experiencing withdrawal symptoms resulting from in utero drug exposure.

© 2021 by NCCD, All Rights Reserved

Mental Abuse or Neglect occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a mental injury by other than accidental means, or creates a substantial risk of impairment of mental functions.

Emotional or psychological abuse or neglect: A pattern of behavior or a severe single incident directed toward a child (e.g., berating, name calling, rejection, bizarre discipline) by a caretaker that interferes with that child's normal daily functioning and can be linked to psychological or physical ailments of the child.

Verbal threat of serious/life-threatening physical harm toward a child: Includes gestures/statements made by the caretaker or the caretaker's behavior, such as stating a fear of harming/killing the child, holding a gun to a child's head, use of a weapon, etc. Evidence of injuries need not be present.

Exposure to domestic violence: Child is exposed to one or more incidents of violence between caretakers that has or may result in demonstrated dysfunction. Exposure to domestic violence may be indicated by the child seeing, hearing, or trying to intervene in the incident of violence, OR the child is known to experience the buildup of tension or aftermath of the assault (e.g., observing victim depression, bruises, or other injuries). Incidents of violence include but are not limited to physical conflict; sexual assault; verbal altercations that include coercion, intimidation, or threats; manipulation or control of children; isolation; or unreasonable control of the adult victim.

When assessing referrals for exposure to domestic violence, consider that some conflict between caretakers is a normal part of a relationship and *is not necessarily* a child protection concern.

Note: *Consider physical abuse and physical neglect that may be the result of exposure to domestic violence*.

Non-organic failure to thrive attributed to mental abuse: Failure to thrive occurs as a syndrome of infancy and early childhood that is characterized by variable degrees of developmental delays.

To select this item, it must be reported by a health care professional with reasonable suspicion that the condition is due to non-organic factors.

Physical Abuse occurs when a caretaker creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon a child a physical injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily functions.

© 2021 by NCCD, All Rights Reserved

Non-accidental or suspicious injury to a child by a caretaker: Suspicious injuries (including injuries that are old, healed, or healing) include injuries that are inconsistent with the caretaker's explanation; multiple inconsistent explanations for injuries; marks that resemble objects such as extension cords, belts, etc.; and/or injuries located in unusual areas of the body, such as the inner thigh, ears, torso, etc. Include asphyxiation, bone fracture, head injury/abusive head trauma, burns/scalding, cuts/bruises/welts/abrasions, internal injuries, sprains/dislocation, gunshot/stab wounds, battered child syndrome, shaken baby syndrome (include injury to child sustained during domestic violence incident).

Note: *Old, healed, or healing injuries that have gone untreated and appear suspicious as reported by a health care professional can be considered for this.*

Poisoning of a child by a caretaker: This includes ingestion, inhalation, injection, or absorption of any substance given to a child that interferes with normal physiological functions. The term "poison" implies an excessive amount as well as a specific group of substances. Virtually any substance can be poisonous if consumed in sufficient quantity.

Munchausen syndrome by proxy: A caretaker falsifies a child's medical history, alters a child's laboratory test, or actually causes an illness or injury in a child in order to gain medical attention for the child, which may result in innumerable harmful hospital procedures. This classification must be supported by medical evidence.

Caretaker action(s) indicates excessive force or force that would reasonably cause injury: Injuries may not have occurred or be visible, such as injuries to a child that are the result of being hit with a fist, choked, etc. Include bizarre discipline practices that result or could result in physical harm.

Exposure to drug-related activity: Allowing child to be present during the sale or manufacture of controlled substances.

Other physical abuse: If the child has suffered a type of physical abuse that is not specified above, the CPS worker may document the type as "Other physical abuse" and specifically describe the type of physical abuse.

"Other physical abuse" may be selected when circumstances exist where the child has not yet experienced harm and there have been no apparent abusive actions, but it can reasonably be concluded that if the circumstances continue without change, significant harm will likely occur in the near future to the extent that the child's health or safety is endangered.

Sexual Abuse occurs when a caretaker(s) or other person(s) responsible for child's care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law.

© 2021 by NCCD, All Rights Reserved

Sexual contact, exploitation, or trafficking: Acts involving a child (under age 18) by a caretaker that may include reports of sibling/adolescent sexual contact where a clear caretaker role exists or there is significant age difference between the siblings; or consensual sex involving a child with a person who has care, custody, and control.

Examples of sexual *contact* may include but are not limited to the following.

- Caretaker intentionally touches child's intimate parts or the clothing directly covering such intimate parts.
- Caretaker forces child to touch caretaker's, child's, or another person's intimate parts or clothing directly covering such intimate parts.
- Caretaker forces another person to touch child's intimate parts or clothing directly covering such intimate parts. "Intimate parts" means the genitalia, anus, groin, breast, or buttocks of any person.
- Caretaker causes or assists a child under the age of 13 to touch caretaker's, child's own, or another person's intimate parts or material directly covering such intimate parts.
- Caretaker engages child in intercourse or sodomy, including acts commonly known as oral sex (cunnilingus, anilingus, and fellatio), anal penetration, vaginal intercourse, and inanimate object penetration.

Examples of sexual *exploitation* may include but are not limited to the following.

- Caretaker of the child allows, permits, or encourages a child to engage in prostitution as defined by the Code of Virginia.
- Caretaker of the child allows, permits, encourages, or engages in the obscene or pornographic photographing, filming, or depicting of a child engaging in any sexual act as defined by the Code of Virginia.

Examples of sexual *trafficking* may include but are not limited to the following.

- Caretaker allows, encourages, or engages in sex trafficking of child. Sex trafficking means the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act.

Disclosure by a child: A child has disclosed an incident of sexual abuse by someone who had care, custody, and control at the time of the alleged incident, whether or not a specific offender is identified.

© 2021 by NCCD, All Rights Reserved

Physical, behavioral, or suspicious indicators consistent with sexual abuse: This includes actions reported by a mandated reporter, even without disclosure.

Other sexual abuse: Most types of sexual abuse a child may suffer can be defined as one of the specified types. However, if the child has suffered a type of sexual abuse that is not one of those specified, the CPS worker may document the type as "Other sexual abuse" and specifically describe the type of sexual abuse. Other sexual abuse may include but is not limited to the following.

- Indecent solicitation of a child or explicit verbal or written enticement for the purpose of sexual arousal, sexual stimulation, or gratification.
- Exposing the male or female genitals, pubic area, or buttocks; the female breast below the top of the nipple; or the depiction of covered or uncovered male genitals in a discernibly turgid state to a child for the purpose of sexual arousal or gratification.
- Forcing a child to watch sexual conduct. "Sexual conduct" includes actual or explicitly simulated acts of masturbation, sodomy, sexual intercourse, bestiality, or physical contact in an act of apparent sexual stimulation or gratification with a person's clothed or unclothed genitals, pubic area, buttocks, or breast.
- French kissing a child younger than 13 years of age by an adult caretaker.

Section 2: Screening Decision

Yes: If one or more maltreatment types are selected in Section 1 and other validation requirements are met (child is under age 18, alleged abuser is caretaker, and jurisdiction exists), select "Yes" (validated as CA/N) and continue to Step 2, Response Priority.

No: If no maltreatment types are selected in Section 1, select "No." There will not be an Investigation or Assessment. There may be alternative actions taken or recommended, however. If so, select all the following alternative actions that apply.

Preventive service referral: The caller was referred to an agency in the community or an existing service program within the agency, such as child support enforcement, private counseling, mediation services, family preservation, homeless prevention, daycare, etc.

Law enforcement: The caller was referred to law enforcement and/or the referral information will be relayed to law enforcement by the worker per policy, but there will be no CA/N Investigation or Assessment in conjunction with law enforcement response.

© 2021 by NCCD, All Rights Reserved

Information passed on to FSS: The caller is providing information for a Family Services Specialist (FSS) on an open case or referral that does not constitute a new referral.

Judicial referral: The caller was referred to the juvenile courts for assistance with visitation, custody matters, CHINS petitions, etc.

Other: Select "Other" if any alternative actions were taken or recommended by the CPS worker and document details of alternative actions.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® RESPONSE PRIORITY DEFINITIONS

PHYSICAL ABUSE

Is medical care required, or are significant bruises, contusions, or burns evident?

- Medical care includes any intervention performed by a health care professional to treat an injury. Do not include forensic medical evaluations solely done for the purpose of documenting injury, or evaluation to determine IF there is an injury.

- Include *significant* bruises, contusions, or burns that did not require medical care. Significance is gauged by considering location (e.g., injuries to soft tissue, face, abdomen, or buttocks are considered more significant than injuries over bony prominences such as elbows, knees, shins); scope (e.g., injuries over multiple body surfaces or covering larger areas are considered more significant than a small, isolated bruise); and recency of injury (e.g., new injuries are considered more significant than old scars). A pattern of injuries apparently inflicted over time should be considered significant.

Is any child age 8 or under or limited by disability?
If the injured child has not reached ninth birthday, or is as vulnerable as a child 8 or under due to known cognitive or physical disability, answer yes. All others, answer no.

Will alleged abuser/neglector have access to child in next 48 hours?
If the alleged abuser/neglector is identified, is it likely that person will be in physical proximity of the child within 48 hours? Also include verbal/written or third-party access if the alleged abuser/neglector has used such indirect contact in an attempt to influence the child's statements or threaten the child in any way.

If the alleged abuser/neglector is unknown, access must be assumed. Answer yes.

Is non-involved caretaker's response appropriate and protective of child?
A non-involved caretaker is one who did not directly participate in the alleged maltreatment of the child. An appropriate and protective response may be characterized by acknowledgment that the alleged abuser/neglector's actions were inappropriate; awareness of and concern for the impact of maltreatment on the child; and acceptance of the child's report of abuse. A protective response may be evidenced by setting limits on the alleged abuser/neglector's contact with the child, involvement with discipline, etc. Consider the emotional and physical ability of the non-perpetrating caretaker to carry out intended protective measures.

© 2021 by NCCD, All Rights Reserved

Were severe or bizarre disciplinary measures used, or was abuse premeditated?

- Did alleged abuser/neglector act in ways that present high potential for serious harm (e.g., throwing a heavy object toward child's head, punching in abdomen)? Did alleged abuser/neglector act in ways that suggest extremely distorted and dangerous concepts of child discipline (e.g., locking in cage, surpassing child's physical or emotional capacity to endure, exposing to severe elements)?

OR

- Is there evidence that alleged abuser/neglector planned in advance to physically harm child? Answer no if caretaker planned in advance to take the action but did not intend the action to cause physical injury.

Will alleged abuser/neglector have access to child in next 48 hours?
If alleged abuser/neglector is identified, is it likely that alleged abuser/neglector will be in physical proximity of the child within 48 hours? Also include verbal/written or third-party access if there is reason to believe the alleged abuser/neglector will attempt to influence the child's statements or threaten the child in any way.

If the alleged abuser/neglector is unknown, access must be assumed. Answer yes.

Has there been a prior founded Investigation OR services needed relating to physical abuse?
Include any prior Investigation/Family Assessment that was founded or where services were indicated *for physical abuse* (Investigations/Assessments determined to be unfounded and screened out reports are excluded).

SEXUAL ABUSE

Does alleged abuser/neglector have access, or is child afraid to go home?

- If alleged abuser/neglector is identified, is it likely that the alleged abuser/neglector will be in physical proximity of the child within 48 hours? Also include verbal/written or third-party access if the alleged abuser/neglector has used such indirect contact to influence the child's statements or threaten the child in any way. If the alleged abuser/neglector is not identified, also answer yes.

- Does child express fear (verbally or nonverbally) of remaining at or returning home?

© 2021 by NCCD, All Rights Reserved

Is non-involved caretaker's response appropriate and protective of child?
A non-involved caretaker is one who did not directly participate in the alleged maltreatment of the child. An appropriate and protective response may be characterized by acknowledgment that the alleged abuser/neglector's actions were inappropriate; awareness of and concern for the impact of maltreatment on the child; and acceptance of the child's report of abuse. A protective response may be evidenced by obtaining medical evaluation, if indicated, and discontinuing contact between alleged abuser/neglector and child. Consider the emotional and physical ability of the non-perpetrating caretaker to carry out intended protective measures. Any attempt by the caretaker to influence the child's statement one way or the other is considered an inappropriate response.

Is non-involved caretaker unaware of abuse or is response to abuse unknown?
Answer yes if:

- Report is from a third party and non-involved caretaker has not yet been informed of the allegation;

- Non-involved caretaker may have learned of the alleged abuse, but caller has no information concerning caretaker's reaction.

Is any child under age 14 or limited by disability?
If the child has not reached 14th birthday, or is as vulnerable as a child under age 14 due to known cognitive or physical disability, answer yes. All others answer no.

PHYSICAL NEGLECT

Is the living situation immediately dangerous; is any child currently left unsupervised who is age 8 or under or too disabled to care for self; does child appear seriously ill or injured and in need of immediate medical care; is caretaker not available and no provision for care has been made; or is the child currently alone with, or repeatedly left alone with, a non-related violent sex offender?
Answer yes if the following:

- 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:

  » Exposure to animals known to be a danger;

  » Unsafe heating or cooking equipment;

  » Substances or objects accessible to the child that may endanger the health and/or safety of the child;

© 2021 by NCCD, All Rights Reserved

- » Lack of water or utilities (heat, plumbing, electricity) and no alternate or safe provisions are made;
- » Exposed electrical wires;
- » Excessive garbage or rotted or spoiled food that threatens health;
- » Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites);
- » Evidence of human or animal waste throughout living quarters;
- » Guns and other weapons are accessible to child;
- » Complete or near-complete absence of food.

OR

- Child is age 8 or under or is as vulnerable as a child age 8 or under due to known cognitive or physical disability AND:
  - » Child is currently alone or is scheduled to be alone within the next 48 hours;
  - » Caretaker does not attend to child to the extent that need for care goes unnoticed or unmet (e.g., caretaker is present but child can play with dangerous objects or be exposed to other serious hazards);
  - » Child is being supervised by an alternate caretaker who is unable to meet child's immediate needs for care and supervision.

OR

- Child's unmet medical need may result in serious harm, serious aggravation of symptoms, increased risk of long-term or permanent injury or impairment, or death if not treated within 48 hours. Examples include but are not limited to the following:
  - » Apparent bone injury that has not been set;
  - » Apparent second- or third-degree burn that has not been medically evaluated;
  - » Untreated dehydration;

© 2021 by NCCD, All Rights Reserved

» Breathing difficulties;

» Severe abdominal pain;

» Loss of consciousness or altered mental status;

» Failure to thrive;

» Untreated exposure to the elements; frostbite.

OR

Caretaker:

- Left the child without affording means of identifying the child and the child's caretaker;
- Is absent from the home for a period of time that creates a substantial risk of serious harm to a child left in the home;
- Left the child with another person without provision for the child's support and the other person is no longer able or willing to provide care.
- Caretaker has currently left, or repeatedly leaves, the child alone in the same dwelling as a person not related by blood or marriage who has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to § 9.1-902.

Are severe caretaker substance abuse, developmental disabilities, or mental illness issues present, AND no other appropriate caretaker is present?
Answer yes if *caretaker*:

- Is currently impaired by alcohol or other controlled substances to the extent that they are not providing for the child's needs for care and safety, and this has resulted or is likely to result in injury, illness, or harm to the child;
- Is cognitively impaired to the extent that they lack basic understanding of child's needs for care and supervision, and this lack of understanding has resulted or is likely to result in injury, illness, or harm to the child; and/or
- Is mentally ill to the extent that they are unable to meet child's needs for care and supervision, and this has resulted or is likely to result in injury illness, or harm to the child. Examples include but are not limited to the following:

© 2021 by NCCD, All Rights Reserved

» Loss of touch with reality;

» Paranoid thoughts, especially those in which child may be seen as evil;

» Severe depression that interferes with ability to function at even most basic levels;

» Suicidal ideation (includes all direct or indirect threats, attempts, or behavioral indicators of suicidal ideation);

AND

- No other adult is present who is able to provide for the child's protection and care.

Is any child age 8 or under or limited by disability?
If any child has not reached ninth birthday, or is as vulnerable as a child 8 or under due to known cognitive or physical disability, answer yes. All others, answer no.

Has there been a prior founded Investigation OR services needed relating to maltreatment?
Include any prior Investigation/Family Assessment that was founded or where services were indicated for maltreatment (Investigations/Assessments determined to be unfounded and screened out reports are excluded).

MENTAL ABUSE OR NEGLECT

Is caretaker's behavior toward child extreme, severe, or bizarre; or does child's behavior put self at risk and caretaker does not respond appropriately?
Examples of extreme, severe, or bizarre behavior include the following.

- Caretaker threatens to harm self in child's presence.

- Bizarre forms of discipline are used to shame or cause other negative emotional impact on the child (e.g., forcing child to wear inappropriate clothing, such as a 10-year-old being forced to wear diapers—this should NOT include incidents of inappropriate clothing due to poverty or current fashion).

- People or pets are murdered or tortured in front of child.

© 2021 by NCCD, All Rights Reserved

- Child is subjected to extreme rejection from family (e.g., abnormally long time-outs based on child's age and developmental level; family acts as if child does not exist).

- Child is singled out for detrimental treatment.

- Caretaker is constantly belittling child or has unrealistic expectations of child.

OR

- Child is suicidal, self-mutilating, or engaging in other behavior that has caused or is likely to cause serious physical injury or death, AND caretaker is unable or unwilling to provide monitoring, support, mental health services, or hospitalization necessary to protect child.

Does information show observable and substantial impairment in child's ability to function in a developmentally appropriate manner?
Examples include chronic somatic complaints; enuresis/encopresis not due to medical condition; long-term withdrawal/depression/isolation from family or school activities; severe aggressive behavior; cruelty toward animals.

Is any child age 8 or under or limited by disability?
If any child has not reached ninth birthday, or is as vulnerable as a child 8 or under due to known cognitive or physical disability, answer yes. All others, answer no.

SUBSTANCE-EXPOSED INFANT

Is the substance-exposed infant under age 2?
If the substance-exposed infant is under the age of 2, select "Yes," as an R1 response is required. If the substance-exposed child is over the age of 2, select "No," as an R3 response is indicated in the absence of any other allegation types.

OVERRIDES

Policy Override
Shall increase to R1 under the following circumstances.

- Family is about to flee or has a history of fleeing: Family is preparing to leave the jurisdiction to avoid Investigation/Family Assessment, or family has fled in the past.

© 2021 by NCCD, All Rights Reserved

- Forensic Investigation would be compromised if Investigation/Family Assessment is delayed: Physical evidence may be lost or altered; attempts are being made to alter statements, conceal evidence, or coordinate false statements.

