State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

DATE: February 7, 2018

TO: Regional Managing Directors
Community-Based Care Lead Agency CEOs
Sheriff's Offices Conducting Child Protective Investigations

THROUGH: David L. Fairbanks, Deputy Secretary

FROM: JoShonda Guerrier, Assistant Secretary for Child Welfare
Rebecca Kapusta, Assistant Secretary for Operations

SUBJECT: CFOP 170-1, Florida's Child Welfare Practice Model
Chapter 9, Newborns or Other New Children in Households with Active Investigation or Ongoing Services, and Chapter 13, Confidentiality of Records
Effective Date: February 15, 2018

PURPOSE: The purpose of this memorandum is to provide notification that CFOP 170-1, Florida's Child Welfare Practice Model, Chapter 9, Newborns or Other New Children in Households with Active Investigation or Ongoing Services, and Chapter 13, Confidentiality of Records, have been updated and will be effective February 15, 2018.

BACKGROUND: The new operating procedure replaces the previous version of CFOP 170-1, Chapter 9 and Chapter 13. The major changes made include:

Chapter 9, Newborns or Other New Children in Households with Active Investigation or Ongoing Services, dated April 19, 2017, has been revised to reflect changes that are in accordance with section 39.701, Florida Statute. The revisions include the following:

- Describes the pre-birth assessment tools that are to be completed by the case manager; this includes the FFA-O or Progress Update, whichever is due next at the time he or she learns of the pregnancy.
- Describes that the assessment must be completed at least 30 days before the child is expected to be born; or within 72 hours after the child welfare professional learns of the pregnancy if the child is expected to be born in less than 30 days.
- Requires that child welfare case manager include any new children within the home in the FFA-Ongoing or Progress Update, whichever is due next at least 30 days before the child moves into the home; or within 72 hours after the child welfare professional learn that the child will be moving into the home.

- Provides that Children's Legal Services file the FFA-Ongoing or Progress Update with the court within 14 days of receipt of the document when completed before a child is expected to be born or to move into a home and after the new child enters the home.

Chapter 13, Confidentiality of Records, dated April 19, 2017, has been revised to reflect 2017 Florida Statute requirements. The revisions include the following:

- Added the requirement for confidentiality at case plan conferences for all participants in accordance with CFOP 170-9, paragraph 5-2.
- Modified requirements to allow family of the child and the alleged perpetrator access to Departments records from no later than 30 days to 60 days from the initial report of abuse, neglect, or abandonment.
- Clarifies that case material regarding HIV/AIDS must be kept within the Medical and Mental Health File Cabinet in FSFN.

ACTION REQUIRED: Please share this memorandum with all child protective investigators, case management providers and other service providers as appropriate.

CONTACT INFORMATION: If you require additional information or have any questions, please contact Atarri Hall, Child Safety Specialist, at (850) 717-4651 or Atarri.Hall@myflfamilies.com.

cc: Grainne O'Sullivan, Statewide Director, Children's Legal Services
Regional Family and Community Services Directors
Center for Child Welfare

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, February 15, 2018

CF OPERATING PROCEDURE
NO. 170-1

Child Welfare

FLORIDA'S CHILD WELFARE PRACTICE MODEL

This operating procedure describes the department's child welfare practice model which has been developed to ensure that all children and families served are treated with respect, fairness and equality. This operating procedure includes a description of the least intrusive and least restrictive interventions necessary to achieve child safety, permanency and well-being. This operating procedure also defines safety concepts for intervention and treatment, provides uniform definitions and standard ratings for the evaluation of caregiver protective capacities, child strengths and needs, the quality and frequency of family visitation and progress in achieving case plan outcomes.

This operating procedure applies to hotline staff, child protection investigators, case managers, licensure, adoption and independent living specialists.

BY DIRECTION OF THE SECRETARY

(Signed original copy on file)

JOSHONDA GUERRIER
Assistant Secretary for
Child Welfare

This operating procedure supersedes CFOP 170-1 dated April 19, 2017.
OPR: Office of Child Welfare
DISTRIBUTION: X: OSGC; ASGO; Region/Circuit Child Welfare staff.

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

Chapter 9, Newborns or Other New Children in Households with Active Investigation or Ongoing Services, has been revised to reflect changes that are in accordance with section 39.701, Florida Statute. The revisions include the following:

- Describes the pre-birth assessment tools that are to be completed by the case manager; this includes the FFA-O or Progress Update, whichever is due next at the time he or she learns of the pregnancy.
- Describes that the assessment must be completed at least 30 days before the child is expected to be born; or within 72 hours after the child welfare professional learns of the pregnancy if the child is expected to be born in less than 30 days.
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Chapter 13, Confidentiality of Records, has been revised to reflect 2017 Florida Statute requirements. The revisions include the following:

- Added the requirement for confidentiality at case plan conferences for all participants in accordance with CFOP 170-9, paragraph 5-2.
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- Clarifies that case material regarding HIV/AIDS must be kept within the Medical and Mental Health File Cabinet in FSFN.

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Chapter 1

INTRODUCTION TO FLORIDA'S CHILD WELFARE SYSTEM AND PRACTICE MODEL

1-1. Purpose. The mission of the Department of Children and Families is to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency (s. 20.19, Florida Statutes). The child welfare system is designed to respond to citizen concerns about children who may be victims of abuse, neglect or abandonment; determine whether children are safe, unsafe or at risk; and provide the appropriate interventions to achieve safety, permanency and well-being. The child welfare system involves many professionals: staff who work directly for the department, sheriff's organizations who have agreements with the department to provide child protection investigations, Attorney General's Office, State Attorney's Office, employees of the department, Community Based Care Lead Agencies, Case Management Organizations or Licensed Child Care Placement agencies. All providers in the child welfare system operate under a uniform set of core procedures that are designed to ensure that families and children receive protection and treatment in a manner that is trauma-informed and least-intrusive.

1-2. Authority.

a. Section 409.1451, Florida Statutes (F.S.), the Road-to-Independence Program.

b. Section 409.175, F.S., Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.

c. Sections 409.401, F.S., Interstate Compact on the Placement of Children; 409.402, F.S., Financial Responsibility for Child; 409.403, F.S., Definitions; Interstate Compact on the Placement of Children; 409.404, F.S., Agreements between party state officers and agencies; and 409.405, F.S., Court placement of delinquent children.

d. Titles II, IV, XVI, XIX and XX, Social Security Act, as amended.

e. 45 Code of Federal Regulations (CFR), Parts 1355 through 1357; 45 CFR, Part 233.110; and 45 CFR, Part 435.118.

f. State Plans for Title IV-E, Temporary Assistance for Needy Families, Medicaid and Title IV-D.

1-3. Statutory Intent. Section 39.001, F.S., establishes the purposes and intent of the child welfare system.

1-4. System Outcomes. Florida's child welfare professionals seek to achieve the following outcomes for children:

a. Safety. Florida's children live free from maltreatment.

b. Permanency. Florida's children enjoy long-term, secure relationships within strong families and communities.

c. Well-Being. Florida's children are physically and emotionally healthy, and socially competent. Florida's family's nurture, protect and meet the needs of their children, and are well integrated into their communities.

1-5. Florida's Child Welfare Practice Model. The practice model provides a set of common core safety concepts for determining when children are safe, unsafe, or at risk of subsequent harm and how to engage caregivers in achieving change. Florida's practice model includes the expectation that when children are safe but at high or very high risk for future maltreatment, affirmative outreach and efforts will be provided to engage families in family support services designed to prevent future maltreatment. When children are determined to be unsafe, safety management and case planning is non-negotiable. While service interventions are voluntary for children determined to be safe but at high or very high risk of future maltreatment, the child welfare professional should diligently strive to use motivational interviewing skills to facilitate the parent(s)/legal guardian(s)' understanding of the need for taking action in the present to protect their children from future harm. To accomplish effective application of the safety concepts, seven professional practices are employed: Engage, Partner, Collect Information, Assess and Understand Information, Plan for Child Safety, Plan for Family Change, and Monitor and Adapt Case Plans.

a. Engage. The family is the primary point of communication, involvement and decision making. CFOP 170-5, Child Protective Investigations, and CFOP 170-9, Family Assessment and Case Planning, provide uniform processes that enhance the ability of Child Protection Investigators and Case Managers to engage with the family and those who know the family. Engagement:

(1) Provides parent(s)/legal guardian(s) with information that empowers them.

(2) Seeks to build partnership with the parent(s)/legal guardian(s) and their resource network to collect sufficient information to complete the family assessment and develop safety plans.

(3) Is essential to co-construction of the Case Plan, which includes goals for what must change, related to enhancing Caregiver Protective Capacities and the identification of treatment services.

(4) Supports the family to undertake and maintain the needed change(s).

b. Partner. Partnering occurs throughout the time a child welfare professional works with the family. Child welfare professionals partner with the family, the family's network, other professionals and community partners to achieve understanding of family dynamics and develop safety decisions and actions, including safety planning and management, case planning and assessment of family progress. The partnering process promotes commitment and accountability of the family and all team members toward common goals for the family.

c. Collect Information. Sufficient, relevant information-gathering is the most essential ingredient for effective decision-making. Information is gathered through the information standards, referred to as the Six Information Domains, which include what must be known about children and caregivers to inform effective decision-making.

(1) These Six Information Domains described in the Family Functioning Assessment. The Six Information Domains are: maltreatment; circumstances surrounding maltreatment; child functioning; adult functioning; general parenting; and parental discipline.

(2) Through the collection of this information, the child welfare professional creates an assessment of family functioning and conditions.

(3) The assessment describes the presence or absence of danger threats to child safety, the vulnerability of children, caregiver protective capacities, the sufficiency of safety plans and progress in achieving case plan outcomes.

(4) Information collection begins at the Florida Abuse Hotline and continues during the investigation and throughout ongoing case management services for children who have been determined to be unsafe.

d. Assess and Understand Information.

(1) Immediate circumstances and information already known about family conditions are assessed to accurately identify children in present danger.

(2) Relevant, sufficient information is gathered, assessed and analyzed to complete the family functioning assessment of the children and the actuarial risk assessment of future harm.

(a) Sufficient information about family conditions is gathered to assess whether a child is safe or in impending danger.

(b) When information clearly supports that the parent(s)/legal guardian(s) or other person with significant caregiver responsibility has sufficient caregiver protective capacities to care for and protect the child despite family conditions, the child is determined to be safe.

e. Plan for Child Safety.

(1) There are two times when safety planning is needed

(a) When a child is found to be in present danger, a Present Danger Plan is put in place to control present danger threats and to allow time for sufficient and relevant information collection through the Family Functioning Assessment process.

(b) When an investigator concludes at the end of the Family Functioning Assessment that a child is unsafe an Impending Danger Safety Plan is developed.

(2) Developing a sufficient Impending Danger Safety Plan to control and manage impending danger that is the least intrusive is completed based upon an In-Home Safety Planning Analysis.

(3) Safety plans are managed throughout the life of the case. During the investigation the investigator is responsible for managing the safety plan. When a case is transferred from investigations to ongoing case management, the Lead Agency/CBC becomes responsible for the management of the Impending Danger Safety Plan .

(4) Safety Planning Analysis is used for children with an out-of-home Impending Danger Safety Plan to create Conditions for Return for these children to return home with an in-home Impending Danger Safety Plan.

f. Plan for Family Change. Information gathered through the Family Functioning Assessment-Ongoing results in the development of case plan outcomes related to what behavior(s) or condition(s) must change to keep a child safe.

(1) The Case Plan includes specific, measurable, attainable, reasonable and timely outcomes that are developed jointly with the family.

(2) The family is assisted in identifying the services and supports necessary to achieve each outcome.

g. Monitor and Adapt Case Plans. The Ongoing Family Functioning Progress Update is a formal and ongoing intervention that occurs on a regular basis following the development of the family's Case Plan.

(1) Monitoring case plans follows a standardized approach to measuring progress related to:

(a) Changes in caregiver protective capacities;

(b) Changes in child needs;

(c) Safety plan sufficiency; and,

(d) Motivational readiness to change.

(2) Case plans are adapted as progress is made to further promote change.

(3) Caregiver progress is assessed and documented in the Six Information Domains.

1-6. Case Flow. Family-centered practice skills should be utilized for all actions and decisions during the life of the case to ensure that we correctly identify an unsafe child and remediate the family conditions in the child's family causing the danger for the child. The following is a high level summary of case flow.

a. The Hotline counselor will gather information in the information domains in order to:

(1) Determine whether to screen-in a report and if so, what type of intake it will be.

(2) Establish response times.

b. The investigator will complete a Present Danger Assessment and if there is present danger, will develop and implement a safety plan.

c. The investigator will conduct a FFA-Investigation and determine of one of the following outcomes:

(1) A child is unsafe and in need of protection and intervention.

(2) A child is safe, however has a risk score of "Very High" or "High" and would benefit from family support services.

(3) A child is safe and has a risk score of low or moderate;- and in some situations the family might benefit from referrals to community resources.

d. Upon completion of the FFA-Investigation the investigator will complete the following activities.

(1) When a child is unsafe:

(a) The investigator will complete the in-home safety analysis to determine whether an in-home safety plan is appropriate.

(b) The investigator will establish Conditions for Return (reunification) if an out-of-home safety plan has been developed.

(c) The investigator will transfer the case to the Lead Agency for Community Based Care (CBC) responsible for ongoing safety plan management and case management.

(2) The investigator will refer a case for family support services when the child(ren) has been determined to be safe but at “Very High” or “High” risk of future maltreatment.

e. The case manager will use the assessment information presented in the FFA-Investigation as a starting point for further assessing the underlying family conditions related to impending danger and caregiver protective capacities. The case manager will collect additional information to complete a Family Functioning Assessment-Ongoing (FFA-Ongoing) which will include:

(1) Scaling caregiver protective capacities.

(2) Scaling child strengths and needs.

(3) Developing a danger statement.

(4) Identifying family goal(s), resources, and potential barriers.

(5) Providing information related to the parent(s)/legal guardian(s)’ motivation to change.

(6) Using the FFA-Ongoing to identify the specific diminished or absent caregiver protective capacities and child needs that will guide the development of case plan goals and outcomes.

f. The case manager will co-construct case plan outcomes with families to the extent that the parents or legal guardians are available, willing and able. Outcomes should reflect the family’s current stage of change in order to best ensure that reasonable efforts are made to assist families with achieving change.

(1) The case plan will identify the actions, activities, tasks and resources, both informal and professional, which are intended to address diminished caregiver protective capacities and child needs. Service provision may be provided when children are in-home or out-of-home.

(2) To ensure permanency for children in out-of-home care, the achievement of change must occur within the timeframes established in Chapter 39, Florida Statutes.

(3) The case manager will continue to assess the child and family to update the information domains, caregiver protective capacities and child needs. The case manager will complete regular Progress Updates that use standardized criteria for measuring family change and progress.

(4) The case will be terminated when the parent(s)/legal guardian(s) have achieved sufficient change in caregiver protective capacities so that a safety plan is no longer required, or when a child has achieved permanency.

g. Supervisors will provide supervision and coaching of staff that models mastery of the department’s core tenets and core competencies through their supervisory activities in the office as well as through field activities with children and families. Supervisors will have the ability to observe and assess the performance of child welfare professionals to:

(1) Treat staff, children and their families and others with respect, dignity and fairness at all times regardless of position, assignment, training or circumstance;

(2) Effectively use engagement skills that include active listening;

(3) Understand the dynamics of a family within the context of family rules, traditions, history and culture;

(4) Effectively work with each family's resistance as they move through the change process; and,

(5) Effectively develop and lead a team of professionals working in collaboration with each other and the family to share information and to plan, provide and evaluate family progress and interventions.

h. Supervisors will ensure that child welfare professionalss exercise due diligence in gathering and assessing required information.

i. Supervisors will ensure that safety and risk are assessed with fidelity to core concepts and definitions.

Chapter 2

CORE SAFETY CONCEPTS

2-1. Purpose. In order to determine whether a child is safe or unsafe with their parent(s)/legal guardian(s) and to provide subsequent interventions, the Child Welfare Practice Model incorporates a set of core safety concepts. These core concepts are essential for establishing that sufficient information is gathered and assessed in a consistent, standardized manner regardless of the provider performing the investigation or ongoing services in Florida. The core safety concepts that all staff must utilize consist of identifying and assessing present and impending danger; planning and establishing the least-intrusive safety plans that assure child safety; managing and controlling safety plans; partnering with caregivers to identify diminished caregiver protective capacities and child strengths and needs; and creating and implementing case plans that enhance the capacity of caregivers to provide protection and well-being for their children.

2-2. Present Danger. Present Danger exists as an immediate, significant, and clearly observable family condition, child condition, individual behavior or action or family circumstances which are in the process of occurring and which obviously endanger or threaten to endanger a child and require immediate action to protect a child. Present danger threats are usually identified at initial contact by an investigator, but may also occur during the course of an investigation or while the family is receiving case management services. Present danger which occurs during ongoing services may involve the parent(s)/legal guardian(s) in an in-home case, a relative or non-relative caregiver or a foster parent. Serious harm will result to the child without prompt response and interventions.

a. The child welfare professional can visibly identify or readily assess historical information for out of control conditions that are immediately harmful to the child. The family conditions are such that the threatening family condition or behavior putting the child in danger could happen at any time and requires an immediate response.

b. The threatening family condition may be readily apparent, or it may be an allegation of significant harm that if true requires protective actions. Examples may include:

(1) Serious injuries to an infant with no plausible explanation and/or the perpetrator is unknown.

(2) Allegations of child sexual abuse.

(3) A criminal history or pending charges for aggravated assault, sexual assault or crimes against children.

(4) Psychotic, delusional or dangerous behavior symptomatic of a mental health issue or substance misuse.

(5) The family condition is dramatic, graphic or notable in its damaging and harmful effect on the child.

(6) The present danger may not include maltreatment.

c. Present Danger Threshold. The qualifiers that must exist to justify present danger are the following:

(1) "Immediate" for present danger means that the dangerous family condition, child condition, individual behavior or act, or family circumstances are active and operating. What might result from the danger for a child could be happening or occur at any moment. What is endangering

the child is happening in the present, it is actively in the process of placing a child in peril. Serious harm will result without prompt investigation and/or case manager response.

(2) "Significant" for present danger qualifies the family condition, child condition, individual behavior or acts, or family circumstances as exaggerated, out of control, and/or extreme. The danger is recognizable because what is happening is onerous, vivid, impressive, and notable. What is happening exists as the matter that must be addressed immediately. Significant is anticipated harm that can result in pain, serious injury, disablement, grave or debilitating physical health conditions, acute or grievous suffering, impairment or death.

(3) Present danger is "Clearly Observable" because there are actions, behaviors, emotions or out-of-control conditions in the home which can be specifically and explicitly described which directly harm the child or are highly likely to result in immediate harm to the child.

d. Danger Threats may manifest as Present Danger when:

(1) Parent/legal guardian/caregiver's intentional and willful act caused serious physical injury to the child, or the caregiver intended to seriously injure the child. This refers to caregivers who anticipate acting in a way that will result in pain and suffering. "Intended" suggests that, before or during the time the child was mistreated, the parents'/primary caregivers' conscious purpose was willfully to act in a manner which would reasonably hurt/harm the child. This threat must be distinguished from an incident in which the parent/legal guardian or caregiver meant to discipline or punish the child, and the child was inadvertently hurt. Examples may include but are not limited to:

(a) Parent/legal guardian or caregiver actions were directed at the child to inflict injury; parent/legal guardian or caregiver shows no remorse for the injuries. Initial information supports that the injuries/child's condition is a result of the deliberate preconceived planning or thinking which the parent/legal guardian or caregiver is responsible. Serious injury locations for present danger should be considered when located on the face/head/neck. Child's injuries may or may not require medical attention.

(b) Bone breaks, deep lacerations, burns, inorganic malnutrition, etc. characterize serious injury.

(c) Children that are unable to protect themselves have sustained a physical injury as a result of the parent/legal guardian or caregiver intentional and willful act. Could include parent/legal guardian or caregiver who used objects to inflict pain.

(2) Child has a serious illness or injury (indicative of child abuse or neglect) that is unexplained, or the parent/legal guardian or caregiver explanations are inconsistent with the illness or injury. This refers to serious injury which parent/legal guardian or caregivers cannot or will not explain. While this is typically associated with injuries, it can also apply when family conditions or what is happening is bizarre and unusual with no reasonable explanation. Generally this will be a danger threat used only at present danger. One example is the following: A child has sustained multiple injuries to their face and head and the parent/legal guardian cannot or will not explain the injuries and the child is very young or non-verbal. The parent(s)' explanation changes over time as to how the injury or illness occurred.

(3) The child's physical living conditions are hazardous and a child has already been seriously injured or will likely be seriously injured. The living conditions seriously endanger a child's physical health. This threat refers to conditions in the home which are immediately life threatening or seriously endangering a child's physical health (e.g., people discharging firearms without regard to who might be harmed; the lack of hygiene is so dramatic as to cause or potentially cause serious illness). Examples may include but are not limited to:

(a) The child's living condition is an immediate threat to the child's safety as there are drugs in baggies on the living room coffee table that are easily accessible to the child and the child is not consistently supervised.

(b) Living condition in the home has caused the child to be injured, such as digesting toxic chemicals and/or material and the child requires immediate medical attention.

(c) Home has no exit and child is vulnerable, unable to access an exit and dependent on parent/legal guardian who has not or will not act.

(4) There are reports of serious harm and the child's whereabouts cannot be ascertained; and/or there is a reason to believe that the family is about to flee to avoid agency intervention; and/or the family refuses access to the child; and the reported concern is significant and indicates serious harm. This threat refers to situations in which the location of the family cannot be determined, despite diligence by the agency to locate the family. The threat also refers to situations where a parent/legal guardian/caregiver refuses to see or speak with agency staff and/or allow agency staff to see the child, is openly hostile or physically aggressive toward the investigator or case manager, is avoiding staff, refuses access to the home, hides the child, or refuses access to the child and the reported concern is significant and indicates serious harm. The hiding of children to avoid agency intervention should be thought of in both overt and covert terms. Information, which describes a child being physically confined within the home or parents who avoid allowing others to have personal contact with the child, can be considered "reported concern is significant and indicates serious harm."

(a) The act of physically restraining a child within the home might be a maltreatment of bizarre punishment or physical injury, and would indicate use of this danger threat.

(b) The threat is qualified by the allegation of maltreatment, information from prior case history and current reports regarding the child. There should be concern for present or impending danger based upon information provided to the agency that would result in serious harm to the child. Generally this will be a danger threat used only at present danger.

(5) Parent/legal guardian or caregiver is not meeting the child's essential medical needs and the child is/has already been seriously harmed or will likely be seriously harmed. This refers to medical care that is required, acute, and significant such that the absence of care will seriously affect the child's health. "Essential" refers to specific child conditions (e.g., blindness, physical or developmental disability, medical condition) which are either organic or naturally induced as opposed to parentally induced. The parents will not or cannot address the child's essential needs. Examples may include but are not limited to:

(a) There is an emergent quality about the required care.

(b) Child has Type 1 diabetes and is unable to self-administer his/her medication and the parent/legal guardian or caregiver has not been administering medication to ensure child safety.

(6) Child shows serious emotional symptoms requiring intervention and/or lacks behavioral control and/or exhibits self-destructive behavior that parent/legal guardian is unwilling or

unable to manage. This refers to specific deficiencies in parenting that result in the exceptional child being unsafe. The status of the child helps to clarify the potential for severe effects. Clearly, exceptional includes physical and mental characteristics that result in a child being highly vulnerable and unable to protect or fend for him or herself. Examples may include but are not limited to:

(a) Present danger considerations are focused both on the child's emotional needs and the parent/legal guardian or caregiver ability to meet those needs. Child's emotional symptoms are serious in that they pose a danger to others or themselves. This could include self-harming, fire-setting, or sexual acting-out on others. Parent/legal guardian or caregiver response places the child in present danger.

(b) Child that requires acute psychiatric care due to self-harming behavior that the parent/legal guardian will not or cannot meet despite the resources and ability to attend to the child's needs.

(7) Parent/legal guardian or caregiver is violent, impulsive, or acting dangerously in ways that seriously harmed the child or will likely seriously harm to the child. Violence refers to aggression, fighting, brutality, cruelty, and hostility. It may be regularly active or generally potentially active. This threat is concerned with self-control. It is concerned with a person's ability to postpone; to set aside needs; to plan; to be dependable; to avoid destructive behavior; to use good judgment; to not act on impulses; to exert energy and action; to inhibit; and/or to manage emotions. This is concerned with self-control as it relates to child safety and protecting children. So, it is the absence of caregiver self-control that places vulnerable children in jeopardy.

(a) When violence includes the perpetrator dynamics of power and control it is considered "intimate partner violence." Physical aggression in response to acts of violence may be a reaction to or self-defense against violence.

(b) For purposes of child protection interventions, is important to accurately identify the underlying causes of the violence and whether or not the dynamics of power and control are present. Refer to CFOP 170-4, Maltreatment Index, for a complete definition of "Family Violence Threatens Child." It should be noted that the Florida criminal code for domestic violence (Chapter 741, F.S.) which provides for law enforcement responses and investigations is narrower in scope than the child welfare maltreatment definition.

(c) Impulsive means that one does not think before one acts. It may mean that a person blurts things out or take actions without thinking about the consequences. Impulsivity (or impulsiveness) involves a tendency to act on a whim, displaying behavior characterized by little or no forethought, reflection, or consideration of consequences. Impulsive actions typically are poorly conceived, prematurely expressed, unduly risky, or inappropriate to the situation that often result in undesirable consequences, which make long term goals and strategies for success more difficult. Individuals suffering from an impulse control frequently experience five stages of symptoms: compelling urge or desire, failure to resist the urge, a heightened sense of arousal, succumbing to the urge (which usually yields relief from tension), and potential remorse or feelings of guilt after the behavior is completed. Impulsivity appears to be linked to all stages of substance abuse and is also linked to sexual abuse.

(d) Parents/legal guardian or caregiver may be behaving in violent or dangerous ways; however this is intended to capture a more specific type of behavior. Examples may include but are not limited to:

1. Child has experienced sexual abuse and/or exploitation and perpetrator has ongoing access to child.

2. Parent/legal guardian or caregiver is described as physically/verbally imposing/threatening, brandishing weapons, known to be dangerous and aggressive, currently behaving in attacking or aggressive ways.

(e) Careful consideration when determining present danger should be made when assessing domestic violence and family violence. The parent/legal guardian or caregiver may not be "actively" violent in the presence of the child welfare professional; however, the domestic violence dynamics within the household are occurring. In addition, there should be consideration of information that indicates that a child and spouse are being mistreated. Concerns are heightened when abuse of a child and spouse are both occurring.

(8) Parent/legal guardian or caregiver is not meeting child's basic and essential needs for food, clothing and/or supervision, AND child is/has already been seriously harmed or will likely be seriously harmed. "Basic needs" refers to the family's lack of:

(a) Minimal resources to provide shelter, food, and clothing; or,

(b) The capacity to use resources to provide for a minimal standard of care if they were available. Examples may include but are not limited to:

1. For present danger, consideration of the parent/legal guardian or caregivers who are unable or unwilling to provide for food, clothing, and/or supervision. The parent/legal guardian or caregiver may be currently intoxicated and/or unavailable, thus leaving the child without supervision when the child is not able to protect themselves.

2. Child is found unsupervised in a dangerous condition, such as being left wandering the streets. There is no parent/legal guardian or caregiver that is currently providing for supervision of the child.

3. Lack of essential food, clothing, and/or supervision that result in child needing acute medical care due to the severity of the present danger.

4. Hospitalized child due to non-organic failure to thrive an unexplained illness.

(9) Parent/legal guardian or caregiver is threatening to seriously harm the child, or is fearful he/she will seriously harm the child. This refers to caregivers who express anxiety and dread about their ability to control their emotions and reactions toward their child. This expression represents a "call for help." Examples may include but are not limited to:

(a) At present danger this refers to parents/legal guardian or caregivers who express intent and/or desire to harm their child.

(b) Parent/legal guardian or caregiver may have a history of harming children in the past and has identified a need for intervention due to their fear of harming their child. Intent should be considered for present danger, in addition access and ability to harm child.

(10) Parent/legal guardian or caregiver views child and/or acts toward the child in extremely negative ways AND such behavior has or will result in serious harm to the child. "Extremely" is meant to suggest a perception which is so negative that, when present, it creates child safety concerns. In order for this threat to be identified, these types of perceptions must be present and the perceptions must be inaccurate.

(a) This is the extreme, not just a negative attitude towards the child. It is consistent with seeing the child, as demon possessed, evil, and responsible for the conditions within the home.

(b) Consideration of parent/legal guardian or caregiver's viewpoint of the child as being in action for present danger.

(11) Other. This category should be used rarely. Consultation with and approval by a supervisor must occur to determine that the threat identified is not covered in any of the standard danger threat definitions. Documentation should accurately describe the threat, including the threshold qualifiers.

2-3. Focus of Family Assessment (FFA-Investigation, FFA-Ongoing, Progress Update).

a. Purpose. The family functioning assessment is the process by which information is gathered, analyzed and assessed to determine child safety in the household where the alleged maltreatment occurred. The essential mission of the department is to identify and protect children who need safety management and to support the enhancement of caregiver protective capacities of the caregiver(s) responsible (treatment/change). The family assessment process provides a current analysis by the child welfare professional responsible at different points in time, beginning with the Family Functioning Assessment-Investigations. After a case involving an unsafe child is transferred to ongoing case management, the family assessment is documented in the Family Functioning Assessment-Ongoing Services (FFA-Ongoing) and Progress Updates. The role of the child welfare professional is to evaluate and describe in the FFA-Investigation, FFA-Ongoing and Progress Updates how the household functions, including a clear understanding as to who provides **any** care, parenting, quality time, and/or discipline for the children. Every type of assessment serves the purpose of identifying family conditions, how the children are vulnerable to those conditions, and whether the parent/legal guardian and other significant caregiver(s) in the household are able to care for and protect the children (caregiver protective capacities).

b. Definitions.