- Law enforcement is requesting immediate response.

- Child victim is under age 2.

- Allegation is exposure to drug-related activity and involves a meth lab.

May decrease by one priority level whenever:

- Child is in alternate safe environment: Child is no longer living where alleged abuse/neglect occurred, or child is temporarily away and will not return for 48 hours if overriding to R2 or 40 work hours if overriding to R3.

- A substantial period of time has passed since the incident occurred: The incident happened long ago, and there is reason to believe no additional incidents have occurred since then.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® INTAKE TOOL
POLICY AND PROCEDURES

The intake tool assists workers with two decisions.

- The purpose of the screening assessment (Step 1) is to assess whether calls meet the definitional criteria for a CA/N Investigation/Family Assessment.

- The response priority decision trees (Step 2) are designed to assist in determining how quickly to initiate the first meaningful contact for assigned Investigations/Assessments. By answering a series of questions, the trees aid in determining the priority level for responding to a case. Each priority level includes a suggested timeframe for response.

  - » Response 1 (R1) = as soon as possible within 24 hours.
  - » Response 2 (R2) = as soon as possible within 48 hours.
  - » Response 3 (R3) = as soon as possible within 40 work hours.

WHICH CASES
The screening assessment (Step 1) is completed for *all calls* alleging CA/N. This includes telephone and all other means of reporting, and includes new reports of CA/N on open cases.

The response priority (Step 2) is completed for all valid reports of CA/N.

WHO
The intake worker.

WHEN
As soon as possible upon receipt of the report.

DECISIONS
The screening assessment (Step 1) assists the worker in determining whether a report meets CA/N Investigation/Family Assessment definitions.

© 2021 by NCCD, All Rights Reserved

The response priority (Step 2) assists workers in determining when they must initiate the first face-to-face contact with the victim. R1 reports require that the first face-to-face contact with the victim occur as soon as possible within 24 hours; R2 reports require that the first face-to-face contact with the victim occur within 48 hours; and R3 reports require that the first face-to-face contact with the victim occur within 40 work hours. The timelines referenced in the decision trees commence at the time the report is made.

APPROPRIATE COMPLETION

Step 1: Screening Assessment

In Section 1, select the specific criteria for all allegations indicated in the report under the appropriate maltreatment category.

In Section 2, indicate whether the report is being validated as a CA/N report by selecting either "Yes" or "No." If any maltreatment criteria were selected and the other validity criteria are met (child under age 18, alleged abuser/neglector is a caretaker, and jurisdiction exists), the report should be validated as CA/N. Reports that do not meet any of the screen-in criteria should not be validated as CA/N reports.

For reports that are not validated as a CA/N report, indicate whether the referral meets criteria for some alternative action (e.g., preventive service referral).

Step 2: Response Priority

Information gathered by agency staff must be analyzed to assess the urgency for response. The response priority decision trees structure this analysis to determine a response priority level. The decision trees ask a series of questions depending on the type of alleged maltreatment (physical abuse, sexual abuse, physical neglect, substance-exposed infant, and mental abuse or neglect). Answers to each question, consisting of "yes" or "no" responses, will lead to another question, and ultimately, a response priority level.

If more than one type of maltreatment is alleged, complete all applicable decision trees to determine the most urgent response priority level.

Overrides

After reviewing all necessary decision trees, consider whether an override should be applied.

A policy override to R1 shall be applied whenever:

- Family is about to flee or has a history of fleeing;

© 2021 by NCCD, All Rights Reserved

- Forensic Investigation would be compromised if Investigation/Assessment is delayed;

- Law enforcement is requesting immediate response;

- Victim child is under age 2;

- Allegation is exposure to drug-related activity and involves a meth lab.

A policy override may be used to decrease response by one level whenever:

- Child is in an alternate safe environment;
- A substantial period of time has passed since the incident occurred.

A discretionary override may be applied if, after completion of all necessary decision trees and application of policy overrides, worker and supervisor determine that there are unique conditions not captured by the tool that warrant a different response priority. A discretionary override may increase or decrease the response time by one level.

Step 3: Differential Response Decision

The final step in assigning a valid referral is to determine whether the referral will be assigned as an Investigation or an Assessment. These decisions are currently guided by state statute and local policy. The worker will check whether the referral is assigned as an Investigation or as a Family Assessment and select all applicable reasons for this decision. If assigned as an Assessment, "No Mandatory Investigation Circumstances Are Present" *must* be selected. NOTE THAT THIS IS NOT A STRUCTURED DECISION AT THIS TIME.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® SAFETY ASSESSMENT

r: 8/20

Case Name: _____ **Case ID:** _____ **Locality:** _____

FSS Name: _____ **Supervisor:** _____

Assessment Date: _____ **Creation Date:** _____

☐ Alternative Caretaker Household

Household Assessed: _____

Factors Influencing Child Vulnerability (conditions that may limit a child's ability to protect self; select any factors that apply to any child)

☐ Age 0–5 years

☐ Any child has diminished developmental/cognitive capacity or exceptional mental health condition

☐ Any child has diminished physical capacity or exceptional medical condition

☐ Any child is not readily accessible to community oversight

SECTION 1: SAFETY FACTOR IDENTIFICATION

The following list of factors are behaviors or conditions that may be associated with a child being in **immediate** danger of serious harm. Identify the presence or absence of each factor by selecting "Yes" or "No." Select "Yes" if the factor applies to any child in the household. The assessment shall cover all children in the home and all others present. The focus of the assessment is on conditions that exist at the time of the assessment.

O Yes O No 1. Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current Investigation/Family Assessment.

Comments:

O Yes O No 2. Caretaker's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.

Comments:

© 2021 by NCCD, All Rights Reserved

○ Yes ○ No **3. There is evidence that the mother used alcohol or other drugs during pregnancy, AND current circumstances suggest the infant's safety is of immediate concern.**

Comments:

○ Yes ○ No **4. The family is refusing access to the child or there is reason to believe that the family is about to flee, AND available information suggests that child safety is of immediate concern.**

Comments:

○ Yes ○ No **5. Caretaker does not provide supervision necessary to protect child from potentially serious harm.**

Comments:

○ Yes ○ No **6. Caretaker fails to protect child from serious physical harm or threatened harm by others.**

Comments:

○ Yes ○ No **7. Domestic violence exists in the home, AND circumstances suggest that child safety (physical and/or emotional) is of immediate concern.**

Comments:

○ Yes ○ No **8. Caretaker is unwilling or unable to meet the child's most basic needs (food, clothing, shelter, and/or medical/dental/mental health care), AND this causes the child to be in imminent danger.**

Comments:

© 2021 by NCCD, All Rights Reserved

O Yes O No **9. Child's physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status.**

Comments:

O Yes O No **10. Caretaker actions cause significant and excessive emotional distress for the child, AND available information suggests that child safety is of immediate concern.**

Comments:

O Yes O No **11. Child sexual abuse is suspected, AND circumstances suggest that child safety is an immediate concern.**

Comments:

O Yes O No **12. Current circumstances, combined with information that the caretaker has or likely has seriously maltreated a child in the past, suggests that child safety may be an immediate concern.**

Comments:

O Yes O No **13. Other safety factors.**

Comments:

IF NO SAFETY FACTORS ARE PRESENT, GO TO SECTION 3 AND SELECT "SAFE."

© 2021 by NCCD, All Rights Reserved

SECTION 2: SAFETY RESPONSE—PLANNING CAPACITIES AND PROTECTING INTERVENTIONS

For each safety factor identified in Section 1, consider the resources available to the family and the community that might help to keep the child safe. Select each protecting intervention taken to protect the child and explain below. Describe all protecting safety interventions taken or immediately planned by you or anyone else, and explain how each intervention protects (or protected) each child.

Planning Capacities

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

☐ 1. Caretaker is capable of participating in a safety plan
☐ 2. Caretaker is willing to participate in a safety plan
☐ 3. Caretaker has at least one supporting safe adult who was not involved in the allegation and is willing and able to participate in a safety plan

Other

☐ 4. _____

Protecting Interventions

Considering each identified safety threat and available planning capacities, determine which of the following protecting interventions will be implemented to control the safety threat. Protecting interventions will allow the child to remain in the home for the present time. A safety plan is required to systematically describe interventions and facilitate follow-through. If there are no available safety interventions that would allow the child to remain in the home, indicate by selecting item 9, and follow procedures for initiating court action to file for custody.

☐ 1. Monitoring or direct services by Family Services Specialist
☐ 2. Use of family resources, neighbors, or other individuals in the community in the development and implementation of a safety plan
☐ 3. Use of community agencies for safety services (specify agency or resource):

☐ 4. Alleged abuser/neglector left the home:
  ☐ Voluntarily
  ☐ In response to police intervention
  ☐ Legal action
  ☐ Other: _____
☐ 5. Non-maltreating caretaker moved to a safe environment with child
☐ 6. Caretaker placed child outside the home with an alternate safe caretaker (specify): _____
☐ 7. Legal action initiated; child remains in the home (explain in summary)
  ☐ Restraining order
  ☐ Protective order
  ☐ Emergency committal order
  ☐ Change in custody/visitation/guardianship
  ☐ Other, specify: _____
☐ 8. Other intervention to allow child to remain in the home: _____
☐ 9. Emergency removal was conducted to remove child from home due to immediate safety issues

© 2021 by NCCD, All Rights Reserved

SECTION 3: SAFETY DECISION

Identify your safety decision by selecting the appropriate line. Select only one. This decision should be based on the assessment of all safety factors, protecting interventions, and any other information known about the case. "Safe" should be selected only if no safety factors were identified in Section 1, Safety Factor Identification.

○ 1. **Safe:** No children are likely to be in immediate danger of serious harm.

○ 2. **Conditionally safe:** Protective safety interventions have been taken and have resolved the unsafe situation for the present time. These interventions are included in the attached safety plan.

○ 3. **Unsafe:** Approved removal and placement was the only possible intervention for the child. Without placement, the child will likely to be in danger of immediate or serious harm. See attached safety plan or court order.

Comments:

If decision is "unsafe" and any children are left in the home, explain why:

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® SAFETY ASSESSMENT
DEFINITIONS

FACTORS INFLUENCING CHILD VULNERABILITY

Age 0 to 5 years

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

Any child has diminished developmental/cognitive capacity or exceptional mental health condition

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

OR

Any child in the household has a mental health condition that significantly impairs ability to protect self from harm (diagnosis may not yet be confirmed but preliminary indications are present). Examples may include but are not limited to severe depression, child/adolescent substance use, or behavioral health challenges.

Any child has diminished physical capacity or exceptional medical condition

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

OR

Any child in the household has a medical condition that significantly impairs ability to protect self from harm (diagnosis may not yet be confirmed but preliminary indications are present). Examples may include but are not limited to severe asthma or medical fragility (e.g., requires assistive devices to sustain life).

Any child is not readily accessible to community oversight

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

© 2021 by NCCD, All Rights Reserved

SECTION 1: SAFETY FACTOR IDENTIFICATION

1. Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current Investigation/Family Assessment
Examples include but are not limited to the following.

- Child fatality or near-fatality, and other children are present in the home.
- Caretaker caused serious injury, other than accidental, such as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, or severe cuts. Also include any other physical injury that seriously impairs the health or well-being of the child (e.g., suffocating, shooting, bruises/welts, bite marks, choke marks) and requires medical treatment.
- Caretaker committed act that placed child at risk of significant/serious pain that could result in impairment or loss of bodily function.
- Threat to cause harm or retaliate against child. Threat of action that would result in serious harm; or household member plans to retaliate against child for CPS Investigation/Family Assessment.
- Caretaker has used excessive physical discipline or force or bizarre physical discipline; or caretaker punished child beyond the duration of the child's endurance.

2. Caretaker's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern
Examples include but are not limited to the following.

- Medical evaluation indicates injury is non-accidental; caretaker denies or attributes injury to accidental causes or there are significant discrepancies or contradictions between caretaker's explanation and medical evaluation.
- Caretaker minimizes the extent of harm to the child or blames the child for the injury.

3. There is evidence that the mother used alcohol or other drugs during pregnancy, AND current circumstances suggest the infant's safety is of immediate concern
Examples include but are not limited to the following.

© 2021 by NCCD, All Rights Reserved

Infant is born with medical complications as a result of in utero substance exposure, and caretaker response suggests inability or unwillingness to meet the infant's exceptional needs.

Caretaker or infant's level of toxicity and/or type of drug present suggests caretaker will be unable to meet the infant's basic needs upon discharge.

Caretaker does not/has not attended to the infant in the hospital.

Behavior of caretaker with inadequate support system suggests caretaker will be unable to meet the infant's basic needs upon discharge.

4. The family is refusing access to the child or there is reason to believe that the family is about to flee, AND available information suggests that child safety is of immediate concern

Examples include but are not limited to the following.

- Family removed the child from a hospital against medical advice to avoid Investigation/Family Assessment.
- Family has previously fled in response to a CA/N Investigation/Family Assessment.
- Family has history of keeping the child away from peers, school, or other outsiders for extended periods to avoid Investigation/Family Assessment.

5. Caretaker does not provide supervision necessary to protect child from potentially serious harm

Examples include but are not limited to the following.

- Caretaker is present but does not attend to 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); and/or caretaker leaves or exposes child to circumstances that create opportunities for serious harm, such as leaving child unattended in vehicle (time period varies with age and developmental stage).
- Caretaker is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).
- Caretaker makes inadequate and/or inappropriate babysitting or childcare arrangements, or demonstrates very poor planning for the child's care.
- Caretaker's substance or alcohol use is having a serious impact on ability to provide adequate supervision to the child.

© 2021 by NCCD, All Rights Reserved

- Caretaker's physical, intellectual, or mental health condition is having a serious impact on ability to supervise the child.

6. Caretaker fails to protect child from serious physical harm or threatened harm by others

Caretaker fails to protect child from serious harm or threatened harm by others, and, as a result, the child is in immediate danger of physical abuse, neglect, sexual abuse, or exploitation by someone with access to the child. This may include but is not limited to the following.

- Caretaker allows an individual(s) with recent, chronic, or severe violent behavior access to child.

- Caretaker knowingly takes child to dangerous locations where drugs are manufactured or sold (e.g., meth labs or drug houses) or to locations used for prostitution or production of pornography.

7. Domestic violence exists in the home, AND circumstances suggest that child safety (physical and/or emotional) is of immediate concern

Examples include but are not limited to the following.

- Child was aware of, witnessed, or heard a domestic violence incident.

- Child was injured (physical or emotional) during a domestic violence incident.

- Caretaker used a weapon during a domestic violence incident OR has used one in the past when the children were present.

- Child attempted to intervene OR has intervened in the past during a domestic violence incident.

- Child is fearful for own safety OR for the safety of a caretaker as a result of domestic violence in the home.

- Caretaker is unable to self-protect or protect child during incidents of domestic violence.

- Domestic violence in the home is increasing in frequency or intensity.

- Other indicators exist of highly dangerous domestic violence situations such as stalking, hostage taking or abduction, abuse of animals, or other controlling behaviors.

© 2021 by NCCD, All Rights Reserved

8. Caretaker is unwilling or unable to meet the child's most basic needs (food, clothing, shelter, and/or medical/dental/mental health care), AND this causes the child to be in imminent danger

Examples include but are not limited to the following.

- No housing/emergency shelter, and child must sleep on the streets.
- No food provided or available to the child, or child is starved/deprived of food/drink for long periods.
- Child is without minimally warm clothing in cold months.
- Caretaker does not seek treatment for child's immediate medical/dental or mental health condition(s) OR does not follow prescribed treatments.
- Child appears malnourished or has been diagnosed as non-organic failure to thrive.
- Child has exceptional needs that caretaker cannot/will not meet. Needs include being medically fragile.
- Child is a threat to self or others, and caretaker will not take protective action

9. Child's physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status

Examples include but are not limited to the following.

- Gas leaking from a stove or heating unit, windows broken/missing, and/or electrical wires exposed.
- Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink, or in the open.
- Lack of water, heat, plumbing, or electricity, and provisions are inappropriate.
- Excessive garbage or rotted/spoiled food and/or human/animal waste that threatens health.
- Guns and other weapons are easily accessible.
- Dangerous drugs are being manufactured on premises with child present.

© 2021 by NCCD, All Rights Reserved

10. Caretaker actions cause significant and excessive emotional distress for the child, AND available information suggests that child safety is of immediate concern
Examples include but are not limited to the following.

- Child fears unreasonable retribution/retaliation from caretaker and/or others in the home.

- Caretaker repeatedly describes or speaks to child in a demeaning or degrading manner.

- Caretaker repeatedly blames child for a particular incident OR views child as responsible for caretaker's or family's problems.

- Caretaker repeatedly expects child to perform or act in a way that is impossible or improbable for child's age or developmental stage (e.g., babies and young children expected not to cry, to be still for extended periods, to be toilet trained, to eat neatly, to care for younger siblings, or to stay alone).

11. Child sexual abuse is suspected, AND circumstances suggest that child safety is an immediate concern
Suspicions of sexual abuse may include but are not limited to the following.

- Child discloses sexual abuse, exploitation, and/or trafficking. Disclosures can be either verbal or behavioral.

- Medical findings are consistent with sexual abuse.

Circumstances suggesting child safety is an immediate concern include but are not limited to the following.

- The alleged abuser has continued access to the child.
- Caretaker blames child for the sexual abuse.

12. Current circumstances, combined with information that the caretaker has or likely has seriously maltreated a child in the past, suggests that child safety may be an immediate concern
This item requires two conditions to answer "Yes." First, *previous* maltreatment was severe OR the caretaker's response to the *previous* intervention was inappropriate (e.g., failure to take recommended safety steps or failure to benefit from professional help). Second, there must be *current* circumstances that, considered in light of the prior incidents, indicate there are safety issues now. In other words, the fact of prior maltreatment does not necessarily mean that "Yes" should be selected for this safety factor.

© 2021 by NCCD, All Rights Reserved

Examples of prior serious or severe maltreatment include but are not limited to the following.

- Prior child fatality or near-fatality as a result of maltreatment.
- Prior serious non-accidental harm or threat of serious harm to any child.
- Termination of parental rights or failed reunification.

13. Other safety factors

This item should ONLY be used if there are other immediate safety issues not identified above. Any factors in the "other" category require a brief narrative description of the caretaker's actions or inactions that result or could likely result in an immediate danger.

SECTION 2: SAFETY RESPONSE—PROTECTIVE FACTORS AND INTERVENTIONS

1. Caretaker is capable of participating in a safety plan

Caretaker has the cognitive, physical, emotional, and mental health capacity to participate in safety services/interventions. Caretaker is able to follow through with interventions to protect child from further danger.

2. Caretaker is willing to participate in a safety plan

Caretaker is willing to accept the involvement and recommendations of the caseworker or other individuals and agencies providing safety services/interventions. Caretaker is motivated to protect child from further danger.

3. Caretaker has at least one supporting safe adult who was not involved in the allegation and is willing and able to participate in a safety plan

Caretaker has a supportive relationship with at least one other safe family member, neighbor, or friend who may be able to assist in safety planning. This support network member cares about child or family, and caretaker is willing to involve this person in the safety plan.

PROTECTING INTERVENTIONS

1. Monitoring or direct services by Family Services Specialist

Actions taken or planned by the Family Services Specialist that specifically address one or more safety threats. Examples include providing assistance in obtaining safety services, including emergency aid such as food or transportation; planning return visits to the home to check on progress as outlined in the safety plan; providing information and/or assistance in obtaining services and resources; and so forth.

© 2021 by NCCD, All Rights Reserved

2. Use of family resources, neighbors, or other individuals in the community in the development and implementation of a safety plan

Applying the family's own strengths as resources to mitigate safety threats, or using extended family members, neighbors, or other individuals to mitigate safety threats. Examples include having a family member, neighbor, or friend move into the home, do daily checks, provide transportation, assist with childcare, and serve as a safety resource for a child.

3. Use of community agencies for safety services (specify agency or resource)

Community resources used as a safety services should be immediately available to the family and be able to reduce the threat of immediate serious harm. Examples include use of shelters, food pantries, domestic violence agencies, community policing, and other services provided by community agencies or providers. DOES NOT INCLUDE long-term therapy or treatment, being put on a waiting list for services, or delays in contact and initiation of services to the family.

4. Alleged abuser/neglector left the home

Alleged abuser/neglector will temporarily or permanently leave the home voluntarily or in response to police intervention or legal action.

Select any that may apply:

- Voluntarily
- In response to police intervention
- Legal action
- Other

5. Non-maltreating caretaker moved to a safe environment with child

A caretaker not suspected of harming the child has taken or plans to take the child to an alternative location where the alleged abuser/neglector will not have access to the child.

6. Caretaker placed child outside the home with an alternate safe caretaker

A caretaker has asked a family member, friend, or other person in the family's life to care for the child during the time of the safety plan.

7. Legal action initiated; child remains in the home (explain in summary)

A legal action, including one initiated by the family and Family Services Specialist, has already commenced or will commence that will effectively mitigate identified safety factors. *May only be used in conjunction with other safety interventions*.

Select all that apply:

- Restraining orders
- Protective order

© 2021 by NCCD, All Rights Reserved

- Emergency committal orders
- Change in custody/visitation/guardianship
- Other

8. Other intervention to allow child to remain in the home

Consider any existing condition that does not fit within one of the listed categories but may support protective interventions for the safety factors identified.

9. Emergency removal was conducted to remove child from home due to immediate safety issues

There may be protecting interventions present in the home, but they do not adequately address the safety factors identified.

SECTION 3: SAFETY DECISION

Safe: No children are likely to be in immediate danger of serious harm.

Conditionally safe: Protective safety interventions have been taken and have resolved the unsafe situation for the present time. These interventions are included in the attached safety plan.

Unsafe: Approved removal and placement was the only possible intervention for the child. Without placement, the child will likely to be in danger of immediate or serious harm. See attached safety plan or court order.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES SDM® SAFETY ASSESSMENT POLICY AND PROCEDURES

The purpose of the safety assessment and plan is (1) to help assess whether any children are currently in *immediate* danger of serious physical harm that may require a protecting intervention, and (2) to determine what interventions should be maintained or initiated to provide appropriate protection.

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

WHICH CASES

All cases that are assigned for Investigation/Family Assessment.

- New referrals on currently active cases.
- Any open cases in which changing circumstances require an assessment of safety due to the following.
  - » Change in family circumstances.
  - » Change in information known about the family.
  - » Change in ability of safety interventions to mitigate safety factors.

WHO

The Family Services Specialist who makes the initial response to the case. For open cases, the Family Services Specialist with responsibility for the case.

WHEN

Safety assessment is both a *process* and a *document*. Safety assessment is an ongoing *process* throughout the life of a case. A worker completes a safety assessment *process* before concluding each face-to-face contact. *Documentation* of the safety assessment using the SDM tool is created to reflect safety status at certain points:

- Within 24 hours of concluding the first face-to-face contact.
- Within 24 hours of any subsequent contact in which there was a change in safety status:

© 2021 by NCCD, All Rights Reserved

  - » One or more safety factors previously present are no longer present;
  - » One or more safety factors not present before are present now;
  - » Changes to safety plan and/or safety decision.

- Prior to placing a child with a non-custodial parent, relative, or interested individual. (*Note*: These safety assessments should be clearly recorded as pertaining to a household other than the household under Investigation.)

- Prior to returning a child to a removal household. Use the safety assessment if considering return PRIOR to the preliminary removal hearing. AFTER the preliminary removal hearing, use the reunification review tool in Section VIII.

- Prior to closing an ongoing case; children must be SAFE to close.

DECISIONS

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

A safety intervention is required for all children when any safety factor has been identified.

APPROPRIATE COMPLETION

Workers should familiarize themselves with the items that are included in the safety assessment and accompanying definitions. Once a worker is familiar with the items on the safety assessment, the worker should conduct initial contact as normal, using good social work practice to collect information from the child, caretaker, and/or collateral sources.

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

All safety factor responses must have a written rationale and description if the response is "Yes." All rationales must be specific to the family situation (do not simply quote the definition).

All children who are household members are included in a safety assessment.

The safety assessment consists of three parts.

© 2021 by NCCD, All Rights Reserved

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

For this section, rely on information available at the time of the assessment. Workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is not expected that all facts about a case can be known immediately. Some information may be inaccessible, and some may be deliberately hidden from the worker. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the safety factors and accompanying definitions. For each item, consider the most vulnerable child. If the safety factor is present, based on available information, select "Yes." If the safety factor is not present, select "No." If there are circumstances the worker determines constitute a safety factor, and these circumstances are not described by one of the existing items, the worker should select "Yes" for "Other safety factors" and briefly describe the factor.

If it is suspected that there are safety issues in relation to a particular factor, but there is little/no evidence to support the suspicion, select "No," but clearly specify the concerns in the narrative section.

Section 2: Safety Response—Planning Capacities and Protecting Interventions. This section is completed only if one or more safety factors were identified. *If one or more safety factors are present, it does not automatically follow that a child must be placed.* In many cases, it will be possible to initiate a temporary plan that will mitigate the safety factors sufficiently so that the child may remain in the home while the Investigation/Family Assessment continues. Consider the relative severity of the safety factor(s), the caretaker's ability and willingness to work toward solutions, the availability of resources, and the vulnerability of the child.

The protecting safety interventions list is made up of general categories of interventions rather than specific programs. The worker should consider each potential category of intervention and determine whether that intervention is available and sufficient to mitigate the safety factor(s) and whether there is reason to believe the caretaker will follow through with a planned intervention. The simple existence of an intervention 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 caretaker would not follow through. Also keep in mind that *the safety intervention is not the service plan*—it is not intended to "solve" the household's problems or provide long-term answers. A safety intervention permits a child to remain home during the course of the Investigation/Family Assessment.

© 2021 by NCCD, All Rights Reserved

If one or more safety factors were identified and the worker determines that interventions are unavailable, insufficient, or may not be used, the final option is to indicate that child will be placed.

If one or more interventions will be implemented, select each category that will be used. If there is an intervention that will be implemented that does not fit the other categories, select intervention 8 (Other intervention to allow child to remain in the home) and briefly describe the intervention. Intervention 9 (Emergency removal was conducted to remove child from home due to immediate safety issues) is used only when a child is unsafe and only a placement can ensure safety.

Section 3: Safety Decision. In this section, the worker records the result of the safety assessment. There are three choices:

a. Safe. Select this line if *no* safety factors were identified. The SDM system guides the worker to leave the child in the home.

b. Conditionally safe. If one or more safety factors has been identified and the worker is able to identify sufficient protective interventions that lead the worker to believe the child may remain in the home for the present time, select this line. Attach safety plan.

c. Unsafe. If the worker determines that one or more children cannot be safely kept in the home even after considering a complete range of interventions, select this line. It is possible that the worker will determine that interventions make it possible for one child to remain in the home while another must be removed. Select this line if ANY child is placed. Ensure that the court report or order is in the hard copy record.

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

- If no safety factors are selected, no interventions should be selected, and the only possible safety decision is "1. Safe," and no intervention is required.
- If one or more safety factors are selected, there must be at least one intervention selected, and the only possible safety decisions are"2. Conditionally safe," intervention is required, or "3. Unsafe," placement is required.
- If one or more interventions are selected, AND placement is not selected as an intervention, the safety decision that should be selected is "2. Conditionally safe," intervention is required. Placement should not be selected as an intervention if other interventions are selected.
- If placement is selected as an intervention, the safety decision must be "3. Unsafe," and placement is required

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY RISK ASSESSMENT

r: 8 /20

Case Name: _____ **Case ID:** _____ **Locality:** _____

FSS Name: _____ **Supervisor:** _____

Assessment Date: _____ **Creation Date:** _____

Primary Caretaker: _____ **Secondary Caretaker:** _____

Prior Assessments: _____ **Prior Investigations:** _____

	NEGLECT	Score
N1.	Current complaint is for neglect O a. No..... 0 O b. Yes 2	
N2.	Number of prior neglect Investigations/Assessments O a. None..... 0 O b. One or two ..... 1 O c. Three or more..... 2	
N3.	Number of prior abuse Investigations/Assessments O a. None or one..... 0 O b. Two or more 1	
N4.	Household has previously received ongoing services or foster care as a result of CA/N (voluntary/court-ordered) O a. No..... 0 O b. Yes..... 2	
N5.	Number of alleged victims involved in the O a. One or two..... 0 O b. Three or more 2	
N6.	Age of youngest child in the home O a. 2 or older..... 0 O b. Under 2 1	
N7.	Primary caretaker has a history of abuse or neglect as a child O a. No..... 0 O b. Yes..... 1	

	ABUSE	Score
A1.	Current complaint is for abuse O a. No.....0 O b. Yes.....1	
A2.	Number of prior abuse Investigations/Assessments O a. None.....0 O b. One.....1 O c. Two or more.....2	
A3.	Number of prior neglect Investigations/Assessments O a. None.....0 O b. One or more 1	
A4.	Household has previously received ongoing services or foster care as a result of CA/N (voluntary/court-ordered) O a. No.....0 O b. Yes.....2	
A5.	Prior injury to a child resulting from CA/N O a. No.....0 O b. Yes.....1	
A6.	Number of alleged victims involved in the O a. One, two, or three.....0 O b. Four or more.....2	
A7.	Primary caretaker blames child for incident O a. No.....0 O b. Yes.....1	

© 2021 by NCCD, All Rights Reserved

NEGLECT	Score	ABUSE	Score
N8. Primary caretaker has/had a drug or alcohol problem ○ a. None/not applicable..... 0 ○ b. One or more apply..... 2 (check all that apply) ☐ Alcohol ☐ During the last 12 months AND/OR ☐ At any other time prior to that ☐ Drug ☐ During the last 12 months AND/OR ☐ At any other time prior to that		A8. Two or more incidents of domestic violence in the household in the past year ○ a. No.....0 ○ b. Yes.....1	
N9. Primary caretaker has criminal arrest history as adult or juvenile ○ a. No..... 0 ○ b. Yes..... 1		A9. Primary caretaker has a history of abuse or neglect as a child ○ a. No.....0 ○ b. Yes.....1	
N10. Characteristics of children in household ○ a. Not applicable..... 0 ○ b. One or more apply (select all that apply and add for score) ☐ Developmental or physical disability..... 1 ☐ Medically fragile/failure to thrive..... 1		A10. Characteristics of children in household ○ a. Not applicable.....0 ○ b. One or more apply (select applicable items and add for score) ☐ Delinquency history.....1 ☐ Mental health/behavioral problem.....1	
TOTAL NEGLECT RISK SCORE		**TOTAL ABUSE RISK SCORE**	

SCORED RISK LEVEL

Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart. The family's scored risk level is based on the highest score on either the neglect or abuse instrument according to the following chart.

Neglect Score	Abuse Score	Scored Risk Level
○ 0–1	○ 0–2	○ Low
○ 2–4	○ 3–5	○ Moderate
○ 5–7	○ 6–8	○ High
○ 8+	○ 9+	○ Very High

© 2021 by NCCD, All Rights Reserved

POLICY OVERRIDES

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

O Yes O No 1. Sexual abuse case AND the alleged abuser/neglector is likely to have access to the child victim
O Yes O No 2. Non-accidental injury to a child under age 3
O Yes O No 3. Severe non-accidental injury
O Yes O No 4. Caretaker action or inaction resulted in death of a child due to abuse or neglect (previous or current)

DISCRETIONARY OVERRIDE

If a discretionary override is made, select "Yes," select override risk level, and indicate reason. Risk level may be overridden one level higher.

O Yes O No 5. If "Yes," override risk level (select one): ☐ Moderate ☐ High ☐ Very High

Discretionary override reason:

Supervisor's review/approval of discretionary override:_____ Date: _____

FINAL RISK LEVEL (select final level assigned): O Low O Moderate O High O Very High

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.

O Open
- ☐ New
- ☐ Continuing services offered
- ☐ Risk low or moderate and no identified safety factors, but case was opened (provide explanation below)

O Did not open
- ☐ Risk was low or moderate, and no identified safety factors were present
- ☐ Risk was high or very high, but case was not opened (provide explanation below)

If the recommended action and action taken do not match, explain why:

Date of Supervisory Approval: _____

Supervisor Signature: _____

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY RISK ASSESSMENT
DEFINITIONS

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

The household includes all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home.

The primary caretaker is the adult living in the household where the allegation occurs who assumes the most responsibility for childcare. When two adult caretakers are present and the Family Services Specialist is in doubt as to which one assumes the most childcare responsibility, the adult with legal responsibility for the child involved in the incident should be selected as the primary caretaker. For example, when a mother and her boyfriend reside in the same household and appear to equally share caretaking responsibilities for the child, the mother is selected. If this does not resolve the question, the legally responsible adult who was an alleged abuser/neglector should be selected. For example, when a mother and a father reside in the same household and appear to share caretaking responsibilities for the child equally and the mother is the alleged abuser/neglector, the mother is selected. In circumstances where both parents are in the household, equally sharing caretaking responsibilities, and both have been identified as alleged abuser/neglectors, the parent demonstrating the more severe behavior is selected. Only one primary caretaker can be identified.

The secondary caretaker is defined as an adult living in the household who has routine responsibility for childcare, but less responsibility than the primary caretaker. A partner may be a secondary caretaker even though that person has minimal responsibility for care of the child.

NEGLECT

N1. Current complaint is for neglect

Score if the current complaint is for any type of neglect. Neglect occurs when a caretaker or other person responsible for child's care neglects or refuses to provide care necessary for child's health; when a child is without parental care or guardianship, caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian, or other person standing in loco parentis; when caretakers or other persons responsible for child's care abandon such child. Current complaints for substance-exposed infants should be included in the scoring of this item.

This includes referred allegations as well as allegations made during the course of the Investigation/Family Assessment.

© 2021 by NCCD, All Rights Reserved

N2. Number of prior neglect Investigations/Assessments

Note: When counting prior Investigations/Assessments, it does not matter whether the prior Investigations were founded or not, or whether the prior Assessments resulted in a determination that services were needed. However, do not count screened-out referrals.

a. Score 0 if there were no Investigations/Assessments *prior* to the current Investigation/Family Assessment.

b. Score 1 if there were one or two Investigations/Assessments for any type of *neglect* prior to the current Investigation/Family Assessment.

c. Score 2 if there were three or more Investigations/Assessments for any type of *neglect* (alone or in combination with an abuse Investigation/Family Assessment) prior to the current Investigation/Family Assessment.

Where possible, history from other county or state jurisdictions should be selected. Exclude Investigations/Assessments of out-of-home alleged abuser/neglectors (e.g., daycare) unless one or more caretakers failed to protect.

N3. Number of prior abuse Investigations/Assessments

Note: When counting prior Investigations/Assessments, it does not matter whether the prior Investigations were founded or not, or whether the prior Assessments resulted in a determination that services were needed. However, do not count screened-out referrals.

a. Score 0 if there were zero or one Investigations/Assessments for any type of abuse *prior* to the current Investigation/Family Assessment.

b. Score 1 if there were two or more Investigations/Assessments for any type of *abuse* prior to the current Investigation/Family Assessment.

Where possible, history from other county or state jurisdictions should be included. Exclude Investigations/Assessments of out-of-home alleged abuser/neglectors (e.g., daycare) unless one or more caretakers failed to protect.

N4. Household has previously received ongoing services or foster care as a result of CA/N (voluntary/court-ordered)

Score 2 if household has previously *received* CPS ongoing or foster care services or is *currently receiving* services as a result of child abuse or neglect. Case may have opened as a result of a referral or court order. Service history includes voluntary or court-ordered family services, but does not include prevention services, delinquency, or CHINS.

© 2021 by NCCD, All Rights Reserved

N5. Number of alleged victims involved in the CA/N incident

Enter the total number of alleged victims involved in the CA/N incident who live in this home.

N6. Age of youngest child in the home

Score the appropriate amount given the current age of the *youngest child* presently in the household where the CA/N incident reportedly occurred. If a child is removed as a result of the current Investigation/Family Assessment, count the child as residing in the home.

N7. Primary caretaker has a history of abuse or neglect as a child

Score 1 if credible statements by the primary caretaker or others, or state records of past allegations, indicate that the primary caretaker was maltreated as a child (maltreatment includes neglect or abuse of a physical, sexual, or other nature).

N8. Primary caretaker has/had a drug or alcohol problem

a. Score 0 if the primary caretaker does not have and has never had a drug or alcohol problem.

b. Score 2 if the primary caretaker has a past or current alcohol/drug abuse problem that interferes with caretaker's or family's functioning. Evidence of such interference includes but is not limited to the following.

- Substance use that affects or has affected the following:
  - » Employment;
  - » Criminal involvement;
  - » Marital or family relationships; or
  - » Ability to provide protection, supervision, and care for the child.
- An arrest in the past two years for driving under the influence or refusing breathalyzer testing.
- Self-report of a problem.
- Treatment received currently or in the past.
- Multiple positive urine samples.
- Health/medical problems resulting from substance use.