(1) "Household" means a common residence shared by two or more individuals whether related or not. (Rule 65C-30.001, Florida Administrative Code [F.A.C.])

(2) "Household Member" means any person who resides in a household, including the caregiver and other family members residing in the home. Household members are any additional relatives or persons residing in the home, including but not limited to visitors expected to stay an indefinite length of time or college students expected to return to the home. (Rule 65C-30.001, F.A.C.)

(3) "Legal Guardian" means that the child has a custodian appointed by court who has assumed the role of the parent.

(4) "Paramour" means a person who is in a social relationship that involves physical or emotional intimacy with a child's parent or caregiver. The intimate partner may or may not be cohabitating with the caregiver.

(5) "Parent" means a woman who gives birth to a child and a man whose consent to the adoption of the child would be required under s. 63.062(1), F.S. If a child has been legally adopted, the term "parent" means the adoptive mother or father of the child. The term does not include an individual whose parental relationship to the child has been legally terminated [defined in s. 39.01(49), F.S., Definitions]

(6) "Significant Caregiver Responsibility" means that specific adult household members have taken on responsibility for major caregiving responsibilities or it is reasonable to view the person as being in a parental role. Things to consider in determining who has significant responsibility include the following:

(a) Household member has routine, day to day care and responsibility for protecting the child such that:

1. The child views such caregiver(s) as one of the primary persons with the authority for their care; and,

2. The caregiver is expected to remain a part of the family unit.

(b) A paramour residing in or frequenting the home has become a parent figure based on one or more of the following:

1. Child welfare professional's observations of interactions between child and paramour.

2. Child's statements about the paramour.

3. Statements from other family members or friends who are familiar with family functioning.

4. The child has a bond with the paramour, even though the household member or paramour may or may not provide any financial support to the family.

5. The paramour frequents the home so often that even though he/she denies any care or supervision responsibilities, the person is an authority figure to the child.

c. Focus Household.

(1) The family functioning assessment will be developed with a focus on the household in which the alleged child victim's parent, legal guardian, paramour (residing or frequenting the home) and/or other adult household member with significant caregiver responsibility is the alleged person responsible for the maltreatment.

(a) The child victim may reside in the household on a full or part-time basis.

(b) If the child's parents or legal guardians have established separate households through divorce or separation, only the household where the maltreating parent resides is assessed for danger threats and family functioning. If during the course of any investigation the investigator learns that the child victim's parent/legal guardian knew about the danger threat occurring in the home where the maltreatment occurred and was unable or unwilling to take actions to protect the child, a FFA-Investigation on the separate household must be developed.

(c) When the person responsible for the maltreatment is a court-appointed guardian or custodian and the child's biological parent is expressing a desire for the child to be placed back in their care, the following will occur:

1. The FFA-I will focus on the household of the guardian or custodian.

2. If the child was placed in the current home as a result of a child protection investigation, regardless of whether the biological parent entered into and/or completed a case plan, the child's biological parent and household will be assessed in a separate FFA-Ongoing.

3. When there is no history of child welfare system involvement, the child's biological parent when in a different household will be assessed using the Other Parent Home Assessment.

4. When Termination of Parental Rights has occurred and a biological parent wishes to regain custody, requirements as described in 65C-16, Adoptions must be followed.

(d) One FFA-Investigation, FFA-O or Progress Update will be created when there is a minor child with a newborn or child(ren) in a home that is under an active investigation and there are no allegations of maltreatment against the minor parent. The minor child who is also a parent must be assessed as a significant caregiver using all of the information domains except adult functioning to describe and document the minor parent's responsibilities, relationships and how he/she contributes to or is impacted by family conditions.

(e) When a child must be removed from a maltreating parent, non-maltreating parents in a separate household will be assessed using Other Parent Home Assessment per requirements in CFOP 170-7, Chapter 5.

(2) Separate information domains will be developed for each parent/legal guardian and significant caregiver residing in the same household.

(3) When more than one family unit resides in the same household, the family unit wherein the alleged maltreatment occurred will be the focus of one FFA when:

(a) The family units clearly function independently from each other as supported by sufficient information gathering and analysis.

(b) The two family units may share some or all of the household expenses but do not have access to or combine family incomes.

(c) The children in each family do not view the parent(s) in the other family unit as having any responsibility or authority over their care.

(d) Some child care duties may be shared on occasion.

(e) When only one of two family units residing together is the focus of the FFA, the non-focus family members will not be identified as participants.

(4) When two families reside together and share caregiving responsibilities, regardless of the household that is responsible for the maltreatment, a separate FFA-Investigation must be created for each family. When there are allegations of maltreatment against minor parent, a separate FFA-Investigation must be created for the minor parent and his/her child(ren) and the other parent/legal guardians in the home and their respective children.

(a) One FFA-Investigation will include and describe the minor parent as a child victim.

(b) One FFA-Investigation will include and describe the minor parent as an alleged perpetrator.

(5) Every type of family assessment must include descriptions of all family members and persons in the family household and resource network, whether or not they will be identified as participants in the case plan. The descriptions should be included in the most appropriate information domain for the parent or significant caregiver, whichever is most relevant, as to:

(a) Other person's relationship to the parent and reason for presence in the home, including family members of any family unit residing in same household.

(b) Impact of other person's presence as to child functioning, adult functioning, parenting and discipline/behavior management.

(c) Assessment of other person's background history information gathered and whether there are patterns of behavior which present safety concerns.

2-4. Information Domains (Family Assessment Areas).

a. Purpose. The six information domains provide the substantive basis for the components of the safety decision and risk assessment processes: (1) the presence or absence of negative family conditions that have or have not crossed the impending danger threshold; and (2) the determination of the likelihood of future maltreatment. The sufficiency of this information and interaction of these components are the critical elements in the determination of a child being safe or unsafe. Information collected should be descriptive of a child's specific abilities given his/her age, whether they are in a normal range, and whether the parent(s)' interactions and expectations are appropriate given the child's age (see Appendix A of this operating procedure, Child Development Stages Matrix). Information collected should also be descriptive of family dynamics when there is intimate partner violence (see Appendix B of this operating procedure, Mapping the Safe and Together Model Critical Components to the Information Domains).

b. Analysis of the information domains is the first step in all versions of the family functioning assessment (FFA-Investigation, FFA-Ongoing and Progress Evaluation). Information gathered and assessed in the domains is essential in order to understand what is occurring in the family day in and day out and to effectively assess child safety and family risk. The information domains are a core component of family assessment functionality in FSFN. The domains support a continuous process over time to assess and take into account changing dynamics of the family over the life of their involvement in the child welfare system.

c. The completion or updating of the family functioning assessment at any point during a child welfare case requires child welfare professionals to obtain sufficient, current information about six information domains: the extent of the maltreatment, circumstances surrounding the maltreatment, child functioning, adult functioning, approach to parenting and methods of discipline and managing their child's behavior.

d. The information domains for adult functioning, parenting and discipline/behavior management will be developed separately for each parent/legal guardian or caregiver in the household with significant responsibilities for the care and protection of the child(ren). The information domain for child functioning will be developed separately for each child in the household.

e. The "Extent of Maltreatment" domain is concerned with the maltreating behavior and immediate effects on a child. It considers what is occurring or has occurred and what the results are (e.g., hitting, injuries, lack of supervision, etc.). The assessment also results in a finding/identification of maltreatment (as in an allegation or verification of the alleged maltreatment). Information that informs this domain includes:

(1) Type of maltreatment;

(2) Severity of maltreatment;

(3) Description of specific events;

(4) Description of emotional and physical symptoms;

(5) Identification of the child and maltreating caregiver; and,

(6) Condition of the child.

f. The "Surrounding Circumstances of the Maltreatment" domain is concerned with the nature of what accompanies or surrounds the maltreatment. It addresses what is going on at the time that the maltreatment occurs or occurred. It serves to qualify the maltreatment by placing it in a context or situation that (1) precedes or leads up to the maltreatment, or (2) exists while the maltreatment is occurring. By selectively "assessing" this element separate from the actual maltreatment, we achieve greater understanding of how serious the maltreatment is. In other words, circumstances that accompany the maltreatment are important and are significant in-and-of themselves and qualify how serious the maltreatment is. Information that informs this domain includes:

(1) The duration of the maltreatment;

(2) History of maltreatment;

(3) Patterns of functioning leading to or explaining the maltreatment;

(4) Parent/legal guardian or caregiver intent concerning the maltreatment (assessment of intent re: parenting/discipline vs. intent to harm);

(5) Parent/legal guardian or caregiver explanation for the maltreatment and family conditions;

(6) Unique aspects of the maltreatment, such as whether weapons were involved;

(7) Caregiver acknowledgement and attitude about the maltreatment; and,

(8) Other problems occurring in association with the maltreatment.

g. The "Child Functioning" domain is concerned with the child's general behavior, emotions, temperament, development, academic status, physical capacity and health status. Refer to Appendix A of this operating procedure for information about child development at different ages. It addresses how a child functions from day to day and their current status rather than focusing on a specific point in time (contact during investigation, time of maltreatment event, case manager's home visit). An assessment

of child functioning must take into account the age of the child and/or any special needs or developmental delays. Among the areas to consider are trust, sociability, self- awareness and acceptance, verbal skills/communication, independence, assertiveness, motor skills, intellect and mental performance, self-control, emotion, play and work, behavior patterns, mood changes, eating and sleeping habits and sexual behavior. Additionally, the assessment of child functioning assesses the child's physical capabilities including vulnerability and ability to make needs known. In terms of a child who is currently receiving ongoing case management, this information should reflect areas of current child need, such as a medical condition that must be managed, symptoms of depression or trauma, or poor academic performance. If the child is in out-of-home care, it should include information as to the child's stability in the current placement. Information about child functioning includes:

(1) General mood and temperament;

(2) Intellectual functioning;

(3) Communication and social skills;

(4) Expressions of emotions/feelings;

(5) Behavior;

(6) Peer relations;

(7) School performance;

(8) Independence;

(9) Motor skills;

(10) Physical and mental health; and,

(11) Functioning within cultural norms.

h. The "Adult Functioning" domain has strictly to do with how adults (the caregivers) in a family household are functioning. This domain is concerned with how the adults (parents/legal guardians or caregivers) in the family household typically feel, think, and act on a daily basis. The domain focuses on current adult functioning separate from parenting. It describes how the adults behave regardless of the fact that they are parents or caregivers. This assessment area is concerned with life management, social relationships, meeting needs, problem solving, perception, rationality, self-control, reality testing, stability, self-awareness, self-esteem, self- acceptance and coherence. It is important that recent (adult related) history is captured here such as employment experiences; criminal history and whatever that tells us about the adult's behavior, impulse control, etc; previous relationships and associated dynamics; and so on. Information that answers this question includes:

(1) Communication and social skills;

(2) Coping and stress management;

(3) Self-control;

(4) Problem solving;

(5) Judgment and decision making;

(6) Independence;

(7) Home and financial management;

(8) Income/Employment;

(9) Citizenship and community involvement;

(10) Rationality;

(11) Self-care and self-preservation;

(12) Substance abuse;

(13) Mental health;

(14) Family and/or domestic violence;

(15) Physical health and capacity; and,

(16) Functioning within cultural norms.

i. The "General Parenting" domain explores the general nature and approach to parenting which forms the basis for understanding caregiver-child interaction in more substantive ways. Refer to Appendix A of this operating procedure for information about positive parenting associated with child development at different ages. When considering this information element, it is important to keep distinctively centered on the overall parenting that is occurring and not allow any maltreatment incident or discipline to influence the assessment. Among the issues for consideration within this element are: parenting styles and the origin of the style, basic care, affection, communication, expectations for children, sensitivity to an individual child, knowledge and expectations related to child development and parenting, reasons for having children, viewpoint toward children, and examples of parenting behavior and parenting experiences. Information that answers this question includes:

(1) Reasons for being a caregiver;

(2) Satisfaction in being a caregiver;

(3) Parent/legal guardian or caregiver knowledge and skill in parenting and child development;

(4) Parent/legal guardian expectations and empathy for a child;

(5) Decision making in parenting practices;

(6) Parenting style;

(7) History of parenting behavior;

(8) Cultural practices; and,

(9) Protectiveness.

j. The "Discipline or Behavior Management" domain includes the broader context of socialization, teaching and guiding the child. It includes methods of discipline as well other ways that the caregiver provides direction, manages behavior, teaches, and directs a child. This domain includes the parent's methods, the source of those methods, purpose or reasons for, attitudes about, context of,

expectations of discipline, understanding, relationship to child and child behavior, and the meaning of discipline. Information that answers this question includes:

(1) Disciplinary methods;

(2) Approaches to managing child behavior;

(3) Perception of effectiveness of utilized approaches;

(4) Concepts and purpose of discipline;

(5) Context in which discipline occurs; and

(6) Cultural practices.

2-5. Information Sufficiency.

a. Purpose. Child welfare professionals must exercise due diligence in gathering all of the information needed to have a **sufficient** basis for assessment, accurate safety determinations, development and management of safety plans and case plans. When information gathered in the six domains is not sufficient, it will lead to inaccurate assessment and understanding of conditions in the home, child vulnerability and caregiver protective capacities. Ultimately, safety plans and case plans will not be based on the right issues. Getting the best possible outcomes for children and families depends on a foundation of sufficient information in each of the domains.

b. Information is sufficient when it fully describes family conditions in a way that aligns with the domain structure and domain descriptions.

(1) Separate information domains are developed for each parent/legal guardian in the household as well as any significant caregiver.

(2) Separate information domains are developed for each child.

(3) Descriptions are provided in the relevant domains for other household members **and** members of the family resource network and their role in the family's daily life is understood.

(4) Information provides a clear picture of current family conditions. Information from the last completed and approved FFA or Progress Update will pre-fill the domains. It is the case manager's responsibility to edit and modify the information that pre-fills the domains to provide:

(a) New information learned about the family.

(b) Document any changes that have occurred since the date of the last FFA.

(c) Additional information that supports the specific caregiver protective capacity and child strengths and needs ratings.

(d) Describe how a child is adjusting to or coping with in-home or out-of-home providers in a safety plan.

(5) Information provides a clear picture and accurate understanding of the domain without having to refer to additional material (e.g., FSFN notes, CPT report, completed assessments, etc.).

(6) Information Is relevant to that domain only (for example, aspects of child functioning are not described in the adult functioning domain, etc.).

(7) Information is essential to gaining a full understanding or complete picture of the domain (e.g., "child has numerous healthy peer relationships" is relevant; providing names of friends is not relevant).

(8) Information covers the core issues associated with the domain (e.g., Extent of Maltreatment – there is information on severity, maltreatment history, description of specific events, behaviors, emotional and physical symptoms, and identification of maltreating parent, etc.).

(9) Information provides a clear rationale for the safety decision and provides confidence that the accurate safety determination was reached.

(10) Information supports the impending danger threshold criteria.

(11) Information supports protective capacity assessment.

c. Information must be validated. All significant information should be validated by either the child welfare professional's direct, personal observation or corroborated through multiple collateral sources. The child welfare professional shall validate all information that is critical to safety decision making. Corroboration is defined as credible and reliable information obtained from multiple sources (more than solely the initial reporting source). "Attempted" contacts would not count as corroboration.

d. Information must be reconciled. The child welfare professional is expected to make the diligent efforts needed to try and resolve any significant discrepancy that will have a bearing on an assessment and interventions. The information provided by the child welfare professional must not contain any discrepancies. There are multiple valid reasons why a case might initially contain a number of apparent discrepancies in information. Research has consistently shown how much eyewitness accounts can vary among subjects when interviewed immediately after an incident. Informational discrepancies can also occur because family members are unsure of how the child welfare professional will use the information and are therefore either intentionally deceitful or only share partial information about factual details. Similarly, collateral sources interviewed can be biased for or against the family and present compromised or inaccurate information in an attempt to influence the outcome of the investigation or ongoing services.

e. Critical Thinking. All decisions made by the child welfare professional shall reflect the use of critical thinking as evidenced by the rationale provided to justify or explain the conclusion reached. Despite the axiom that any decision is only as good as the information it is based upon, having essential information available to inform the decision making process does not necessarily guarantee the "right" decision is reached. The final criterion for information sufficiency is that the FFA provides any reader with a clear understanding of:

(1) What information went into the decision making process?

(2) How this information is interrelated to provide the rationale for the decision reached?

(3) The overall determination of safe – unsafe as a result of the correction application of the safety formula components.

(4) The determination that safety planning is adequate to control danger threats in the home to ensure child safety.

(5) The ongoing services determination over the course of case management as to whether there is progress in achieving change in caregiver protective capacities.

2-6. Definition of "Least Intrusive."

a. "Least intrusive" means the combination of interventions that will be the most effective, cause the least disruption to the child and family's normal routines and will be aligned to the fullest extent feasible with the family's preferences, culture and values. Determination of the "least intrusive" safety action should be guided by consideration and balancing of several issues:

(1) Identification of interventions or actions that will be most effective and supportive.

(2) Parent's right for self-determination.

(3) Child's need to be protected by persons the child is most familiar and comfortable with.

(4) Child's need for routines and surroundings which are "normal" to the extent possible.

b. The child welfare professional will seek to reinforce the parent in taking responsibility for the child's safety, permanency and well-being by working to elicit the parent's ideas and preferences regarding the implementation of any non-negotiable interventions or actions.

c. Judicial interventions are more intrusive and will be used when required by law or administrative code.

2-7. Caregiver Protective Capacities.

a. "Caregiver Protective Capacity" means the personal and caregiving behavioral, cognitive and emotional characteristics that specifically and directly can be associated with being protective to one's children. When the caregivers responsible are able to effectively manage negative family conditions in the home for the long term, the child is safe. Protective capacities are personal qualities or characteristics that contribute to vigilant child protection.

(1) The characteristic prepares the person to be protective.

(2) The characteristic enables or empowers the person to be protective.

(3) The characteristic is necessary or fundamental to being protective.

(4) The characteristic must exist prior to being protective.

b. Investigators will determine whether each of the protective capacities is adequate or inadequate when completing a FFA-Investigation.

c. Case managers will gather additional information in the information domains in order to more precisely assess and rate caregiver protective capacities using a four point scale when completing the FFA-Ongoing or Progress Update. Case managers may change the protective capacities identified in the FFA-Investigations. Caregiver protective capacities that are not adequate will become the primary focus of case plan outcomes and measuring parent progress with achieving change.

d. Protective capacities must be assessed and rated for the parent(s)/legal guardians and other persons in the household with significant responsibility for the care and protection of child(ren). The accurate identification of Caregiver Protective Capacities is informed by knowledge of a child's specific abilities given his/her age, whether they are in a normal range, and whether the parent(s)' interactions

and expectations are appropriate given the child's age. When a child has any special medical, mental health or physical condition, the appraisal of protective capacities assesses whether the parent is able to understand and provide for such special needs. See Appendix A of this operating procedure, Child Development Stages Matrix, for summary descriptions of child behaviors that are within a normal range as to physical, socio-emotional, and cognitive development; indicators of developmental concern, and associated positive parenting characteristics.

e. Scaling Criteria. Based on the information domains, the case manager will rate caregiver protective capacities for each caregiver in the household. The ratings of caregiver protective capacities are used to systematically identify ones that need to be the focus of case plan outcomes and interventions.

(1) An "A" or "B" rating for any indicator reflects that a parent/legal guardian is doing well in that area.

(2) A "C" or "D" rating reflects that a parent/legal guardian is not doing well and requires attention.

(3) These are the common criteria applied to each individual rating.

A=EXCELLENT. Caregiver demonstrates exceptional ability in this area.

B=ACCEPTABLE. Caregiver demonstrates average ability in this area.

C=SOME ATTENTION NEEDED. Caregiver demonstrates some need for increased support in this area.

D=INTENSIVE SUPPORT NEEDED. Caregiver demonstrates need for intensive support in this area.

f. "Behavioral Protective Capacity" means specific action, activity, performance that is consistent with and results in protective vigilance. The following are behavioral protective capacities:

(1) The parent/legal guardian/caregiver demonstrates impulse control. This refers to a person who is deliberate and careful, and who acts in managed and self-controlled ways.

(a) Examples may include:

1. People who do not act on their urges or desires.

2. People that do not over-react as a result of outside stimulation.

3. People who think before they act.

4. People who are able to plan.

(b) Case Management Scaling Guide.

A. Parent/Caregiver consistently acts thoughtfully regardless of outside stimulation, avoids whimsical responses, and thinks before they take action. Parent/Caregiver is able to plan in their actions when caring for children and making life choices.

B. Parent/Caregiver regularly is acts thoughtfully regardless of their on their urges or desires, avoids acting as a result of outside stimulation, avoids whimsical responses, thinks before they take action, and are able to plan when caring for children and making life choices.

When parent/caregiver does act on urges/desires, they do not result in negative effects to their children or family.

C. Parent/Caregiver routinely (weekly/monthly) acts upon their urges/desires, is influenced by outside stimulation, thinks minimally before they take action, and are notable to plan, resulting in their actions having negative effects on their children and family.

D. Parent/Caregiver frequently (daily) acts upon their urges/desires, is highly influenced by outside stimulation, does not think before taking action, and does not plan. Parent/Caregiver's inability to control their impulses results in negative effects on their children and family.

(2) The parent/legal guardian/caregiver takes action.

(a) Takes action refers to a person who is action oriented as a human being, not just a caregiver. Examples may include:

1. People who perform when necessary.

2. People who proceed with a course of action.

3. People who take necessary steps.

4. People who are expedient and timely in doing things.

5. People who discharge their duties.

(b) Physically able refers to people who are sufficiently healthy, mobile and strong. Examples may include:

1. People who can move quickly when an unsafe situation presents (e.g., active toddlers who may dart out toward the street or water source, pool, canal, etc.).

2. People who can lift children.

3. People who are able to physically manage a child's behaviors.

4. People with physical abilities to effectively deal with dangers (e.g., a child with special needs who may be prone to 'running' away, a child who requires close supervision, etc.).

(c) Assertive and responsive refers to being positive and persistent. Examples may include:

1. People who are firm and purposeful.

2. People who are self-confident and self-assured.

3. People who are secure with themselves and their ways.

4. People who are poised and certain of themselves.

(d) Adequate energy refers to the personal sustenance necessary to be ready and "on the job" of being protective. Examples may include:

1. People who are alert and focused.

2. People who can move, are on the move, ready to move, will move in a timely way.

3. People who are motivated and have the capacity to work and be active.

4. People who express force and power in their action and activity.

5. People who are not lethargic to the point of incapacitation or inability to be protective.

6. People who are rested or able to overcome being tired.

(e) Uses resources to meet basic needs refers to knowing what is needed, getting it, and using it to keep a child safe. Examples may include:

1. People who get people to help them and their children.

2. People who use community public and private organizations.

3. People who will call on police or access the courts to help them.

4. People who use basic community services such as food and shelter.

(f) Case Management Scaling Guide.

A. Parent/Caregiver takes action, is assertive and response, and is physically able to respond to caregiving needs, such as chasing down children, lifting children, and is able to physically protect their children from harm consistently. Parent/Caregiver may have physical limitations, however demonstrates the ability to accommodate those physical limitations in order to take action.

B. Parent/Caregiver is able to take action, is assertive and responsive, and/or is physically able to respond to caregiving needs, however requires assistance on occasion to be able to meet children's needs. Parent/Caregiver may have a physical limitation, and occasionally is not able to demonstrate the ability to accommodate those physical limitations in order to take action.

C. Parent/Caregiver regularly is not able to take action, be assertive and responsive, and/or physically respond to caregiving needs. Parent/Caregiver needs assistance on a regular basis (weekly). Parent/Caregiver may have a physical limitation, an on a regular basis is not able to accommodate those physical limitations in order to take action.

D. Parent/Caregiver is not able to take action, be assertive and responsive, and/or physically respond to meeting caregiving needs of children. Parent/Caregiver requires assistance routinely (daily). Parent/Caregiver may have a physical limitation, and routinely is not able to accommodate that physical limitation in order to take action.

(3) The parent/legal guardian/caregiver sets aside her/his needs in favor of a child.

(a) This refers to people who can delay gratifying their own needs, who accept their children's needs as a priority over their own. Examples may include:

1. People who do for themselves after they have done for their children.

2. People who sacrifice for their children.

3. People who can wait to be satisfied.

4. People who seek ways to satisfy their children's needs as the priority.

(b) This refers to people who adjust and make the best of whatever caregiving situation occurs. Examples may include:

1. People who are flexible and can adapt.

2. People who accept things and can move with them.

3. People who are creative about caregiving.

4. People who come up with solutions and ways of behaving that may be new, needed and unfamiliar but more fitting.

(c) Case Management Scaling Guide.

A. Parent/Caregiver identifies their child's needs as their number one priority. Parent/Caregiver has demonstrated through their actions that they place their child's needs above their own by waiting to be satisfied, sacrificing for their children, and through seeking ways to satisfy their child's needs as a priority. Parent/Caregiver does not need to be prompted by others in viewing their needs as secondary to the child's.

B. Parent/Caregiver views the child's needs as a priority, however at times struggles to place their children's needs before their own. The lack of viewing the child's needs as a priority does not result in the children being maltreated or exposed to danger.

C. Parent/Caregiver recognizes the need to place their child's needs as a priority, however is not able to set aside their own needs in favor of their child's needs, resulting in the child being maltreated and/or exposed to danger.

D. Parent/Caregiver does not recognize the need to place the child's needs as a priority and does not set aside their own needs in favor of the child's, resulting in the child being maltreated and/or exposed to danger on regular occasions.

(4) The parent/legal guardian/caregiver demonstrates adequate skill to fulfill caregiving responsibilities.

(a) This refers to the possession and use of skills that are related to being protective. Examples may include:

1. People who can feed, care for, supervise children according to their basic needs.

2. People who can handle, manage, oversee as related to protectiveness.

3. People who can cook, clean, maintain, and guide, shelter as related to protectiveness.

(b) Case Management Scaling Guide.

A. Parent/Caregiver is able to feed, care for, and supervise child. Parent/Caregiver has the skills necessary to cook, clean, maintain, guide and shelter child as related to protectiveness.

B. Parent/Caregiver is able to feed, care for, and supervise child, however at times requires assistance in fulfilling these duties. Parent/Caregiver is able to seek assistance in meeting child's needs and the need for assistance does not result in the child's needs being unmet and/or children being maltreated.

C. Parent/Caregiver has minimal skills related to providing for the basic needs of child. Parent/Caregiver lacks the ability to consistently feed, and/or care, and or/supervise child resulting in maltreatment and/or danger. Parent/Caregiver recognizes the need for assistance, however does not act to seek resources to assist in fulfilling caregiving responsibilities.

D. Parent/Caregiver has little to no skills related to providing for basic needs of child. Parent/Caregiver does not feed, and/or, care, and/or supervise child resulting in child being maltreated and/or in danger. Parent/Caregiver does not recognize the need to provide for basic needs of child and/or the parent/caregiver will not or cannot seek resources to assist in fulfilling caregiving responsibilities.

(5) The parent/legal guardian/caregiver is adaptive as a caregiver. This refers to people who adjust and make the best of whatever caregiving situation occurs.

(a) Examples may include:

1. People who are flexible and can adapt.

2. People who accept things and can move with them.

3. People who are creative about caregiving.

4. People who come up with solutions and ways of behaving that may be new, needed and unfamiliar but more fitting.

(b) Case Management Scaling Guide.

A. Parent/Caregiver is flexible and adjustable, is able to accept things and move, is creative in their caregiving, and are able to come up with solutions and ways of behaving that may be new, needed and unfamiliar but are fitting to their child's needs.

B. Parent/Caregiver is able to be flexible and adjustable in most situations, is able to accept most things and move forward, displays some creativity in their caregiving, and is able to come up with solutions and ways of behaving that are new, needed, and unfamiliar with some assistance. On occasion the parent/caregivers adaptation is not fitting to their child's needs, however this does not result in maltreatment and/or danger.

C. Parent/Caregiver lacks flexibility in most situations, including routine caregiving responsibilities. Parent/Caregiver struggles with adapting to meet child needs, including identifying solutions for ways of behaving or caretaking that does not result in maltreatment and/or

danger to child. Parent/Caregiver acknowledges their struggle with flexibility and adaptation, however has not sought assistance in changing their behavior.

D. Parent/Caregiver is not flexible and/or adaptive in caregiving duties, resulting in children being maltreated and/or in danger. Parent/Caregiver cannot or will not acknowledge their lack of flexibility and/or adaptability in caregiving. Parent/Caregiver has not sought assistance in changing their behavior.

(6) The parent/legal guardian/caregiver has a history of protecting. This refers to a person with many experiences and events in which he or she has demonstrated clear and reportable evidence of having been protective.

(a) Examples may include:

1. People who have raised children (now older) with no evidence of maltreatment or exposure to danger.

2. People who have protected their children in demonstrative ways by separating them from danger, seeking assistance from others or similar clear evidence.

3. Caregivers and other reliable people who can describe various events and experiences where protectiveness was evident.

(b) Case Management Scaling Guide.

A. Parent/Caregiver has raised children (older) with no evidence of maltreatment or exposure to danger, have demonstrated ways of protecting their children by separating them from danger, seeking assistance from others. Parent/Caregiver can describe events and experiences where they have protected children in the past.

B. Parent/Caregiver has raised children (older) with minimal exposure to danger or evidence of maltreatment. This may or may not include prior child welfare system involvement with the family. Parent/Caregiver is able to seek assistance from others and can describe events and experiences where they have protected their children in the past, as well as describe how they were not able to protect their children in past. Parent/Caregiver is able to differentiate between prior protective actions and lack of protective actions.