© 2021 by NCCD, All Rights Reserved

- Child was diagnosed with fetal alcohol spectrum or exposure (FAS or FAE), or child had a positive toxicology screen at birth AND primary caretaker was birthing parent.

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

Indicate whether the drug or alcohol problem was/has been present *during* the past 12 months AND/OR was present at any time prior to 12 months.

N9. Primary caretaker has criminal arrest history as adult or juvenile

Indicate whether the primary caretaker has been arrested or convicted prior to the current complaint as either an adult or a juvenile. This includes DUI but excludes all other traffic offenses. Information may be located in the case narrative material, reports from other agencies, etc. Also, review any police reports in the file for this information.

N10. Characteristics of children in household

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 if any child in the household is/has any or all of the following.

- Developmental or physical disability, including a formal diagnosis of any of the following: intellectual disability, learning disability (as indicated by school records), other developmental problem, or significant physical handicap.

- Medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention or diagnosed as failure to thrive.

ABUSE

A1. Current complaint is for abuse

Score if the current complaint is for abuse. This includes referred allegations as well as allegations made during the course of the Investigation/Family Assessment.

A substance-exposed infant should be accounted for under item N1, "Current complaint is for neglect."

© 2021 by NCCD, All Rights Reserved

A2. Number of prior abuse Investigations/Assessments

Score the appropriate amount given the count of all Investigations/Assessments, founded or not, for any type of abuse (physical, mental, or sexual abuse/sexual exploitation) *prior* to the complaint resulting in the current Investigation/Family Assessment. Where possible, abuse history from other county or state jurisdictions should be included. Exclude screened-out referrals and Investigations/Assessments of out-of-home alleged abuser/neglectors (e.g., daycare) unless one or more caretakers failed to protect.

A3. Number of prior neglect Investigations/Assessments

Note: When counting prior Investigations/Assessments, it does not matter whether the prior Investigations were founded or not, or whether the prior Assessments resulted in a determination that services were needed. However, do not count screened-out referrals.

a. Score 0 if there were no Investigations/Assessments for any type of neglect *prior* to the current Investigation/Family Assessment.

b. Score 1 if there were one or more Investigations/Assessments for any type of neglect prior to the current Investigation/Family Assessment.

A4. Household has previously received ongoing services or foster care as a result of CA/N (voluntary/court-ordered)

Score 2 if household has previously *received* child welfare services or is currently receiving services as a result of child abuse or neglect. Case may have opened as a result of a referral or court order. Service history includes voluntary or court-ordered family services but does not include delinquency or CHINS.

A5. Prior injury to a child resulting from CA/N

Score 1 if prior to the current Investigation/Family Assessment, a child sustained an injury from abuse and/or neglect. Injury sustained as a result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn.

A6. Number of alleged victims involved in the CA/N incident

Enter the total number of alleged victims involved in the CA/N incident who live in this home.

A7. Primary caretaker blames child for incident

Score 1 if the primary caretaker blames child for incident. Blaming refers to caretaker's statement that maltreatment incident occurred because of child's action or inaction (for example, claiming that the child seduced them, or child deserved beating because they misbehaved).

© 2021 by NCCD, All Rights Reserved

A8. Two or more incidents of domestic violence in the household in the past year
Score 1 if in the previous year there have been two or more physical assaults or acts of intimidation/threats/harassment between caretakers or between a caretaker and another adult in the home.

A9. Primary caretaker has a history of abuse or neglect as a child
Score 1 if credible statements by the primary caretaker or others indicate that the primary caretaker was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse).

A10. Characteristics of children in household

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 for each if any child in the household:

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

- Has mental health or behavioral problems not related to a physical or developmental disability (includes ADHD/ADD). This could be indicated by the following:

  » A DSM diagnosis;

  » Receiving mental health treatment;

  » Attendance in a special classroom because of behavioral problems; or

  » Currently taking psychotropic medication.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY RISK ASSESSMENT
POLICY AND PROCEDURES

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

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

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

WHICH CASES
All Investigations and Assessments except out-of-family caretaker.

WHO
The Family Services Specialist who is conducting the Investigation/Family Assessment.

WHEN
After the safety assessment has been completed and the worker has reached a conclusion regarding the allegation AND prior to the referral being closed or promoted to a case. This is no later than 45 days after the complaint was received, or within 60 days if an extension was granted. For non-removal households, within 45 days of identification.

DECISIONS
The risk assessment identifies the level of risk of future involvement.

The risk level guides the decision of whether to open a case. For open cases, the risk level guides the minimum contact standards (see SDM® Contact Standards section).

© 2021 by NCCD, All Rights Reserved

Risk-Based CPS Case Open/Close Guide	
Risk Level	**Indicated Decision**
Low	Close (only if safety decision is "safe")
Moderate	Close (only if safety decision is "safe")
High	Open to CPS
Very High	Open to CPS

APPROPRIATE COMPLETION

The risk assessment is completed based on conditions that exist at the time the incident is reported and investigated as well as on the prior history of the family. Only one household can be assessed on the risk assessment. *Choose the household in which the CA/N incident is alleged. If more than one household is involved, there should be a case on each household and one risk assessment completed for each case*.

Scoring Individual Items

A score for each assessment item is derived from the worker's observation of the characteristics it describes. Some characteristics are objective (such as prior CA/N history or the age of the child). Others require the worker to use discretionary judgment based on his or her assessment of the family. Sources of information used to determine the worker's endorsement of an item may include statements by the child, caretaker, or collateral persons; worker observations; reports; or other reliable sources.

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

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

Policy Overrides

After completing the risk assessment, the Family Services Specialist determines whether any policy override reasons apply. Policy overrides reflect incident seriousness and/or child vulnerability concerns, and the agency has determined that they warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. Policy overrides require supervisor approval.

Note: Select "Yes" or "No" as appropriate for each policy override.

1. Sexual abuse case AND the abuser is likely to have access to the child victim.

2. Non-accidental injury to a child under age 3.

© 2021 by NCCD, All Rights Reserved

3. Severe non-accidental injury (e.g., brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child and requires medical treatment).

4. Caretaker action or inaction resulted in the death of a child due to abuse or neglect (previous or current).

Discretionary Overrides

A discretionary override is applied by the Family Services Specialist to increase the risk level in any case in which the Family Services Specialist believes that the risk level set by the assessment is too low. This may occur when the Family Services Specialist is aware of conditions affecting risk that are not captured within the items on the risk assessment. Discretionary overrides may increase the risk level by one unit (for example, from low to medium, or medium to high, but NOT from low to high).[1] Discretionary overrides require supervisor approval.

After completing the override section the highest risk level obtained is the final risk level.

[1] At the time of risk reassessment, discretionary overrides may increase *or decrease* risk by one level. However, at the time of initial assessment, risk level may only be increased.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® CONTACT STANDARDS

ONGOING WORKER SDM® MINIMUM CONTACT STANDARDS FOR CPS		
Risk Level	**Parent/Guardian and Child Contacts**	**Location**
Low	**One** face-to-face contact per month with parent/guardian and child **One** collateral contact	**Must** be in parent/guardian's residence
Moderate	**Two** face-to-face contacts per month with parent/guardian and child **Two** collateral contacts	**One** must be in parent/guardian's residence
High	**Three** face-to-face contacts per month with parent/guardian and child **Three** collateral contacts	**One** must be in parent/guardian's residence
Very High	**Four** face-to-face per contacts month with parent/guardian and child **Four** collateral contacts	**Two** must be in parent/guardian's residence
Additional Considerations		
Contact Definition	Each required contact shall include at least one parent/guardian and one child. During the course of a month, each parent/guardian and each child in the household shall be contacted at least once. Collateral contacts are defined as contacts with people who have information about the family and/or are providing interventions for the family/children. This includes police, attorneys, teachers, neighbors, relatives, and treatment providers, among others. Collaterals do not include the principals in the case, such as the child, parents, or foster parents.	
Designated Contacts	The ongoing worker/supervisor/service team may delegate face-to-face contacts to providers with contractual relationship to the agency and/or to other agency staff, such as social work aides or other service providers outlined in the case plan. However, the ongoing worker must always maintain at least one face-to-face contact with the parent/guardian and child per month, as well as monthly contact with the service provider designated to replace the ongoing worker in face-to-face contacts.	
Child Placed Out of Home	If a child in an ongoing CPS case is placed out of the home, the ongoing worker should use the foster care contact standards for as long as the child remains out of the home.	

© 2021 by NCCD, All Rights Reserved

ONGOING WORKER SDM® MINIMUM CONTACT STANDARDS FOR FOSTER CARE CASES WITH GOAL OF RETURN HOME	
Risk Level	**Documented Contacts With Parent/Guardian**
Low	**One** face-to-face contact per month with parent/guardian **One** collateral contact
Moderate	**Two** face-to-face contacts per month with parent/guardian **Two** collateral contacts
High	**Three** face-to-face contacts per month with parent/guardian **Three** collateral contacts
Very High	**Three** face-to-face contacts per month with parent/guardian **Three** collateral contacts
Documented Contacts With Children	
At least one face-to-face contact per month with each child in the out-of-home residence.	
Additional Considerations	
Contact Definition	During the course of a month, each parent/guardian and each child shall be contacted at least once.
Designated Contacts with Parent/Guardian	The ongoing worker must always maintain at least one face-to-face contact per month with the parent/guardian. However, the ongoing worker may delegate remaining contacts to service providers outlined in the service plan, or to other agency staff.
Designated Contacts with Child	The ongoing worker may delegate some of the contacts to service providers outlined in the service plan, or to other agency staff. However, the ongoing worker must always maintain at least one face-to-face contact per quarter with the child in the out-of-home residence.
Overrides	
A discretionary override to these contact standards is permitted based on unique case circumstances that are documented by the ongoing worker and approved by the supervisor.	

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT/REVIEW

r: 8/20

Case Name:_____ **Case ID:**_____ **Locality:** _____

FSS Name:_____ **Supervisor:**_____

Assessment Date: _____ **Creation Date:** _____ **Case Opened Date:** _____

Primary Caretaker:_____ **Secondary Caretaker:** _____

1. Child Name:_____ **4. Child Name:** _____

2. Child Name:_____ **5. Child Name:** _____

3. Child Name:_____ **6. Child Name:** _____

A. CARETAKER

It is important to acknowledge and understand the impact of the caretaker's cultural identity, current or previous trauma history, and resiliency when assessing each domain. Assess each caretaker according to the current level of functioning.

		Caretaker Score	
		Primary	**Secondary**
SN1.	**Substance Use or Abuse**		
	○ a. Teaches and demonstrates healthy understanding of alcohol and substances .....+3		
	○ b. Alcohol or prescribed medication use or no use 0		
	○ c. Alcohol or substance abuse .....-3		
	○ d. Alcohol or substance dependency..... -5	_____	_____
	If c or d, indicate which substance(s) caretaker abuses:		
SN2.	**Coping Skills/Daily Functioning**		
	○ a. Positive coping skills/daily functioning .....+3		
	○ b. Adequate coping skills/daily functioning 0		
	○ c. Limited coping skills/daily functioning .....-3		
	○ d. Inadequate coping skills/daily functioning ..... -5	_____	_____

© 2021 by NCCD, All Rights Reserved

		Caretaker Score	
		Primary	Secondary

SN3. Resource Management and Basic Needs

O a. Resources are sufficient to meet basic needs and are adequately managed.....+2
O b. Resources may be limited but are adequately managed.....0
O c. Resources are insufficient or not well-managed.....-2
O d. No resources, or resources severely limited and/or mismanaged ..... -4 _____ _____

SN4. Protective and Parenting Behaviors

O a. Strong skills.....+2
O b. Adequately parents and protects child 0
O c. Inadequately parents and protects child.....-2
O d. Destructive or abusive parenting..... -4 _____ _____

SN5. Household Relationships/Family Violence

O a. Supportive.....+2
O b. Minor or occasional discord 0
O c. Frequent discord or some family or domestic violence.....-2
O d. Chronic discord or severe family or domestic violence..... -3 _____ _____

SN6. Social or Community Support System

O a. Strong support system.....+1
O b. Adequate support system 0
O c. Limited or somewhat negative support system .....-1
O d. No support system or negative support system ..... -3 _____ _____

SN7. Health and Wellness

O a. Preventive health care is practiced.....+1
O b. Health concerns do not affect family functioning.....0
O c. Health concerns or disabilities affect family functioning.....-1
O d. Serious health concerns or disabilities result in inability to care for child..... -2 _____ _____

© 2021 by NCCD, All Rights Reserved

Caretaker Score
Primary Secondary

SN8. Communication Skills

- ○ a. Strong skills ..... +1
- ○ b. Functional skills 0
- ○ c. Limited skills ..... -1
- ○ d. Severely limited skills ..... -2 _____ _____

SN9. Other Identified Caretaker Strength/Need (not assessed in SN1–SN8)

- ○ a. Significant strength ..... +1
- ○ b. Not applicable 0
- ○ c. Minor need ..... -1
- ○ d. Significant need ..... -2 _____ _____

B. CHILD

It is important to acknowledge and understand the impact of the child's identity, culture, current or previous trauma history, and resiliency when assessing each domain. Assess each child according to the current level of functioning.

Score

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6
CSN1. Coping Skills/Daily Functioning						
○ a. Strong coping skills/resiliency ..... +3						
○ b. Adequate coping skills 0						
○ c. Limited coping skills ..... -3						
○ d. Severely limited coping skills ..... -5	_____	_____	_____	_____	_____	_____
CSN2. Family Relationships						
○ a. Nurturing/supportive relationships ..... +3						
○ b. Positive relationships 0						
○ c. Strained relationships ..... -3						
○ d. Harmful relationships ..... -5	_____	_____	_____	_____	_____	_____

© 2021 by NCCD, All Rights Reserved

	Score					
	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6

CSN3. Physical and Emotional Well-being

- O a. Preventive health care is practiced ..... +2
- O b. Medical/emotional needs met 0
- O c. Medical/emotional needs impair functioning ..... -2
- O d. Medical/emotional needs severely impair functioning ..... -4

CSN4. Child Development

- O a. Advanced development ..... +2
- O b. Age-appropriate development 0
- O c. Limited development ..... -2
- O d. Severely limited development ..... -4

CSN5. Substance Use or Abuse

- O a. No substance use by active decision ..... +1
- O b. Experimentation or no use 0
- O c. Alcohol or other substance use ..... -1
- O d. Severe alcohol or substance use/abuse ..... -3

CSN6. Education

Does child have a specialized educational plan?

- O No
- O Yes, describe: _____

- O a. Outstanding academic achievement ..... +1
- O b. Satisfactory academic achievement 0
- O c. Academic difficulty ..... -1
- O d. Severe academic difficulty ..... -3

CSN7. Social Relationships

- O a. Strong social relationships ..... +1
- O b. Adequate social relationships 0
- O c. Limited social relationships ..... -1
- O d. Poor social relationships ..... -2

© 2021 by NCCD, All Rights Reserved

Score

Child 1 Child 2 Child 3 Child 4 Child 5 Child 6

CSN8. Delinquent/CHINS Behavior

(Delinquent behavior includes any action which, if committed by an adult, would constitute a crime.)

O a. No delinquent/CHINS behavior .....+1
O b. Resolved delinquent/CHINS behavior 0
O c. Occasional delinquent/CHINS behavior .....-1
O d. Significant delinquent/CHINS behavior .....-2

CSN9. Other Identified Child Strength/Need (not assessed in CSN1–CSN8)

O a. Significant strength .....+1
O b. Not applicable 0
O c. Minor need .....-1
O d. Significant need .....-2

C. PRIORITY NEEDS AND STRENGTHS

Please select and provide a brief description of up to three most serious needs and greatest strengths for the caretaker (items SN1–SN9).

Caretaker:	**Priority Needs**	**Caretaker:**	**Priority Strengths**
1.		1.	
2.		2.	
3.		3.	

For each child in the household, select all identified needs and strengths.

Child:	**Needs**	**Child:**	**Strengths**
1.		1.	
2.		2.	
3.		3.	

D. COMMENTS

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT/REVIEW
CARETAKER DEFINITIONS

SN1. Substance Use or Abuse

a. Teaches and demonstrates healthy understanding of alcohol and substances. Caretaker may use alcohol or prescribed medications; however, their use does not negatively affect parenting skills and functioning, AND caretaker teaches and demonstrates an understanding of the choices made about use or abstinence and the effects of alcohol and drugs on behavior and society.

b. Alcohol or prescribed medication use or no use. Caretaker may have a history of substance use and/or may currently use alcohol or prescribed medication; however, such use does not negatively affect parenting skills and functioning, or caretaker does not use alcohol or prescribed medication.

c. Alcohol or substance abuse. Caretaker uses alcohol and/or substances, resulting in negative consequences in some areas, such as family, social, health, legal, or financial; AND/OR caretaker needs (or continues to need) treatment to alleviate negative consequences to the family.

d. Alcohol or substance dependency. Caretaker uses alcohol and/or substances, resulting in behaviors that impede their ability to meet their own AND/OR the child's basic needs; or caretaker experiences impairment in most areas, including family, social, health, legal, and financial; or caretaker needs (or continues to need) intensive structure and support to achieve abstinence from alcohol or drugs.

Substances include alcohol, illegal drugs, inhalants, and prescription or over-the-counter drugs/supplements.

SN2. Coping Skills/Daily Functioning

a. Positive coping skills/daily functioning. Caretaker demonstrates resiliency through the ability to deal with adversity, crises, and conflicts in a positive, proactive, and/or constructive manner.

b. Adequate coping skills/daily functioning. Although some concerns may be present, caretaker regularly demonstrates responses that are consistent with circumstances, and there are no interferences with family functioning.

© 2021 by NCCD, All Rights Reserved

c. Limited coping skills/daily functioning. Based on available evidence, caretaker's responses appear concerning in that they occasionally interfere with family functioning, parenting, employment, or other aspects of daily living. Examples include but are not limited to the following.

- Repeated observations or multiple reliable reports of low self-esteem, apathy, withdrawal from social contact, flat affect, somatic complaints, changes in sleeping or eating patterns, difficulty in concentrating or making decisions, low frustration tolerance, or hostile behavior.
- Frequent conflicts in personal relationships.
- Speech is sometimes illogical or irrelevant.
- Frequent loss of work days due to unsubstantiated somatic complaints.
- Difficulty coping with crisis situations such as loss of a job, divorce or separation, or an unwanted pregnancy.

d. Inadequate coping skills/daily functioning. Caretaker appears to have severe problems that prohibit adequate daily functioning and are seriously disruptive to the family or are incapacitating. Examples include but are not limited to the following.