C. Parent/Caregiver has demonstrated minimal ability to raise children without exposure to danger or maltreatment. Parent/Caregiver has had frequent (three or more) contacts with the child welfare system due to repeated exposure to maltreatment and parental conduct. Parent/Caregiver is not able to articulate how they have protected their children in the past and/or how they could take protective measures to ensure that their children are protected.

D. Parent/Caregiver has not been able to raise children without exposure to danger and/or maltreatment. Parent/Caregiver has had repeated contact with child welfare system (three or more reports within 1 year) due to repeated exposure to maltreatment and parental conduct.

g. "Cognitive Protective Capacity" means specific intellect, knowledge, understanding and perception that result in protective vigilance. The following are cognitive protective capacities:

(1) The person is self-aware as a parent/legal guardian/caregiver. This refers to sensitivity to one's thinking and actions and their effects on others or on a child.

(a) Examples may include:

1. People who understand the cause – effect relationship between their own actions and results for their children.

2. People who are open to who they are, to what they do and to the effects of what they do.

3. People who think about themselves and judge the quality of their thoughts, emotions and behavior.

4. People who see that the part of them that is a caregiver is unique and requires different things from them.

(b) Case Management Scaling Guide.

A. Parent/Caregiver understands the cause-effect relationship between their own actions and effects on child. They are open to who they are and to what they do and the effects of what they do. They are able to think about themselves and judge the quality of their thoughts, emotions, and behaviors. They are able to view their role as a caregiver as being unique.

B. Parent/Caregiver is able to understand the cause-effect relationship between their own actions and effects on children, however at times struggle to be open in regards to themselves and the quality of their thoughts, emotions, and behaviors in relation to providing for care of the child. The Parent/Caregiver struggles do not result in child being maltreated and/or being in dangerous situations.

C. Parent/Caregiver is able to understand the cause-effect relationship between their own actions, however are not able to relate their actions to the effects on their child. Parent/Caregiver is not open in reflecting their own thoughts, emotions, and/or behavior in relation to providing for care of their children, resulting in children being maltreated and/or in danger. Parent/Caregiver recognizes the need for understanding the causal relationship and the effects on child.

D. Parent/Caregiver is not able to understand the cause-effect relationship between their own actions and is not able to relate those actions to the effects on their child. Parent/Caregiver is not open in regard to their own thoughts, emotions, and/or behavior, resulting in child being maltreated and/or in danger. Parent/Caregiver does not recognize the need for understanding the causal relationship of their actions and the effects on child.

(2) The parent/legal guardian/caregiver is intellectually able/capable and has adequate knowledge to fulfill caregiving duties. This refers to information and personal knowledge that is specific to caregiving that is associated with protection.

(a) Examples may include:

1. People who know enough about child development to keep kids safe.

2. People who have information related to what is needed to keep a child safe.

3. People who know how to provide basic care which assures that children are safe.

(b) Case Management Scaling Guide.

A. Parent/caregiver possesses essential knowledge regarding caregiving and child development. Parent/caregiver seeks to increase their knowledge in correlation with child's needs and is able to recognize the need for increased knowledge as being essential to providing for child safety. Parent/caregiver may have cognitive limitations, however has supports and/or resources to assist in knowledge development.

B. Parent/caregiver possesses essential knowledge regarding caregiving and child development, however at times struggles in recognizing the correlation with child's needs and the need for increased/varied knowledge for providing for child safety. Parent/caregiver is open to seeking assistance and may or may not have a support network to assist in increasing their knowledge regarding child development. Maltreatment has not occurred as a result of the parent/caregiver's knowledge capacity.

C. Parent/caregiver lacks essential knowledge regarding caregiving and child development and does not correlate the lack of knowledge to the responsibility for child safety and development. Parent/caregiver may have a cognitive delay that affects their ability to increase their knowledge regarding caregiving and safety and the lack of resources or supports for their cognitive delay is a contributing factor to the parent/caregiver intellectual capacity. Parent/caregiver is not or will not seek assistance in increasing their knowledge. Maltreatment has occurred as a result of the parent/caregivers knowledge capacity.

D. Parent/caregiver lacks essential and basic child development knowledge in regards to caregiving needs and child safety. Parent/caregiver may have a cognitive delay that is debilitating and is not being addressed through informal or formal supports. The parent/caregiver knowledge is such that it leaves children in danger and has resulted in maltreatment. Parent/caregiver is not or will not seek assistance in increasing their knowledge or accessing supports to develop knowledge regarding child development and child safety.

(3) The parent/legal guardian/caregiver recognizes and understands threats to the child. This refers to mental awareness and accuracy about one's surroundings, correct perceptions of what is happening and the viability and appropriateness of responses to what is real and factual.

(a) Examples may include:

1. People who recognize threatening situations and people.

2. People who are alert to danger from persons and their environment.

3. People who are able to distinguish threats to child safety.

(b) Case Management Scaling Guide.

A. Parent/Caregiver is attuned with their surroundings, in particular to their perceptions regarding life situations, recognizing dangerous and threatening situations and people. Parent/caregivers are reality orientated and consistently operate in realistic ways.

B. Parent/Caregiver is aware of their surroundings and life situations. Parent/Caregiver is aware of dangerous and threatening situations and people, however at times struggles to correlate the impact of dangerous and threatening situations and people with their role as a parent/caregiver. Parent/Caregiver ability does not result in children being maltreated and/or unsafe. Parent/Caregiver is able to recognize the need for increased awareness and is able to access resources without assistance in increasing their mental awareness in regards to providing for safety of children.

C. Parent/Caregiver frequently is not aware of their surroundings and life situations. In particular this occurs when presented with dangerous and/or threatening situations. Parent/caregiver is not able to recognize the correlation with child safety and mental awareness, resulting in children being maltreated and/or unsafe. Parent/Caregiver is not or will not access resources to increase their mental awareness without assistance.

D. Parent/Caregiver is not aware of their surrounding and life situations, particularly when caring for children. Parent/Caregiver does not recognize dangerous and/or threatening situations/people, resulting in children being maltreated and/or unsafe. Parent/Caregiver may have an unmanaged mental health condition that affects their ability to be aware. The unmanaged mental health condition is known to the Parent/Caregiver and they have not or will not seek assistance to manage the mental health condition.

(4) The parent/legal guardian/caregiver recognizes the child's needs. This refers to seeing and understanding a child's capabilities, temperament, needs and limitations correctly.

(a) Examples may include:

1. People who know what children of a certain age or with particular characteristics are capable of.

2. People who respect uniqueness in others.

3. People who see a child essentially as the child is and as others see the child.

4. People who recognize the child's needs, strengths and limitations. People who can explain what a child requires, generally, for protection and why.

5. People who see and value the capabilities of a child and are sensitive to difficulties a child experiences.

6. People who appreciate uniqueness and difference.

7. People who are accepting and understanding.

(b) Case Management Scaling Guide.

A. Parent/Caregiver consistently recognizes the child's needs, strengths and limitations. Parent/Caregiver is able to appreciate the uniqueness and differences in children with acceptance and understanding. Parent/caregiver is sensitive to the child and their experiences.

B. Parent/Caregiver recognizes the child's needs, strengths and limitations. Parent/Caregiver is able to appreciate the uniqueness and differences in children, however at times struggles in understanding and accepting the child's differences and uniqueness. At times the Parent/Caregiver struggles with identifying with the child and their experiences. Parent/Caregiver is

aware during these times and may have sought assistance in continuing to develop their parenting skills in regards to recognizing child's needs and differences. The Parent/Caregiver has supports and/or resources available for assistance. Children have not been maltreated and/or unsafe due to the Parent's/Caregiver's capacity of being able to recognize child needs and strengths.

C. Parent/Caregiver does not identify with the child's needs, strengths, and/or limitations resulting in the parent/caregiver acting in ways that have resulted in the child being maltreated and/or unsafe. The Parent/Caregiver is able to recognize their inability to identify with children and is open to assistance in increasing their parenting capacity.

D. Parent/Caregiver does not identify with the child's needs, strengths, and/or limitations that have resulted in the child being maltreated and/or unsafe. The Parent/Caregiver does not see value in the capabilities of the child and are not sensitive to the child and their experiences. Parent/Caregiver view of the child is incongruent to the child and how others view the child. Parent/Caregiver is not able to recognize their inability to identify with child and the child's needs and are not willing or able to seek assistance in increasing their parenting capacity.

(5) The parent/legal guardian/caregiver understands his/her protective role. This refers to awareness. This refers to knowing there are certain solely owned responsibilities and obligations that are specific to protecting a child.

(a) Examples may include:

1. People who possess an internal sense and appreciation for their protective role.

2. People who can explain what the "protective role" means and involves and why it is so important.

3. People who recognize the accountability and stakes associated with the role.

4. People who value and believe it is his/her primary responsibility to protect the child.

(b) Case Management Scaling Guide.

A. Parent/Caregiver values and believes that it is their primary responsibility to protect the child. Parent/Caregiver is convicted in their beliefs and poses an internal sense and appreciation for their protective role. Parent/Caregiver is unwavering in their protective role and is able to articulate the significance of their role.

B. Parent/Caregiver believes that protecting their child is a primary responsibility, however at times struggles with their internal sense and appreciation for their protective role resulting in times where the Parent/Caregiver has abdicated their role for protectiveness to others without regard for the protectiveness of the alternate caregiver. Parent/Caregiver recognizes their limitations in regards to protectiveness and their actions have not resulted in maltreatment and/or an unsafe child.

C. Parent/Caregiver does not value and/or believe that their primary responsibility is to protect the child. Parent/Caregiver may have an internal sense for being protective, however does not or cannot internalize the primary responsibility for protection of the child. Parent/Caregiver does not or cannot accept responsibility for child protection, resulting in children being maltreated and/or unsafe.

D. Parent/Caregiver does not recognize and/or value the responsibility to protect children as a primary role of a caregiver. Parent/Caregiver does not have an internal sense for being protective and takes no responsibility for keeping children safe, resulting in children being maltreated and/or unsafe.

(6) The parent/legal guardian/caregiver plans and is able to articulate a plan to protect children. This refers to the thinking ability that is evidenced in a reasonable, well-thought-out plan.

(a) Examples may include:

1. People who are realistic in their idea and arrangements about what is needed to protect a child.

2. People whose thinking and estimates of what dangers exist and what arrangement or actions are necessary to safeguard a child.

3. People who are aware and show a conscious focused process for thinking that results in an acceptable plan.

4. People whose awareness of the plan is best illustrated by their ability to explain it and reason as to why it is sufficient.

(b) Case Management Scaling Guide.

A. Parent/Caregiver has developed, either currently or in the past, plans to protect children. Parent/Caregiver is realistic in their planning and arrangement about what is needed to ensure child safety. Parent/Caregiver is aware of danger and is focused on their processing and development of a plan for safety.

B. Parent/Caregiver is realistic in their plan for child safety and is able to make arrangements to ensure child safety, however may or may not have developed a plan for protection in the past. Parent/Caregiver is able to articulate a plan and has the resources to execute the plan if needed. Parent/Caregiver is realistic in their plan for child safety and is able to make arrangements to ensure child safety, however may or may not have developed a plan for protection in the past. Parent/Caregiver is able to articulate a plan and has the resources to execute the plan if needed.

C. Parent/Caregiver does not recognize the need to plan for child safety and has not developed a plan in the past or has developed plans that were unrealistic to ensure safety, thus resulting in maltreatment and/or children being unsafe. Parent/Caretaker may have cognitive limitations that affect their ability to conceptualize a plan for protection and are open to assistance in developing plans and/or accessing resources.

D. Parent/Caregiver does not recognize the need to develop a plan to ensure child safety and has not developed a plan in the past or has developed plans that were unrealistic, resulting in children being maltreated and/or unsafe. Parent/Caregiver does not correlate the inaction of developing a plan and children being maltreated and/or unsafe. Parent/Caretaker may have cognitive limitations that affect their ability to conceptualize a plan for protection. Parent/Caregiver is unwilling or unable to seek assistance in developing plans and/or accessing resources to assure child safety. Parent/Caregiver is unrealistic and unaware of the necessity as parents/caregivers to develop and execute plans for protection of children.

h. "Emotional Protective Capacity" refers to specific feelings, attitudes, identification with a child and motivation that result in protective vigilance. The following are emotional protective capacities:

(1) The parent/legal guardian/caregiver is able to meet own emotional needs. This refers to the parent/caregiver satisfying their feelings in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular children.

(a) Examples may include:

1. People who use personal and social means for feeling well and happy that are acceptable, sensible and practical.

2. People who employ mature, responsible ways of satisfying their feelings and emotional needs.

3. People who understand and accept that their feelings and gratification of those feelings are separate from their child.

(b) Case Management Scaling Guide.

A. Parent/Caregiver recognizes and understands their own emotional needs and is effectively managing their needs in ways that do not interfere with their ability to parent and does not take advantage of others. Parent/Caregiver makes choices in regards to satisfying their feelings and emotional needs that are mature, acceptable, sensible, and practical.

B. Parent/Caregiver recognizes their own emotional needs, however struggles to manage their needs in ways that do not interfere with their ability to parent and/or takes advantage of others. Parent/Caregiver makes choices in regards to satisfying their emotional needs that at times are not mature and/or acceptable and/or sensible and/or practical. Parent/Caregiver choices do not result in maltreatment and/or unsafe. Parent/Caregiver has and uses resources necessary to ensure children are safe while ensuring their emotional needs are met.

C. Parent/Caregiver shows limited understanding and recognition of their own emotional needs. Parent/Caregiver often seeks to satisfy their own emotional needs through means that take advantage of others, primarily their children. Parent/Caretaker uses avenues to satisfy their own emotional needs that are unacceptable, resulting in children being maltreated and/or unsafe.

D. Parent/Caregiver does not recognize their own emotional needs, resulting in their needs being unmanaged and interfering with their ability to parent children. The unmanaged needs results in children being maltreated and/or unsafe.

(2) The parent/legal guardian/caregiver is resilient as a caregiver. This refers to responsiveness and being able and ready to act promptly.

(a) Examples may include:

1. People who recover quickly from setbacks or being upset.

2. People who spring into action.

3. People who can withstand challenges and stress.

4. People who are effective at coping as a caregiver.

(b) Case Management Scaling Guide.

A. Parent/Caregiver has demonstrated that they are able to recover from or adjust easily to misfortune and/or change. Recovery and adjustment are focused on maintaining their role as a caregiver and providing for protection of their children. Parent/Caregiver recognizes the need for resiliency as a caregiver and is effective at taking action and coping as a caregiver.

B. Parent/Caregiver has demonstrated that they are able to recover from or adjust under most situations in regards to misfortune and/or change. Recovery and adjustment are mostly focused on their role as a caregiver and for providing protection. Parent/Caregiver struggles with coping and taking action during these times. Children are not maltreated and/or unsafe due to the parents coping and/or taking action.

C. Parent/Caregiver when faced with adversity/challenges is not able to recover or adjust. Recovery and adjustment requires frequent interventions by support and resources. Parent/Caregiver cannot focus their role during these times to caretaking, resulting in children being maltreated and/or unsafe.

D. Parent/Caregiver does not respond to adversity/challenges and recovery or adjustment is non-existent. Parent/caregiver does not respond to interventions by supports and resources and children are maltreated and/or unsafe due to the parent/caregivers responses.

(3) The parent/caregiver is tolerant as a caregiver. This refers to caregiver who is able to endure trying circumstances with even temper, be understanding and sympathetic of experiences, express forgiveness under provocation, broad-minded, and patient as a caregiver.

(a) Examples may include:

1. People who can let things pass;

2. People who have a big picture attitude, who don't overreact to mistakes and accidents; and,

3. People who value how others feel and what they think.

(b) Case Management Scaling Guide.

A. Parent/Caregiver maintains an even temper and patience under trying circumstances. Parent/Caregiver recognizes the need for tolerance as a caregiver and works to ensure that they are open minded and understanding as a caregiver.

B. Parent/Caregiver frequently maintains an even temper and displays patience under most situations. Parent/Caregiver at times struggles with temper and patience, however does not impact their role as a caregiver or result in maltreatment and/or unsafe children. Parent/Caregiver is aware of their challenges with tolerance and has the ability to access resources to assist in increasing their tolerance.

C. Parent/Caregiver frequently cannot or will not maintain their temper and/or patience while providing care for children. Parent/Caregiver is aware of their decreased tolerance however are not able to correlate the need for tolerance in parenting. Parent's/Caregiver's lack of tolerance has resulted in children being maltreated and/or being unsafe. Parent/Caregiver is willing to access resources and/or supports to increase their tolerance as a caregiver.

D. Parent/Caregiver cannot or will not maintain their temper and/or patience while providing care for children. Parent/Caregiver is not aware of their decreased tolerance and is not able to correlate the need for tolerance in parenting. Parent/Caregiver lack of tolerance has resulted in children being maltreated and/or being unsafe. Parent/Caregiver cannot or will not access resources and/or supports to increase their tolerance as a caregiver.

(4) The parent/legal guardian/caregiver expresses love, empathy and sensitivity toward the child; experiences specific empathy with regard to the child's perspective and feelings. This refers to active affection, compassion, warmth and sympathy.

(a) Examples may include:

1. People who fully relate to, can explain and feel what a child feels, thinks and goes through.

2. People who relate to a child with expressed positive regard and feeling and physical touching.

3. People who are understanding of children and their life situation.

(b) Case Management Scaling Guide.

A. Parent/Caregiver is able to relate to their child and demonstrates actions that are reflective of expressing love, affection, compassion, warmth, and sympathy for the child and their experiences. Parent/Caregiver is able to explain child feelings and emotions and is able to respond accordingly.

B. Parent/Caregiver is able to relate to the child, however at times struggles to demonstrate either physically or verbally, love affection, compassion, warmth, and sympathy. While the Parent/Caretaker acknowledges their love, compassion, warmth, and sympathy, they struggle with displaying affection to the child. This does not result in child being maltreated and/or unsafe.

C. Parent/Caregiver frequently cannot or will not relate to their children's feelings. Parent/Caregiver does not express love, empathy, and/or sympathy for the child on a frequent or consistent basis. Parent/Caregiver is able to recognize the absence of relating to the child's feelings. The Parent's/Caregiver's feeling towards the child results in the child being maltreated and/or unsafe.

D. Parent/Caregiver is not able to relate to the child's feelings. The Parent/Caregiver does not express any love, empathy, and/or sympathy for the child. The Parent's/Caregiver's lack of feelings towards the child results in the child being maltreated and/or unsafe.

(5) The parent/caregiver is stable and able to intervene to protect children. This refers to the mental health, emotional energy, and emotional stability of the parent/caregiver in providing for protection of children.

(a) Examples may include:

1. People who are doing well enough emotionally that their needs and feelings don't immobilize them or reduce their ability to act promptly and appropriately.

2. People who are not consumed with their own feelings and anxieties.

3. People who are mentally alert, in touch with reality.

4. People who are motivated as a caregiver and with respect to protectiveness.

(b) Case Management Scaling Guide.

A. Parent's/Caregiver's mental, emotional stability and energy are sufficient to meet the needs of the child. Feelings and emotions are not paralyzing to the Parent/Caregiver. Parent/Caregiver is alert and reality orientated to their own emotions/feelings and actions. Parent/Caregiver is motivated in ensuring their own mental, emotional stability and energy are sufficient to ensure that the child is safe.

B. Parent's/Caregiver's mental, emotional stability, and energy are sufficient under most daily routines, however during times of adversity or challenges the Parent's/Caregiver's struggle to maintain their stability. Parent/Caregiver seeks resources and supports during these times and accesses resources to ensure that child is safe.

C. Parent/Caregiver is frequently not able to maintain emotional stability during daily routines, resulting in the child's needs not being met. Parent/Caregiver is aware of instability, however is immobilized in taking action to access resources or supports to provide for child safety, resulting in child being maltreated and/or unsafe.

D. Parent/Caregiver is not able to maintain emotional stability during daily routines and challenging life events. Parent/Caretaker is not aware of their instability and has taken no action to access resources and/or supports to ensure for child safety, resulting in child being maltreated and/or unsafe.

(6) The parent/caregiver is positively attached to the child. This refers to a strong attachment that places a child's interest above all else.

(a) Examples may include:

1. People who act on behalf of a child because of the closeness and identity the person feels for the child.

2. People who order their lives according to what is best for their children because of the special connection and attachment that exists between them.

3. People whose closeness with a child exceeds other relationships.

4. People who are properly attached to a child.

(b) Case Management Scaling Guide.

A. Parent/Caregiver demonstrates their attachment to the child through actions such as ordering their lives according to what is best for their child, displays affectionate regard for their child and the child's experiences, and identifies their closeness with the child exceeds other personal relationships.

B. Parent/Caregiver demonstrates their attachment to the child through actions, however at times struggles with ordering their lives according to what is best for the child, displaying their affection for the child, and identifying the closeness of the relationship with the child. Parent/Caregiver attachment struggle are not intentional and the Parent/Caregiver is aware of the

struggle. Parent/Caregiver has or has the ability to seek resources and/or supports for increasing their parenting capacity. Children have not been maltreated and/or unsafe due to the parental and child attachment.

C. Parent/Caregiver frequently does not demonstrate their attachment to the child. This is evidenced by the ordering of their lives, lack of affectionate regard for the child, and the parent identifying other relationships as being their primary relationship. Child has suffered maltreatment and/or is unsafe as a result of the Parent's/Caregiver's lack of attachment to the child.

D. Parent/Caregiver has no attachment to the child, shows no regard for the child and the parent/caregiver relationship. Parent/Caregiver does not identify as a parent/caregiver. Parent/Caregiver cannot or will not seek resources and/or supports to enhance their attachment and does not recognize the correlation between the lack of attachment and maltreatment.

(7) The parent/legal guardian/caregiver is supportive and aligned with the child. Supportive refers to actual, observable sustaining, encouraging and maintaining a child's psychological, physical and social well-being.

(a) Examples may include:

1. People who spend considerable time with a child filled with positive regard.

2. People who take action to assure that children are encouraged and reassured.

3. People who take an obvious stand on behalf of a child.

(b) Aligned refers to a mental state or an identity with a child. Examples may include:

1. People who strongly think of themselves as closely related to or associated with a child.

2. People who think that they are highly connected to a child and therefore responsible for a child's well-being and safety.

3. People who consider their relationship with a child as the highest priority.

(c) Displays concern for the child refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure. Examples may include:

1. People who show compassion through sheltering and soothing a child.

2. People who calm, pacify and appease a child.

3. People who physically take action or provide physical responses that reassure a child, that generate security.

(d) Case Management Scaling Guide.

A. Parent/Caregiver demonstrates that they are strongly related and/or associated with the child, thus showing compassion for the child by calming, pacifying, and appeasing

children as needed. Parent/Caregiver is aligned with the child, as demonstrated by the actions and responses towards the child. Parent/Caregiver identifies their relationship with the child as being the highest priority.

B. Parent/Caregiver frequently is aligned with the child through their actions, however at times struggles in demonstrating compassion for the child and/or being responsive. The Parent's/Caregiver's actions do not result in the child being maltreated and/or unsafe. The Parent/Caregiver acknowledges their struggle, and has the resources and/or supports to increase their responsiveness and compassion for the child.

C. Parent/Caregiver does not identify with the child through their actions and lacks compassion for the child. Parent/Caregiver is infrequently non-responsive to the child when the child needs to be calmed, pacified, and/or appeased. The Parent/Caregiver acknowledges their inability to align with the child, but cannot or will not take actions to increase their alignment with the child. The Parent's/Caregiver's actions have resulted in children being maltreated and/or unsafe.

D. Parent/Caregiver is not aligned with the child as demonstrated by their non- responsiveness to the child and the lack of compassion for the child. Parent/Caregiver does not express concern and/or does not acknowledge their lack of alignment with the child. The lack of Parent/Caregiver actions has resulted in the child being maltreated and/or unsafe.

2-8. Impending Danger.

a. Definition. "Impending danger" refers to a child being in a continuous state of danger due to caregiver behaviors, attitudes, motives, emotions and/or situations posing a specific threat of severe harm to a child. Impending danger is often not immediately apparent and may not be active and threatening child safety upon initial contact with a family. Impending danger is often subtle and can be more challenging to detect without sufficient contact with families. Identifying impending danger requires thorough information collection regarding family/ caregiver functioning to sufficiently assess and understand how family conditions occur.

b. Danger Threshold and Criteria. The "Danger Threshold" is the point at which negative family conditions go beyond being concerning and become dangerous to a child's safety. Negative family conditions that rise to the level of the Danger Threshold and become Impending Danger Threats are in essence negative circumstances and/or caregiver behaviors, emotions, etc. that negatively impact caregiver performance at a heightened degree and occur at a greater level of intensity. The danger threshold criteria must be applied when considering and identifying any of the impending danger threats. The specific justification for identifying any of the impending danger threats is based on a specific description of how negative family conditions meet the danger threshold criteria. In order to qualify that impending danger exists, the following criteria must be met:

(1) Observable. Refers to family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen and understood and are subject to being reported and justified. The criterion "observable" does not include suspicion, intuitive feelings, difficulties in child welfare professional -family interaction, lack of cooperation, or difficulties in obtaining information.

(2) Vulnerable Child. Refers to a child who is dependent on others for protection and is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. All children age 0-6 years are vulnerable given their young age. For children older than 6, vulnerability is judged according to age; physical and emotional development; ability to communicate needs; mobility; size; and dependence and susceptibility. In determining when a child older than 6 years is vulnerable to a specific danger threat in the home the following should be considered:

(a) Based upon the nature of the danger threat, how does the child's physical development, mobility and size make him or her susceptible to the threat?

(b) Based upon the nature of the danger threat, how does the child's emotional development make him or her susceptible to the threat?

(c) To what degree does the child's inability to communicate needs make him or her susceptible to the danger threat?

(d) To what degree does the child's inability or unwillingness to share or disclose information make him or her susceptible to the danger threat?

(e) To what degree does the child demonstrate any capacity for self-protection?

(3) Out of Control. Refers to family behavior, conditions or situations which are unrestrained resulting in an unpredictable and possibly chaotic family environment not subject to the influence, manipulation, or ability within the family's control. Such out-of-control family conditions pose a danger and are not being managed by anybody or anything internal to the family system.

(4) Imminent. Refers to the belief that dangerous family behaviors, conditions, or situations will remain active or become active within the next several days to a couple of weeks. This is consistent with a degree of certainty or inevitability that danger and severe harm are possible, even likely outcomes, without intervention.

(5) Severe. Includes such severe harm effects as serious physical injury, disability, terror and extreme fear, impairment and death.

c. Impending Danger Threats. Impending danger threats are typically more subtle in nature than present danger and can best be described as a pervasive "state of danger." Impending danger threats result from persistent and ongoing out-of-control negative family conditions in the home. Impending danger places a child in a continual, imminent, but not present position of being seriously or severely maltreated. Impending danger can only be identified after gathering sufficient information in the six information domains. Impending danger threats are associated with or related to four main domain areas: Maltreatment and the Nature of Maltreatment, Child Functioning, Adult Functioning, and Parenting.

d. The **six impending danger threats related to the nature, scope, extent and circumstances surrounding the maltreatments,** are as follows:

(1) Parent/legal guardian/caregiver's intentional and willful act caused serious physical injury to the child, or the caregiver intended to seriously injure the child.

(a) Fractures, deep lacerations, extensive bruising, burns or inorganic malnutrition characterize serious injury.

(b) Typically involves the use of objects to inflict pain/cause injury.

(c) Child has no ability to protect themselves from physical injury or excessive corporal punishment.

(2) The child's physical living conditions are hazardous and a child has already been seriously injured or will likely be seriously injured. The living conditions seriously endanger a child's physical health. Examples may include:

(a) Extreme lack of hygiene with potential to cause serious illness.

(b) Toxic chemical or materials easily within reach of child.

(c) Unsecured, loaded firearms/ammunition in child's presence.

(d) Illicit or prescription drugs accessible by children.

(3) Parent/legal guardian/caregiver is not meeting the child's essential medical needs and the child is/has already been seriously harmed or will likely be seriously harmed. Examples may include:

(a) Parent is not maintaining child's medical regimen or meeting treatment needs despite the seriousness of the injury/illness.

(b) Parent has not called 911 to seek emergency medical response.

(4) "Other." Any other observation or information which would indicate a threat to the child's safety. This maltreatment may not be selected without supervisor approval and the investigator providing detailed justification (i.e., why no other impending danger threat was appropriate).

NOTE: The next two threats rarely manifest as impending danger because by the time the FFA-Investigation has been completed either the child/family has been located or other sufficient information has been gathered to rule out these threats or to help identify other more appropriate impending danger in the home. **Supervisors should carefully review the rationale provided by the investigator when these two threats are identified as impending dangers.**

(5) Child has a serious illness or injury (indicative of child abuse) that is unexplained, or the parent/legal guardian/caregiver explanations are inconsistent with the illness or injury. Examples may include:

(a) Multiple injuries or singular severe injury that could not have occurred accidentally.

(b) Despite seriousness of injury, parent reportedly does not know how child was injured.

(c) Explanation for how child was injured changes over time.

(6) There are reports of serious harm and the child's whereabouts cannot be ascertained and/or there is a reason to believe that the family is about to flee to avoid agency intervention and/or refuses access to the child and the reported concern is significant and indicates serious harm. Examples may include:

(a) Family is intentionally avoiding contact with CPI.

(b) Caregiver is hiding the child with relative or family friend and refuses to disclose location.

e. There is **one impending danger threat related to child functioning** which is identified primarily based on the investigator having sufficient information on how the child functions on a day-to-day basis including, but not limited to, details on the child's physical health, development, emotion and temperament, intellectual functioning, behavior and self-control:

(1) Child shows serious emotional symptoms requiring intervention and/or lacks behavioral control and/or exhibits self-destructive behavior that parent/legal guardian/caregiver is unwilling or unable to manage. Examples may include:

(a) Child is self-injurious.

(b) Child is setting fires.

(c) Child is sexually acting out.

(d) Child is addicted to drugs or alcohol.

f. There is **one impending danger threat related to adult functioning** which is identified primarily based on sufficient information as to how the caregiver functions on a daily basis including, but not limited to, the individual's overall life management, physical health, emotion and temperament, cognitive ability, intellectual functioning, self-control and patterns of criminal behavior, history of family and/or domestic violence, impulse control, substance use/abuse and mental health issues:

(1) Parent/legal guardian/caregiver is violent, impulsive, or acting dangerously in ways that seriously harmed the child or will likely seriously harm to the child. Examples may include:

(a) Child is being sexually abused and perpetrator has ongoing access to child.

(b) Caregiver is physically assaultive/threatening.

(c) Caregiver is brandishing a weapon.

(d) Domestic violence dynamics are present in the household.

(e) Caregiver is involved in substance misuse.

(f) Caregiver is violating "no contact" supervision restrictions by order of the court.

g. There are **three impending danger threats related to parenting and discipline/behavior management** which are determined primarily based on sufficient information as to how the caregiver typically parents including, but not limited to, the parents disciplinary approaches, the rationale or purpose of discipline, and the circumstances or behaviors that generally elicit parental disciplinary actions:

(1) Parent/legal guardian/caregiver is not meeting child's basic and essential needs for food, clothing and/or supervision, AND child is/has already been seriously harmed or will likely be seriously harmed. Child is hospitalized due to non-organic failure to thrive. Examples may include:

(a) Child is unsupervised in a dangerous environment or condition.

(b) Lack of basic, essential food, clothing, or shelter that result in child needing medical care or attention.

(c) Child needs to be hospitalized for non-organic failure to thrive.

(2) Parent/legal guardian/caregiver is threatening to seriously harm the child; child is fearful he/she will seriously harm the child. Examples may include:

(a) Parent expresses intent or desire to harm child.

(b) Parent makes statements about the family's situation being hopeless.

(c) Child describes extreme mood swings in parent, drug or alcohol use that exacerbate parent's volatility and frustration with child.

(3) Parent/legal guardian/caregiver views child and/or acts toward the child in extremely negative ways and such behavior has or will result in serious harm to the child. Examples may include:

(a) Parent describes the child as evil or has singled the child out for being responsible for the family's problems.

(b) Child expresses fear of being left with caregiver.

(c) Child describes being subjected to confinement or bizarre forms of punishment.

2-9. Child Strengths and Needs.

a. Purpose. Child strengths and needs measure the extent to which certain desired conditions are present in the life of the child within a recent timeframe. Child strengths and needs are assessed by the case manager based upon the assessment of child functioning.

(1) These child indicators are directly related to a child's well-being and success (e.g., emotion, behavior, family and peer relationships, development, academic achievement, and life skill attainment).

(2) When the department is involved with families whose children are unsafe, the case manager is responsible for assuring that the child's physical and mental health, developmental and educational needs are addressed by their parents, as well other caregivers when children are in an out-of-home setting.

(3) A current description of child strengths and needs will be provided in the FFA-Ongoing or Progress Update as part of "child functioning."

b. Child strengths and needs should be relevant and descriptive as to the child's specific abilities given his/her age. See Appendix A of this operating procedure, Child Development Stages Matrix, for summary descriptions of child behaviors that are within a normal range as to physical, socio-emotional, and cognitive development; indicators of developmental concern, and associated positive parenting characteristics.

c. Scaling Criteria. Based on the assessment of child functioning, the case manager will rate child strengths and needs to systematically identify critical child needs that should be the focus of case plan outcomes interventions.

(1) An "A" or "B" rating for any indicator reflects that a child is doing well in that area.

(2) A "C" or "D" rating reflects that a child is not doing well and requires attention.

(3) These are the common criteria applied to each individual rating:

A=EXCELLENT. Child demonstrates exceptional ability in this area.

B=ACCEPTABLE. Child demonstrates average ability in this area.

C=SOME ATTENTION NEEDED. Child demonstrates some need for increased support in this area.

D=INTENSIVE SUPPORT NEEDED. Child demonstrates need for intensive support in this area.

d. Specific Child Strength and Need Definitions and Ratings.

(1) Emotion/Trauma. The degree to which, consistent with age, ability and developmental level, the child is displaying an adequate pattern of appropriate self-management of emotions.

A. Child is able to experience a wide range of emotions and can manage emotions to the best of developmental ability. Child recovers readily from experiences.

B. Child may have occasional brief periods of anger, sadness, worry, etc. that are temporarily disruptive but these periods do not interfere with building friendships with peers or adults in their social, educational or family life. Child may have occasional nightmares, but tolerates these without major disruption.

C. Child's experience of anger, sadness, worry, etc. are frequent enough to cause some disruption in social, educational, or family life.

OR

Child has some symptoms of trauma such as a startle response, frequent difficulty sleeping or staying awake, bed wetting, overeating or under-eating, and these symptoms are causing some distress for the child.

D. Child experiences out-of-control anger, profound sadness or worry so much that child is unable to maintain friendships, is falling behind academically.

OR

Child has pervasive trauma symptoms such as a startle response that is so severe child cannot tolerate many environments; sleep disruption that is causing severe academic or health problems; bed wetting; eating patterns that are causing significant weight gain or loss; or child is experiencing despair or hopelessness to the point of thinking of self-harm.

(2) Behavior. The degree to which, consistent with age, ability and developmental level, the child is displaying appropriate coping and adapting behavior.

A. Child manages his/her own behavior above developmental expectations. Child is developing a sense of right and wrong and his/her approach is to seek to do what is right. He/she has an advanced awareness of the impact of behavior on others; keen empathy for others, and seeks to act in ways that promote the good and well-being of others.

OR

Child is not old enough to think about life choices and behaviors. (Children 0-3)

B. Child generally understands right and wrong and primarily seeks to do what is right. Motivation may still be more to please others or avoid punishment. Child will err, but not substantially more than would be expected for developmental level.

C. Child violates rules and expectations in ways that are disruptive to their normal routines or relationships. Child may be old enough to think about their behavior; however child has frequent (weekly) struggles with making appropriate life choices. The child's behaviors are difficult for parent/caregiver to manage. Child may run away on occasion. The child's behavior may have resulted in child care or school suspension, or involvement with juvenile justice.

D. Child consistently violates rules and expectations so that life around the child cannot be carried on. Child may be old enough to think about their behavior. Child may be frequently running away. Child's behavior is harmful to self or others including self-injury, extreme risk-taking, persistent violence toward others, sexual violence, cruelty to animals, or fire-setting.

(3) Development /Early Learning (applies to children under the age of 6 years). The child is achieving developmental milestones based on age and developmental capacities; child development in key domains is consistent with age and ability appropriate expectations.

A. Child's physical and cognitive skills are above age expectations in all domains based upon normal developmental milestones.

OR

Child with developmental delays is receiving special interventions and is demonstrating excellent progress.

B. Child's physical and cognitive skills are at or near age expectations in most of the major domains.

OR

Child with developmental delays is receiving special interventions and is beginning to demonstrate some progress.

C. Child's physical and cognitive skills are mixed, near expectations in some domains but showing significant delays in others.

OR

Child with developmental delays is or may be receiving special interventions and is demonstrating very slow gains that are below desired goals.

D. Child's physical and cognitive skills show significant delays in most domains.

OR

Child with developmental delays is or may be receiving special interventions and is showing minimal to no improvement.

(4) Academic Status (applies to children 6 years of age and older). The child, according to age and ability, is actively engaged in instructional activities; reading at grade level or IEP expectation level; and meeting requirements for annual promotion and course completion leading to a high school diploma or equivalent or vocational program.

A. Child is reading at or well above grade level and is meeting and exceeding all requirements for grade-level promotions.

OR

Child is exceeding goals set forth in an IEP or Section 504 plan.

B. Child is reading at or close to grade level and is adequately meeting all requirements for grade-level promotions.

OR

Child is adequately meeting goals set forth in an IEP or Section 504 plan.

C. Child is reading a year below grade level and is meeting some but not all requirements for grade-level promotions.

OR

Child is only meeting some of the goals set forth in an IEP or Section 504 plan.

D. Child is reading two years below grade level and is not meeting core requirements for grade-level promotions.

OR

Child is not meeting any of the goals set forth in an IEP or Section 504 plan.

(5) Positive Peer/Adult Relationships. The child, according to age and ability, demonstrates adequate positive social relationships.

A. Child interacts with other children and with adults above expectations for developmental level. Child excels in making and keeping friends.

OR

Child is not old enough to think about life choices and behaviors. (Children 0-3 would meet this criteria.)

B. Child interacts with other children and adults in ways that would be expected for developmental level.

C. Child has some difficulty making or keeping friends and/or has some discomfort relating to adults. However, child has sufficient social interactions outside of the household.

D. Child has extreme difficulty making or maintaining friendships and experiences social isolation, ostracism, or bullying.

(6) Family Relationships. Child demonstrates age and developmentally appropriate patterns of forming relationships with family members.

A. Child experiences his/her family as a safe and supportive place and has a strong sense of belonging. Child does not express any concerns about safety nor shows any symptoms of fear or trauma.

B. Child is generally comfortable in his/her family. Child expresses some concerns or worries about family conflicts that appear to be normal. Child has a basic sense of safety and security.

C. Child has some conflicts with one or more family members that disrupt the child's feeling of safety or belonging.

D. Child experiences no security or belonging with family; child experiences persistent conflict with one or more family members that makes it extremely uncomfortable to be present in the family.

(7) Physical Health. Child is achieving and maintaining positive health status which includes physical, dental, audio and visual assessments and services. If the child has a serious or chronic health condition, the child is achieving the best attainable health status given the diagnosis and prognosis.

A. Child is demonstrating excellent overall health.

OR

If child has a chronic condition, he/she is attaining the best possible health status that can be expected given the health condition.

B. Child is demonstrating an adequate level of overall physical health status.
OR
If child has a chronic condition, it is responding adequately to medical treatment.

C. Child is demonstrating an inconsistent or inadequate level of overall physical health. The child's physical health may be outside normal limits for age, growth and weight range.
OR
If child has a chronic condition, the symptoms are becoming problematic.

D. The child is demonstrating a consistently poor level of overall physical health. The child's physical health is significantly outside normal limits for age, growth and weight range. Any chronic condition is becoming more uncontrolled, possibly with presentation of acute episodes.

(8) Cultural Identity. Important cultural factors such as race, class, ethnicity, religion, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ), or other forms of culture are appropriately considered in the child's life. (NOTE: The goal of responding to a C or D would not be to change the cultural identity or belonging, but to resolve the conflict or help the child cope with the conflict.)

A. Child identifies with his/her culture, has a sense of cultural awareness, and/or is motivated to explore his/her culture. Child has an identified support network to assist in exploring and/or identifying with his/her culture.
OR
Child is of an age where they are not aware of their culture; however, they have a support network that will cultivate the child's sense of cultural identity.

B. Child identifies with his/her culture, has a sense of cultural awareness. Child shows some motivation to explore his/her culture.
OR
Child is of an age where they are not aware of their culture; however, their support network shows some motivation to cultivate the child's sense of cultural identity.

C. Child does not identify with his/her culture, but does have a sense of cultural awareness. Child does not have a support network to assist in exploring and/or identifying with his/her culture.
OR
Child is of an age where they are not aware of their culture and their support network shows little motivation to cultivate the child's sense of cultural identity.

D. Child does not identify with his/her culture, lacks a sense of cultural awareness, and expresses no motivation in exploring and/or identifying their culture. Child has minimal supports to assist with motivation, exploration, and/or identification of culture.
OR
Child is of an age where they are not aware of their culture and their support network shows no motivation and/or support for cultivation of the child's cultural identity.

(9) Substance Awareness. The assessment of substance awareness is multi-dimensional. First, the assessment includes the child/youth's awareness of alcohol and drugs, and their own use. Second, for children who have experienced the negative impacts of parent/caregiver substance misuse within their home, the assessment includes their awareness of alcohol and drugs and treatment/recovery for their parent(s).

A. Child can voice the dangers of alcohol and drugs and the negative effects on daily life choices and makes conscious decisions to refrain from use of drugs and alcohol.

OR

Child is aware of the effects of drugs and alcohol within the family dynamic, including treatment and recovery for their parent(s), and makes daily life choices to refrain from the use of drugs and alcohol.

OR

Child is of an age where it is not reasonable to understand any of the family dynamics related to drug and alcohol use within the family.

B. Child is somewhat aware of alcohol and drugs and their negative effects on daily life choices. Child has refrained from use of alcohol and drugs.

OR

Child is aware of the effect of drugs and alcohol with the family dynamic, and is aware of some basic information in regards to treatment and recovery for their parent(s).

C. Child is aware of alcohol and drugs. Child chooses to use alcohol on limited occasions. Alcohol use has not resulted in disruption to school and/or relationships.

OR

Child is partially aware of the effect of alcohol and drugs within the family dynamic, and has no information in regards to treatment and recovery for their parent(s).

D. Child uses drugs and/or alcohol on a regular basis and this has led to decreased school performance, disruption of social network, arrest, injury, or illness.

OR

Child is not aware of drugs or alcohol use within the family, including information regarding treatment and recovery for their parents.

(10) Preparation for Adult Living Skill Development (applies only to children 13 and over). Child, according to age and ability, is gaining skills, education, work experience, long-term relationships and connections, income, housing and other capacities necessary for functioning upon adulthood. Also includes adolescent sexual health and awareness.

A. Child excels with developing long-term life skills, supportive relationships and connections. Child is motivated in their life skill development and recognizes the significance of developing life skills. Child has an identified support network to assist in achieving life skill development. According to age and ability, child is developing necessary life skills for adult living.

B. Child is making adequate progress with developing long-term life skills, relationships and connections. Child displays motivation, however requires assistance with maintain their motivation. Child has a support network in place to assist in achieving life skill development and motivation. According to age and ability, child has gained adequate for adult living.

C. Child is making less than adequate progress with developing life skills, long-term supportive relationships and connections. Child is minimally engaged with life skill development, despite the level of support present. Child may or may not have a support network in place for life skill development. According to age and ability, child is beginning to gain life skill capacities that are not yet adequate.

D. Child is making very limited progress with developing life skills, long-term supportive relationships and connections.

OR

Child is not aware of the need for developing life skills, long term supportive relationships, and connections. Child may or may not have a support network in place for life skill development. According to age and ability, child is not gaining necessary life skill capacities.

2-10. Stages of Change.

a. Definition. The "Stages of Change" provide a way to understand the cognitive process for human change. The knowledge regarding how and why change occurs among individuals is important for understanding the rationale for the design of the ongoing family functioning assessment and has direct implications for how ongoing case managers should behave when intervening with caregivers. It is also known as "Trans-Theoretical Model (TTM)" developed by Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992. The specific stages of change are:

(1) Pre-Contemplation. Not currently considering change. Not ready to change.

(a) The parent/legal guardian or caregiver is yet to consider the possibility of change. The caregiver does not actively pursue help. Problems are often identified by others. Concerning their situation and change, caregivers are reluctant, resigned, rationalizing or rebelling. Denial and blaming are common.

(b) The parent/legal guardian or caregiver is communicating during ongoing family functioning assessment conversations that he does not acknowledge that there are problems and he does not consider the need to change. The parent/legal guardian or caregiver who is in the pre-contemplation stage of change tends to demonstrate some level of resistance. They are reluctant to participate in conversations during the ongoing family functioning assessment. They may express "fake cooperation" as a form of resistance and may even acknowledge that they are willing to complete services, but in reality they do not have intentions to change or they do not believe that change is possible. They may be rationalizing problems or blaming others; making excuses; or accusing the ongoing case manager of interfering in their lives. They could be actively rebelling against intervention by being overtly argumentative during conversations.

(c) The majority of parents/legal guardians or caregivers who begin the ongoing case management process do so as involuntary clients. These parents/legal guardians or caregivers tend to be in pre-contemplation about all, or some, of the problems that were identified during the investigation. They likely feel forced or coerced to be involved with case management and as a result, they feel a sense of powerlessness.

(2) Contemplation. Thinking about change. Ambivalent about change: "Sitting on the fence."

(a) The parent/legal guardian/caregiver considers change, and rejects it. The parent/legal guardian/caregiver might bring up the issue or ask for consultation on his or her own. The parent/legal guardian/caregiver considers concerns and thoughts, but no commitment to change.

(b) Parents/legal guardians/caregivers may begin the ongoing family functioning process thinking about problems and considering the need to change but they have likely not made a decision that change is necessary. The conversations that occur during the ongoing family functioning assessment are intended to facilitate parents/legal guardians/caregivers to begin weighing the pros and cons for change. Parents/legal guardians/caregivers who are in the Contemplation stage for change are ambivalent. They consider the need for change, but they are hesitant to fully acknowledge problems, and they are not sure they want to give up negative patterns of behavior.

(c) When parents/legal guardians/caregivers begin the assessment as highly resistant, efforts to facilitate change should concentrate on moving caregivers from pre-contemplation to a mindset of contemplating the need for change. Simply getting parents/legal guardians/caregivers to minimally acknowledge problems and start thinking about the need for change is a realistic objective for intervention in the short term when parents/legal guardians/caregivers are very resistant to participating in the ongoing family functioning assessment much less open to thinking about change.

(3) Preparation. Getting ready to make a change. Parent/legal guardian/caregiver has some experience with change and is trying to change: "Testing the waters."

(a) This stage represents a period of time when a window of opportunity to move toward change opens. The parent/legal guardian/caregiver may be modifying current behavior in preparation for further change. A near-term plan to change begins to form.

(b) As a result of the raising of self-awareness that occurs during the ongoing family functioning assessment, many parents/legal guardians/caregivers will move toward taking increasing ownership for their problems (or at least some of their problems) and they will start talking about not only the need for change, but what specific behavioral change would look like. When conversations are productive and begin to elicit parent/legal guardian/caregiver feedback regarding what must change, there emerges a period of time when a window of opportunity opens for engaging parents/caregivers to commit to taking steps to change.

(4) Action. Ready to make a change. Parent/legal guardian/caregivers are practicing new behavior for 3-6 months. The parent/caregiver engages in particular actions intended to bring about change. There is continued commitment and effort.

(a) Parents/legal guardians/caregivers who are in the Action stage are not only taking steps to change, including participating in a change process with the ongoing case manager and other changed focused services, but they also express a belief and attitude that the actions taken to address problems will result in things being different.

(b) In effect, when a parent/legal guardian/caregiver completes the ongoing family functioning process and commits him/herself to participating in services and working toward achieving outcomes and case plan outcomes, s/he is moving into Action stage.

(c) If at the conclusion of the ongoing family functioning assessment or in the months following the implementation of the case plan, a parent/legal guardian/caregiver communicates that s/he is ready, willing and able to make change and then proceeds to take the steps to do so, s/he is in the Action stage.

(5) Maintenance. Continuing to support behavior change. Continued commitment to sustaining new behavior post-6 months to 5 years.

(a) The parent/legal guardian/caregiver has successfully changed behavior for at least 6 months. He or she may still be using active steps to sustain behavior change and may require different skills and strategies from those initially needed to change behavior. The parent/legal guardian/caregiver may begin resolving associated problems.

(b) A parent/legal guardian/caregiver does not reach the Maintenance Stage of change until she/he demonstrates sustained behavioral change for at least 6 months. Parents/legal guardians/caregivers may still be actively involved in completing their case plans and participating in services, but significant progress has been made toward the achievement of outcomes related to caregiver protective capacities and child well-being.

(c) It is important to note that a parent/caregiver is not likely to be in the Maintenance stage for all outcomes in the case plan at the same time. In most cases, it will be more likely that parents/caregivers could be in the Maintenance stage for one outcome related to caregiver protective capacities while still remaining in the Action stage or even Contemplation stage related to other outcomes.

(d) In ongoing case management, the change process is evaluated at least every 90 days, or at critical junctures during the ongoing case management and services to determine when sufficient change has occurred such that no intervention is required and the case can be closed.

(6) Relapse (Is the stage of change specific to substance use; adopted by the Substance Abuse and Mental Health Administration). Resumption of old behaviors:

(a) The assessment of stage of change has been incorporated into most substance abuse treatment programs, and treatment interventions should be thoughtfully matched to the stage of change in which the individual is currently. Addiction programs may use stages of change models that have been customized around addiction. The first five stages of change in this curriculum are appropriate for a range of challenges. The six stage of "relapse" has been added and is specific to addictions.

(b) Substance abuse is a complex and chronic disease that has biological and behavioral components. A comprehensive treatment program, tailored to the individual, is necessary for the treatment success. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. Most people working to overcome an addiction experience relapse. It is much more common to have at least one relapse than not.

(c) Relapse is not the same as treatment failure. Recurrence of substance use can happen at any point during recovery. When a parent relapses, it is important to help the parent recognize the difference between lapses (a period of substance use) and relapse (the return to problem behaviors associated with substance use), and to work with the parent to re-engage him or her in treatment as soon as possible.

(d) It also important to note that a urine toxicology screen will not tell you whether the individual has had a lapse versus a relapse. Part of effecting long-term change includes working with parents to identify the specific factors that preceded their substance use. What were the emotional, cognitive, environmental, situational, and behavioral precedents to the relapse?

(e) Child welfare professionals can help a parent/legal guardian/caregiver plan for the potential of relapse and for ensuring safety of the child. Parents who learn triggers can become empowered to plan proactively for the safety of their children and to seek healthy ways to neutralize or mitigate the trigger. One element in the process of recovery is to develop a relapse prevention plan.

b. The ongoing case manager is expected to seek to engage caregivers in conversations that promote problem recognition, if not acceptance, and reinforce a caregiver's internal desire for change. Adopting the principle that change can be facilitated by influencing internal motivation, the conversations that occur with caregivers during the ongoing family functioning assessment attempt to raise self-awareness regarding the need for change, to instill hope for change and to elicit caregiver input.

2-11. Family Time/Family Visitation.

a. Definition. "Family time" is meaningful and regular contact which is intended to allow the parents the opportunity to see how their children are doing; gain confidence; demonstrate protective capacities; and practice what they are learning. Family time also allows children the opportunity to be

with parents and other family members they care about. Family time includes opportunities for the parents to:

(1) Attend any type of school, sporting, or extracurricular activity;

(2) Attend (in person or by phone) a doctor's appointment, medication management, therapy sessions (such as family, speech, vocational, or physical), or special needs training (such as nebulizers); and,

(3) Participate in monitored telephone calls, face-time, skyping, e-mails, letters, exchange of photographs, etc.

b. Types of Family Connections. Chapter 39 addresses and encourages family time (also known as "visitation") on three family relationship levels:

(1) Family time between the parent and child (s. 39.402(9)(a), F.S.);

(2) Family time among siblings who are separated in various placements (s. 39.402(9)(b), F.S.); and,

(3) Grandparent visitation (s. 39.509, F.S.).

c. Family Time/Visitation Quality Ratings. An assessment of the overall "frequency" and "quality" of family time and other visitation opportunities is a required component of Judicial Reviews. In order to standardize the criteria used for frequency and quality, the following ratings have been developed.

(1) Visitation Frequency ("Compliance" with Case Plan). Update of the overall visitation frequency. Visits that are appreciably shortened by unreasonably late arrival/early departure should be considered missed. Ratings are as follows:

(a) Consistent. Caregiver regularly attends visits or calls in advance to reschedule (90-100% compliance).

(b) Routine. Caregiver may miss visits occasionally and rarely requests to reschedule visits (65-89% compliance).

(c) Sporadic. Caregiver misses or reschedules many scheduled visits (26-64% compliance).

(d) Rarely or Never. Caregiver does not visit or visits 25% or fewer of the allowed visits (0-25% compliance).

(2) Quality of Face-to-Face Visits. Quality of overall visits and other family time opportunities is based on case manager's direct observation whenever possible, supplemented by observation of child, reports of foster parents, etc. Ratings are as follows:

(a) Excellent. Parent/legal guardian/caregiver **consistently:**

1. Demonstrates parental role.

2. Demonstrates knowledge of child's development.

3. Responds appropriately to child's verbal/non-verbal signals.

4. Puts child's needs ahead of his/her own.

5. Shows empathy toward child.

(b) Adequate. Parent/legal guardian/caregiver **occasionally:**

1. Demonstrates parental role.

2. Demonstrates knowledge of child's development.

3. Responds appropriately to child's verbal/non-verbal signals.

4. Puts child's needs ahead of his/her own.

5. Shows empathy toward child.

(c) Not Adequate. Parent/legal guardian/caregiver **rarely:**

1. Demonstrates parental role.

2. Demonstrates knowledge of child's development.

3. Responds appropriately to child's verbal/non-verbal signals.

4. Puts child's needs ahead of his/her own.

5. Shows empathy toward child.

(d) Adverse. Parent/legal guardian/caregiver **never:**

1. Demonstrates parental role.

2. Demonstrates knowledge of child's development.

3. Responds appropriately to child's verbal/non-verbal signals.

4. Puts child's needs ahead of his/her own.

5. Shows empathy toward child.

2-12. Evaluation of Case Plan Outcomes.

a. Definition of Outcomes. An outcome in a case plan for a parent/legal guardian identifies specific behavior that is a demonstration of an enhanced caregiver protective capacity thus remediation of danger threat. An outcome is expected to be "S.M.A.R.T." which is an acronym that represents a best practice framework for creating effective goals to succeed with change. "SMART" outcomes reflect the following :

(1) Specific;

(2) Measurable;

(3) Attainable;

(4) Reasonable; and,

(5) Timely.

b. The Ongoing Family Functioning Progress Update Criteria are used to evaluate outcome progress and change. Therefore, the criteria assess progress related to (1) that specific behavior and (2) parent(s) readiness to change. Related to progress assessment, the completion of the Progress Update occurs when the criteria have been applied to all outcomes in the case plan.

c. Terms Used in the Progress Evaluation Criteria. The following are every day terms, but to encourage reliable use of the criteria it is important that users understand how these terms are defined and applied as part of the criteria.

(1) Behavior means observable responses, actions, conduct, and manner as represented and identified in an outcome set in the case plan.

(2) Consistent means recurring as in a pattern or developing pattern.

(3) Criteria means for measuring behavior change, for judging the change of a behavior.

(4) Demonstrated means to show as a means of proof that a behavior is occurring.

(5) Diminished means lessened in usefulness or significance with respect to a personal characteristic's effect.

(6) Enhanced means already heightened and significant (with respect to a personal characteristic's effect.

(7) Evident means easy to see, clear, obvious, apparent.

(8) Outcome means specific behavior change that is supported, agreed to, and expected.

(9) Repeated means done again and again, done enough to represent a possible developing pattern.

(10) Sustained means to keep up for several weeks to months to years; to become habitual in manner.

d. Progress Toward Outcome Achievement Ratings. Note that use of the word "caregiver" in the ratings indicators refers to the parent/legal guardian.

(1) Indicators of Excellent Progress. Excellent Progress means that the caregiveris demonstrating actions that are evidence of significant progress towards achieving changes in one or more protective capacities. Caregiveris demonstrating considerable commitment of time and energy.

(a) The caregiver takes ever increasing responsibility for demonstrating behavior as an expression of self-sufficiency.

(b) The caregiver adjusts priorities in his or her life in relationship to parenting and protective responsibilities.

(c) The caregiver is more self-aware about the behavior and can explain it in relationship to the reason for Department/agency involvement.

(d) The caregiver is open about the value of the changed behavior, the need for the changed behavior, and the circumstances that required the changed behavior.

(e) The caregiver sees and accepts the effects of the changed behavior and values the effects.

(f) The caregiver indicates satisfaction about the changed behavior.

(g) The caregiver prefers the changed behavior over previous ways of behaving.

(h) The caregiver recognizes the possibility of relapse and the inevitable consequences.

(i) The caregiver can reflect on the positive benefits resulting from the changed behavior.

(j) The caregiver is motivated to work on other changes and adjustments in his or her life.

(k) There is evidence of secondary gains such as changes in life circumstances, changes in child behavior, changes in relationships, and so on.

(2) Indicators of Acceptable Progress. Acceptable Progress means that the caregiver is demonstrating actions that are evidence of beginning progress towards achieving changes in one or more protective capacities. The caregiver is demonstrating an acceptable level of commitment and energy.

(a) The caregiver is actively participating in planned services.

(b) The caregiver acknowledges the need to change.

(c) The caregiver is committed to addressing what must change.

(d) The caregiver acknowledges his or her responsibility for child protection.

(e) The caregiver makes the correlation between his or her diminished protective capacities and threats to child safety.

(f) The caregiver assertively takes action to address what must change.

(g) The caregiver is beginning to demonstrate enhanced protective capacities associated with what must change to create a safe environment.

(h) The caregiver demonstrates change in perceptions, attitudes, motives, emotions, and behaviors that are associated with his or her protective capacities.

(i) The caregiver is purposively using services (i.e., counseling, skill building, education) to enhance protective capacities

(3) Indicators of Not Adequate Progress. Not Adequate Progress means that the caregiver is demonstrating minimal actions that do not reflect a sufficient commitment of time or energy to achieve the necessary changes in one or more protective capacities; or, Caregiver is ready and willing to participate in services but progress is not being made based on service/treatment availability, service/treatment accessibility or service/treatment is not of sufficient intensity.

(a) The caregiver seems to be contemplating the need to change (is moving from pre-contemplation to contemplation).

(b) The caregiver may not agree completely with what must change, but he or she is open to discussing issues.