- Inability to maintain healthy personal relationships.
- Feelings of hopelessness or helplessness.
- Failure to accept responsibility.
- Maladaptive coping skills.
- Stays in bed all day; completely neglects personal hygiene.

SN3. Resource Management and Basic Needs

a. Resources are sufficient to meet basic needs and are adequately managed. Caretaker has a history of consistently providing safe, healthy, and stable housing; nutritious food; appropriate clothing; health care; and transportation.

b. Resources may be limited but are adequately managed. Caretaker provides adequate housing, food, clothing, health care, and transportation. Caretaker may need occasional assistance but is able to access community resources to meet their needs.

© 2021 by NCCD, All Rights Reserved

c. Resources are insufficient or not well-managed. Caretaker is unable to consistently provide adequate housing, food, clothing, health care, and/or transportation to meet child's basic needs. Family has insufficient financial resources or has difficulty managing financial resources to adequately provide for basic care needs related to health and safety. If family is homeless, there is no evidence of harm or threat of harm to child.

d. No resources, or resources severely limited and/or mismanaged. Caretaker is unable to provide adequate housing, food, clothing, health care, and/or transportation to meet child's basic needs. Conditions exist in the household that have caused illness or injury to family members. Family has no financial resources or mismanages resources to the extent that child is deprived of minimal basic care to meet health and safety needs. If family is homeless, this results in harm or threat of harm to child.

SN4. Protective and Parenting Behaviors

a. Strong skills. Caretaker displays good knowledge and understanding of age-appropriate parenting skills and integrates the use of skills daily. Caretaker expresses hope for and recognizes child's abilities and strengths and encourages participation in the family and the community. Caretaker practices developmentally appropriate boundaries, teaches body safety, and accepts child's gender identity/sexual orientation. Caretaker advocates for the family and responds to changing needs.

b. Adequately parents and protects child. Caretaker displays adequate parenting patterns that are age-appropriate for child in areas of expectations, discipline, communication, protection, and nurturing. Caretaker has basic knowledge and skills to parent. Caretaker may not accept child's gender identity/sexual orientation, but it does not cause conflict as a result.

c. Inadequately parents and protects child. Caretaker needs strengthening of basic parenting skills. Caretaker has some unrealistic expectations or gaps in parenting skills. Caretaker has difficulty accepting child's gender identity/sexual orientation, and it causes conflict as a result.

d. Destructive or abusive parenting. Caretaker displays destructive or abusive parenting patterns that result in harm to child. Caretaker has abused a child or has failed to protect a child from abuse. Include abusive behavior resulting from caretaker's rejection of child's gender identity/sexual orientation.

© 2021 by NCCD, All Rights Reserved

SN5. Household Relationships/Family Violence

a. Supportive. Internal or external stressors (e.g., illness, financial problems, divorce, custody, special needs) may be present, but caretaker maintains positive interactions (e.g., mutual affection, respect, open communication, empathy) and shares responsibilities that are mutually agreed upon by household members. Caretaker mediates disputes and promotes nonviolence in the home. Individuals are safe from threats, intimidation, or assaults by other household members.

b. Minor or occasional discord. Internal or external stressors are present, but caretaker is functioning despite some disruption of positive interactions. Custody and visitation issues can be resolved with minimal disruptions. Conflicts may be resolved through less adaptive strategies such as avoidance; however, household members do not control one another or threaten physical or sexual assault within the household; or there is no history of family or domestic violence. Family members may use occasional negative statements about one another, but no long-lasting impacts occur.

c. Frequent discord or some family or domestic violence. Internal or external stressors are present. Caretaker's positive interactions are disrupted. Lack of cooperation in household is the result of emotional or verbal abuse by caretaker(s). Custody and visitation issues are characterized by frequent conflicts. Caretaker's pattern of adult relationships creates significant stress for child. Adult relationships are characterized by occasional physical outbursts that may result in injuries, and/or controlling behavior that results in isolation or restriction of activities. Caretaker seeks help in reducing threats of violence. Derogatory or negative language is used and creates a long-lasting impact on family members.

d. Chronic discord or severe family or domestic violence. Internal or external stressors are present. Caretaker engages in minimal or no positive interactions. Lack of cooperation in the household is the result of severe or chronic emotional or verbal abuse by caretaker(s). Custody and visitation issues are characterized by harassment and/or severe conflict, such as multiple reports to law enforcement and/or CPS. Caretaker's pattern of adult relationships places child at risk for maltreatment and/or contributes to severe emotional distress. Violent or controlling behavior has resulted or may result in injury. Derogatory or negative language has resulted in a clinical diagnosis for the victim.

SN6. Social or Community Support System

a. Strong support system. Caretaker regularly engages with a strong, constructive, mutual support system. Caretaker interacts with extended family; friends; or cultural, religious, and/or community support or services that provide a wide range of resources.

© 2021 by NCCD, All Rights Reserved

b. Adequate support system. As needs arise, caretaker uses extended family; friends; or cultural, religious, and community resources to provide support and/or services such as childcare, transportation, supervision, role modeling for caretaker and child, parenting and emotional support, guidance, etc.

c. Limited or somewhat negative support system. Caretaker has a limited support system or is reluctant to use available support. Caretaker perceives services and supports as unavailable or inaccessible. The informal resources that caretaker uses for support (e.g., friends, relatives, neighbors) may have some negative impact on the family by supporting inappropriate caretaker practices/behaviors or by introducing negative influences. Individuals may experience conflict with cultural or community identity that creates difficulties and internal conflict.

d. No support system or negative support system. Caretaker has no support system. Any support system identified by caretaker has a significant negative impact on caretaker and/or on family members (e.g., boyfriend who encourages substance abuse).

SN7. Health and Wellness

a. Preventive health care is practiced. Caretaker manages their own physical and mental health concerns. They teach, promote, and model good health and hygiene practices.

b. Health concerns do not affect family functioning. Caretaker's health and physical issues are managed through treatment, or caretaker has no current health concerns that affect family functioning. Caretaker accesses physical/mental health resources for themselves (e.g., is medication compliant, attends follow-up health appointments).

c. Health concerns or disabilities affect family functioning. Caretaker has physical or mental health concerns or conditions, such as diagnosis of a mild to moderate disorder, that affect family functioning or family resources. This may be due to lack of treatment or inconsistent treatment.

d. Serious health concerns or disabilities result in inability to care for child. Caretaker has serious or chronic physical or mental health concern(s) or condition(s) that significantly affect the ability to care for and/or protect child. Examples include but are not limited to the following.

- Observed, reported, or diagnosed chronic depression; paranoia; excessive mood swings; impulsive, obsessive, or compulsive behavior; or other severe mental, emotional, or psychological disorders.

© 2021 by NCCD, All Rights Reserved

- Suicidal ideation or suicide attempts.
- Reports hearing voices or seeing things.
- Repeated referrals for mental health or psychological evaluations.
- Recommended or actual hospitalization for emotional problems within the past year.

SN8. Communication Skills

a. Strong skills. Caretaker's communication skills facilitate successful access to services and resources to promote family functioning. If caretaker requires translation services, they obtain such services when needed.

b. Functional skills. Caretaker's communication skills are no barrier to effective family functioning, accessing resources, or assisting children in the community or school. If caretaker requires translation services, they use such services when/if provided.

c. Limited skills. Caretaker has limited communication skills, resulting in difficulty accessing resources and often interferes with family functioning. If caretaker requires translation services, they experience difficulty accessing such services or are reluctant to use services.

d. Severely limited skills. Caretaker has severely limited communication skills, resulting in an inability to access resources that severely affects family functioning. If caretaker requires translation services, they are unwilling or unable to communicate even when provided with such services.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT/REVIEW
CHILD DEFINITIONS

For each item, if not applicable due to child's age, score as 0.

CSN1. Coping Skills/Daily Functioning

a. Strong coping skills/resiliency. Child displays healthy coping skills in dealing with crises and trauma, disappointment, and daily challenges. Child is able to develop and maintain trusting relationships. Child is also able to advocate and accept guidance and services.

b. Adequate coping skills. Child displays developmentally appropriate emotional/coping responses that do not interfere with school, family, or community functioning. Child may demonstrate some depression, anxiety, or withdrawal symptoms that are situation related. Child is able to frequently advocate for and accept guidance and services.

c. Limited coping skills. Child has occasional difficulty dealing with situational stress, crises, or problems, which impairs daily functioning. Child displays symptoms including but not limited to depression, running away, somatic complaints, hostile behavior, or apathy.

d. Severely limited coping skills. Child's ability to perform in one or more areas of functioning is severely impaired due to chronic/severe symptoms such as fire setting, suicidal behavior, or violent behavior toward people and/or animals.

CSN2. Family Relationships

For a child in voluntary diversion or court-ordered placement, score child's family of origin, basing assessment on visits and other contact such as telephone calls, letters, or electronic communication. If child has no contact with their family, select "c."

a. Nurturing/supportive relationships. Child experiences positive interactions with family members. Child has sense of belonging within the family. Family defines roles, has clear boundaries, and supports child's growth and development.

b. Positive relationships. Child experiences positive interactions with family members and feels safe and secure in family, despite some unresolved family conflicts.

© 2021 by NCCD, All Rights Reserved

c. Strained relationships. Stress/discord within the family interferes with child's sense of safety and security. Child has limited connections within family. Family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own.

d. Harmful relationships. Chronic family stress, conflict, or violence severely impedes child's sense of safety and security. Family is unable to resolve conflicts on their own and are unable or unwilling to obtain outside assistance.

CSN3. Physical and Emotional Wellbeing

a. Preventive care is practiced. Child has no known physical or mental health care needs. Child receives routine preventive and medical/dental/vision care and immunizations.

b. Medical/emotional needs met. Child has no unmet physical or mental health care needs. Special conditions (including need for prescribed medications) may exist but are adequately addressed.

c. Medical/emotional needs impair functioning. Child has condition(s) that may impair daily functioning. Special conditions exist that are not adequately addressed, and/or routine medical/dental/vision/mental health care is needed.

d. Medical/emotional needs severely impair functioning. Child has serious, chronic, acute medical or mental health condition(s) (including need for prescribed medications or hospitalizations) that severely impairs functioning, and needs are unmet.

CSN4. Child Development

For this item, base assessment on developmental milestones as described in appendix.

a. Advanced development. Child's developmental milestones are above chronological age level.

b. Age-appropriate development. Child's developmental milestones are consistent with chronological age level.

c. Limited development. Child only exhibits some developmental milestones expected for chronological age level.

d. Severely limited development. Most developmental milestones are two or more age levels behind chronological age expectations.

© 2021 by NCCD, All Rights Reserved

CSN5. Substance Use or Abuse

a. No substance use by active decision. Child does not use alcohol or other substances and is aware of consequences of use. Child avoids peer relations/social activities involving alcohol and other substances, and/or chooses not to use despite peer pressure/opportunities to use.

b. Experimentation or no use. Child does not use alcohol or other substances. Child may have experimented with alcohol or other substances, but there is no indication of sustained use. No demonstrated history or current problems related to substance use.

c. Alcohol or other substance use. Child's alcohol or other substance use results in disruptive behavior and discord in relationships in school/community/family/work. Use may have broadened to include multiple substances.

d. Severe alcohol or substance use/abuse. Child's recurrent alcohol or other substance use results in the severe disruption of functioning (e.g., loss of relationships, job, school suspension/expulsion/drop-out, problems with the law). Child may need intensive structure and support to achieve abstinence from alcohol or other substances to include medical intervention to detoxify.

Substances include alcohol, illegal drugs (including nicotine products), inhalants, and prescription or over-the-counter drugs/supplements.

CSN6. Education

Does child have a current specialized education plan (individualized education program [IEP], child study, etc.)?

a. Outstanding academic achievement. Child is working above grade level or is exceeding the expectations of their specialized education plan.

b. Satisfactory academic achievement. Child is working at grade level or is meeting the expectations of the specialized education plan.

c. Academic difficulty. Child is working below grade level in at least one, but not more than half, of their academic subject areas. Child is struggling to meet the goals of the existing education plan.

d. Severe academic difficulty. Child is working below grade level in more than half of academic subject areas. Child is not meeting the goals of the existing education plan due to trauma/behavioral needs not being managed. Select "d" for a child who is required by law to attend school and is not attending.

© 2021 by NCCD, All Rights Reserved

CSN7. Social Relationships

a. Strong social relationships. Child enjoys and participates in a variety of constructive, age-appropriate social activities. Child enjoys reciprocal, positive relationships with others. Child identifies with cultural and community heritage and beliefs and is connected with people who share similar belief systems.

b. Adequate social relationships. Child demonstrates adequate social skills. Child maintains stable relationships with others; occasional conflicts are minor and easily resolved. Child may experience some conflict and may struggle with cultural/community identity, yet is able to cope.

c. Limited social relationships. Child demonstrates inconsistent social skills, which leads to difficulties establishing or maintaining social relationships. Child may experience intergenerational and/or societal conflict surrounding values and norms related to cultural/community differences. Conflicts are more frequent, serious, and child may be unable to resolve them.

d. Poor social relationships. Child has poor social skills as demonstrated by frequent conflictual relationships. Child is socially disconnected, resulting in isolation, lack of support, and lack of access to resources.

CSN8. Delinquent/CHINS Behavior

Delinquent behavior includes any action which, if committed by an adult, would constitute a crime. Child in need of services/supervision (CHINS) behavior includes offenses that are unique to children (e.g., truancy, runaway).

a. No delinquent/CHINS behavior. Child has no arrest history, and there are no other indications of criminal or CHINS behavior.

b. Resolved delinquent/CHINS behavior. Child has successfully completed probation, and there has been no criminal or CHINS behavior in the past two years.

c. Occasional delinquent/CHINS behavior. Child is engaging or has engaged in occasional, nonviolent delinquent behavior or CHINS behavior and may have been arrested or placed on probation within the past two years.

d. Significant delinquent/CHINS behavior. Child is engaging or has engaged in violent or repeated nonviolent delinquent behavior or chronic CHINS behavior. This behavior has or could have resulted in arrests, incarcerations, or probation.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT/REVIEW
POLICY AND PROCEDURES

The Family Strengths and Needs Assessment (FSNA) is used to systematically identify critical family needs and help develop effective service plans. The FSNA serves several purposes:

- It ensures that all family members and Family Services Specialists (FSS) consistently consider each family's strengths and needs in an objective format;
- It provides an important service planning reference for FSS and supervisors;
- It serves as a mechanism for monitoring service referrals made to address identified family and child needs; and
- The initial FSNA, when followed by regular strengths and needs reviews, permits FSS and supervisors to easily assess changes in family functioning and evaluate the impact of services on the case.

WHICH CASES
The FSNA is completed on In Home and Permanency cases where the goal is return home, including a separate FSNA for non-removal households receiving reunification services. (It may also be completed for other cases for the purpose of making referrals to appropriate community resources.)

The child assessment portion is completed for each child who will be included in the service plan.

WHO
The assigned FSS completes the FSNA.

WHEN
The FSNA must be completed prior to the development of the service plan and no later than 30 calendar days from the date of assignment to the ongoing worker. For non-removal households, within 45 days of identification.

Review: For CPS cases, every 90 days after completion of the service plan, and for foster care cases, in conjunction with all SDM reunification reviews.

© 2021 by NCCD, All Rights Reserved

DECISIONS

The FSNA is used to identify family needs that must be addressed in the family's service plan. The FSS identifies the need areas for the family by assessing the primary caretaker (and, if present, the secondary caretaker) and the child. Priority need areas are those with negative point values as assessed by the FSS for *either* the primary or secondary caretaker. For the child, priority needs areas are also determined by areas with negative point values. The FSS also identifies family and child strengths as assessed on the tool, *and* any other strengths identified through the assessment process.

After assessing the strengths and needs items, the FSS lists the three greatest needs and strengths identified. (Consider both the primary and secondary caretaker when identifying these priority needs.) Priority items must then be incorporated into the service plan and addressed immediately. For the child, all needs should also be incorporated into the service plan.

APPROPRIATE COMPLETION

Only one household can be assessed on the FSNA. The household assessed must be the same household for which the family risk assessment was completed. Whenever possible, the family should be involved in the process of gathering information used to complete the FSNA.

The household is assessed by completing all items. If there are two caretakers, each is assessed and scored separately.

For the caretakers, list in order of greatest to least the top three needs identified. List in order the top three strengths identified. For the child, all needs should be addressed in the service plan. A negative point value (e.g., -3) indicates a need, while a positive point value (e.g., +3) indicates a strength.

Assessing must be done in accordance with the item definitions provided. It is the use of the definitions that helps provide consistency in the assessment process.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® REASSESSMENT OVERVIEW

Which SDM® Reassessment Tools and When?		
Case Type	**Tools**	**When**
All children living in home*	• Risk reassessment • Family strengths and needs assessment (FSNA)	• Every 90 days
All children in foster care with return home goal Children in voluntary placement longer than 90 days	• Reunification review • FSNA	• 60-day dispositional hearing (optional) • Court review • Permanency plan hearing • For children in voluntary placement longer than 90 days, each subsequent 90-day period
Court-Ordered		
One or more children living in home with open case plans AND one or more children in foster care with return home goal	• Reunification review • FSNA review	• 60-day dispositional hearing • Every 90 days thereafter If this results in an assessment more than 30 days old on the date of a hearing, review to be sure all information is still correct and revise if needed.*

Note:

- *Children living in the home who are NOT included in the case plan are not counted or assessed.*
- *Children living out of the home with a permanency plan goal other than return home are not counted or assessed.*

*Since reviews must be current in preparation for court hearings, AND no more than 90 days can elapse between assessments for children in the home, requiring a review every 90 days satisfies the latter, and allowing for the occasional need to refresh the assessment for court purposes satisfies the former.

Safety

A safety assessment is not required at specific time intervals. For open cases in which a child is in the home and new information or circumstances require that the safety of the child be assessed, the safety assessment should be used according to instructions in the SDM safety assessment section of this manual. A safety assessment is also required prior to closing a case.

For CPS cases where the child is temporarily staying with relatives as part of a safety plan, complete a new safety assessment prior to the child returning home.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY RISK REASSESSMENT FOR CPS CASES

r: 8/20

Case Name: _____ **Case ID:** _____

Locality: _____ **FSS Name:** _____

Supervisor: _____ **Assessment Date:** _____

Creation Date: _____

R1. Number of prior Protective cases **Score**

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

R2. Household has previously received child welfare services (voluntary/court-ordered)

○ a. No 0
○ b. Yes ..... 1 _____

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

○ a. No 0
○ b. Yes ..... 1 _____

R4. Child characteristics (select applicable items and add for score)

☐ a. No child has any of the characteristics listed below 0
☐ b. One or more children in household is developmentally or physically disabled 1
☐ c. One or more children in household is medically fragile or diagnosed with failure to thrive ..... 1 _____

The following case observations pertain only to the period since the last risk assessment/reassessment.