(c) The caregiver vacillates back and forth between considering change and being motivated to maintain problematic behavior.

(d) The caregiver generally maintains appointments with the Department/agency.

(e) The caregiver is willing to participate in services related to enhancing a particular caregiver protective capacity.

(f) The caregiver's involvement at this point may be more related to compliance than change, but he or she generally follows through on participating in planned services.

(g) The caregiver is beginning to reflect how his or her actions/behavior is impacting his or her ability to adequately parent, to assure protection.

(h) The caregiver has a sense that things may need to change or at least that the current status quo is not working.

(i) The caregiver may not fully acknowledge and agree with what must change, but he or she can communicate the negative consequences of continuing with the way things are.

(j) The caregiver is open to discussing alternative ways of behaving, thinking, and/or feeling.

(k) The caregiver is somewhat receptive to seeking specific feedback, knowledge, skill regarding what must change.

(l) The caregiver is somewhat assertive in communicating needs.

(m) The caregiver appears to demonstrate increased problem solving related to the reasons that the Department/agency is involved.

(4) Indicators of No Progress. No Progress means that caregiver is demonstrating behaviors that are a significant indication that the caregiver has not made any commitment of time or energy to achieve the necessary changes in one or more protective capacity.

(a) The caregiver maintains that problems are separate from him or herself.

(b) The caregiver continues to blame his or her problems on others.

(c) The caregiver maintains that problems are unchangeable.

(d) The caregiver maintains that there is not a problem that needs to be addressed.

(e) The caregiver continues to have rigid beliefs about his or her right to behave how he or she wants.

(f) The caregiver refuses or avoids participation in services which enhance a particular caregiver protective capacity.

(g) The caregiver rejects discussion or feedback related to what must change.

(h) The caregiver is completely non-assertive and is withdrawn from engaging in intervention.

(i) The caregiver is completely closed off regarding the need to address what must change.

(j) The caregiver's current functioning makes it unlikely that he or she could benefit from change interventions.

(k) The caregiver is inflexible and avoids contact with the Department/agency and/or treatment service providers.

(l) The caregiver may verbalize commitment but does not follow through; interaction is characteristically passive aggressive or "fake cooperation."

2-13. Overall Case Plan Compliance Ratings for Judicial Cases. Judicial reviews require an overall assessment of the extent to which caregiver(s) are compliant with the overall goals of their case plan. These ratings apply to the progress being made on all case plan outcomes. It is an overall professional judgment made by the case manager.

a. Substantially Compliant.

(1) Caregiveris demonstrating actions that are evidence of significant progress towards achieving changes in one or more protective capacities.

(2) Caregiveris demonstrating considerable commitment of time and energy to accomplish all case plan outcomes.

(3) The circumstances which caused the creation of the case plan have been significantly remedied to the extent that the safety and well-being of the child will not be endangered upon the child's remaining with or being returned to the child's parent.

b. Partially Compliant.

(1) Caregiver is demonstrating actions that are evidence of beginning progress towards achieving changes in one or more protective capacities.

(2) Caregiver is demonstrating an acceptable level of commitment of time and energy to accomplish case plan outcomes.

c. Not Compliant. Though able to do so, the caregiver is demonstrating minimal actions that do not reflect a sufficient commitment of time or energy to achieve case plan outcomes.

Chapter 3

PLANNING FOR CHILD WELFARE PROFESSIONAL SAFETY

3-1. Purpose. Each case has the potential for problematic interactions with parents because many individuals feel threatened simply by the child welfare professional showing up at their home. Even more challenging are the unavoidable conflicts that arise when the child welfare professional has to initiate an involuntary safety intervention as part of a protective action. Parents can verbally threaten or even attempt to assault the child welfare professional under these circumstances. The first step in ensuring safety is to evaluate the situation before the initial contact.

3-2. Preparation. In order to effectively evaluate personal safety prior to initial contact and subsequent home visits, the child welfare professional must consider the following information:

a. Be prepared for potentially volatile family dynamics:

(1) Is there a history of assaultive behavior by anyone in the family (i.e., aggravated assault, aggravated battery, battery on a law enforcement office or other person of authority, or use of a weapon in the commission of a crime, etc.)?

(2) Is there a history of domestic violence?

(3) Does the report indicate the possibility of a family member with an unmanaged mental illness who is exhibiting violent or unpredictable behavior?

(4) Are there firearms or other weapons noted in the report?

(5) Is someone in the home abusing alcohol or drugs, likely to currently be under the influence of any substance, or selling and/or manufacturing drugs?

(6) Has the family reacted aggressively during prior investigations?

(7) Does the report describe any household members as potentially violent or hostile?

(8) Are the injuries to the child reportedly severe or life-threatening?

(9) Is it likely the child will be removed from the family situation on this visit?

(10) Does the family have potentially dangerous pets?

b. Consider site logistics, including:

(1) Is the family's geographic location extremely isolated or dangerous? Drive by and observe the house and neighborhood prior to initiating the visit.

(2) Is the home visit after normal working hours?

(3) Does the housing situation or neighborhood increase concerns for an investigator's personal safety?

(4) Are individuals in the household known gang members?

(5) Are there any animals in the home that may pose a threat to the child welfare professional?

(6) Learn the safest route to and from the family's home.

(7) Be sure the car is in good working order, and park it in a way that allows a quick exit, such as backing the vehicle in for a quick departure.

(8) Carry a cell phone with a charged battery.

(9) Plan to make initial contacts with another staff person or law enforcement when circumstances warrant.

c. Always inform the supervisor or other personnel of the child welfare professional's interview/ visitation schedule and approximate return time when there is contact with the family.

3-3. On-site Precautions. The child welfare professional should always take the following precautions:

a. Place all personal items in the car trunk prior to leaving for the home visit.

b. Have access by telephone to a supervisor or designated staff person for consultation.

c. Memorize the address and home's location.

d. Closely observe each person in and around the area and watch for signs that may indicate the potential for personal violence.

e. Follow one's instincts. Any time the child welfare professional feels frightened or unsafe, he or she should assess the immediate situation and take whatever action is necessary to obtain protection.

f. When inside the home, the child welfare professional should:

(1) Ask who else is currently home or expected to return soon.

(2) Identify which rooms have closed doors (and possibly contain individuals).

(3) Identify how many exit points are in the home.

(4) Be aware of the best location within the home for the interview to be conducted.

(5) Avoid sitting with your back to a door or window.

(6) Avoid having to walk past someone to leave the home.

3-4. Supervisor.

a. The supervisor should ensure that all child welfare professionals in their unit know local safety planning protocols and expectations, including when law enforcement must be contacted to accompany a child welfare professional.

b. The supervisor will identify under what circumstances, if any, a supervisor consultation will be required to ensure personal safety planning is adequate.

Chapter 4

FAMILY SUPPORT SERVICES

4-1. Purpose. Florida's practice model includes the expectation that when children are safe but at high or very high risk for future maltreatment, affirmative outreach and efforts will be provided to engage families in family support services. Family Support services are intended to prevent the occurrence of a future child abuse investigation and/or child maltreatment by:

a. Strengthening protective factors that will increase the ability of families to nurture their children successfully.

b. Enhancing the social and emotional well-being of each child and the family.

c. Enabling families to use other resources and opportunities available in the community.

d. Assisting families with creating or strengthening family resource networks to enhance and support childrearing.

4-2. Description of Population to be Served.

a. When the child protective investigator has determined that children in the family are safe however the family has a high or very high risk level as determined by the actuarial risk assessment.

b. Victims of Human Trafficking who have been determined to be safe by the child protective investigator or have no safety determination ("Other" investigation or community children).

c. Families with children who have been determined safe by the child protective investigator but at low to moderate risk of future maltreatment as determined by the actuarial risk assessment may be referred; however, they are not required to be served.

d. If family support services are provided, including ongoing contact and case activities, those services must be captured in FSFN. Case coordination includes communication, information sharing, and collaboration with providers and staff serving the family as well as with the family being served. Coordination activities may include but are not limited to: reducing barriers to obtaining services; establishing linkages; face to face visits and home visits. Referrals to agencies in the community that typically involve a one-time only interaction with a family are not considered Family Support Services (e.g., food pantry, clothing closet, etc.) and documentation in the Family Support Module is not required. For cases requiring no ongoing case coordination the CBC will develop and/or approve local policy.

e. When children have been determined to be safe by the child protective investigator regardless of risk level, Family Support Services are voluntary.

4-3. Local Family Support Services Array. The CBC will develop and/or approve local policy for Family Support Services for high and very high risk families that defines:

a. The referral process(es);

b. Service descriptions, to include at least monthly face to face home visits on Human Trafficking cases and cases with a high or very high risk level as determined by the actuarial risk assessment completed by the Child Protective Investigator;

c. Duration of service;

d. Staff qualifications, to include requirements of s. 409.1754(2)(a)1, F.S., specific to human trafficking;

e. Expectations or conditions for family participation in Family Support Services; and,

f. Methods for quality assurance and monitoring to ensure that policies are followed and services are of sufficient quality and effectiveness.

4-4. Provider Outreach and Family Engagement.

a. The Family Support Services provider will conduct follow-up outreach and engagement efforts with the family to collaboratively:

(1) Review and discuss the family circumstances and the current risk level.

(2) Identify barriers to sustained safety and intervention choices and options that would be effective ways to lower current risk.

(3) Develop a plan to mitigate the identified barriers to the child(ren)'s future safety.

(4) Establish a timeframe for completion of the plan.

(5) Commit to follow and complete the plan.

b. The family has a right to request closure of their case at any time.

(1) While participation with Family Support Services is voluntary, it is expected that, should a family determined to be at high or very high risk become unwilling to engage and participate or if the family has been identified as not making progress in efforts to reduce risk, a "close the loop" staffing must occur and be documented in FSFN.

(2) Human trafficking cases in which the family is no longer participating or making progress in efforts to reduce risk will also require a "close the loop" staffing.

(3) During this "close the loop" staffing, the potential need for an in home report, additional service needs as well as ongoing risk will be discussed and the outcome documented in FSFN.

(a) At a minimum, those individuals included in the "close the loop" staffing must be the referring Child Protective Investigator, the referring Child Protective Investigator Supervisor, any service providers working with the family and the individual responsible for case coordination.

(b) Efforts should be made to complete the staffing with the referring Child Protective Investigator or Investigator Supervisor. However, if they are no longer employed in the same capacity or unable to participate despite reasonable notice, an individual who is knowledgeable regarding the family's prior investigations can suffice.

(c) During the "close the loop" staffing, discussion should include ongoing risk, services provided, unresolved service needs and benefit to the family as well as attempts to re-engage the family.

4-5. FSFN Documentation. Family Support functionality in FSFN will be used to document all "Family Support Services" provided to families. The following information must be documented in FSFN as indicated below:

a. The begin date and the date case is closed. The date the family agrees to engage in services as verified by the service provider is considered to be the begin date.

b. A brief summary of the reason for the family referral and the recommendations from the assessment will be described in the "Status Begin Comments" narrative field. The summary will include services to be provided and expected outcomes.

c. The Family Support Type will be "Prevention".

d. The FSFN Family Support module requires the creation of a "Risk Factor" page which can be updated based on subsequent assessments. The initial risk level entered must be the risk level as determined by the actuarial risk tool completed at the conclusion of the investigation. Any subsequent risk levels determined by assessments completed by the service provider shall be documented using either the "Update" or "Closure" options, as appropriate.

(1) When a family has been referred for family support services due to Human Trafficking and there was no actuarial risk assessment completed by the child protective investigator, then the risk level will be entered as Very High.

(2) The FSFN Family Support module requires the creation of a "Risk Factor" page which can be updated based on subsequent assessments. "Risk factor" as used on this page in FSFN does not refer to the items that were marked on the actuarial risk assessment. Rather, the service provider should conduct an assessment of barriers to sustainable safety and, collaboratively with the family, identify areas of family life that will be addressed. The CBC will determine the policy for its case managers or contracted agents as to when the risk factor page must be completed.

e. Any additional assessments that the service provider refers the family to (such as mental health and substance abuse) shall be uploaded into case notes.

f. Status Ending Comments should include a summary of the reason for case closure including a family's refusal to begin or continue receiving services offered. Summary must include the documentation of successful interventions. If there is a "close the loop" staffing, the outcome and efforts to reengage the family must be documented.

g. If a case remains open over 12 months, rationale for continuing Family Support Services must be captured in a case note.

h. Contact notes will summarize the essence of what happened during each contact as it related specifically to the Family Support Services being provided.

i. The Family Support Services Module will only be utilized as described in this chapter.

(1) The Family Support Module in FSFN will not be used to capture information regarding the utilization of Safety Management Services for children who have been determined to be unsafe by a child protective investigator.

(2) The Family Support Module in FSFN will not be utilized to capture information related to Post Adoption Services. Documentation of Post Adoption Services will be entered on the Post Adoption Services page beginning April 2016, following the release of a FSFN build.

Chapter 5

HOME STUDIES

(Draft Pending)

Chapter 6

CRIMINAL HISTORY AND DELINQUENCY RECORD CHECKS FOR INVESTIGATIONS, PLACEMENT AND EMERGENCY PLACEMENT

(Draft Pending)

Chapter 7

CASE TRANSFER FROM INVESTIGATIONS TO CASE MANAGEMENT

7-1. Purpose. To ensure that the transfer of primary responsibility for a case involving an unsafe child is based on sufficient information and understanding as to the impending danger threats that must be managed with a safety plan and remediated with a case plan. To the fullest extent possible, this will be achieved through face-to-face discussion(s) between the child welfare professionals responsible for current and future safety management.

7-2. Procedures.

a. A case transfer conference shall occur for each child transferred per requirements in Rule 65C-30.002, F.A.C.

b. Prior to the case transfer conference, the investigator shall ensure that the child's record in FSFN provides:

(1) Up-to-date documentation of investigative activities.

(2) A completed family functioning assessment containing sufficient, reconciled and corroborated assessment information.

(3) The name and location of child's school and/or child care provider, if available.

(4) The name and location of child's medical provider(s) and copies of any health or medical information, if available.

(5) If the child is in out-of-home care, any documented diligent efforts to identify and locate all relatives of the child, to include:

(a) All adult grandparents.

(b) All parents of siblings of the child where such parent has legal custody.

(c) Other adult relatives of the child including relatives suggested by the parent(s).

(6) The child's date and location of birth if the child is under court ordered supervision, if available.

(7) A photograph of the child who was removed, if available.

(8) Fingerprints of the child placed in out-of-home care, if available.

(9) The status of the inquiry into whether the child may have Native American heritage.

(10) Any court or other documents related to shelter.

(11) Any other documentation or actions agreed upon between the department staff or sheriff's office performing the investigation and the contracted service provider.

c. Investigators are responsible for scheduling case transfer conferences with case management staff as soon as the family functioning assessment is complete and a child is determined

to be unsafe. Given local protocols for case transfer, the conference may be scheduled by the CBC/Lead Agency.

(1) The primary case manager who will be assigned to the case should attend the conference whenever possible.

(2) Parents or legal guardians and the family's support network will be included in the case transfer meeting whenever possible and appropriate.

d. The Lead Agency/CBC will ensure that case transfer preparation activities per requirements in CFOP 170-9, Chapter 1, paragraph 1-2 are completed.

e. Investigators are responsible for following the local process established to schedule case transfer conferences with case management staff as soon as the Family Functioning Assessment-Investigation (FFA-I) is complete and a child is determined to be unsafe.

f. When safe and appropriate, the use of a family team meeting/conference model is the preferred method for engaging families at case transfer.

g. During the case transfer conference, the investigator will summarize the information collected on:

(1) Identified danger threats.

(2) Caregiver protective capacity.

(3) Safety actions put in place as a result of safety planning.

(4) Conditions for return if child has been relocated or removed.

(5) The level of parental cooperation in complying with the safety actions to date.

(6) The risk level established by investigator.

(7) All other critical information needed regarding the child and family including assessment information provided by the Child Protection Team or any other professional evaluation obtained during the investigation.

h. Participants at the conference will review and discuss the current safety plan and develop modifications as needed.

i. If there is any additional information needed, an agreement will be reached as to when such information will be provided by the investigator.

j. Once the case transfer conference has been completed, full responsibility for the case by the case management conferencewill begin.

7-3. Supervisor. Supervisors will ensure that sufficient information is available for the case transfer conference by reviewing the thoroughness of the Family Functioning Investigation (FFA-Investigation) in providing adequate documentation of how the danger threat is manifested in the home and the capacity of the safety plan to adequately manage the identified threat(s). The following questions will help determine if the information reviewed provides sufficient rationale or justification for safety and case management services:

a. Can the investigator describe and does the FFA-Investigation documentation support sufficient information on the maltreatment, circumstances accompanying the maltreatment, child functioning, adult functioning, general parenting, and disciplinary and behavior management?

b. What additional information, if any, may be needed on the family in order for the case manager to begin the FFA-Ongoing?

c. Is it clear how impending danger is manifested in the family?

d. Are the current safety actions adequately controlling and managing the danger threats in the household?

e. Does the safety planning analysis provide sufficient rationale for the type of safety plan selected (i.e., in-home vs. out-of-home)?

f. Are the current safety management providers demonstrating a sufficient level of effort and diligence to ensure child safety? How are these behaviors or actions being measured?

g. What is the risk of subsequent maltreatment?

h. Are there any indications that the safety plan may need to be adjusted? Is there a need to schedule a safety planning conference immediately to update the plan prior to holding the case transfer conference?

7-4. FSFN Documentation.

a. The investigator will ensure that closure activities per CFOP 170-5, Chapter 25, have been completed and documented including any follow-up information agreed upon at the case transfer staffing. The investigation closure reason for all unsafe children will be “Closing Open to Ongoing Case Management.” This date may be later than the date the case was accepted by the CBC/Lead Agency based on investigation activities not completed at the time of the case transfer meeting.

b. The supervisor will document the case transfer review with the investigator using the Supervisor Consultation page and “Closure” as the type of consultation.

c. The CBC/Lead Agency is responsible for ensuring that the following information is documented accurately in FSFN:

(1) Record the case transfer conference using “Meetings” functionality in FSFN, selecting Case Transfer Meeting (ESI) to document that the meeting has been completed and any follow-up information to be provided by the investigator that was agreed upon.

(2) The actual date and time that the case has been accepted by using the “Case Accepted” box on the Case Transfer meeting page.

Chapter 8

CHILD WELFARE PROFESSIONAL MANADATED REPORTING IN OPEN CASES

8-1. Mandated Reporting. Section 39.201(1)(a), F.S., requires "*any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in this chapter, or that a child is need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care shall report such knowledge or suspicion*." All child welfare professionals shall make reports to the Hotline using any of the reporting means available (via telephone, facsimile, Florida Relay Services or on-line reporting).

a. During an investigation or ongoing services, any new incident of abuse, neglect, abandonment or exploitation of a child that occurs must be reported. An insufficient safety plan or a continuation of family conditions associated with the danger threats are not a basis for a call to the hotline

b. During an investigation or ongoing services, when it is learned that a non-maltreating parent in a separate household is known or suspected to be responsible for maltreatment the child welfare professional must make a report to the hotline. When the hotline intake is accepted, separate FFA-Investigations will be developed by the CPI.

c. During ongoing services, when a non-maltreating parent is assessed and it is determined that they meet the criteria for abandonment, an FFA-Ongoing will be developed by the case manager unless the child is suspected to be in present or impending danger. If the child is suspected to be in present or impending danger, a report to the hotline will be made.

d. If a child is suspected to be in present danger, the case manager must take immediate actions to determine if safety plan modifications are needed to manage the danger threats. Requirements in CFOP 170-7, paragraph 2-3 must be followed. A situation involving present danger does not in-and-of itself necessitate a report to the hotline. When the case manager resolves a situation involving present danger and determines that there is not a new incident of child abuse, neglect, abandonment or exploitation, a Present Danger Assessment will be documented per CFOP 170-7, paragraph 2-3h.

8-2. Providing Name of Reporter. The child welfare professional must provide their name when they are a social worker as defined in s. 39.01(71), F.S., "any person who has a bachelor's, master's or doctoral degree in social work."

a. When the professional making a report provides their name as required or by choice, it will afford the investigator assigned to conduct the investigation an opportunity to conduct a more thorough follow-up interview.

b. The name of any person reporting child abuse, abandonment, or neglect may not be released to any person other than employees of the department responsible for child protective services, the Florida Abuse Hotline, law enforcement, the child protection team, or the appropriate state attorney, without the written consent of the person reporting.

8-3. Safety Planning. A child welfare professional making a report on a family they are investigating or responsible for in ongoing case management shall act immediately to create or modify any existing safety plan as needed to protect the child per safety planning requirements in CFOP 170-7, Chapter 11.

8-4. Present Danger Assessment. When a case manager has assessed a present danger situation and as a result does not suspect that a new incident of child maltreatment has occurred, a Present

Danger Assessment should be documented. The case manager's assessment of present danger is further described in CFOP 170-7, Chapter 2, paragraph 2-3.

Chapter 9

NEWBORNS OR OTHER NEW CHILDREN IN HOUSEHOLDS WITH ACTIVE INVESTIGATION OR ONGOING SERVICES

9-1. Purpose. This chapter provides guidance to the child welfare professional on requirements to assess any child joining a household that is involved in an active investigation or ongoing services case. This includes the birth of a new child in any focus household. This chapter provides guidance on the assessment as part of the Family Functioning Assessment-Initial (FFA), Family Functioning Assessment-Ongoing (FFA-O) or Progress Update.

9-2. Legal Authority.

a. Section 39.301(23), Florida Statutes.

b. Section 39.701(1)(h)(1-3), Florida Statues.

c. Rule 65C-30.015, Florida Administrative Code (F.A.C.).

9-3. Required Assessment. The child welfare professional must complete an assessment in any of the following circumstances:

a. A child joins a focus household that is under investigation for allegations of abuse, neglect or abandonment or receiving ongoing services. The child welfare professional will follow requirements in CFOP 170-1, Chapter 2, paragraph 2-3c(3) to determine if the child is a member of the focus household.

b. A child will be residing in the home of the parent/significant caregiver receiving ongoing case management services. “Resides” means that the child will live in a home on a permanent basis including any timesharing custody agreements.

9-4. Conduct Family Functioning Assessment – Initial. If a child joins a focus household under investigation for allegations of abuse, neglect or abandonment the Child Protective Investigator (CPI) must:

a. Add the name and demographics of the child to the investigation and the FFA.

b. Assess the child as a part of the FFA. Include information as outlined in CFOP 170-1, Chapter 2, paragraph 2-4 about the child and the impact on family dynamics in each of the domains.

c. The CPI must re-evaluate and update any safety plan already in place.

9-5. Conduct Pre-Birth Assessment During Ongoing Services.

a. When a parent/significant caregiver or a minor in a focus household is pregnant, the case manager responsible will conduct a pre-birth assessment. The case manager’s supervisor should provide active collaboration and guidance. The case manager must complete the pre-birth assessment whether the current safety plan for the siblings is in-home or out-of-home.

b. The case manager will complete the pre-birth assessment as part of the FFA-O or Progress Update, whichever is due after learning of the pregnancy. Per s. 39.701(1)(h)1, F.S., the case manager must complete the assessment as follows:

(1) At least 30 days before a child is expected to be born; or,

(2) Within 72 hours after learning of the pregnancy, if the child is expected to be born in less than 30 days.

c. The case manager must convene a multidisciplinary staffing or family team meeting to plan for the newborn's care and supervision. The case planning conference should inform the development of the FFA-Ongoing or Progress Update. Participants must include the following persons:

(1) The mother and father, whether in the same or separate households.

(a) The case manager and supervisor will determine whether there should be separate case planning conferences when one or both parents are responsible for family or intimate partner violence. Please see CFOP 170-7, Chapter 4, for additional information on handling cases involving intimate partner violence.

(b) The case manager must complete a home study and obtain home study approval prior to a non-maltreating parent's participation in a case planning conference.

(2) When the conference involves a minor parent(s), the minor parent's birth parents (unless termination of parental rights has occurred or it is not in the best interest of the mother).

(3) The Guardian ad litem (GAL)/Attorney ad litem (AAL) if appointed for a sibling. If a GAL attorney or AAL participate in the case planning conference, the counsel for mother and father must also be permitted to participate.

(4) Any current caregivers.

(5) Any other parties deemed appropriate by the case manager or invited by the parent(s) may also participate.

d. Participants in the case planning conference will:

(1) Determine prenatal care and pre-birth needs.

(2) Identify the anticipated needs of both mother and father to care for the child when born.

(a) If mother had to stop taking medications during pregnancy, when can she resume taking her medications?

(b) Will the parent(s) have access to mental health or substance abuse treatment services, including Medication Assisted Treatment?

(3) Identify the services and supports to address family needs when the child is born.

e. The case manager will document pre-birth assessment information in the FFA-O or Progress Update, whichever is due. The FFA-O or Progress Update will document the following pre-birth assessment information in addition to the standard requirements in CFOP 170-1, Chapter 2, paragraph 2-4, Information Domains:

(1) Child Functioning. As age appropriate, what are the feelings expressed by the child(ren) about having a new baby in the home?

(2) Adult Functioning.

(a) Who are the new child's parents? Do they reside together?

(b) Was this a planned pregnancy? If not, how does each parent feel about the pregnancy? What are the parent(s) concerns, if any?

(c) What is the plan for the mother's pre-natal care? Are there any barriers to accessing pre-natal care?

(d) If the mother had prior births, did she experience post-partum depression?

(e) If the parents do not reside together, how much time will the new child spend in the focus household?

(f) How is the care of the new baby expected to affect daily household routines and responsibilities of significant caregivers in the home?

(g) Will adults be able to provide or access necessary housing and resources to care for the new child?

(h) Does the parent/significant caregiver have any history that is of concern regarding the safety of the mother or the new child? Is there any history of family or intimate partner violence? If yes, are there any current indicators of intimate partner violence or a perpetrator's pattern of coercive control?

(i) Does the parent/significant caregiver have a current or past history of mental illness or substance use disorder?

1. Is she/he currently in substance abuse treatment?

2. Is she/he being drug-tested by a substance abuse treatment provider?

(j) Is either parent/significant caregiver taking prescribed medications for a substance use disorder or other mental health disorder? If the parent who is pregnant is taking prescribed medications, the following must be ascertained:

1. What are the prescribing physician's recommendation for taking the medication during pregnancy?

2. If it is not safe to continue with current medications, what needs to happen to stabilize the mother's mental health while pregnant?

3. Is it possible that the new child will be born substance-exposed?

(3) Parenting/Behavior Management.

(a) What are the expectations of each parent/significant caregiver, if any, for the shared care and financial support of the new child?

1. If a parent is facing incarceration or for other reasons will not be able to care for the newborn, who will care for the child?

2. If a non-maltreating parent is going to care for the newborn, when will the child welfare professional complete an Other Parent Home Assessment (OPHA)?

(b) Are there others residing in the household who will have significant responsibilities for the care of the new child? Is there a shared agreement and understanding among

all household members as to how the new child will be cared for and what, if any, supports will be needed?

(c) How might care of the new child affect the current family conditions that resulted in the investigation or the need for ongoing services?

9-6. Conduct Newborn or New Child Assessment During Ongoing Services.

a. When a baby is born or a new child enters the home, the case manager will immediately re-evaluate the current safety plan to determine if new safety plan actions or tasks are needed to protect the new child. The case manager must modify or create a safety plan for a newborn prior to the child's release from the hospital.

(1) The case manager should generate a new report to the Hotline only if he/she suspects the new child was abused, abandoned, or neglected.

(2) The case manager will notify the circuit GAL program, if currently involved with a sibling, of the new child and any related safety plan actions.

(3) The case manager will follow requirements in CFOP 170-7, Chapter 5, Safety Plan Involving Release of a Child with Non-Maltreating Parent/Legal Guardian, if a newborn will receive care from a non-maltreating parent/legal guardian, including background checks.

b. The case manager must add any new child to the FSFN case shell.

c. The case manager will include the new child as a participant in the FFA-O or Progress Update, whichever is due next. Per s. 39.701(1)(h)1, F.S., the assessment must be completed as follows:

(1) At least 30 days before a newborn or new child moves into the home; or,

(2) Within 72 hours after learning the child will be moving into the home in less than 30 days.

d. The case manager will complete the information domains for adult functioning, parenting and discipline and identify the parent's protective capacities. The case manager will provide information about the newborn in a separate "child functioning" information domain.

e. The FFA-O or Progress Update will provide the following information in addition to the standard requirements in CFOP 170-1, Chapter 2, paragraph 2-4, Information Domains; and CFOP 170-9, Chapter 6, Evaluating Family Progress. The case manager should not repeat any information already provided in the FFA-O or a prior Progress Update.

(1) Child Functioning.

(a) The case manager will provide the following information when the new child is a newborn:

1. Was the child born full-term?

2. Was the newborn within a healthy weight range?

3. Was the child substance-exposed at birth? If so, what were the effects?

4. What are the ongoing possible effects that the newborn's parent(s) or significant caregivers should monitor?

(b) The case manager will provide the following information for any new child:

1. Who are the new child's parents? Why is the new child in the home? How much time is the new child spending in the focus household?

2. Has the new child been diagnosed with any special needs or conditions that require special care and/or ongoing medical monitoring?

3. Does the child have any behaviors that require a Child Placement Agreement per CFOP 170-11, Chapter 4?

(2) Adult Functioning. The child welfare professional will provide the following information unless it has already been provided in the previous FFA-O or a Progress Update as the result of a pre-birth assessment:

(a) The case manager will provide the following information when the child is a newborn:

1. What are the parent(s)' current concerns, if any?

2. What is the plan for the mother's post-natal care? Are there any barriers to accessing post-natal care?

3. Does mother have any symptoms of "baby blues" or post-partum depression?

(b) The case manager will provide the following information for any new child:

1. How has the care of the new child affected daily household routines and responsibilities of significant caregivers in the home?

2. Are adults able to provide or access necessary housing and resources to care for the new child?

3. Do the parent/significant caregiver have any history that is of concern regarding the safety of the mother or the new child? Is there any history of family or intimate partner violence? If yes, are there any current indicators of Intimate partner violence or a perpetrator's pattern of coercive control?

4. Does the parent/significant caregiver have a current or past history of mental illness or substance use disorder?

5. Is either parent/significant caregiver taking prescribed medications for a substance use disorder or other mental health disorder? If yes, who prescribes the medication?

6. Is a parent/significant caregiver with a prior substance abuse history currently prescribed with pain medication (e.g., mother prescribed Oxycodone because of a C-Section)?

7. Is a parent currently receiving mental health or substance abuse treatment?

8. Is a parent being drug-tested by a substance abuse treatment provider?

(3) Parenting/Behavior Management.

(a) If the child is a newborn, were there any concerns raised by hospital staff about the infant and mother-child interactions? Were any concerns raised about siblings or other persons visiting?

(b) Is there shared agreement among all household members as to how to care for the new child?

(c) If there is a parent in a separate household, what are the visitation or shared custody arrangements? If the parent is a non-maltreating parent, has a home study been completed and approved?

(d) How has the care of the new child affected the care and supervision of other children in the home?

(e) If the new child has special needs, is the parent/caregiver able to address those needs?

(f) How has care of the new child affected family dynamics or conditions?

(g) Do the parent/significant caregivers need additional services or supports?

f. The case manager will update the Safety Analysis to determine whether the criteria for an in-home safety plan are met. The Safety Analysis will provide sufficient information about family conditions to determine whether any changes are necessary to the existing safety plan. As appropriate, the case manager will review and update, or create, Conditions for Return.

g. For Progress Updates, the case manager will be responsible for the following:

(1) Provide information in the domains that describes whether the parent/significant caregiver is making progress towards achieving the outcomes in the case plan.

(2) Assess the impact of care of the new child on parent/significant caregiver's ability to continue participation in services.

(3) Describe any changes in the family's change strategies.

(4) Determine whether any modifications to case plan outcomes, tasks, and services are necessary.

9-7 CLS Staffings.

a. All staffings with CLS will be conducted and documented per the requirements in CFOP 170-7, Chapter 1, paragraph 1-8.

b. CLS staffings must be requested after the case manager completes an FFA-O or Progress Update in the following situations:

(1) In a non-judicial case, a CLS staffing for judicial action must be requested if there are concerns that the criteria for an in-home safety plan are not met per 65C-30.007(9)(d), F.A.C.

(2) In a judicial case, a CLS staffing must be requested as follows:

(a) Prior to the birth of a child.

(b) After the birth of a child or a new child entering the home.

(3) Documentation must be provided to the CLS attorney prior to the staffing including, but not limited to, the FFA-O or Progress Update. Documentation must include an OPHA if the non-maltreating parent of a new baby is not currently a part of the case.

(4) Participants at the staffing will discuss the following:

(a) The completed FFA-O or Progress Update.

(b) The OPHA if there is a new father involved.

(c) Recommended case plan modifications.

(d) Whether there is a need to seek or continue a shelter of the new child.

(e) Whether there is a legal basis to amend any pending dependency petition if there has not yet been an adjudication of dependency.

(f) In the case of a dependent minor parent, the requirements in 65C-28.010, F.A.C. and whether a petition for adjudication of the new born baby would be legally sufficient.

(g) Whether to file a supplemental or new dependency petition, whichever is legally appropriate.

(5) Regardless of the outcome of the staffing conducted, in a judicial case CLS must file the FFA-O or Progress Update completed before a child is expected to be born or to move into a home with the court within 14 days of receipt of the document, and must file the FFA-O or Progress Update completed after the birth of a child or a new child entering the home within 14 days of receipt of the document in accordance with s. 39.701(1)(h)1, F.S.

9-8. Supervisor Consultation and Approval.

a. A supervisor consultation will be conducted prior to the approval of the FFA-O or Progress Update to determine if a pre-birth assessment, newborn child assessment, or new child assessment is incorporated.

b. The supervisor consultation will determine the following:

(1) There was sufficient information collection and assessment.

(2) The case manager engaged the parent(s) and other family members as appropriate in identifying family needs and planning for care of the newborn.

(3) The case manager identified needed services or other actions including any CLS actions.

9-9. FSFN Documentation. The case manager will provide documentation of a pre-birth or new child assessment per requirements in CFOP 170-9, Chapter 4, paragraph 4-11.

Chapter 10

NEW ADULTS IN HOUSEHOLDS WITH ACTIVE INVESTIGATION OR ONGOING SERVICES

10-1. During an Investigation.

a. When it is learned that a new adult is in the home **before** sufficient information has been gathered to determine that a child is safe, the investigator must add the adult to the investigation and conduct assessment activities as required in CFOP 170-5.

b. When it is learned that a new adult is in the home **after** sufficient information has been gathered to determine that a child is safe, the investigator will determine whether the new information represents a significant change in family circumstances to warrant additional investigative or assessment activities.

10-2. During Ongoing Services.

a. There must be prompt action to assess a new adult in the home in any of the following circumstances:

(1) Household where child resides with an in-home safety plan, regardless of the focus household as defined in this operating procedure, paragraph 2-3c.

(2) Non-maltreating parent household that child has been released to.

(3) Non-maltreating parent with a concurrent permanency goal, whether or not child currently visits home.

(4) Household which provides care to child under a family-made arrangement.

(5) Relative/non-relative caregiver's household.

b. Background screening of any new adult in the home must be conducted to review and assess any criminal, child abuse or other child welfare services history.

(1) Prior abuse reports.

(2) NCIC, FCIC and local criminal histories including local law enforcement arrests and call out history.

(3) Clerk of Court records (CCIS) and Department of Corrections (DOC) records.

c. The child welfare professional with primary or secondary responsibility for the household will collect and assess and information to determine:

(1) Whether the new adult is a paramour and has significant caregiver responsibility as defined in Chapter 2, paragraph 2-3 of this operating procedure.

(2) How the family dynamics and conditions are likely to change as a result of the new adult.

(3) Whether the new adult may contribute to new danger threats.

10-3. Supervisor Consultations and CLS Staffings. In cases involving a new paramour or adult with significant caregiving responsibility, the child welfare professional will engage in a supervisor case

consultation to discuss their assessment and the interventions necessary, including any safety plan or case plan modifications that are necessary.

10-4. Required FSFN Documentation.

a. Case notes will be used by the primary and/or secondary worker to document any new information learned about a new adult.

b. When the adult is a member of the focus household with significant caregiver responsibility the primary worker responsible will add the adult to the FSFN case and will develop the adult functioning.

c. When the adult is not part of the focus household, the assessment of the adult will be included in the most relevant information domain.

d. The primary worker will update any assessment which is currently under development including the:

(1) FFA-Investigation.

(2) FFA-Ongoing.

(3) Progress Update.

(4) Any type of home study.

e. The case manager will incorporate new assessment information into the next required Progress Update per CFOP 170-9, Chapter 6.

Chapter 11

INVESTIGATIONS INVOLVING AN ONGOING CASE

11-1. Coordination with Case Management. In an ongoing services case, a new investigation must be thoughtfully coordinated between the case manager assigned to work with the family and CLS when there is an open court case.

a. While the investigator will be fully responsible for information collected, analysis and safety determinations, there must be collaboration and teamwork with the case manager. There must be concerted efforts by the investigator and case manager to ensure that information already known is shared and that new information is collected and assessed.

b. The CPI must contact the case manager when a new report comes in on an ongoing services case. To the extent practical, the investigator will contact the assigned case manager prior to commencement and attempt to schedule a joint home visit to conduct face-to-face interviews with the parents and children.

c. When the investigator determines that the children are in present danger, the investigator will enact a Present Danger Plan with the family, coordinating with the case manager to the fullest extent possible. The investigator will document the Present Danger Assessment regardless of the determination as to whether present danger exists.

d. The investigator and case manager will communicate through-out the investigation to discuss information learned and any action(s) required due to the new investigation.

11-2. Safety Plan Modifications.

a. If a child is determined to be impending danger, the case manager is responsible for coordinating with the investigator to schedule a safety planning conference no later than 2 business days for the family's safety management team to review the sufficiency of the current impending danger safety plan and make any changes needed.

(1) During the safety planning conference the team will review the agreed upon responsibilities and current safety actions in place and make recommendations for changes in the ongoing monitoring, modification and management of the plan.

(2) If the existing case is non-judicial, consideration should be given to requiring additional accountability of the parents through dependency proceedings (i.e., from non-judicial to judicial safety and case planning) and/or the need for an out-of-home safety plan to replace an in-home safety plan.

b. The investigator is required to complete a new FFA-Investigation if the initial investigation which resulted in ongoing services has been closed.

c. The case manager will complete a Progress Update when the new investigation has been completed when there are any maltreatment findings or when substantial changes to the safety plan must be made.

Chapter 12

CASE NOTE AND MEETINGS DOCUMENTATION

12-1. Purpose. Each child record in FSFN must contain a specific record of all case activities provided by the investigator, case manager or other child welfare professionals working on the case who have FSFN access. Notes create a point-in-time log of the child welfare professional's activities. Case notes and documentation of meetings create an audit trail for compliance with federal and state requirements. Case notes are a vitally important record of activities pertaining to any given case and are used to transfer information about a case within the Department, among case managers and service providers and in court. Up-to-date notes ensure that information known and activities that have been occurred are known to any other person who needs to access immediate and relevant information about a case or provider. A child welfare professional's notes may be subpoenaed and used as evidence in legal proceedings.

12-2. Individual Contacts with Children, Parents and Other Team Members.

a. All case activities, including contacts and attempted contacts with a child, the child's parent or caregiver and collaterals must be entered in FSFN no later than two business days after the actual contact or other event.

b. Notes are automatically date and time stamped with the date and time that the note was entered. The worker responsible for the note entry will enter the actual contact begin and end date and time. The worker will also complete the note category, type and participants that the note pertains to.

c. When a face-to-face contact is required, the "Face to Face" hyperlink on the FSFN case note page should be completed in order to document for each participant selected whether a face to face contact was completed, attempted or not attempted. A "Reason Not Seen" will be provided for face-to-face contacts that were attempted or not completed.

d. Case notes will provide the most pertinent facts gathered and observations about the child or family that will be used in developing or updating a family assessment or FFA-O, Progress Update, Other Parent Home Assessment, any type of home study or other case record documentation.

(1) Case notes will contain cohesive information that provides a summary of what was learned as a result of the contact or effort to achieve the contact.

(2) Notes can be brief, capturing the most important facts learned including behaviors/conditions observed. Notes do not have to be in a formal sentence or paragraph structure or provide a flowing narrative.

(3) Case notes shall not contain a specific reference to the child's or any other family member's HIV infection or AIDS. A general term such as child's "chronic illness" will be used.

(4) Conclusions, opinions or analyses that are gathered from persons contacted must be labeled as such and attributed to the person making them. Notes may only reflect phrases, quotes, sentence fragments, lists. Examples may include:

(a) Discussed school attendance, grades, child's friends and activities.

(b) Explored possible ways to help child (parent, caregiver, etc.).

(c) Mother stated her worries about child's hitting and biting behaviors in child care; concerns about husband's abusive and controlling behaviors (won't allow her to work outside

home; inadequate weekly allowance for household expenses; not allowed to have cell phone; not allowed to use car).

e. When a child makes a disclosure of maltreatment to an investigator or a case manager that is likely to result in a criminal investigation, more detailed documentation should be provided as follows:

(1) To the extent possible, document the questions that the child welfare professional asked to elicit the child's response.

(2) Document as closely as possible the child's statements.

f. Any time an investigator completes a sequence or duplicate merge, the affected report numbers and the rationale for the merge must be documented in the case notes.

g. A FSFN user may create a chronological note for another user provided he or she logs into FSFN using his or her unique and assigned User ID and password. Under no circumstances should a FSFN user ever log into the system using another person's User ID and password.

(1) If the "Worker Making Contact" is not the same as the person for whom the FSFN user is creating the note, this this should be clearly documented and explained in the chronological note narrative section.

(2) The FSFN user for whom the note was created is responsible for validating the accuracy of the information.

12-3. Handwritten Field Notes. Contact notes may be handwritten in the field and scanned into the case note page in FSFN as long as the child welfare professional's supervisor considers them to be legible.

a. The child welfare professional is required to create a note in FSFN to capture the note type, date, time, persons contacted and a summary of the important facts gathered. The note should include a statement to see the associated scanned note.

b. A word document may be created and the contents copied to the Contact Note text field. It should be noted that use of the following two characters "< the symbol for less than" and ">the symbol for greater than" will result in text being deleted in FSFN when narrative from a word document is copied.

c. Supervisors of child welfare professionals will work with staff to ensure that handwritten case notes are:

(1) Legible;

(2) Succinct; and,

(3) Relevant.

12-4. Team Meetings, Hearings, Staffings, etc. The FSFN Meeting page will be used to formally document meetings, participants and meeting outcomes. The Meeting page may also be used to schedule a meeting and notify intended participants.

a. The Meeting page will be used to document the following:

(1) Administrative Review.

(2) Adoption Applicant Review Committee.

(3) Adoption Match Staffing.

(4) Adoption Meeting.

(5) Adoption Quarterly Staffing.

(6) Case Plan Conference.

(7) Case Staffing.

(8) Case Transfer Staffing.

(9) Child Protection Team Staffing.

(10) Children's Medical Services Staffing.

(11) Comprehensive Medical Assessment Team Staffing (CMAT).

(12) Human Trafficking Staffings.

(13) Department of Juvenile Justice Staffing.

(14) Educational Meeting.

(15) Family Team Conference.

(16) High Risk Staffing.

(17) Independent Living Staffing.

(18) Investigations Meeting.

(19) Legal Consultation.

(20) Legal Meeting.

(21) Legal Staffing.

(22) Mediation.

(23) Medical Staffing.

(24) Mental Health Staffing.

(25) Multi-Disciplinary Staffing.

(26) Other Meeting.

(27) Other Staffing.

(28) Peer Review Meeting.

(29) Permanency Planning.

(30) Permanency Staffing.

(31) Placement Meeting.

(32) Pre-Trial Conference.

(33) Reunification Staffing.

(34) Safety Management Staffing.

(35) Safety Planning Meeting.

(36) Separated Sibling Staffing – Adoption.

(37) Separated Sibling Staffing – Placement.

(38) Service Staffing.

(39) Supervisory Meeting.

(40) Transfer Staffing (Between Programs).

(41) Transition Planning – Initial.

(42) Transition Planning – Ongoing.

(43) Transition Planning – Closure.

b. The following information about meetings will be recorded:

(1) Date and time of meeting.

(2) Brief statement as to reason for meeting and outcomes, in particular any decisions made.

(3) Participants.

(4) Meeting type as listed above.

c. When a required monthly face-to-face contact with a parent/legal guardian occurs during a meeting, in addition to the meeting documentation the contact should be documented in Case Notes. The face-to-face contact note should describe any conversation with the parent that is not reflected in the Meeting note. A cross reference to the Meeting note should also be provided.

d. Other than face-to-face contacts, there should not be a duplicate entry in Case Notes about a meeting documented in the meetings page.

12-5. FSFN Documentation.

a. The FSFN Supervisor Consultation page will be used to document all of the following:

(1) All consultations with investigators associated with any type of investigation, including pre-commencement activities, Present and Impending Danger Assessments, safety planning and management activities such as emergency placement approvals, 2nd Tier Consultations, other secondary case reviews and any Rapid Safety Feedback.

(2) All required consultations with case managers associated with FFA-O or Progress Updates.

b. The FSFN Case Note page will be used to document ongoing case management activities as follows:

(1) When a case note is about a face-to-face or other type of contact with a case participant, the participants must be selected using the FSFN functionality for all note types to document specifically who was seen or interviewed.

(2) The Note type of "Review, Supervisor" should be used for required monthly or quarterly case reviews.

(a) Supervisory review notes will document which case participants were included in the review.

(b) When the review also serves the dual purpose of a required supervisor consultation, a cross reference should be entered in Supervisor Case Consultation page to ensure credit for required consultation (do not enter same details or "cut and paste;" only enter a brief cross-reference).

(3) The Note type of "Supervisor Consultation" should be used for consultations associated with including any required safety plan management activities such as approval of a Family-Made Arrangement, Judicial Reviews and other case planning/monitoring activities.

c. The CBC/Lead Agency will ensure that the FSFN Meeting page is used to document the following activities:

(1) Record the case transfer conference using "Meetings" functionality in FSFN, selecting Case Transfer Meeting (ESI) to document that the meeting has been completed and any follow-up information that is necessary to complete the transfer.

(2) The actual date and time that the case has been accepted by using the "Case Accepted" box on the Case Transfer meeting page.

(3) The Meeting type "Supervisor Meeting" should be used when the supervisor, child welfare professional and another program manager and/or specialist meet and there is not an existing meeting value for a required purpose (e.g., CPT staffing, permanency staffing, reunification staffing, etc.).

(4) The Meeting type "Supervisor Staffing" should be used when the meeting is for the purpose of assigning or transferring the case after it has been accepted for ongoing services.

d. The following FSFN resources are located on the Center for Child Welfare FSFN "How Do I Guide" page:

(1) Supervisor Consultation – How Do I Guide.

(2) Case Notes – How Do I Guide.

(3) Meetings – How Do I Guide.

Chapter 13

CONFIDIENTIALTY OF RECORDS

13-1. Purpose. Federal regulations limit the use of confidential information regarding Title IV-E funded services for purposes directly related to the administration of the program. Section 39.202, F.S., provides confidentiality of reports and records in cases involving child abuse and neglect. Other privacy and security requirements apply to individually identifiable information about children and families, such as the Healthcare Portability and Accountability Act (HIPAA) and CFOP 50-2, Security of Data and Information Technology Resources.

13-2. Requirements.

a. All child welfare employees, authorized agents and volunteers must receive a copy of CFOP 50-2 upon employment or service with the Department. Receipt of this information shall be documented in the employee's or volunteer's personnel file. Pre-service entry-level training shall include current revisions to confidentiality laws and shall be available on an ongoing basis.

b. Information in case records generated as a result of child abuse and neglect investigations is confidential and shall be released only under the specific circumstances provided in s. 39.0132, F.S., s. 39.202, F.S. and s. 39.2021, F.S. Child welfare professionals must become familiar with these statutes and must consult with the region legal counsel or the Children's Legal Services attorney prior to responding to requests for information.

c. An oral request from the public shall be reduced to a written memo reciting the records requested and the date of the request. Any written requests shall be dated to indicate when it was received. When the requested information is provided, the original request will be dated to show how and when the requested material was sent. The name(s) of the employee(s) who gathered the information and the attorney who reviewed the documents will also be recorded. Such records of compliance with the requests for materials/records shall be maintained by regions in the case file or, if the request extends to records in more than one case file, in a separate file entitled "Public Records Requests."

d. Pursuant to s. 39.202(8), F.S., the Department shall affix a stamped notice on the first sheet of all documents released pursuant to that section, stating:

> "Pursuant to section 39.202(8), Florida Statutes, a person who knowingly or willfully makes public or discloses to any unauthorized person any confidential information contained in the central abuse hotline is subject to the penalty provisions of section 39.205, Florida Statutes."

e. The name of any person reporting child abuse, abandonment or neglect shall not be released to any person other than employees of the Department responsible for child protective investigations, the Florida Abuse Hotline, the child protection team, law enforcement, or the appropriate state attorney, without the written consent of the person reporting.

f. The name and all information identifying the reporter must be blacked out (redacted) before allowing access by persons otherwise authorized by law to examine copies of records. Final reports of investigations shall be printed without reporter information. Reports made public after petitioning the court pursuant to section 119.07(7), F.S., must have all reporter names and identifying information removed or blacked out prior to release. This redaction process must be reviewed by the region general counsel or Children's Legal Services attorney prior to releasing the information.

g. Any information in the case record that pertains to the adoption of a child or a child's sibling shall not be released without first consulting with the region general counsel or Children's Legal

Services attorney. Disclosure of adoption records is governed by the provisions of section 63.162, F.S., and usually requires a court order.

h. If a case record contains non-department procured or funded medical, psychological, or psychiatric reports, school records, or information about clients received from domestic violence centers, which the Department has obtained through consent of the subject, the information must not be released without written authorization of that person which shall include the gathering and release of information for treatment purposes. The person requesting access to the record shall be told of the existence of any such report and referred to the generating source. These reports are confidential and cannot be shared without the consent of the subject.

(1) A limited exception exists if the report, record, or other information has been filed in the official court record. Section 39.0132(3), F.S., allows access to documents in the official court record, subject to the provisions of section 63.162, F.S., to the child, parents or legal custodians of the child and their attorneys, law enforcement agencies, and the Department and its designees.

(2) Also, section 39.0132(3), F.S., does not apply to reports or opinions which form the basis for a dependency petition and which may be discoverable under the Rules of Juvenile Procedure. When a discovery request pertaining to a case in dependency litigation is received, the region general counsel or Children's Legal Services attorney must be consulted prior to the release of any information.

i. Pursuant to section 39.202(6), F.S. all records and reports of the child protection team (CPT) are confidential and exempt from the provisions of section 119.07(1), F.S. and section 456.057, F.S. and shall not be disclosed, except, upon request, to the state attorney, law enforcement, the Department, and necessary professionals in furtherance of the treatment or additional evaluative needs of the child, or by order of the court.

j. Anyone authorized to receive copies of an abuse report and related case material is subject to the same requirements to maintain confidentiality as is the Department employee releasing the information.

(1) For this reason, recipients of case material, other than those authorized Department staff and others authorized in section 39.00145(4), F.S., must be asked to sign a statement acknowledging they have received a written notice warning them as to the confidential nature of the records they are receiving, that they understand their responsibility to maintain confidentiality and the penalty for violations.

(2) In addition, confidentiality requirements must be explained to all participants at a case plan conference conducted per requirements in CFOP 170-9, paragraph 5-2.

k. Child welfare staff who utilize laptop computers are reminded that this operating procedure and the security requirements of CFOP 50-2 are applicable to such usage.

13-3. Access to Child Abuse Investigative and Related Case Records. Pursuant to section 39.202, F.S., the following persons or entities have access to Department records (excluding the name of the reporter except as provided in paragraph 13-2e of this operating procedure) concerning child abuse, neglect or abandonment:

a. The Public. Except for information identifying persons reporting abuse, abandonment or neglect, all records involving the death of a child determined to be a result of abuse, abandonment, or neglect shall be released to the public [s. 39.202(2)(o), F.S.]. In addition, section 39.00145(4), F.S., allows access to Department records to others entitled under this chapter to receive that information.

b. State and County.

(1) Employees, authorized agents, or contract providers of the Department, the Department of Health, or county agencies responsible for carrying out s. 39.202, F.S.:

(a) Child or adult protective investigations;

(b) Ongoing child or adult protective services;

(c) Healthy Start services; and,

(d) Licensure or approval of adoptive homes, foster family homes, child care facilities, family child care homes, informal child care providers who receive subsidized child care funding, or other homes used to provide for the care and welfare of children.

(2) Employees or agents of the Department of Juvenile Justice responsible for the provision of services to children pursuant to Chapter 985, F.S.

c. Law Enforcement. Criminal justice agencies of appropriate jurisdiction [s. 39.202(2)(b), F.S.] and the state attorney of the judicial circuit in which the child resides or in which the alleged abuse or neglect occurred [s. 39.202(2)(c), F.S.].

d. Family of the Child. The parent, or legal custodian of any child who is alleged to have been abused, neglected, or abandoned, and the child, and their attorneys. Access must be granted no later than 60 days after the Department receives the initial report of abuse, neglect or abandonment. However, any information otherwise made confidential or exempt by law (such as SNAP (food stamp) records, independent medical, psychological, psychiatric reports, CPT records, and HIV information) shall only be released in accordance with the federal or state statute, rule, or regulation access provisions applicable to the particular information. Investigators and case managers shall seek the advice of the region legal counsel or Children's Legal Services attorney prior to releasing such information.

e. Alleged Perpetrator. Any person alleged in the report as having caused the abuse, abandonment, or neglect of a child. Access shall be made available no later than 60 days after the receipt of the initial report. When the alleged perpetrator is not a parent, the access shall be limited to information involving the protective investigation only and shall not include any information relating to subsequent dependency proceedings. Further, any information otherwise made confidential (see paragraph d above) shall not be released. [s. 39.202(2)(e), F.S.]

f. Court. A court upon its finding that access to such records may be necessary for the determination of an issue before the court; however, such access shall be limited to inspection in camera [in the judge's chambers rather than the courtroom] unless the court determines that public disclosure of the information is necessary for the resolution of an issue then pending before the court. [s. 39.202(2)(f), F.S.]

g. Grand Jury. A grand jury, by subpoena, upon its determination that access to such records is necessary in the conduct of its official business. [s. 39.202(2)(g),F.S.]

h. Department Officials. Any appropriate official of the Department responsible for:

(1) Administration or supervision of the Department's program for the prevention, investigation, or treatment of child abuse, abandonment, or neglect, or abuse, neglect, or exploitation of a vulnerable adult, when carrying out his or her official function; or,

(2) Taking appropriate administrative action concerning an employee of the Department alleged to have perpetrated child abuse, abandonment, or neglect, or abuse, neglect or exploitation of a vulnerable adult; or,

(3) Employing and continuing employment of personnel of the Department or Agency for Persons with Disabilities. [s. 39.202(2)(h), F.S.]

NOTE: Legislators are not officials of the Department. A legislator's request for case-specific information must go through the chairman of the committee, which has oversight responsibility for Department programs. The region general counsel or Children's Legal Services managing attorney must review such requests.

i. Auditors and Researchers. Any person engaged in the use of such records or information for bona fide research, statistical, or audit purposes. However, no information identifying the subjects of the report shall be made available to the researcher. [s. 39.202(2)(i), F.S.]

j. Administrative Hearings. The Division of Administrative Hearings (DOAH) for purposes of any administrative challenge. [s. 39.202(2)(j), F.S.]

k. Florida Advocacy Council (FAC). Any appropriate official of the FAC investigating a report of known or suspected child abuse, abandonment, or neglect, the Auditor General or the Office of Program Policy Analysis and Government Accountability (OPPAGA) for the purpose of conducting audits or compliance reviews pursuant to law, or the guardian ad litem for the child. [s. 39.202(2)(k), F.S.]

l. State Child Welfare Agencies. Employees or agents of an agency of another state that has comparable jurisdiction to the jurisdiction described in paragraph 13-3b of this operating procedure. [s. 39.202(2)(l), F.S.]

m. Public Employees Relations Commission (PERC). PERC for the sole purpose of obtaining evidence for appeals filed pursuant to s. 447.207, F.S. Records may be released only after deletion of all information which specifically identifies persons other than the employee. [s. 39.202(2)(m), F.S.]

n. Department of Revenue. Employees or agents of the Department of Revenue responsible for child support enforcement activities. [s. 39.202(2)(n), F.S.]

o. Other Professionals. The Department may release to professional persons such information as is necessary for the diagnosis and treatment of the child or the person perpetrating the abuse, neglect or abandonment [s. 39.202(3), F.S.].

13-4. HIV/AIDS Information. The following procedures apply to information about HIV/AIDS in the child's FSFN record and information access:

a. Case notes shall not contain any reference to the child's or any other family member's HIV infection or AIDS. A general reference may be used such as the child's "chronic illness."

b. The Department shall disclose to adopting or out-of-home care parents the medical condition, but not the name, of an HIV/AIDS positive child prior to the decision being made to adopt or accept the child into the caregiver's home. Only after the out-of-home care parents have made the commitment to adopt or accept the child into the home shall the name of the child be provided.

c. The out-of-home care parents shall be provided with documentation of the complete medical history and condition of a child placed in their care, including HIV/AIDS status. This documentation must be maintained by the out-of-home care parents and held as confidential information with access

strictly limited to the child's physician(s) and other providers of medical and dental care when treatment is required.

d. Medical documentation needed for school enrollment, child care or similar purpose must be acquired from the physician and may not contain any reference to the child's HIV/AIDS status.

e. With the exception of the child's medical records provided to out-of-home care parents (and to the child's natural parents or other legal guardian), all case material which discloses that the child or any other family member has HIV infection or AIDS must be kept within the FSFN Medical and Mental Health File Cabinet and the hard copy file in a designated "Confidential Information" section used to safeguard sensitive case information.

f. The child and family case records shall not be segregated or flagged in any way which would permit their identification as case records of HIV/AIDS infected children or family members.

13-5. Domestic Violence Information.

a. Child welfare case records shall not contain any reference to the location of a domestic violence shelter, or information indicating that any named individual(s) (e.g., mother and children) are currently residing in a domestic violence shelter. If absolutely necessary, current address information shall state only that the individual is currently residing in a "safe location". See s. 39.908, F.S. (location confidential); and s. 90.5036, F.S. (domestic violence advocates who are employed or who volunteer at a domestic violence center may claim a privilege to refuse to disclose a confidential communication with a victim).

b. Per s. 39.301(9)(a)6a, F.S., the safety plan for the parent who is a victim of domestic violence may not be shared with the perpetrator. This includes the sharing of any information in the Confidential Child Safety Plan.

13-6. Foster Family Home Licensing Files. Public records law exempts all identifying information (except name) in the foster family home licensing file regarding foster parents (including those who became adoptive parents), their spouses and their children, unless otherwise ordered by the court. Such exempted information includes: the home, business, work, child care, or school addresses; telephone numbers; social security numbers; birth dates; photographs of licensees, their family and other adult household members; identifying information about such persons in neighbor references; the floor plan of the foster family home, and identifying information about such persons contained in similar sensitive personal information that is provided to the Department or CBC lead agency by such persons.