R5. New Protective case since the initial risk assessment or last reassessment

○ a. No 0
○ b. Yes ..... 2 _____

© 2021 by NCCD, All Rights Reserved

Score

R6. Caretaker substance abuse problem interferes with their or family's functioning since last risk assessment/reassessment

- ○ a. No history of alcohol or drug abuse problem 0
- ○ b. No current alcohol or drug abuse problem; no intervention needed 0
- ○ c. Yes; substance abuse problem does not interfere with the caretaker's or the family's functioning 0
- ○ d. Yes; substance abuse problem interferes with the caretaker's or the family's functioning ..... 1 _____

R7. Problems with adult relationships

- ○ a. None of the following apply 0
- ○ b. Yes, harmful relationships with adults 1
- ○ c. Yes, domestic violence ..... 2 _____

R8. Primary caretaker provides care that is

- ○ a. Consistent with child needs 0
- ○ b. Inconsistent with child needs ..... 1 _____

R9. Caretaker's progress with case plan (if two caretakers in household, base score on the caretaker who demonstrates the least progress) **Score**

- ○ a. Not applicable; all services unavailable 0
- ○ b. Successfully completed all services recommended or actively participating in services; pursuing objectives detailed in service plan 0
- ○ c. Some progress in pursuing objectives in service plan 2
- ○ d. Has participated but is not meeting objectives; refuses involvement in services or failed to comply/participate as required ..... 4 _____

TOTAL SCORE _____

SCORED RISK LEVEL

Assign the family's risk level based on the following chart:

Score	Risk Level
0–2	○ Low
3–5	○ Moderate
6–8	○ High
9–16	○ Very High

© 2021 by NCCD, All Rights Reserved

POLICY OVERRIDES

Select "Yes" if condition is applicable in the case during the current review period. If *any* condition is applicable, override final risk level to very high.

O Yes O No 1. Sexual abuse case AND the abuser is likely to have access to the child victim.
O Yes O No 2. Non-accidental injury to a child under age 3.
O Yes O No 3. Severe non-accidental injury.
O Yes O No 4. Caretaker action or inaction resulted in death of a child due to abuse or neglect.

DISCRETIONARY OVERRIDE

If a discretionary override is made, select "Yes," select override risk level, and indicate reason. Risk level may be overridden one level higher or lower.

O Yes O No 5. If "Yes," override risk level (select one): O Low O Moderate O High O Very High

Reason:_____

Supervisors review/approval of discretionary override: _____ Date: _____

FINAL RISK LEVEL (select final level assigned): O Low O Moderate O High O Very High

CASE STATUS (at close of review)

O Case remains open for CPS In-Home services
O Case transferred to Foster Care services
O Case closed. If closed, reason:_____ Closure Date: _____

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY RISK REASSESSMENT FOR CPS CASES
DEFINITIONS

R1. Number of prior Protective cases

Make selection for the item based on the count of all Investigations/Assessments for any type of *abuse or neglect prior* to the Investigation/Family Assessment resulting in the current case. In counting Investigations/Assessments, the conclusion (i.e., founded or not) does not matter. Where possible, history from other jurisdictions and/or other states should be included. Exclude screened-out referrals and Out-of-Family Investigations unless one or more caretakers failed to protect.

R2. Household has previously received child welfare services (voluntary/court-ordered)

Select "b" if the household received child welfare services *prior* to the current event. Where possible, include history from other jurisdictions and/or other states. Service history includes voluntary or court-ordered family services.

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

a. Score 0 if no statements reported by the primary caretaker or others indicate that the primary caretaker was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse) OR if maltreatment history is unknown.

b. Score 1 if primary caretaker reports that they were maltreated as a child OR the agency is aware of prior maltreatment history.

R4. Child characteristics

Choose each that apply to any child in the household.

a. Score 0 if no child in the household exhibits characteristics listed below.

b. Score 1 if any child is developmentally or physically disabled, including any of the following: intellectual disability, learning disability, other developmental problem, or significant physical handicap.

c. Score 1 if any child in the household is medically fragile, defined as having a chronic and/or terminal physical condition requiring medical intervention OR is diagnosed as failure to thrive.

© 2021 by NCCD, All Rights Reserved

R5. New Protective case since the initial risk assessment or last reassessment

Select "b" if at least one Investigation/Family Assessment has been initiated *since the initial risk assessment or last reassessment*. This includes open or completed Investigations/Family Assessments, regardless of Investigation/Family Assessment conclusion, that have been initiated since the initial risk assessment or last reassessment. Exclude screened-out referrals and Out-of-Family Investigations unless one or more caretakers failed to protect.

R6. Caretaker substance abuse problem interferes with their or family's functioning since last risk assessment/reassessment

Indicate if the primary and/or secondary caretaker has a current substance abuse problem that interferes with the caretaker's or the family's functioning AND the caretaker is not addressing the problem. If both caretakers have a substance abuse problem, rate the more negative behavior of the two caretakers. Examples of not addressing the problem may include but are not limited to the following.

- Substance use that affects or affected caretaker's life domains or their ability to ensure safety and well-being for the child.
- An arrest since the last assessment/reassessment related to their substance use.
- Caretaker gave birth to a substance-exposed infant.

Score as follows (*prescription drug use that is legal and non-abusive should not be scored*).

a. Score 0 if there is no history of a substance abuse problem.

b. Score 0 if there is no current substance abuse problem that requires intervention.

c. Score 0 if there is a substance abuse problem and it *does not* interfere with caretaker's or the family's functioning.

d. Score 1 if there is a substance abuse problem and it *does* interfere with caretaker's or the family's functioning.

R7. Problems with adult relationships

Score this item based upon current status of adult relationships in the household.

a. Score 0 if no problems are observed.

b. Score 1 if yes, there are adult relationships that are harmful to domestic functioning or the care the child receives (but not at the level of domestic violence).

© 2021 by NCCD, All Rights Reserved

c. Score 2 if yes, domestic violence is present. Household has had, since the most recent assessment, physical assault(s) or periods of intimidation/threats/ harassment between caretakers or between a caretaker and another adult.

R8. Primary caretaker provides care that is

a. Consistent with child needs: Physical care of child (age-appropriate feeding, clothing, shelter, hygiene, and medical care of child) does not threaten the child's well-being or result in harm to the child.

b. Inconsistent with child needs: Physical care of child (age-appropriate feeding, clothing, shelter, hygiene, and medical care of child) threatens the child's well-being or results in harm to the child. Inadequate supervision should not be included in this item.

R9. Caretaker's progress with case plan

Make the selection on this item based on whether the caretaker has demonstrated or is beginning to demonstrate skills learned from participation in services. If there are two caretakers in the household, base the answer on the caretaker who demonstrates the least progress.

a. Score 0 if not applicable. All desired services were unavailable during the last assessment period.

b. Score 0 if caretaker successfully completed all services recommended or is actively participating in services; or is pursuing objectives detailed in the case plan. Caretaker demonstrates skills toward reaching the behavioral objectives agreed upon in the case plan.

c. Score 2 if caretaker is participating in services, has made some progress but is not fully complying with case plan objectives, or has not yet demonstrated the skills learned from participation in services.

d. Score 4 if caretaker has participated in services but is not meeting case plan objectives; or if caretaker refuses services, sporadically follows the case plan, or has not demonstrated the necessary skills due to a failure or inability to participate.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY RISK REASSESSMENT FOR CPS CASES
POLICY AND PROCEDURES

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

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

WHICH CASES
All open In Home cases in which *all children* who are receiving case management services remain in the home.

WHO
The FSS.

WHEN
In conjunction with every case plan review, which is every 90 days after completion of the initial case plan.

A reassessment should be completed sooner if there are new circumstances or new information that would affect risk.

If a new referral is received while a case is open, an initial risk assessment (not a risk reassessment) will be completed during the Investigation/Family Assessment, according to policy and procedures of the SDM risk assessment in this manual.

DECISIONS
The risk reassessment guides the decision to close a case and, for cases that remain open, the level of service.

- All cases in which risk is reduced to low should be considered for closure unless special circumstances exist.

© 2021 by NCCD, All Rights Reserved

- Cases in which risk remains or is reduced to moderate should be considered for closure if there is a corresponding reduction in priority needs as indicated in the family strengths and needs review (see policy and procedures in the SDM FSNA section of this manual).

- High- or very high-risk cases should remain open unless special circumstances exist.

APPROPRIATE COMPLETION

For cases that remain open following reassessment, the NEW SDM risk level guides minimum contact standards that will be in effect until the next reassessment is completed. Use the SDM® Contact Standards table in the risk assessment section of this manual.

Items R1–R4: Using the definitions, determine the appropriate response for each item and enter the corresponding score. Note that items R1 and R2 refer to the period of time PRIOR to the Investigation/Family Assessment that led to the opening of the current case. Scores for these two items should be identical to corresponding items on the initial risk Assessment unless additional information has become available.

Item R3 may change if new information is available or if there has been a change in primary caretaker.

Item R4 may change if a child's condition has changed, or if a child with a described condition is no longer part of the household (children in foster care with a plan to return home are considered part of the household).

Items R5–R9: These items are scored based ONLY on observations since the most recent assessment or reassessment.

Using the definitions, determine the appropriate response for each item and enter the corresponding score.

After entering the score for each individual item, enter the total score and indicate the corresponding risk level.

Policy Overrides

As on the initial risk assessment, the agency has determined that there are certain conditions that are so serious that a risk level of very high should be assigned regardless of the risk assessment score. *The guidance overrides refer to incidents or conditions that occurred since the initial risk assessment or last reassessment*. If one or more guidance override conditions exist, select the reason for the override and select "Very High" for the final risk level. Guidance overrides require supervisor review.

© 2021 by NCCD, All Rights Reserved

Discretionary Override

The FSS uses discretionary overrides whenever the FSS believes that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment, in which the FSS could only *increase* the risk level, the risk reassessment permits the FSS to increase or *decrease* the risk level by one step. The reason an FSS may now decrease the risk level is that after a minimum of three months, the FSS has acquired significant knowledge of the family. If the FSS applies a discretionary override, the reason should be written in for item 5, discretionary override. The FSS then selects the override risk level. Discretionary overrides require supervisory review.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES r: 08/20
SDM® FAMILY REUNIFICATION REVIEW

Case Name: _____ **Case ID:** _____ **Locality:** _____

FSS Name: _____ **Supervisor:** _____

Assessment Date: _____

Household Assessed: _____ **Custody/Placement Date:** _____

Completion Date: _____

Complete for cases where **any** child is placed out of the home.

SECTION 1: FAMILY REUNIFICATION RISK REVIEW

Score

R1. Most recent risk assessment level (after overrides)

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

R2. Caretaker progress toward meeting needs identified in case plan

- O a. If case plan has been in effect for less than 30 days at the time of the reunification review, this item cannot be assessed 0
- O b. Successfully met all current case plan responsibilities; continuing cooperation with services; significant progress in all applicable high-need areas (as identified in the FSNA [initial or review]) .. -2
- O c. Actively participating in programs; pursuing responsibilities detailed in the case plan; continuing progress in all applicable high-need areas (as identified in the FSNA [initial or review]) . -1
- O d. Partial participation in pursuing responsibilities in the case plan; demonstrates progress in at least one applicable high-need area (as identified in the FSNA [initial or review]) 0
- O e. Some level of participation in pursuing responsibilities of the case plan; marginal progress toward reducing needs (as identified in the FSNA [initial or review]) 2
- O f. Lack of involvement/no involvement in service recommendation (as identified in the FSNA [initial or review]) ..... 4 _____

R3. Has a new Protective case opened AND required a new identified service; OR was a new Protective case founded since the last family risk assessment, risk reassessment, or reunification review?

- O a. No 0
- O b. Yes ..... 6 _____

TOTAL SCORE ____

© 2021 by NCCD, All Rights Reserved

RISK LEVEL
Assign the family's risk level based on the following chart.

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

OVERRIDES

Policy Overrides
Select "Yes" if condition is applicable in the case during the current review period. If *any* condition is applicable, override final risk level to very high.

☐ 1. Sexual abuse case AND the abuser is likely to have access to the child victim AND has not successfully completed treatment.
☐ 2. Non-accidental injury to a child under age 3, AND caretaker has not successfully completed treatment.
☐ 3. Severe non-accidental injury, AND caretaker has not successfully completed treatment.
☐ 4. Caretaker action or inaction resulted in death of a child due to abuse or neglect, AND caretaker has not successfully completed treatment.

Discretionary Override
If a discretionary override is made, select "Yes," select override risk level, and indicate reason. Risk level will be overridden one level higher.

O Yes O No 5. If "Yes," override risk level(select one): O Moderate O High O Very High

Discretionary override reason:

Supervisor Review/Approval:_____ Approval Date: _____

FINAL RISK LEVEL: O Low O Moderate O High O Very High

© 2021 by NCCD, All Rights Reserved

SECTION 2: FAMILY VISITATION PLAN EVALUATION (See definitions and complete per child as instructed in Appropriate Completion section below.)

Family Visitation Frequency Engagement With Family Visitation Plan	Quality of Face-to-Face Family Visitation	
	Strong/Acceptable Quality*	Limited/Unsafe Quality
Excellent Engagement		
Good Engagement		
Fair Engagement		
Poor or No Engagement		

*Shaded cells indicate acceptable family visitation.

Comments:

SECTION 3: REUNIFICATION SAFETY REVIEW

IF RISK LEVEL IS LOW OR MODERATE AND CARETAKER HAS ATTAINED AN ACCEPTABLE LEVEL OF FAMILY VISITATION (EXCELLENT/GOOD ENGAGEMENT, STRONG/ACCEPTABLE QUALITY), COMPLETE A REUNIFICATION SAFETY REVIEW. OTHERWISE, GO TO SECTION 4.

SECTION 3A: SAFETY FACTOR REVIEW

Directions: Review the safety factors listed in the initial assessment to determine if any previously identified factors are still present or if any new factors are currently present.

Factors Influencing Child Vulnerability (conditions that may limit a child's ability to protect self; select any factors that apply to any child)

☐ Age 0–5 years

☐ Any child has diminished developmental/cognitive capacity or exceptional mental health condition

☐ Any child has diminished physical capacity or exceptional medical condition

☐ Any child is not readily accessible to community oversight

© 2021 by NCCD, All Rights Reserved

A. Safety Factor Identification

The following list of factors are behaviors or conditions that may be associated with a child being in **immediate** danger of serious harm. Identify the presence or absence of each factor by selecting "Yes" or "No." Select "Yes" if the factor applies to any child in the household. The assessment shall cover all children in the home and all others present. The focus of the assessment is on conditions that exist at the time of the assessment.

O **Yes** O **No** **1. Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current Investigation/Family Assessment.**

Comments:

O **Yes** O **No** **2. Caretaker's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.**

Comments:

O **Yes** O **No** **3. There is evidence that the mother used alcohol or other drugs during pregnancy, AND current circumstances suggest the infant's safety is of immediate concern.**

Comments:

O **Yes** O **No** **4. The family is refusing access to the child or there is reason to believe that the family is about to flee, AND available information suggests that child safety is of immediate concern.**

Comments:

O **Yes** O **No** **5. Caretaker does not provide supervision necessary to protect child from potentially serious harm.**

Comments:

O **Yes** O **No** **6. Caretaker fails to protect child from serious physical harm or threatened harm by others.**

Comments:

© 2021 by NCCD, All Rights Reserved

O Yes O No **7. Domestic violence exists in the home, AND circumstances suggest that child safety (physical and/or emotional) is of immediate concern.**

Comments:

O Yes O No **8. Caretaker is unwilling or unable to meet the child's most basic needs (food, clothing, shelter, and/or medical/dental/mental health care), AND this causes the child to be in imminent danger.**

Comments:

O Yes O No **9. Child's physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status.**

Comments:

O Yes O No **10. Caretaker actions cause significant and excessive emotional distress for the child, AND available information suggests that child safety is of immediate concern.**

Comments:

O Yes O No **11. Child sexual abuse is suspected, AND circumstances suggest that child safety is an immediate concern.**

Comments:

O Yes O No **12. Current circumstances, combined with information that the caretaker has or likely has seriously maltreated a child in the past, suggests that child safety may be an immediate concern.**

Comments:

© 2021 by NCCD, All Rights Reserved

○ **Yes** ○ **No** **13. Other safety factors.**

Comments:

○ **14. No safety factors.**

Comments:

IF THERE ARE NO SAFETY FACTORS PRESENT, GO TO PART C AND SELECT "SAFE."

B. Safety Response—Planning Capacities and Protecting Interventions

For each safety factor identified in Section 1, consider the resources available to the family and the community that might help to keep the child safe. Select each protecting intervention taken to protect the child and explain below. Describe all protecting safety interventions taken or immediately planned by you or anyone else, and explain how each intervention protects (or protected) each child.

Planning Capacities

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

☐ 1. Caretaker is capable of participating in a safety plan.
☐ 2. Caretaker is willing to participate in a safety plan.
☐ 3. Caretaker has at least one supporting safe adult who was not involved in the allegation and is willing and able to participate in a safety plan.

Other

☐ 4. _____

© 2021 by NCCD, All Rights Reserved

Protecting Interventions

Considering each identified safety threat and available planning capacities, determine which of the following protecting interventions will be implemented to control the safety threat. Protecting Interventions will allow the child to remain in the home for the present time. A safety plan is required to systematically describe interventions and facilitate follow-through. If there are no available safety interventions that would allow the child to remain in the home, indicate by selecting item 9, and follow procedures for initiating court action to file for custody.

☐ 1. Monitoring or direct services by Family Services Specialist.
☐ 2. Use of family resources, neighbors, or other individuals in the community in the development and implementation of a safety plan.
☐ 3. Use of community agencies or services as a safety resource (specify agency or resource):.

☐ 4. Alleged abuser/neglector left the home:
- ☐ Voluntarily
- ☐ In response to police intervention
- ☐ Legal action
- ☐ Other: _____

☐ 5. Non-maltreating caretaker moved to a safe environment with the child.
☐ 6. Caretaker placed child outside the home(specify): _____
☐ 7. Legal action initiated; child remains in the home (explain in summary)
- ☐ Restraining Order
- ☐ Protective Order
- ☐ Emergency committal order
- ☐ Change in custody/visitation/guardianship
- ☐ Other, specify: _____

☐ 8. Other intervention to allow child to remain in the home: _____
☐ 9. Emergency removal was conducted to remove child(ren) from home due to immediate safety issues

C. Safety Decision

Identify your safety decision by selecting the appropriate line. Select only one. This decision should be based on the assessment of all safety factors, protecting interventions, and any other information known about the case. "Safe" should be selected only if no safety factors were identified in Section 1, Safety Factor Identification.

○ 1. **Safe:** There are no children likely to be in immediate danger of serious harm.

○ 2. **Conditionally safe:** Protective safety interventions have been taken and have resolved the unsafe situation for the present time. These interventions are included in the attached safety plan.

○ 3. **Unsafe:** Approved removal and placement was the only possible intervention for the child. Without placement, the child will likely to be in danger of immediate or serious harm. See attached safety plan or court order.

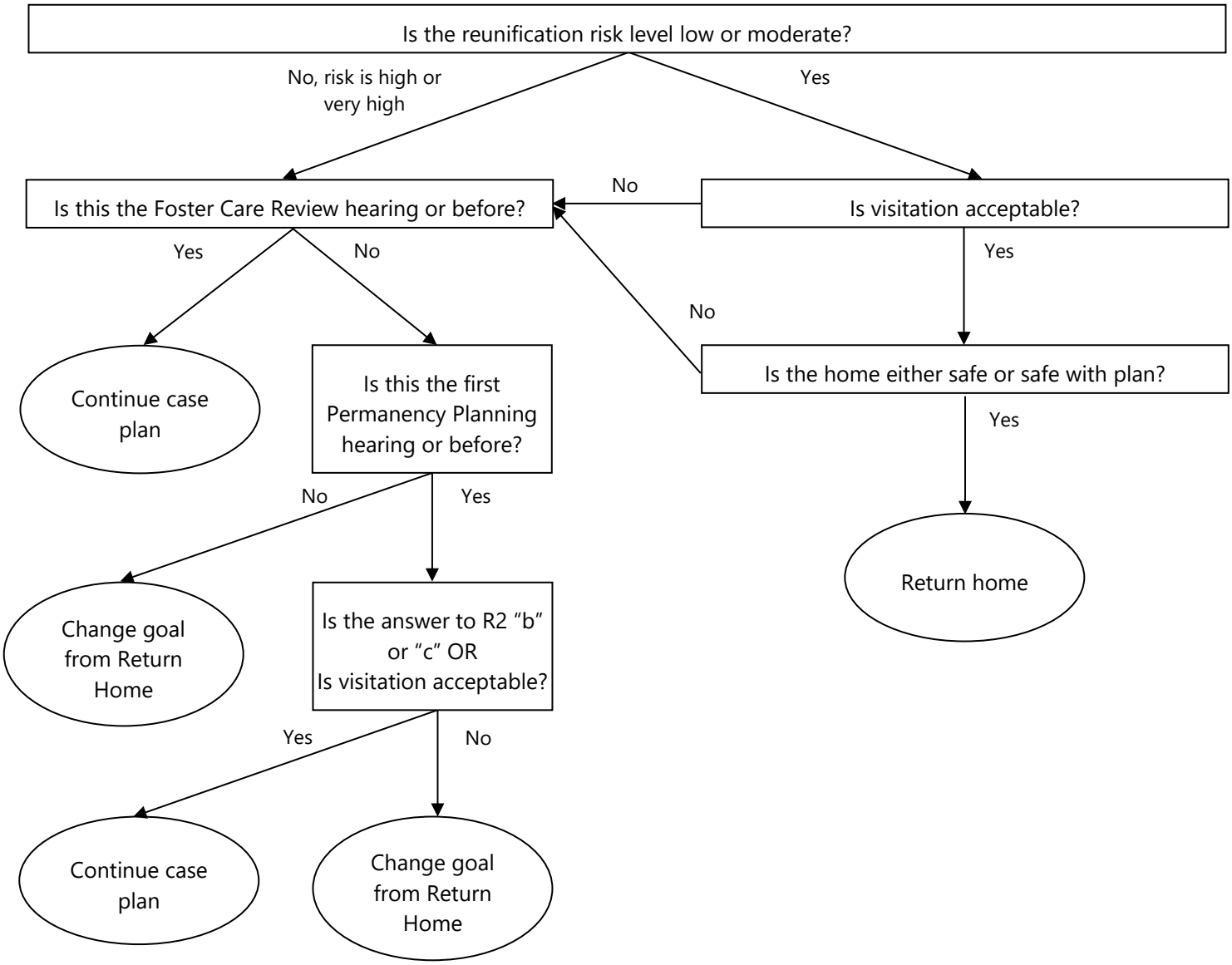
Comments:

© 2021 by NCCD, All Rights Reserved

If decision is "unsafe" and any children are left in the home, explain why:

SECTION 4: PLACEMENT/PERMANENCY PLAN GUIDELINES

Complete for each child and enter results below in Section 5.



© 2021 by NCCD, All Rights Reserved

SECTION 5: PERMANENCY PLAN RECOMMENDATION SUMMARY (record recommendation for each child)

Child's Name	Recommendation		
	Return Home	**Continue Case Plan**	**Change Goal From Return Home***
1.			
2.			
3.			
4.			

***If "Change Goal From Return Home," schedule a family partnership meeting.

POLICY OVERRIDE

☐ If child has been in foster care for 15 out of last 22 months, recommendation must be "Change Goal From Return Home."

Final recommendation: _____

Family Services Specialist Signature	Date	Supervisor Review/Approval	Date

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY REUNIFICATION REVIEW
DEFINITIONS

SECTION 1: FAMILY REUNIFICATION RISK REVIEW

R1. Most recent risk assessment level

The initial risk level on the risk assessment is used to score this item. If a new protection case was opened while this case is still open and a new risk assessment was completed, use the most recent risk assessment level. Note: Do not use the risk reassessment level.

R2. Caretaker progress toward meeting needs identified in case plan

Assess this item based on whether the caretaker consistently demonstrates the skills learned from participation in recommended service(s). High-need areas include major problems where a negative score may be identified on the FSNA (initial or review).

a. If case plan has been in effect for less than 30 days at the time of the reunification review, this item cannot be assessed.

b. Successfully met all current case plan responsibilities; continuing cooperation with services; significant progress in all applicable high-need areas. Caretaker has successfully met *all* current case plan responsibilities. After meeting these responsibilities, they continue to cooperate with service recommendations. Caretaker demonstrates significant progress in all applicable high-need areas.

c. Actively participating in programs; pursuing responsibilities detailed in the case plan; continuing progress in all applicable high-need areas. Caretaker is actively participating in all services and demonstrates an effort in pursuing the responsibilities detailed in the case plan. They continue to show progress in all applicable high-need areas.

d. Partial participation in pursuing responsibilities in the case plan; demonstrates progress in at least one applicable high-need area. Caretaker is participating in some services. They also show some progress in at least one high-need area.

e. Some level of participation in pursuing responsibilities in the case plan; marginal progress toward reducing needs. Caretaker is participating in services, has made some progress but is not fully complying with case plan objectives, or has not yet demonstrated the skills learned from participation in services.

f. Lack of involvement/no involvement in service recommendation. Caretaker has made no progress based on service recommendations due to a failure or inability to participate.

© 2021 by NCCD, All Rights Reserved

R3. Has a new Protective case opened AND required a new identified service; OR was it founded since the last family risk assessment, risk reassessment, or reunification review?

a. No, no referrals have been received, a report was unfounded, or an assessment did not require services since the last family risk assessment, risk reassessment, or reunification review.

b. Yes, a new Protective case was opened AND required new identified service; OR a new Protective case was founded since the last family risk assessment, risk reassessment, or reunification review.

SECTION 2: VISITATION PLAN EVALUATION

Family Visitation Frequency—Engagement With Family Visitation Plan

Excellent engagement:	Caretaker regularly attends family visits and calls in advance if they need to reschedule (90% to 100% participation).
Good engagement:	Caretaker may miss family visits occasionally and rarely requests to reschedule (65% to 89% participation).
Fair engagement:	Caretaker misses or reschedules many scheduled family visits (26% to 64% participation).
Poor or no engagement:	Caretaker does not have family visits or attends 25% or fewer of the scheduled family visits (0% to 25% participation).

Quality of Face-to-Face Family Visitation

Quality of family visits is based on the FSS's direct observation whenever possible, supplemented by case aides, family members, observation of child, reports of foster parents, etc. The following are behaviors to look for, depending on the age and developmental level of the child, the context of desired outcomes in planning with families that ensure safety, and the opportunities a caretaker may have had to demonstrate these behaviors.

© 2021 by NCCD, All Rights Reserved

Quality of Face-to-Face Visit	
Strong/Acceptable Quality	**Limited/Unsafe Quality**
Caretaker: • Visits are currently unsupervised. • Consistently demonstrates acts of protection and supportive behaviors toward the child that are consistent with goals. • Often reinforces appropriate roles and boundaries for child (e.g., a caretaker preserves caretaker-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 child's physical and emotional needs; responds adequately to these needs. • Demonstrates effective limit-setting and discipline strategies. • Demonstrates a focus on the child during visits; shows empathy toward child. • Demonstrates interest in school, other child activities, medical appointments, etc.	Caretaker: • Has not been successful in progressing visitation toward unsupervised and/or extended visits, or has had significant visitation setbacks that have required increasing supervision due to safety concerns for the child. • May not demonstrate protective capacities and supportive behaviors toward the child that are consistent with goals. • May struggle or have severely limited ability to reinforce appropriate roles and boundaries for child (e.g., preserve caretaker-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. • Unable or unwilling to demonstrate modeled responses to child's needs. • May not be focused on child during parenting time and/or conducts self inappropriately during visit (e.g., arrives for parenting time while substance impaired, reinforces "parentification" of child, knowingly makes false promises to child, acts aggressively toward *visitation supervisor* in presence of child).

© 2021 by NCCD, All Rights Reserved

SECTION 3: REUNIFICATION SAFETY REVIEW

Factors Influencing Child Vulnerability

Age 0 to 5 years
Any child in the household is under the age of 5. Younger children are considered more vulnerable, as they are less verbal and less able to protect themselves from harm. Younger children also have less capacity to retain memory of events. Infants are particularly vulnerable, as they are nonverbal and completely dependent on others for care and protection.

Any child has diminished developmental/cognitive capacity or exceptional mental health condition
Any child in the household has diminished developmental/cognitive capacity, which has an impact on ability to communicate verbally or to care for and protect self from harm.

OR

Any child in the household has a mental health condition that significantly impairs ability to protect self from harm (diagnosis may not yet be confirmed but preliminary indications are present). Examples may include but are not limited to severe depression, child/adolescent substance use, or behavioral health challenges.

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

OR

Any child in the household has a medical condition that significantly impairs ability to protect self from harm (diagnosis may not yet be confirmed but preliminary indications are present). Examples may include but are not limited to severe asthma or medical fragility (e.g., requires assistive devices to sustain life).

Any child is not readily accessible to community oversight
The child is isolated or less visible within the community (e.g., the family lives in an isolated community, the child may not attend a public or private school, and the child is not routinely involved in other activities within the community).

© 2021 by NCCD, All Rights Reserved

Section A: Safety Factor Identification

1. **Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current Investigation/Family Assessment**
   Examples include but are not limited to the following.

   - Child fatality or near-fatality, and other children are present in the home.
   - Caretaker caused serious injury, other than accidental, such as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, or severe cuts. Also include any other physical injury that seriously impairs the health or well-being of the child (e.g., suffocating, shooting, bruises/welts, bite marks, choke marks) and requires medical treatment.
   - Caretaker committed act that placed child at risk of significant/serious pain that could result in impairment or loss of bodily function.
   - Threat to cause harm or retaliate against child. Threat of action that would result in serious harm; or household member plans to retaliate against child for CPS Investigation/Family Assessment.
   - Caretaker has used excessive physical discipline or force or bizarre physical discipline; or caretaker punished child beyond the duration of the child's endurance.

2. **Caretaker's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern**
   Examples include but are not limited to the following.

   - Medical evaluation indicates injury is non-accidental; caretaker denies or attributes injury to accidental causes or there are significant discrepancies or contradictions between caretaker's explanation and medical evaluation.
   - Caretaker minimizes the extent of harm to the child or blames the child for the injury.

3. **There is evidence that the mother used alcohol or other drugs during pregnancy, AND current circumstances suggest the infant's safety is of immediate concern**
   Examples include but are not limited to the following.

© 2021 by NCCD, All Rights Reserved

Infant is born with medical complications as a result of in utero substance exposure, and caretaker response suggests inability or unwillingness to meet the infant's exceptional needs.

Caretaker or infant's level of toxicity and/or type of drug present suggests caretaker will be unable to meet the infant's basic needs upon discharge.

Caretaker does not/has not attended to the infant in the hospital.

Behavior of caretaker with inadequate support system suggests caretaker will be unable to meet the infant's basic needs upon discharge.

4. The family is refusing access to the child or there is reason to believe that the family is about to flee, AND available information suggests that child safety is of immediate concern

Examples include but are not limited to the following.

- Family removed the child from a hospital against medical advice to avoid Investigation/Family Assessment.
- Family has previously fled in response to a CA/N Investigation/Family Assessment.
- Family has history of keeping the child away from peers, school, or other outsiders for extended periods to avoid Investigation/Family Assessment.

5. Caretaker does not provide supervision necessary to protect child from potentially serious harm

Examples include but are not limited to the following.

- Caretaker is present but does not attend to 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); and/or caretaker leaves or exposes child to circumstances that create opportunities for serious harm, such as leaving child unattended in vehicle (time period varies with age and developmental stage).
- Caretaker is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).
- Caretaker makes inadequate and/or inappropriate babysitting or childcare arrangements, or demonstrates very poor planning for the child's care.
- Caretaker's substance or alcohol use is having a serious impact on ability to provide adequate supervision to the child.

© 2021 by NCCD, All Rights Reserved

- Caretaker's physical, intellectual, or mental health condition is having a serious impact on ability to supervise the child.

6. Caretaker fails to protect child from serious physical harm or threatened harm by others

Caretaker fails to protect child from serious harm or threatened harm by others, and, as a result, the child is in immediate danger of physical abuse, neglect, sexual abuse, or exploitation by someone with access to the child. This may include but is not limited to the following.

- Caretaker allows an individual(s) with recent, chronic, or severe violent behavior access to child.

- Caretaker knowingly takes child to dangerous locations where drugs are manufactured or sold (e.g., meth labs or drug houses) or to locations used for prostitution or production of pornography.

7. Domestic violence exists in the home, AND circumstances suggest that child safety (physical and/or emotional) is of immediate concern

Examples include but are not limited to the following.

- Child was aware of, witnessed, or heard a domestic violence incident.

- Child was injured (physical or emotional) during a domestic violence incident.

- Caretaker used a weapon during a domestic violence incident OR has used one in the past when the children were present.

- Child attempted to intervene OR has intervened in the past during a domestic violence incident.

- Child is fearful for own safety OR for the safety of a caretaker as a result of domestic violence in the home.

- Caretaker is unable to self-protect or protect child during incidents of domestic violence.

- Domestic violence in the home is increasing in frequency or intensity.

- Other indicators exist of highly dangerous domestic violence situations such as stalking, hostage taking or abduction, abuse of animals, or other controlling behaviors.

© 2021 by NCCD, All Rights Reserved

8. Caretaker is unwilling or unable to meet the child's most basic needs (food, clothing, shelter, and/or medical/dental/mental health care), AND this causes the child to be in imminent danger

Examples include but are not limited to the following.

- No housing/emergency shelter, and child must sleep on the streets.
- No food provided or available to the child, or child is starved/deprived of food/drink for long periods.
- Child is without minimally warm clothing in cold months.
- Caretaker does not seek treatment for child's immediate medical/dental or mental health condition(s) OR does not follow prescribed treatments.
- Child appears malnourished or has been diagnosed as non-organic failure to thrive.
- Child has exceptional needs that caretaker cannot/will not meet. Needs include being medically fragile.
- Child is a threat to self or others, and caretaker will not take protective action

9. Child's physical living conditions are hazardous and immediately threatening, based on the child's age and developmental status

Examples include but are not limited to the following.

- Gas leaking from a stove or heating unit, windows broken/missing, and/or electrical wires exposed.
- Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink, or in the open.
- Lack of water, heat, plumbing, or electricity, and provisions are inappropriate.
- Excessive garbage or rotted/spoiled food and/or human/animal waste that threatens health.
- Guns and other weapons are easily accessible.
- Dangerous drugs are being manufactured on premises with child present.

© 2021 by NCCD, All Rights Reserved

10. Caretaker actions cause significant and excessive emotional distress for the child, AND available information suggests that child safety is of immediate concern
Examples include but are not limited to the following.

- Child fears unreasonable retribution/retaliation from caretaker and/or others in the home.

- Caretaker repeatedly describes or speaks to child in a demeaning or degrading manner.

- Caretaker repeatedly blames child for a particular incident OR views child as responsible for caretaker's or family's problems.

- Caretaker repeatedly expects child to perform or act in a way that is impossible or improbable for child's age or developmental stage (e.g., babies and young children expected not to cry, to be still for extended periods, to be toilet trained, to eat neatly, to care for younger siblings, or to stay alone).

11. Child sexual abuse is suspected, AND circumstances suggest that child safety is an immediate concern
Suspicions of sexual abuse may include but are not limited to the following.

- Child discloses sexual abuse, exploitation, and/or trafficking. Disclosures can be either verbal or behavioral.

- Medical findings are consistent with sexual abuse.

Circumstances suggesting child safety is an immediate concern include but are not limited to the following.

- The alleged abuser has continued access to the child.
- Caretaker blames child for the sexual abuse.

12. Current circumstances, combined with information that the caretaker has or likely has seriously maltreated a child in the past, suggests that child safety may be an immediate concern
This item requires two conditions to answer "Yes." First, *previous* maltreatment was severe OR the caretaker's response to the *previous* intervention was inappropriate (e.g., failure to take recommended safety steps or failure to benefit from professional help). Second, there must be *current* circumstances that, considered in light of the prior incidents, indicate there are safety issues now. In other words, the fact of prior maltreatment does not necessarily mean that "Yes" should be selected for this safety factor.

© 2021 by NCCD, All Rights Reserved

Examples of prior serious or severe maltreatment include but are not limited to the following.

- Prior child fatality or near-fatality as a result of maltreatment.
- Prior serious non-accidental harm or threat of serious harm to any child.
- Termination of parental rights or failed reunification.

13. Other safety factors

This item should ONLY be used if there are other immediate safety issues not identified above. Any factors in the "other" category require a brief narrative description of the caretaker's actions or inactions that result or could likely result in an immediate danger.