13-7. Penalties.

a. A person who knowingly and willfully makes public or discloses to any unauthorized person any confidential information contained in the central abuse registry is subject to the penalty provisions of section 39.205(6), F.S. (second degree misdemeanor).

b. A person who unlawfully discloses HIV/AIDS information is subject to the penalty provisions of section 384.34, F.S. (second degree misdemeanor).

13-8. Sharing Records with Children.

a. Subsection 39.00145(2), Florida Statutes, allows a child who is subject of the record, the child's caregiver, guardian ad litem, or attorney the right to "inspect and copy any official record pertaining to the child," subject only to the provisions of section 63.162, F.S., pertaining to adoption records. The following sections of Chapter 39, F.S., are examples of where the law specifically allows a child access to his or her dependency records:

(1) Section 39.504(5), F.S., copy of injunction order shall be delivered to the protected party.

(2) Section 39.01(51), F.S., includes child in the definition of party.

b. No document shall be released without review and approval of Children's Legal Services attorney. See also, C.E.B. v. Birkin, 566 So.2d 907 (Fla. 4th DCA 1990) [child has clear right under s. 39.0132(3), F.S. (1998), to inspection of the official record; "official record" includes any documents that were considered by the judge in reaching the court's determination].

c. Care, concern, and sensitivity should guide sharing of records with children. Investigators and case managers must be aware that some records could be disturbing to the child and be prepared to appropriately respond to the child's reaction. Considering the child's maturity and chronological age, it is recommended that the record sharing take place during a face-to-face meeting with the child and an adult the child knows and trusts. In no case should copies of records simply be handed over to the child.

d. The child is entitled to copies of any official court records, except adoption records, pertaining to his or her case. Therefore, copies of any documents which have been filed with the court and which are also in the Department's case record may be provided to the child. This would include petitions, orders, predisposition reports, judicial review social studies, psychological reports, child protection team reports, medical reports, and any other report or record which has been filed in the official court record. The region general counsel or Children's Legal Services attorney shall be consulted prior to release of any information (other statutory confidentiality provisions may be applicable so as to require referral of the requesting party to the originating source). In addition, the child may be given unredacted copies of notes or minutes of case planning meetings.

e. The client is entitled to one free copy of the client file to which he or she has statutory access. The Department may charge a fee for subsequent copies based upon CFOP 15-9, Chapter 2, Charges for Providing Copies of DCF Records or Publications.

13-9. Medical/Mental Health Information/Criminal Records in FSFN.

a. Information protected by the Health Insurance Portability and Accountability Act (HIPPA) has special requirements for scanning and viewing.

(1) Medical and mental health records, whether written text or photographs, must be scanned into the Medical and Mental Health section of the File Cabinet only. Such information is protected by the same security used with the Medical and Mental Health screens in FSFN.

(2) Access to information stored in the Medical and Mental Health File Cabinet requires a special security profile for FSFN users assigned to the case, his or her supervisor and certain other designated child welfare personnel.

b. Any criminal records obtained from the Hotline's Criminal Intelligence unit OR national records obtained as a result of a fingerprint check **MUST NEVER** be scanned and uploaded to FSFN.

Appendix A: Child Development Stages Matrix

0-3 Months

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Rapid height & weight gain ✓ Reflexes: sucking, grasping ✓ Lifts head ✓ Responds to sounds by blinking, startling, crying ✓ Shows growing ability to follow objects and to focus	✓ Concerned with satisfaction of needs ✓ Smiles in response to caregiver's voice ✓ Prefers primary caregiver to stranger	✓ From birth, infant begins to "learn" with eyes, ears, hands, etc. ✓ Vocalizes sounds (coos) ✓ Smiles when faces evoke memories of pleasure	✓ Sucks poorly and feeds slowly ✓ Doesn't follow objects with eyes ✓ Doesn't respond to loud sounds ✓ Doesn't grasp and hold objects ✓ Doesn't smile at the sound of the primary caregiver's voice	✓ Makes eye contact with infant ✓ Interact with infant by talking, smiling, singing, etc. ✓ Gently rocks/bounces infant ✓ Picks infant up when distressed ✓ Allows for self-soothing (infant sucks fingers/pacifier, etc.)

3-6 Months

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Rolls over ✓ Holds head up when held in sitting position ✓ Lifts knees, makes crawling motions ✓ Reaches for objects	✓ Smiles and laughs socially ✓ Responds to tickling ✓ Begins to distinguish own image in mirror from others' images	✓ Has recognition memory for people, places, and objects ✓ Uses both hands to grasp objects ✓ Exhibits visual interests ✓ Joins with caregiver in paying attention to labeling objects and events (4-6 months)	✓ Doesn't hold head up ✓ Doesn't coo, make sounds, or smile ✓ Doesn't respond to sounds or turn head to locate sounds ✓ Doesn't roll over in either direction ✓ Not gaining weight	✓ Helps infant "practice" sitting ✓ Encourages floor time on a blanket for rolling and reaching ✓ Responds to fears, cries by holding, talking, and reassuring ✓ Talks and plays with infant

6-12 Months

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Sits alone ✓ Feeds self-finger foods; holds own bottle (6-9 months) ✓ Crawls, pulls up, and walks with support (9-12 months) ✓ Baby teeth begin to emerge	✓ Indicates preference for primary caregivers ✓ May cry when strangers approach (stranger anxiety) ✓ Shows signs of separation anxiety ✓ Repeats performances for attention (9-12 months) ✓ Drops objects on purpose for others to pick up (10-12 months)	✓ Finds objects hidden repeatedly in one place, but not when moved ✓ Plays peek-a-boo ✓ Has recall memory for people, places, and objects (9-12 months) ✓ Imitates speech sounds ✓ Says da-da and ma-ma and knows who these people are (10-12 months) ✓ Uses preverbal gestures to communicate (by 12 months)	✓ Doesn't smile or demonstrate joy ✓ Unable to sit without support ✓ Does not follow objects with both eyes ✓ Does not actively reach for objects ✓ Doesn't look or react to familiar caregivers ✓ Does not babble ✓ Shows no interest in playing peek-a-boo (by 8 months)	✓ Discipline consists of redirecting to different activity. Sharp discipline, scolding, and verbal persuasion are not helpful ✓ Holds and cuddles baby ✓ Reads to baby ✓ Names objects when baby points to something ✓ Maintains consistent bed time routine of cuddling, rocking, and soothing

12-18 Months

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Walks alone ✓ Manipulates small objects with improved coordination ✓ Drinks from a cup with a lid and uses a spoon ✓ Builds tower of 2 blocks ✓ Removes hat, socks, and shoes	✓ Extends attachment for primary caregivers to the world; seems in love with the world and wants to explore everything ✓ Recognizes image of self in mirrors ✓ Solitary or parallel play ✓ Fears heights, separation, strangers, and surprises	✓ Begins to show intentional behavior, initiates actions (drops, throws, shakes, bangs) ✓ Is curious about everything around him or her ✓ Sorts toys and other objects into groups ✓ Understands object permanence – realizes objects exist when out of sight and will look for them ✓ Says first words (mama, dada, doggie, bye-bye)	✓ Doesn't respond to name ✓ Unable to finger feed ✓ Not gaining weight ✓ Flat affect (no smiling) ✓ Not interested in play such as peek-a-boo ✓ Not taking steps ✓ Cannot hold spoon ✓ Doesn't look at pictures in book	✓ Encourages exploration ✓ Applauds child's efforts ✓ Interprets new/unfamiliar situations ✓ Talks to child in simple clear language about things going on in the environment

18-24 Months

Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Runs and walks up steps ✓ Can help get undressed ✓ Drinks from a cup ✓ Eats with a spoon ✓ Scribbles spontaneously ✓ Loves to practice new skills ✓ Makes tower of 4 blocks	✓ Likes to hand things to others as play ✓ May have temper tantrums ✓ Shows affection to familiar people ✓ Plays simple pretend, such as feeding a doll ✓ Explores alone but with caregiver close by	✓ Begins to make two-word combinations that mean something ✓ Imitates words readily and understands a lot more that he or she can say ✓ Shows memory improvements, understand cause and effect; experiments to see what will happen ✓ Begins to sort shapes and colors	✓ Cannot walk ✓ Does not speak at least 6 words ✓ Does not imitate actions or words ✓ Cannot push a wheeled toy ✓ Does not follow simple instructions ✓ Doesn't notice or mind when a caregiver leaves or returns	✓ Provides opportunities to choose ✓ Sets appropriate limits ✓ Assists child in coping with range of emotions ✓ Support new friendships and experiences ✓ Responds to wanted behaviors more than disciplining unwanted behaviors

2-3 Years

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Has developed sufficient muscle control for toilet training ✓ Is highly mobile – skills are refined ✓ Uses spoon to feed self ✓ Throws and kicks a ball ✓ Disassembles simple objects and puts them back together ✓ Has refined eye-hand coordination-can do simple puzzles, string beads, stack blocks	✓ Has great difficulty sharing ✓ Has strong urges and desires, but is developing ability to exert self-control ✓ Wants to please parents but sometimes has difficulty containing impulses ✓ Displays affection – especially for caregiver ✓ Initiates own play activity and occupies self ✓ Is able to communicate and converse ✓ Begins to show interest in peers	✓ Is capable of thinking before acting ✓ Explores language ability – becomes very verbal ✓ Enjoys talking to self and others ✓ Loves to pretend and to imitate people around him or her ✓ Enjoys creative activities – i.e., block play, art ✓ Thinks through and solves problems in head before acting (has moved beyond action-bound stage)	✓ Cannot run, jump, or hop ✓ Cannot feed self with spoon ✓ Does not speak in simple sentences that use normal word order ✓ Does not enjoy make-believe games ✓ Does not spontaneously show affection for familiar playmates ✓ Does not express a wide range of emotions ✓ Does not separate easily from primary caregiver ✓ Does not object to major changes in routine	✓ Provides opportunities for child to make choices ✓ Encourages independence and provides guidance with self-care (dressing, hand washing, etc.) ✓ Sings, plays, and dances with child ✓ Counts objects and identifies colors with child ✓ Encourages creativity

3-4 Years

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Continues to run, jump, throw, and catch with better coordination ✓ Walks up and down stairs, one foot on each step ✓ Rides tricycle ✓ Uses scissors ✓ Can button and lace ✓ Eats and dresses by self with supervision ✓ Uses toilet or potty-chair; bladder and bowel control are usually established	✓ Emotional self-regulation improves ✓ Understands taking turns and sharing ✓ Self-conscious emotions become more common ✓ Forms first friendships ✓ Shows concerns for a crying friend ✓ May get upset with major changes in routine	✓ Asks “why” questions – believes there is a reason for everything and he or she wants to know it ✓ Engages actively in symbolic play – has strong fantasy life, loves to imitate and role-play ✓ Speech can be understood by others ✓ Should be able to say about 500 to 900 words ✓ Understands some number concepts ✓ Converses and reasons ✓ Is interested in letters ✓ Scribbles in a more controlled way – is able to draw circles, recognizable objects	✓ Falls down a lot or has trouble with stairs ✓ Drools or has very unclear speech ✓ Doesn’t use sentences of more than three words ✓ Can’t work simple toys (such as peg boards, simple puzzles, turning handle) ✓ Doesn’t make eye contact ✓ Doesn’t play pretend or make-believe ✓ Doesn’t want to play with other children or with toys ✓ Lashes out without any self-control when angry or upset	✓ Provides a sense of security by maintaining household routines and schedules ✓ Supports child’s need for gradual transitioning. *Example:* Provides warning of changes so child has time to shift gears: "We're leaving in 10 minutes” ✓ Points out colors and numbers in the course of everyday conversation ✓ Encourages independent activity to build self-reliance. ✓ Provides lots of sensory experiences for learning and developing coordination — sand, mud, finger paints, puzzles ✓ Reads and sings and talks to build vocabulary

4-6 Years

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Has refined muscle development and is better coordinated, so that he or she can learn new skills ✓ Has improved finger dexterity – ties shoes; draws more complex picture; writes name ✓ Climbs, hops, skips, and likes to do stunts. Gross motor skills increase in speed and endurance	✓ Plays cooperatively with peers ✓ Enhanced capacity to share and take turns ✓ Recognizes ethnic and sexual identification ✓ Displays independence ✓ Protects self and stands up for rights ✓ Identifies with parents and likes to imitate them ✓ Often has “best friends” ✓ Likes to show adults what he or she can do ✓ Continually forming new images of self-based on how others view him or her	✓ Is developing longer attention span ✓ Understands cause and effect relationships ✓ Engages in more dramatic play and is closer to reality, pays attention to details ✓ Is developing increasingly more complex and versatile language skills ✓ Expresses ideas, asks questions, engages in discussions ✓ Speaks clearly ✓ Is able to draw representative pictures ✓ Knows and can name members of family and friends ✓ Increased understanding of time	✓ 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 ✓ Excessively fearful, anxious, night terrors ✓ Lack impulse control, little ability to delay gratification ✓ Exaggerated response (tantrums, aggression) to even mild stressors ✓ Enuresis, encopresis, self-stimulating behavior – rocking, head-banging	✓ Encourages exploration ✓ Applauds child’s efforts ✓ Interprets new/unfamiliar situations ✓ Reinforces good behavior and achievements ✓ Encourages child to express feelings and emotions ✓ Encourages physical activity with supervision ✓ Gives child chances to make choices ✓ Uses time-out for behavior that is not acceptable

6-9 Years

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Gradual replacement of primary teeth by permanent teeth throughout middle childhood ✓ Fine motor skills: writing becomes smaller and more legible; drawings become more organized and detailed and start to include some depth ✓ Gross motor skills: can dress and undress alone; Organized games with rough-and-tumble play become more common	✓ May have a special friend ✓ Likes action on television ✓ Enjoys books and stories ✓ May argue with other children but shows cooperation in play with a particular friend ✓ Self-concept includes identifying own personality traits and comparing self with others ✓ Becomes more responsible and independent ✓ Still obeys adults to avoid trouble ✓ Can adapt ideas about fairness to fit varied situations	✓ Thought becomes more logical, helping the child categorize objects and ideas ✓ Can focus on more than one characteristic of concrete objects ✓ Attention becomes more selective and adaptable ✓ Can us rehearsal and organization as memory strategies ✓ Emotional intelligence is developing: self-awareness and understanding of own feelings; empathy for the feelings of others; regulation of emotion; delaying gratification ✓ Vocabulary increases rapidly ✓ Makes the transition from “learning to read” to “reading to learn” ✓ Carries on long conversation	These indicators may be present in any child between 6-11 years ✓ Low self-esteem ✓ Acts sad and/or nervous much of the time ✓ Aggressive much of the time (hits, fights, curses, breaks or throws objects) ✓ Exhibits poor impulse control ✓ Has difficulty concentrating or sitting still ✓ Scapegoated/ ignored by other children ✓ Poor grades ✓ Doesn’t respond to positive attention/praise ✓ Seeks adult approval/attention excessively ✓ Suspicious/mistrustful of adults; doesn’t turn to adults for help/comfort ✓ Little frustration tolerance; difficult to engage and keep interested in goal directed activity ✓ Cannot adapt behavior to different social settings ✓ Doesn’t understand a person’s identity remains the same regardless of outward changes (e.g., costume) ✓ Can’t understand concepts of space, time, and dimension ✓ Can’t differentiate real from pretend ✓ Can’t understand the difference between behavior and intent (breaking a lamp is equally bad regardless of whether on purpose or an accident)	✓ Shows affection for child; recognizes accomplishments ✓ Helps child develop a sense of responsibility – asks child to help with household tasks such as setting the table ✓ Talks with child about school, friends, and things to look forward to in the future ✓ Encourages child to think about consequences before acting ✓ Makes clear rules and sticks to them ✓ Engages in fun activities together ✓ Praises child for good behavior ✓ Supports child in takin on new challenges ✓ Gets involved in child’s school

9-11 Years

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Girls' adolescent grown spurt begins ✓ Gross motor skills are better coordinated (running, jumping, throwing and catching, kicking, batting, and dribbling) ✓ Reaction time improves, which contributes to motor skill development ✓ Fine motor skills improve; depth cues evident in drawings through diagonal placement, overlapping objects, and converging lines	✓ Self-esteem rises ✓ Distinguishes between effort and luck as causes of successes and failures; can become critical of others quickly ✓ Has adaptive set of strategies for regulating emotion ✓ Peer groups emerge ✓ Friendships are based on the pleasure of sharing through activities or time spent together ✓ Sibling rivalry tends to increase	✓ Planning improves ✓ Can apply several memory strategies at once ✓ Long-term knowledge base grows in size and organization ✓ Improves in cognitive self-regulation (monitoring and directing progress toward a goal) ✓ Grasps double meanings of words as reflected in comprehension of metaphors and humor ✓ Improved understanding of complex grammatical constructions ✓ Conversational strategies become more refined	These indicators may be present in any child between 6-11 years ✓ Low self-esteem ✓ Acts sad and/or nervous much of the time ✓ Aggressive much of the time (hits, fights, curses, breaks or throws objects) ✓ Exhibits poor impulse control ✓ Has difficulty concentrating or sitting still ✓ Scapegoated/ ignored by other children ✓ Poor grades ✓ Doesn't respond to positive attention/praise ✓ Seeks adult approval/attention excessively ✓ Suspicious/mistrustful of adults; doesn't turn to adults for help/comfort ✓ Little frustration tolerance; difficult to engage and keep interested in goal directed activity ✓ Cannot adapt behavior to different social settings ✓ Doesn't understand a person's identity remains the same regardless of outward changes (e.g., costume) ✓ Can't understand concepts of space, time, and dimension ✓ Can't differentiate real from pretend ✓ Can't understand the difference between behavior and intent (breaking a lamp is equally bad regardless of whether on purpose or an accident)	✓ Helps child develop own sense of right and wrong. Talks with child about risky things, peer pressure, etc. ✓ Encourages child to respect other people ✓ Spends quality time listening to child and talking about accomplishments and possible challenges ✓ Talks with child about normal physical and emotional changes of puberty ✓ Is affectionate and honest with child.

11-15 Years

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ Period of rapid skeletal and sexual maturation ✓ Preoccupation with body image ✓ Acne may appear ✓ Boys ahead of girls in endurance and muscular strength ✓ Rapid growth may mean large appetite but less energy ✓ There is a wide variation in beginning and completion of puberty (body hair, increased perspiration and oil production in hair and skin. Girls: breast and hip development, onset of menstruation. Boys: growth in testicles and penis, wet dreams, deepening of voice) ✓ Increased possibility of acting on sexual desires	✓ Critical of adults; annoyed by younger siblings; obnoxious to live with ✓ Wants unreasonable independence ✓ Dramatizes and exaggerates own positions; has many fears, worries, and tears ✓ Resists any show of affection ✓ Often moody; anger is common; resents being told what to do; rebels at routines ✓ Intense interest in teams and organized, competitive games; considers membership in clubs important; has whole gang of friends ✓ Girls show more interest in opposite sex than boys do ✓ Recognizes that differences exist between and within groups ✓ May experience prejudice, discrimination, or bias due to ethnicity or poverty	✓ Thrives on arguments and discussions; challenges adults ✓ Increasingly able to memorize, think logically; engage in introspection ✓ Can plan realistically for the future; may have interest in earning money ✓ Is critical of own artistic products ✓ Interested in world and community; may read a great deal ✓ Needs to feel important and believe in something ✓ Social cognition: o Belief in an imaginary audience, that others are as preoccupied with one as oneself is (e.g., “everyone is looking at me”) o Personal fable – belief in personal uniqueness (e.g., “no one understands me”) and belief that self is invulnerable (“I won’t get hurt”) ✓ Able to understand other points of view, but tends to be egocentric	✓ By end of period, physically immature, small, not showing signs of puberty or secondary sex characteristics (wide range here; girls mature earlier) ✓ Poor motor skills, coordination ✓ Lack of peer group relationships and identification with peers ✓ Can’t think hypothetically; doesn’t consider consequences of actions ✓ Can’t put him/herself in place of another; doesn’t consider how behavior affects others ✓ Difficulty problem solving; doesn’t work through systematically and weigh solutions ✓ Poor school performance ✓ Doesn’t reject or question parental standards and express self through clothes, hair, and other lifestyle choices ✓ Poor self-esteem ✓ Emotional and behavioral problems (anxiety, depression, withdrawal, aggression, lack of impulse control, anti-social behavior) ✓ Withdrawal from friends and from activities once enjoyed ✓ Changes in eating and sleeping habits ✓ Abuse of alcohol or drugs	✓ Is tolerant, understanding, and supportive ✓ Accepts youth’s feelings but tries to help youth evaluate more objectively ✓ Avoids being defensive; child is not challenging the adult’s authority ✓ Sets limits, but gives opportunities for independence whenever possible ✓ Answers questions about bodily changes openly and honestly ✓ Encourages group activities and discourages solo dating ✓ Doesn’t nag boys about food intake and seeming “laziness” ✓ Discusses ways to manage and handle stress ✓ Finds ways to spend time together ✓ Provides consistent, loving discipline with limits, restrictions, and rewards

15-21 Years

Physical	Social & Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
✓ By end of period, physically immature, small, not showing signs of puberty/ secondary sex characteristics (wide range; girls mature earlier) ✓ Poor motor skills, coordination ✓ Lack of peer group rel. and identification with peers ✓ Can't think hypothetically; doesn't consider consequences of actions ✓ Can't put him/herself in place of another; doesn't consider how behavior affects others ✓ Difficulty problem solving; doesn't work through systematically and weigh solutions ✓ Poor school performance ✓ Doesn't reject or question parental standards and express self through clothes, hair, and other lifestyle choices ✓ Poor self-esteem ✓ Emotional and behavioral problems (anxiety, depression, withdrawal, aggression, lack of impulse control, anti-social behavior) ✓ Withdrawal from friends and from activities once enjoyed ✓ Changes in eating Abuse of alcohol or drugs	✓ Relationships with parents range from friendly to hostile ✓ Usually has many friends and few confidants ✓ Worries about failure ✓ May appear moody, angry, lonely, impulsive, self-centered, confused, and stubborn ✓ Has conflicting feelings about dependence and independence ✓ Girls may form identity and prepare for adulthood through establishing relationships and emotional bonds ✓ Interest in forming romantic relationships part of separation task; implies separation from family ✓ Cultural differences may cause conflict	✓ May lack information or self-assurance about personal skills and abilities ✓ Continuing formal operational thought with abstract, idealistic, logical, hypothetical-deductive reasoning, complex problem solving, and critical thinking ✓ May enjoy debating and arguing ✓ Has a strong sense of awareness ✓ May be judgmental of adults or peers if they do not do what is "fair" ✓ Seriously concerned about the future ✓ Beginning to integrate knowledge leading to decisions about future	✓ Physically immature, small, not showing signs of puberty or secondary sex characteristics ✓ Unable to form or maintain satisfactory relationships with peers ✓ Can't put him/herself in place of another; doesn't consider how behavior affects others ✓ Poor self-esteem / guilt ✓ Overcompensates for negative self-esteem by being narcissistic, unrealistically self-complimentary; grandiose expectations for self ✓ Engages in self-defeating, testing, and aggressive, antisocial, or impulsive behavior ✓ Lacks capacity to manage intense emotions; moods change frequently and inconsistently ✓ Has emotional disturbances: depression, anxiety, post-traumatic stress disorder, attachment problems, conduct disorders	✓ Recognizes and compliments physical maturity ✓ Provides accurate information on consequences of sexual activity ✓ Tries not to pry; but is available to talk and listen ✓ Maintains positive relationship by being respectful and friendly ✓ Accepts feelings; doesn't overreact and avoids disapproval ✓ Recognizes and accepts current level of interest in opposite sex ✓ Encourages experiences with a variety of people (e.g., older, younger, different cultures) ✓ Encourages talking about and planning for future

Adapted from One or More of the Following Sources

Chadwick Trauma-Informed Systems Project. (2013). Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model (1st ed.). San Diego, CA: Chadwick Center for Children and Families.

Reducing the Trauma of Investigation, Removal and Initial Out-of-Home Placement Project. (2008-2009). Trauma Informed Practice Strategies for Caseworkers. Portland State University, Center for Improvement of Child and Family Services.

Child Welfare Trauma Training Toolkit. (2013). The National Child Traumatic Stress Network.

Child and Adolescent Development Resource Book. (2005). The Pennsylvania Child Welfare Training Program. University of Pittsburgh, School of Social Work.

Florida State University, Center for Prevention and Early Intervention. www.cpeip.fsu.edu

John Hopkins University. http://www.hopkinsmedicine.org/healthlibrary/conditions/pediatrics/your_childs_growth_and_development_85,P01019/

Centers for Disease Control and Prevention. http://www.cdc.gov/ncbddd/actearly/milestones/index.html

Appendix B: Mapping the Safe and Together™ Model Critical Components to the Information Domains

A Guide for Integrating the Safe and Together Model, FCADV's Child Protection Investigations Project, and Florida's Safety Methodology

Coercive Control & Actions To Harm Children (1st & 2nd Critical Components)

MALTREATMENT

When domestic violence is the reason for the hotline call: Use the following questions to guide information gathered in this domain:

- During the alleged domestic violence incident, what was the perpetrator's pattern of coercive control and actions taken to harm the child?
- What has been the immediate physical, emotional and behavioral impact of the perpetrator's behavior on the child?

To ensure accurate assessment, safety planning and partnership with the family, the domestic violence perpetrator should be identified as the sole source of the maltreatment related to the domestic violence.[1]

When domestic violence is not the reason for the hotline call: Other maltreatments such as bone fracture, sexual abuse, and inadequate supervision may be perpetrated by a caregiver who is abusive to the adult partner, and therefore part of their overall pattern of abuse. Using a lens that focuses on how domestic violence perpetrators directly or indirectly harm children will allow the best understanding of the maltreatment. More over maltreatment perpetrated by an adult domestic violence survivor may be the direct or indirect result of the domestic violence.[2]

CIRCUMSTANCES SURROUNDING THE MALTREATMENT

When domestic violence is not the reason for the hotline call: Answer the following questions:

- Are there indicators of the perpetration of patterns of coercive control, including actions taken to harm the child?
- If there are indicators, how are these patterns relevant to the reported maltreatment and family functioning?

When there is a prior history of documented domestic violence perpetration by caregiver: Answer the following question: What are the connections between any prior documented incidences of domestic violence?

- Is coercive control currently occurring but not the reason for the referral?
- Is the perpetrator, whether in the home or not, still negatively influencing the family functioning through fear and intimidation or other forms of control?
- How has the prior domestic violence perpetration effected current family functioning? For example, have the mother and child have been forced to live in **a homeless shelter because they have fled the domestic violence.**

[1]There may be other maltreatment attributable to the domestic violence survivor. The definition of coercive control ("power and control") ensures that the assessment of the impact of the perpetrator's behavior on the child is broader than just "Was the child physically harmed?" or "Did her or she see or hear the incident?" The Safe and Together model also encourages an integrated, holistic look at the perpetrator's pattern: the domestic violence perpetrator's behaviors almost always directly and indirectly involve, target and impact the child. This doesn't mean that the domestic violence survivor is not charged with a type of maltreatment when the specific facts to the maltreatment warrant it.

CIRCUMSTANCES SURROUNDING THE MALTREATMENT (continued)

When domestic violence is the reason for the hotline call: Use the following questions to guide information gathered in this domain:

- What is the perpetrator's overall pattern of coercive control and actions taken to harm the child?
- How have these behaviors manifested over time?
- How has prior, more severe violence impacted the current situation?
- What does the perpetrator say about the violence and abuse?
- How does their justification and explanation help us understand the extent of their control and their pattern of abuse?
- How do the circumstances of the abuse help us understand and further our assessment of the family functioning? For example, if this incident of physical violence targeted the caregiver's contact with her family, what else can we learn about how the perpetrator sabotages contact with family and perhaps other outside contact, including schools and medical providers?

The Safe and Together model offers a clear focus on the broader pattern of the perpetrator's pattern including the intent behind the abuse, the behaviors leading up to the abuse, actions and statements of responsibility for the abuse, and prior abuse in this and other relationships. In the circumstances section you can include broader themes like jealousy, interference with outside relationships, undermining parenting, financial control and interfering with the other caregiver's relationship with children. Factors that impact the perpetrator's overall dangerousness can be included here including military or other training to use violence; violence during pregnancy, history of sexual assault, use of weapons, prior threats to kill or harm; threats or history of taking a child. Additionally, social and cultural factors that might help the perpetrator avoid consequences are relevant here as well.

CHILD FUNCTIONING

When domestic violence is the reason for the hotline call: What has been the overall impact of the perpetrator's ongoing behavior pattern on the child across multiple domains?

It is important to consider the following incident-based harm such as physical injury and emotional trauma and more chronic impact such as disruption in housing, family functioning, academic performance, social relationships, and healthy behavior and development.

When domestic violence is not the reason for the referral, answer the following question: Could current or prior exposure to the domestic violence perpetrator's behavior explain any of the concerns related to the child functioning?

When there is no identified domestic violence in the current referral or in the history: Can any of the current concerns in the child's functioning be caused by unidentified domestic violence?

For example, could a child's aggression be the results of domestic violence?

- Could a child's academic and/or social issues be connected to frequent moves, or other potential consequences of domestic violence?

CHILD FUNCTIONING (continued)

As it relates to domestic violence as a factor, the meaningful completion of this domain requires the ability to connect what is known from the first two domains about the perpetrator's pattern of coercive control and actions taken to harm the child and the child's daily functioning. For example, without an understanding of the domestic violence perpetrator's overall pattern of behavior, it will be more difficult to link a child's current academic and behavioral issues with the recent escalating, threatening (but non-violent behavior) of a caregiver. It will also be harder to tie basic needs and care issues, like housing stability and access to appropriate medical care, to the perpetrator's behavior without an understanding of the pattern which might have led to multiple housing moves, loss of employment and other things that would affect a child's basic needs and functioning.