14. No safety factors

This item should ONLY be selected if there are NO identified safety factors. Consider additional information gathered during Investigation/Assessment in determining appropriate services and ongoing interventions.

SECTION 4: PLACEMENT/PERMANENCY PLAN GUIDELINES

Continue case plan. Do not return the child to the removal home. Continue reunification efforts with the household.

Change permanency plan (PP) goal. Change the permanency plan goal from reunification to removal home to placement with relative, adoption, permanent foster care, independent living, or another planned permanent living arrangement. Stop efforts to return the child to the removal home.

Return home. Recommend that the child returns to the removal home.

SECTION 5: PERMANENCY PLAN RECOMMENDATION SUMMARY

Return the child to the removal home. Based on the reunification review results, recommend that the child is eligible to return to the removal home.

Continue case plan. Based on the reunification review results, recommend to keep the child in foster care and continue reunification efforts with the removal household.

Change goal from return home. Based on the reunification review results, recommend a change in the child's permanency plan goal to return home, placement with relative, adoption, permanent foster care, independent living, or another planned permanent living arrangement.

© 2021 by NCCD, All Rights Reserved

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY REUNIFICATION REVIEW
POLICY AND PROCEDURES

The SDM family reunification review consists of five sections that are used to evaluate risk, visitation engagement, and safety issues; describe permanency plan guidelines; and record the permanency plan goal and case status. Results are used to reach a permanency plan recommendation and to guide decisions about whether to return a child home. The family reunification review is conducted in conjunction with the family strengths and needs review.

WHICH CASES

All cases in which at least one child is out of the home with a goal of return home (court ordered only). Also, all ongoing CPS cases where the child has been in a voluntary placement for more than 90 days.

***Note*: In certain situations, the SDM system should be used with CHINS cases: (1) when the request for custody is due to CA/N allegations but, for whatever reason, the case is ultimately adjudicated as a CHINS case; and (2) when the child enters care with a CHINS petition, but by final adjudication the judge decides that it is a CA/N case.**

WHO

The FSS.

WHEN

- For cases in which all children are in foster care, in conjunction with the court review and permanency plan hearing(s).
  - » Prior to the court review and permanency planning hearing(s);
  - » At the 60-day hearing, if return home is a possibility;
  - » Any time a trial home visit is being considered;
  - » Any time a return home is being considered.

- For dual cases (one or more children in foster care and one or more at home with a treatment plan), at the time of the 60-day dispositional hearing and every 90 days thereafter. However, if any reassessment is more than 30 days old at the time of the court hearing, it should be updated.

© 2021 by NCCD, All Rights Reserved

DECISIONS

The family reunification review results determine whether a case is eligible for a recommendation for reunification to the removal home if the home is safe or conditionally safe. If families have effectively reduced risk to low or moderate and have achieved good or excellent engagement with visitation, a reunification safety review is conducted and the results are used to determine if the home environment is safe. The permanency plan guidelines and recommendation sections guide decisions to return a child home or to change the permanency goal.

APPROPRIATE COMPLETION

Section 1: Family Reunification Risk Review

Complete the reunification risk review. For question R2 (progress with service plan), enter a score of 0 if the plan has been in place less than 30 days at the time of the 60-day hearing.

Section 2: Visitation Plan Evaluation

For each child, indicate the level at which the caretaker has engaged in the visitation plan (excellent, good, fair, poor). Then, for each child, indicate the evaluation of the quality of family visitation (strong/acceptable or limited/unsafe).

Section 3: Reunification Safety Review

If risk is high or very high OR caretakers have not achieved a good or excellent visitation engagement rating, skip to Section 4. If risk has been reduced to low or moderate AND the caretakers have achieved a good or excellent visitation engagement rating, complete a reunification safety review.

Section 3A: Safety Assessment

First, review the safety assessment(s) that led to the removal of the child. Complete safety assessment.

A. Safety Factor Identification

Identify if any safety factors are present.

B. Safety Response—Planning Capacities and Protecting Interventions

This section is completed only if one or more safety factors were identified. *If one or more safety factors are present, it does not automatically follow that a child cannot be returned*. In many cases, it will be possible for a temporary plan to be initiated that will mitigate the safety factors sufficiently so that the child may return home while case services continue. Consider the relative severity of the safety factor(s), the caretaker's ability and willingness to work toward solutions, the availability of resources, and the vulnerability of the child.

© 2021 by NCCD, All Rights Reserved

The safety intervention list is made up of general categories of interventions rather than specific programs. The FSS should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the safety factor(s), and whether there is reason to believe the caretaker 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 FSS may determine that even with an intervention the child would be unsafe; or the FSS may determine that an intervention would be satisfactory but has reason to believe the caretaker would not follow through. Also keep in mind that *the safety intervention is not the case plan*: It is not intended to "solve" household problems or provide long-term answers. A safety *intervention* permits a child to return home while case services continue.

If one or more safety factors were identified and the FSS determines that interventions are unavailable, insufficient, or may not be used, the child will remain in placement.

If one or more interventions will be implemented, select each category that will be used. If there is an intervention that will be implemented that does not fit the other categories, select line 8 and briefly describe the intervention.

C. Safety Decision

In this section, the FSS records the result of the safety assessment. There are three choices:

a. **Safe.** Select this line if *no* safety factors were identified. The SDM model guides the worker to recommend reunification.

b. **Conditionally safe.** If one or more safety factors were identified and the worker was able to identify sufficient protective interventions that lead the worker to believe the child may return home for the present time. Attach safety plan.

c. **Unsafe.** If the FSS determines that one or more children cannot safely return home even after considering a complete range of interventions. It is possible that the worker will determine that interventions make it possible for one child to return home while another must remain out of the home. Select this line if ANY child is returned.

- Accurate completion of the safety tool adheres to the following logic.
- If no safety factors are selected, there should be no interventions selected and the only possible safety decision is *1. Safe, no intervention required*.
- If one or more safety factors AND one or more interventions are selected, the safety decision is *2. Conditionally safe, requiring intervention*. Child may be recommended for return home after safety interventions are in place.

© 2021 by NCCD, All Rights Reserved

- If one or more safety factors are selected and no interventions are selected, the safety decision must be *3. Unsafe, requiring continued placement*.

Section 4: Placement/Permanency Plan Guidelines
The decision tree provided in Section 4 is used to determine if a child is to be recommended for reunification to the removal home or maintained in foster care, or if a recommendation for a change in the permanency plan goal is warranted. Follow the tree to conclusion.

Section 5: Permanency Plan Recommendation Summary
Complete Section 5 for *all* reunification reviews. Enter the name and date of placement for each child in placement and select the recommended permanency goal. If "Change Goal From Return Home" is selected, you MUST document the new permanency plan.

Select an override if an override will be used to change the permanency plan goal recommendation to "Change Goal From Return Home" for any child. Document the rationale and the new permanency plan goal recommendation. Indicate supervisory approval of all overrides.

© 2021 by NCCD, All Rights Reserved

Appendix

Kansas Milestone Chart

© 2021 by NCCD, All Rights Reserved

Developmental Milestones Chart

Developed by the Institute for Human Services for the Ohio Child Welfare Training Program

July 2008

Overview: This developmental milestones chart is designed specifically for child welfare staff. It includes normal expectations of developmental milestones for children birth through adolescence, and information about the possible effects of maltreatment.

How to Use: Child welfare professionals will find many ways to use this chart. Below are some suggestions:

- Review the chart prior to scheduled interactions with children to prompt your recall of common milestones and to help you identify potential developmental delays or concerns.
- Copy the chart that corresponds to the age of the child you will be seeing, and use it to assess the child's achievement of milestones and apparent delays. Circle apparent delays, or developmental areas needing further assessment.

Written by IHS for the Ohio Child Welfare Training Program Final 2008.
Adapted, with permission, for State of Kansas Department for Children and Families-January 2017

Kansas
Department for Children and Families
Families Make a Strong Kansas

Infants and Toddlers

Physical	Cognitive	Social	Emotional	Possible Effects of Maltreatment
Newborn: rough, random, uncoordinated, reflexive movement 3 mo: head at 90-degree angle, uses arms to prop; visually track through midline 5 mo: purposeful grasp; roll over; head lag disappears; reaches for objects; transfer objects from hand to hand; plays with feet; exercises body by stretching, moving; touch genitals, rock on stomach for pleasure 7 mo: sits in "tripod"; push head and torso up off the floor; support weight o n legs; "raking" with hands 9 mo: gets to and from sitting; crawls, pulls to standing; stooping and recovering; finger- thumb opposition; eye- hand coordination, but no hand preference 12 mo: walking 15 mo: more complex motor skills 2 yrs: learns to climb up stairs first, then down	Sensorimotor: physically explores environment to learn about it; repeats movements to master them, which also stimulates brain cell development 4-5 mo: coos, curious and interested in environment 6 mo: babbles and imitates sounds 9 mo: discriminates between parents and others; trial and error problem solving 12 mo: beginning of symbolic thinking; points to pictures in books in response to verbal cue; object permanence; some may use single words; receptive language more advanced than expressive language 15 mo: learns through imitating complex behaviors; knows objects are used for specific purposes 2 yrs: 2 word phrases; uses more complex toys and understands sequence of putting toys, puzzles together	Attachment: baby settles when parent comforts; toddler seeks comfort from parent, safe-base exploration 5 mo: responsive to social stimuli; facial expressions of emotion 9 mo: socially interactive; plays games (i.e., patty- cake) with caretakers 11 mo: stranger anxiety; separation anxiety; solitary play 2 yr: imitation, parallel and symbolic, play	Birth-1 yr: learns fundamental trust in self, caretakers, environment 1-3 yr: mastery of body and rudimentary mastery of environment (can get others to take care of him) 12-18 mo: "terrible twos" may begin; willful, stubborn, tantrums 18-36 mo: feel pride when they are "good" and embarrassment when they are "bad" 18-36 mo: Can recognize distress in others – beginning of empathy 18-36 mo: are emotionally attached to toys or objects for security	Chronic malnutrition: growth retardation, brain damage, possibly mental retardation Head injury and shaking: skull fracture, mental retardation, cerebral palsy, paralysis, coma, death, blindness, deafness Internal organ injuries Chronic illness from medical neglect. Delays in gross and fine motor skills, poor muscle tone Language and speech delays; may not use language to communicate Insecure or disorganized attachment: overly clingy, lack of discrimination of significant people, can't use parent as source of comfort Passive, withdrawn, apathetic, unresponsive to others "Frozen watchfulness", fearful, anxious, depressed Feel they are "bad"

Physical	Cognitive	Social	Emotional	Possible Effects of Maltreatment
				Immature play – cannot be involved in reciprocal, interactive play

Preschool

Physical	Cognitive	Social	Emotional	Possible Effects of Maltreatment
Physically active Rule of Three: 3 yrs, 3 ft, 33 lbs. Weight gain: 4-5 lbs per year Growth: 3-4 inches per year Physically active, can't sit still for long Clumsy throwing balls Refines complex skills: hopping, jumping, climbing, running, ride "big wheels" and tricycles Improving fine motor skills and eye-hand coordination: cut with scissors, draw shapes 3– 3 ½ yr: most toilet trained	Ego-centric, illogical, magical thinking Explosion of vocabulary; learning syntax, grammar; understood by 75% of people by age 3 Poor understanding of time, value, sequence of events Vivid imaginations; some difficulty separating fantasy from reality Accurate memory, but more suggestible than older children Primitive drawing, can't represent themselves in drawing till age 4 Don't realize others have different perspective Leave out important facts. May misinterpret visual cues of emotions	Play: Cooperative, imaginative, may involve fantasy and imaginary friends, takes turns in games Develops gross and fine motor skills; social skills; experiment with social roles; reduces fears Wants to please adults Development of conscience: incorporates parental prohibitions; feels guilty when disobedient; simplistic idea of "good and bad" behavior Curious about his and other's bodies, may masturbate No sense of privacy primitive, stereotypic understanding of gender roles	Self-esteem based on what others tell him or her Increasing ability to control emotions; less emotional outbursts Increased frustration tolerance Better delay gratification Rudimentary sense of self Understands concepts of right and wrong Self-esteem reflects opinions of significant others Curious Self-directed in many activities	Poor muscle tone, motor coordination Poor pronunciation, incomplete sentences Cognitive delays; inability to concentrate Cannot play cooperatively; lack curiosity, absent imaginative and fantasy play Social immaturity: unable to share or negotiate with peers; overly bossy, aggressive, competitive Attachment problems: overly clingy, superficial attachments, show little distress or over-react when separated from caregiver Underweight from malnourishment; small stature Excessively fearful, anxious, night terrors

Physical	Cognitive	Social	Emotional	Possible Effects of Maltreatment
	Receptive language better than expressive till age 4			Reminders of traumatic experience may trigger severe anxiety, aggression, preoccupation Lack impulse control, little ability to delay gratification Exaggerated response (tantrums, aggression) to even mild stressors Poor self-esteem, confidence; absence of initiative Blame self for abuse, placement Physical injuries; sickly, untreated illnesses Enuresis, encopresis, self-stimulating behavior – rocking, head-banging

School Aged

Physical	Cognitive	Social	Emotional	Possible Effects of Maltreatment
Slow, steady growth: 3 -4 inches per year Use physical activities to develop gross and fine motor skills Motor & perceptual motor skills better integrated 10-12 yr: puberty begins for some children	Use language as a communication tool Perspective taking: 5-8 yr: can recognize others' perspectives, can't assume the role of the other 8–10 yr: recognize difference between behavior and intent; age 10-11 yr: can accurately recognize and consider others' viewpoints Concrete operations: Accurate perception of events; rational, logical thought; concrete thinking; reflect upon self and attributes; understands concepts of space, time, dimension Can remember events from months, or years earlier More effective coping skills Understands how his behavior affects others	Friendships are situation specific Understands concepts of right and wrong Rules relied upon to guide behavior and play, and provide child with structure and security 5-6 yr: believe rules can be changed 7-8 yrs: strict adherence to rules 9-10 yrs: rules can be negotiated Begin understanding social roles; regards them as inflexible; can adapt behavior to fit different situations; practices social roles Takes on more responsibilities at home Less fantasy play, more team sports, board games Morality: avoid punishment; self-interested exchanges	Self-esteem based on ability to perform and produce Alternative strategies for dealing with frustration and expressing emotions Sensitive to other's opinions about themselves 6-9 yr: have questions about pregnancy, intercourse, sexual swearing, look for nude pictures in books, magazines 10-12 yr: games with peeing, sexual activity (e.g., strip poker, truth/dare, boy-girl relationships, flirting, some kissing, stroking/rubbing, re-enacting intercourse with clothes on)	Poor social/academic adjustment in school: preoccupied, easily frustrated, emotional outbursts, difficulty concentrating, can be overly reliant on teachers; academic challenges are threatening, cause anxiety Little impulse control, immediate gratification, inadequate coping skills, anxiety, easily frustrated, may feel out of control Extremes of emotions, emotional numbing; older children may "self-medicate" to avoid negative emotions Act out frustration, anger, anxiety with hitting, fighting, lying, stealing, breaking objects, verbal outbursts, swearing Extreme reaction to perceived danger (i.e., "fight, flight, freeze" response) May be mistrustful of adults, or overly solicitous, manipulative May speak in unrealistically glowing terms about his parents

Physical	**Cognitive**	**Social**	**Emotional**	**Possible Effects of Maltreatment**
				Difficulties in peer relationships; feel inadequate around peers; over-controlling Unable to initiate, participate in, or complete activities, give up quickly Attachment problems: may not be able to trust, tests commitment of foster and adoptive parent with negative behaviors Role reversal to please parents and take care of parent and younger siblings Emotional disturbances: depression, anxiety, post-traumatic stress disorder, attachment problems, conduct disorders

Adolescents

Physical	Cognitive	Social	Emotional	Possible Effects of Maltreatment
Growth spurt: Girls: 11-14 yrs Boys: 13-17 yrs Puberty: Girls: 11-14 yrs Boys: 12-15 yrs Youth acclimate to changes in body	Formal operations: precursors in early adolescence, more developed in middle and late adolescence, as follows: Think hypothetically: calculate consequences of thoughts and actions without experiencing them; consider a number of possibilities and plan behavior accordingly Think logically: identify and reject hypotheses or possible outcomes based on logic Think hypothetically, abstractly and logically Think about thought: leads to introspection and self-analysis Insight, perspective taking: understand and consider others' perspectives, and perspectives of social systems Systematic problem solving: can attack a problem, consider multiple solutions, plan a course of action Cognitive development is uneven, and impacted by emotionality	Young (12 – 14): psychologically distance self from parents; identify with peer group; social status largely related to group membership; social acceptance depends on conformity to observable traits or roles; need to be independent from all adults; ambivalent about sexual relationships, sexual behavior is exploratory Middle (15 – 17): friendships based on loyalty, understanding, trust; self-revelation is first step towards intimacy; conscious choices about adults to trust; respect honesty & straightforwardness from adults; may become sexually active Morality: golden rule; conformity with law is necessary for good of society	Psycho-social task is identity formation Young adolescents (12-14): self-conscious about physical appearance and early or late development; body image rarely objective, negatively affected by physical and sexual abuse; emotionally labile; may over-react to parental questions or criticisms; engage in activities for intense emotional experience; risky behavior; blatant rejections of parental standards; rely on peer group for support Middle adolescents (15-17): examination of others' values, beliefs; forms identity by organizing perceptions of one's attitudes, behaviors, values into coherent "whole"; identity includes positive self-image comprised of cognitive and affective components Additional struggles with identity formation include minority or bi-racial status, being an adopted child, gay/lesbian identity	All of the problems listed in school age section Identity confusion: inability to trust in self to be a healthy adult; expect to fail; may appear immobilized and without direction Poor self-esteem: pervasive feelings of guilt, self-criticism, overly rigid expectations for self, inadequacy May overcompensate for negative self-esteem by being narcissistic, unrealistically self-complimentary; grandiose expectations for self May engage in self-defeating, testing, and aggressive, antisocial, or impulsive behavior; may withdraw Lack capacity to manage intense emotions; may be excessively labile, with frequent and violent mood swings

Physical	Cognitive	Social	Emotional	Possible Effects of Maltreatment
				May be unable to form or maintain satisfactory relationships with peers Emotional disturbances: depression, anxiety, post-traumatic stress disorder, attachment problems, conduct disorders

Content in this chart was adapted from "The Field Guide to Child Welfare Volume III: Child Development and Child Welfare"
By Judith S. Rycus, Ph.D., and Ronald C. Hughes, Ph.D
Child Welfare League of America Press 1998