ADULT FUNCTIONING

In cases with current or historical domestic violence perpetration, this domain provides another opportunity to look for the perpetrator's pattern of behavior. Domestic violence perpetrators are diverse in their appearance of overall function. Some domestic violence perpetrators appear very functional in all domains of their life except for their violence and abuse towards their family. Other perpetrators may have multiple issues such as substance abuse or mental diagnoses or wider criminal behavior. From the perspective of a safety and risk assessment, one important question is "How does the perpetrator overall functioning affect his dangerousness?" For example, for a domestic violence perpetrator who is also an alcoholic: Is he more dangerous when he is drinking? Does his abuse escalate or subside when he is sober? This domain also provides the opportunity to look for signs and symptoms of trauma or other indicators in adults that might indicate unidentified domestic violence victimization. Issues such as substance abuse or the apparent inability to keep a job or stable housing may be the indicators of an abusive partner. A meaningful assessment of this domain will seek to identify and describe the role any prior or current unidentified domestic violence may be having on adult survivor's daily functioning, e.g., not permitted to control household budget or use the car.

*At the same time, prior domestic violence victimization in one or more relationships does not automatically indicate the presence of general relationship or mental health issues. From a perpetrator pattern-based, survivors' strengths-based approach, it is very important to understand the adult survivor's strengths, protective capacities and decision making in the face of the perpetrator's pattern as part of good assessment of any of the domains including parental functioning.

*Because domestic violence perpetrator's patterns often continue to be impactful even when they are not in the home or after a relationship ends, it is very important to assess the adult functioning of a perpetrator who may be incarcerated, out of the home on an injunction or separated/divorced.

When there is an identified domestic violence perpetrator, how might their current or prior abusive behavior be connected to the current adult functioning of the perpetrator:

- Employment: Has the domestic violence perpetrator lost his job as result of his violence and abuse?
- Social Functioning: Who is part of the support and kinship network of the domestic violence perpetrator? Do members of his support or kinship network provide support for positive change or not? What is the history of damage to social and family relationships created by the perpetrator's violence?
- Criminal behavior: Is the domestic violence part of larger pattern of anti-social or criminal behavior? If so, does this increased risk and danger?
- Day to day functioning: Are there cognitive, mental health or substance abuse concerns? If they are present are they associated with increased risk and danger?
- Housing/homelessness: Has the domestic violence led to housing instability or homelessness? Is the perpetrator dependent on the adult survivor for housing?

ADULT FUNCTIONING (continued)

- Is our assessment of adult functioning of the perpetrator considering how the perpetrator's choices are outside the cultural and social norms, and are indicative of poor problem solving and judgment?

For the domestic violence survivor how might the perpetrator's behavior (current or prior) be causing and/or exacerbating issues with current adult functioning:

- Have the perpetrator's behaviors contributed to any of the survivor's housing instability, employment issues or other financial issues? If so, how?
- Have the perpetrator's behaviors caused and/or exacerbated any of the survivor's substance abuse and/or trauma related mental health issues? If so, how?
- Have the perpetrator's behaviors undermined any of the survivor's recovery or treatment efforts?
- Have the perpetrator's behaviors contributed to the disruption of the survivor's social and kinship support networks?

When there is no identified domestic violence in the current referral or in the history: Can any of the current concerns in the adult functioning be caused by unidentified domestic violence? For example, could an adult's employment issue be the result domestic violence? Could an adult's housing issues or frequent moves be a consequence of domestic violence?

*Related to the gender responsive nature of the Safe and Together model, it is important to consciously bring attention to, and describe how, a male caregiver's overall functioning impacts his parenting ability and the overall household environment for the child.

PARENTING

When there is an identified domestic violence perpetrator, how might their current or prior abuse be connected to the current adult parental functioning of the perpetrator:

- How does the domestic violence perpetrator support the overall safety and well-being of the child, including basic and emotional needs?
- In what ways has the domestic violence perpetrator's behavior weakened their own relationship with the child?
- How has the child's warmth and feelings toward the perpetrator changed as result of their behavior?
- Has the perpetrator's pattern of behavior led to the child being overly compliant or alternatively oppositional to the caregiver?
- What is the perpetrator's overall involvement with taking care of the child's basic needs including, feeding, bathing, medical care?
- How does the perpetrator support or hinder the child's academic success?
- How does the domestic violence perpetrator's behavior support or undermine the other caregiver's parenting abilities?
- How does the domestic violence perpetrator's behavior interfere with the relationship between the other caregiver and the child?
- Does the perpetrator's needs overshadow the needs of the child?

For the domestic violence survivor how might the perpetrator's behavior (current or prior) be causing and/or exacerbating current parental functioning issues:

- When there are parenting issues with the adult survivor, it is important to understand how the perpetrator's past and present behavior may be influencing the survivor's parenting?

PARENTING (continued)

- Has the perpetrator turned the child against the adult survivor?
- What is the influence of the perpetrator who is no longer in the home?
- How have financial control and/or sabotage of outside relationships interfered with the adult survivors parenting?
- What is known about the survivor's parenting prior to the perpetrator's involvement in the family or when not present in the home?

Have the survivor's protective efforts been so successfully that the child does not understand why the survivor and perpetrator are no longer together? **When there is no identified domestic violence in the current referral or in the history:** Can any of the current concerns in the adult parenting be caused by unidentified domestic violence?

Core to the assessment of the domestic violence perpetrator as parent is the ability and willingness to treat the other parent with respect and to support their parenting and their relationship with the children.

In domestic violence cases, the meaningful completion of this domain involves identifying and describing how the domestic violence perpetrator's pattern of behavior effects their own parenting relationship and the parenting of the other caregiver. In order to be gender responsive and accurate in our assessments, we need to ask both these questions. We also need to ensure that we are actively seeking to examine the male caregiver's parenting role and their indirect impact on the parenting of their partner. For example, in a situation where there has been domestic violence, a series of missed doctor's appointments might not mean the failure of the primary caregiver, but might be an indicator of control over transportation or other behaviors disruptive of the household functioning.

We also ask basic questions like "Has the perpetrator's behavior pattern made meeting the child's emotional and other needs easier or harder?" For example, for a child who requires medication to control ADHD, we would want to know if the perpetrator is being supportive, negative or neutral about the child receiving medication. A gender responsive approach requires conscious attention to a male caregiver's role in the basic parenting of the child; otherwise social expectations will often lead us to attribute the negative (or positive) impact of the male caregiver to the female caregiver.

Similarly, the Safe and Together model's gender responsive approach to assessing parenting capacity also involves documenting both the heroic protective efforts of domestic violence survivors (injunctions, fleeing, separation and divorce, calling law enforcement) and the day-to-day efforts associated with nurturing, caring for and stabilizing a child who is being impacted by a perpetrator's behavior. This means ensuring that every day normal activities such as making sure that the child is fed regularly and is medically tended to is documented in the context of the perpetrator's behavior. For example, this might be written like "Despite the perpetrator's decision to take the family car when he was ordered out of the home, mother has been able to maintain the child's routine, including weekly doctor's appointments, through a network of friends and family.

As in the other domains, when there is no identified history of domestic violence it is important to look for indicators of coercive control such as an authoritarian parenting style. A gender responsive approach suggests that another indicator of unidentified domestic violence may be the presence of a marginalized female caregiver. While a marginalized female caregiver may be the result of other factors such as substance abuse, this situation can result from a pattern of undermining the female caregiver by an abusive partner.

DISCIPLINE AND BEHAVIOR MANAGEMENT

When there is an identified domestic violence perpetrator, how might their current or prior abuse be connected to the current parental disciplining of the perpetrator: What are the implications for the disciplinary approach of each caregiver of the perpetrator's pattern of coercive control and actions used to harm the child?

- Does the perpetrator engage in rigid and harsh discipline?
- Does the perpetrator use discipline that is inappropriate for the ages and stage of development for the child in the home?
- How does the perpetrator of domestic violence respond to specific resistance or defiance of the child in the home?
- Does the perpetrator undermine or reverse the appropriate discipline of the other caregiver?
- Does the perpetrator engage in physical discipline of child? Is this appropriate and safe?

For the domestic violence survivor, how might the perpetrator's behavior (current or prior) be causing and/or exacerbating current parental disciplining issues?

- How much does fear of the domestic violence perpetrator's reaction to the child's behavior influence the adult survivor'**s disciplining decisions?**
- Is the survivor more lenient because she wants to make up for the perpetrator's harsh parenting/disciplining?
- How much does the perpetrator interfere with the survivor's ability to effectively discipline the child?
- What has the perpetrator done to undermine the adult survivor's authority with the child?

When there is no identified domestic violence in the current referral or in the history: Can any of the current concerns with discipline be caused by unidentified domestic violence

Core to the assessment of the domestic violence perpetrator as a parent is the ability and willingness to treat the other parent with respect and to support their parenting and their relationship with the children.

These issues are similar to those outlined in the Parenting domain. In domestic violence cases, the meaningful completion of this domain would specifically look for ways the domestic violence perpetrator has, through behavior patterns, negatively shaped the disciplinary approach of the adult survivor? Basic questions in this domain include: "Does the domestic violence perpetrator support the adult survivor's disciplinary choices?" "Does the adult domestic violence survivor make decisions to protect the child from the abusive discipline of the perpetrator?" "How does the fear of the domestic violence perpetrator's reaction to a child's mistakes or failure to listen affect the household functioning?"

The adult survivor's disciplinary approaches may be shaped by the domestic violence perpetrator's pattern in several ways. If the domestic violence survivor has been traumatized by the violence, this may result in difficulties regulating emotional responses and impulsive behavior. Also the domestic violence perpetrator's pattern may result in developmental delays, aggression, or difficult or high risk behavior on the part of the child. The domestic violence perpetrator may even encourage defiant or disobedient behavior (even when not in the home). The response to these tactics of domestic violence needs to be contextualized in light of the perpetrator's behaviors.

Since this domain highlights a wide range of parenting strategies to address child behavioral issues and the broader role of teaching and guiding a child, it is an ideal domain for assessing and documenting the following: What kind of role model is the domestic violence perpetrator for the child? Does the perpetrator's parenting including manipulation that split children from one another, e.g., favoring one child over another, and/or splitting a child from the other caregiver. It is not uncommon for a domestic violence perpetrator to use both fear and rewards to control family members.

Survivor's Protective Efforts (3rd Critical Component)

MALTREATMENT

When domestic violence is the reason for the hotline call: Describe specifically what was done to manage child safety and well-being before, during and after the incident. Make sure you use a comprehensive lens and give survivors credit for day to day actions.

- What basic care activities by the adult survivor were occurring prior and during the incident?
- What were the adult survivor's specific strategies to minimize, reduce, and prevent the event from occurring?
- What did the adult survivor do during the incident to reduce the physical and emotional danger to the child?
- After the incident, what did the adult survivor do to take care of the physical and emotional needs of the child?

In this area you need to make sure that protective efforts are contextualized to the situation and that the survivor's efforts are valued for what was possible before, during or after the incident versus the ultimate outcomes of the incident which would be the sole responsibility of the perpetrator.

CIRCUMSTANCES SURROUNDING THE MALTREATMENT

When domestic violence is the reason for the hotline call: Assess for long term patterns of care, and management of safety and well-being.

- What does the adult survivor do day to day to maintain the child's well-being?
- What is the adult survivor's day to day strategy to address the safety of the child?
- In response to the abuse, what major life choices has the adult survivor made in order to promote the safety and well-being of the child?
- How does the adult survivor's behavior support the healing of the child from trauma?
- How does the adult survivor's behavior provide day to day stability and nurturance for the child?

As with all assessment of protective efforts, the assessment needs to be comprehensive. A domestic violence survivor's continuing relationship with a perpetrator, unwillingness or inability to call law enforcement or get an injunction does not mean she has not engaged in significant and meaningful protective efforts.

CHILD FUNCTIONING

When domestic violence is present in the hotline call or present in the history of the family: What has been the influence of the adult survivor's protective efforts on the child's functioning across the domains of functioning? In essence what is the nexus between the survivor's efforts and the functioning of the child?

- What information can be documented about the connection between the adult survivor's pattern of protective efforts and the positive functioning of the child?

In many cases with domestic violence, the children are functioning well in some or all areas of their life. This is often the result of the adult domestic violence survivor's and other people's protective efforts.

In this, as in all areas, the protective efforts need to be evaluated by a standard that values the survivor's day to day efforts and considered in the context of what is reasonable and possible given the perpetrator's pattern of control. For example, many survivors support their children to maintain contact with extended family but some can't because it has become difficult or dangerous because of the perpetrator's behavior.

ADULT FUNCTIONING

When domestic violence is present in the hotline call or present in the history of the family: How has the adult survivor managed to maintain adult functioning despite the violence?

- What information can be documented to describe how the perpetrator has interfered with the survivor's adult functioning?
- What was survivor's adult functioning in key areas prior to violence and abuse?
- How does the survivor function when the perpetrator is not a factor in her decision making?
- How are we making a strengths-based, contextualized assessment of the survivor's problem solving, judgment, self-care, self-preservation, and stress management abilities?

It is imperative to start this conversation about domestic violence survivors and adult functioning from a strengths-based perspective. Many domestic violence survivors will demonstrate significant skills around problem solving, stress management, impulse control and other key domains of adult functioning. Because domestic violence exists from the choices of the perpetrator and not the adult survivor, the starting point needs to be that the survivor may not have any adult functioning issues except for being the target of a perpetrator's abuse. This is the best starting point for an assessment of adult functioning for domestic violence survivors.

Once the survivor's strengths are identified, they can be contextualized in the ways that the perpetrator's behavior may have comprised her adult functioning. For example, it's important to see that an adult survivor might have the skills and desire to work but not be allowed to because of the perpetrator's control. Similarly, it would be important to understand when the adult survivor's depression and anxiety was related to the perpetrator's behavior. It is also important to able to identify issues of functioning that existed prior to the current domestic violence. For example, some adult survivors have pre-existing substance abuse and/or mental health problems.

While it is important to see the specific nature of the domestic violence perpetrator's behavior and to see it as a parenting choice, it is also important to be able to articulate the significance of that behavior for overall adult functioning as well.

PARENTING

When domestic violence is present in the hotline call or present in the history of the family: How has the adult survivor managed to maintain parenting despite the violence?

- What are the adult survivor's day to day parenting responsibilities including meeting the child's basic care needs?
- What information can we document to describe how the perpetrator has interfered with the adult survivor's parenting?
- What was adult survivor's parenting in key areas prior to violence and abuse?
- How does the adult survivor function as a parent when the perpetrator is no longer a factor in her decision making?
- How are we making a strengths-based, contextualized assessment of the survivor's care of the child, satisfaction of being a caregiver, skill level and parenting style, and protectiveness factors?

Domestic violence perpetrator's behavior can have tremendous influence over a partner's parenting. It may lead to more lenient parenting as an effort to compensate for the harsh parenting of the perpetrator or it may lead to more harsh discipline in order protect the child from worse consequences from the perpetrator. The perpetrator's control over finances or social environment may force a survivor into criminal behavior to make sure that the child's basic needs are being met or the perpetrator's tactics may deny her the natural respite support of relatives that she would access except for his control over her and the child. **It is bad practice to assess the adult survivor's parenting without assessing for the perpetrator's influence over it.**

PARENTING (continued)

It is important to be able to look at the perpetrator's pattern and its impact on the overall family functioning to understand the parenting of the adult survivor. For example, when the perpetrator uses a child as a spy or turns them emotionally against his partner, how does that affect her parenting?

Gender responsiveness plays a critical role here in order to ensure that mothers are getting full credit for all their day to day basic care efforts as part of the assessment of their parenting.

DISCIPLINE AND BEHAVIOR MANAGEMENT

When domestic violence is present in the hotline call or present in the history of the family: How has the managed to maintain her healthy discipline despite the violence?

- Where can we describe how the perpetrator has interfered with the adult survivor's disciplining?
- What was adult survivor's discipline in key areas prior to violence and abuse?
- How does the adult survivor discipline when the perpetrator is not a factor in her decision making?
- How are we making a strengths based, contextualized assessment of an adult survivor's disciplining and behavior management?

Similar to the parental and adult functioning it is very important to start with strengths-based approach to assessing an adult survivor's discipline and behavior management. Domestic violence perpetrator's behavior can have tremendous influence over a partner's discipline and behavior management. **It is bad practice to assess the adult survivor's discipline and behavior management without assessing for the perpetrator's influence over it.**

It is important to be able to look at each of the perpetrator's patterns and its impact on the overall family functioning to get a clear picture of the discipline and behavior management of the adult survivor. For example, when the perpetrator's choice to expose the child to the abuse leads to academic and behavioral issues with the child, how does this control limit or shape the survivor's options to address these issues? It is often unsafe and/ineffective to address these issues in a family therapy setting because unless the perpetrator is willing to take responsibility for their behavior. What if the perpetrator is also undercutting the survivor's efforts to set up structure and routine? How would this affect her behavior management?

Impact of Perpetrator's Pattern on Children (4th Critical Component)

MALTREATMENT

When domestic violence is the reason for the hotline call: The strongest documentation will make clear the nexus between the perpetrator's behavior and its impact on the child. Examples of this might include:

- "The step-father's attempted strangulation of Charlie's mother produced extreme fear for her life as evidenced by his call to the police and the statement that he was worried that his stepfather was going to kill his mother."
- "Because of Charlie's fear for his mother's safety, he didn't want to go to school the next day."

Good documentation of the impact the maltreatment has on the child will record each of the perpetrator's behaviors during the incident and look for connections that may support the symptoms and condition of the child. A picture of the child's symptoms and impact might include assessing the following:

- What was interference in the normal daily family routine by the perpetrator's behaviors and the subsequent events e.g., arrival of the police or seeking shelter?
- How did the child's fear or other emotional state manifest in behavior at the time and immediately afterwards?
- What was the impact of any verbal statements made by the perpetrator before during and after the incident? For example, assaults with verbal threats to kill might be more frightening?
- What was the immediate post violence traumatic impact on the child's sleep, eating, mood, and ability to function?

CIRCUMSTANCES SURROUNDING THE MALTREATMENT

When domestic violence is present in the hotline call or present in the history of the family: The documentation should seek to make clear the nexus between the overall perpetrator's pattern of behavior and its medium and long term impact on the child. This would include looking at the nexus between the perpetrator's behavior beyond immediate trauma to other domains of child's functioning such as academic performance or safe housing.

In domestic violence cases, the meaningful completion of this domain requires the ability to connect what is known from the first two domains about the perpetrator's pattern of coercive control and actions taken to harm the child and the child's daily functioning. For example, without a picture of the domestic violence perpetrator's overall pattern of behavior, it will be more difficult to link a child's current academic and behavioral issues with the recent escalating, threatening, but non-violent behavior, of a caregiver. It will also be harder to tie basic needs and care issues, like housing stability and access to appropriate medical care, to the perpetrator's behavior without an understanding of the pattern which might have led to multiple housing moves, loss of employment and other things that could affect a child's basic needs and functioning.

CHILD FUNCTIONING

When domestic violence is present in the hotline call or present in the history of the family: What has been the overall impact of the perpetrator's pattern of coercive control and actions to the child across all domains of the child's functioning? This needs to be examined from an age and developmental stage perspective.

- How has the domestic violence perpetrator's behavior pattern interfered with the child's normal healthy development?
- For a young child, has the coercive control interfered with their basic care needs being met including medical needs and child care needs?

CHILD FUNCTIONING (continued)

- For a school age child, how has the perpetrator's behavior impacted their emotional responses, their behavior within and outside of their family, and their academic performance?
- Has the coercive control interfered with the child's relationship with relatives or friends?
- As a result of the perpetrator's behavior, has the child's sense of home being a safe stable environment been compromised?
- Is the potential role of the perpetrator's behavior being factored into any diagnosis or other issues identified in the child's behavior, mood or development?
- Has the domestic violence perpetrator interfered the implementation or recommendations of medical professionals or therapists for the treatment of the child's physical or emotional condition?

To fully assess the impact of the domestic violence perpetrator's impact on child functioning, there needs to be a "multiple pathways to harm" framework. The focus on the physical danger and traumatic impact of the incident of violence needs to be expanded to include the following questions:

- How is the child's functioning being impacted by the perpetrator's influence over the adult survivor's adult functioning, parenting and discipline?
- How has the perpetrator's pattern influenced the family functioning by impacting housing, employment and other areas that shape the child's academic, financial and social needs?

Good documentation in this domain articulates the nexus between the perpetrator's behavior and the impact on the child. The following gives an example of how this can be accomplished :

"Because of father's multiple physical assaults against mother, the family has been dislocated three times in the last four years. Twice the mother fled to a domestic violence shelter to protect the children from more violence, once the family was evicted because of the perpetrator's violence and another time, through stalking behaviors, he located the family who had been living in safe stable housing and forced them to move in with his family. As a result of these behaviors by the perpetrator, the children have lost significant time in school (20 days last year), been forced to change schools once and have gone from being high performing students to being on academic probation. One of the children has been suspended for fighting at the most recent school."

ADULT FUNCTIONING

When domestic violence is present in the hotline call or present in the history of the family: What is the impact of the perpetrator's adult functioning on the child?

Recognizing the three dimensionality of the perpetrator is important when assessing this domain. The adult functioning of domestic violence perpetrators varies widely. Some are engaged in anti-social behavior and others are very involved with the community and civic activity. Some have issues with substance abuse and others do not. Some have emotional and cognitive issues and others do not.

Positive adult functioning of a perpetrator can have multiple effects on a child. Father's regular employment can be source of stability and strength for a child and at the same time it could be mechanism for economic control. For example, in a situation where the domestic violence perpetrator has undermined the adult functioning of the other caregiver while maintaining his own economic functioning can be used as threat to keep the adult survivor in the relationship e.g., "If you leave me I'll get full custody of the children because you can't support them."

As it relates to how the perpetrator impacts the child through impacting the survivor's adult functioning there is great variability as well. One of the principal pathways to harming a child for a perpetrator is through their control and abuse of the child's other parent. As indicated above it is important to contextualize the adult survivor's functioning.

PARENTING

When domestic violence is present in the hotline call or present in the history of the family: What is impact of the perpetrator's parenting on the children? Understanding the three dimensionality of the perpetrator is important when assessing this domain. The overall parenting of domestic violence perpetrators varies widely with some common themes re-occurring: physical abuse, punishments that are inappropriate for age and developmental level, harsh discipline, inability to focus on the needs of the child over their own needs, undermining of the other person's parenting, and interfering with the other caregiver's relationship with the child. Some perpetrators are not engaged in the parenting of their child whereas others might be coaching the child's sports team. Some are not at all invested in the child and others are highly invested. Some have not identified with a parenting role and others are strongly identified with a parenting role.

Positive parenting by a perpetrator can have multiple effects on a child. A parent's regular involvement in the life a child can be source of stability and strength for that child and at the same time it could be a source of confusion, grief and loss. For example a child can experience confusion if the same person who takes them to sporting activities and on family outings, also abuses the other parent.

As it relates to how the perpetrator impacts the children through impacting the survivor's adult functioning there is great variability as well. One of the principal pathways to harming a child for a perpetrator is through their control and abuse of the child's other parent. As indicated above it is important to contextualize the adult survivor's parenting.

DISCIPLINE AND BEHAVIOR MANAGEMENT

When domestic violence is present in the hotline call or present in the history of the family: What is the impact of the perpetrator's discipline on the children?

Similar to the adult functioning and parenting, in this domain, the three dimensionality of the perpetrator is important. The overall discipline of domestic violence perpetrators varies widely with some common themes re-occurring: physical abuse, punishments that are inappropriate for age and developmental level, harsh discipline, inability to focus on the needs of the child over their own needs, undermining of the other persons parenting, and interfering with the other caregiver's relationship with the child. Some perpetrators are not engaged in the disciplining of their child and others might do all of it.

Any positive healthy discipline and behavior management by the perpetrator must be integrated with the overall pattern of behavior. For example, some domestic violence perpetrators marginalize their partner's role with the child and take over all the parenting and discipline. While some of the specific behavior management techniques might be positive, the assessment would not be complete if it didn't include the broader context of control and marginalization of the other parent.

As it relates to how the perpetrator impacts the child through impacting the survivor's adult functioning there is great variability as well. One of the principal pathways to harming a child for a perpetrator is through their control and abuse of the child's other parent. As indicated above it is important to contextualize the adult survivor's parenting.

Substance Abuse, Mental Health and Culture (5th Critical Component)

MALTREATMENT

When domestic violence is the reason for the hotline call: Are substance abuse, mental health issues, culture, other socio economic issues or other information significant to the maltreatment?

- Was the perpetrator drinking or using other drugs at the time of the incident? Did that use escalate the fear and/or the level of harm?
- Did the perpetrator' training and/or experience with weapons, martial arts, military service, or gang involvement increase the level of fear and/or harm during the incident?
- Is the perpetrator involved with a profession or a have a position in the community that would make family members more afraid to access resources or fearful that outside involvement would escalate the situation?
- Are there cultural or socio-economic factors that make the adult and child survivors more vulnerable, e.g., immigration status, language barriers, physical disability, cultural and religious beliefs, medical condition, criminal history, being part of historically discriminated against group, substance abuse and/or mental health history?
- Is there an economic imbalance between the perpetrator and the adult survivor that allows for more control?
- Do the perpetrator's family and/or community tolerate and/or enable the control?
- What aspects of the cultural, community or family relationships support the adult survivor's protective efforts?
- Did the perpetrator use race, gender, or sexual orientation as a tactic of abuse?

CIRCUMSTANCES SURROUNDING THE MALTREATMENT

When domestic violence is present in the hotline call or present in the history of the family: Are substance abuse, mental health issues, culture, other socio economic issues or other information significant to the circumstances around the maltreatment?

- How has the perpetrator's drinking or using other drugs over time impacted the family functioning and levels of fear and control? For example, while a perpetrator may not become violent every time he drinks, the family may get scared of the potential for violence every time the perpetrator drinks.
- Does the perpetrator use violence and abuse to facilitate access to money for drugs and alcohol?
- Does the perpetrator use violence and control to deflect questions about the consequences of substance use?
- How has the perpetrator's standing in the community increased the isolation of the family from resources?
- Is the perpetrator' training or experience with weapons, martial arts, military service, or gang involvement associated with fears about accessing law enforcement or related to limitations of incarceration or other interventions to improve the situation?
- Are there cultural or socio-economic factors that make the adult and child survivors more vulnerable, e.g., immigration status, language barriers, physical disability, cultural and religious beliefs, medical condition, criminal history, being a member of a group that has been historically discriminated against, or having a substance abuse or mental health history?
- Is there a racial, gender, sexual orientation aspect to the overall pattern of coercive control?

CIRCUMSTANCES SURROUNDING THE MALTREATMENT (continued)

- Is there an economic imbalance between the perpetrator and the adult survivor that allows for more control?
- Does the perpetrator's family or community tolerate or enable the control?
- What aspects of the cultural, community or family relationships support the adult survivor's protective efforts?

CHILD FUNCTIONING

When domestic violence is present in the hotline call or present in the history of the family: How does the child's functioning intersect with these other issues?

Domestic violence intersects with issues of race, class, gender, immigration status, religion, substance abuse, mental health as well as an entire range of other issues. Child functioning is shaped by all these things. Consider the following possible intersections as examples of a wide range of factors:

- A gay or transgendered child who's parent is a domestic violence perpetrator who is homophobic and has rigid gender expectations may be targeted for abuse in the family.
- A mother who is undocumented and partnered with a citizen or legal immigrant may be very susceptible to threats of being deported if there is a call to the police.
- A child's delinquency or substance abuse issues may become the identified issue instead of the perpetrator's chronic domestic violence.
- In affluent, privileged families a child may have reason to hide the abuse to protect the family image.

Racism, classism and other forms of oppression and discrimination intersects with a child's functioning as it relates to perpetrator behavior. For example, the education system may respond differently to an African-American male who is acting aggressive in school because of his father's violence than a Caucasian male. Service options to address traumatic responses may be different based on neighborhood, economic status and race. Cultural values about therapy and other outside interventions may also shape child functioning.

ADULT FUNCTIONING

When domestic violence is present in the hotline call or present in the history of the family: How does the overall intersection of the domestic violence and other factors shape adult functioning?

Racism and other forms of discrimination can increase the negative overall assessment of a domestic violence perpetrator. For example, our overall assessment of a domestic violence perpetrator who is poor or a person of color is likely to be more negative than someone who comes from a higher socio-economic status or is Caucasian. The behavior focus of the Safe and Together model requires an articulation of the specific behaviors related to the domestic violence, making it less likely that assessment will be biased by cultural, racial or economic stereotypes.

Similarly the assessment of the adult functioning of the survivor can be influenced by the racism, homophobia or other forms of discrimination.

- Is the perpetrator playing on racial or gender stereotypes to increase their control over the adult survivor?
- Are service providers and others taking an overly pathologized view of the adult survivor because of racism or other forms of discrimination?

ADULT FUNCTIONING (continued)

- When English is not the primary language, is the overall adult functioning assessment incomplete or inappropriately being confused with lower intellectual levels? Is culturally appropriate adult functioning misinterpreted as being limited or poor functioning? For example, are culturally appropriate healing practices being confused for lack of concern for health and well-being?
- Substance abuse by the domestic violence perpetrator and its impact on adult functioning needs to be appropriately factored into the assessment and any case plan.

The assessment of substance abuse is often not integrated into the overall assessment of the domestic violence because it is perceived primarily as an adult functioning issue. Here are some of the questions that can be asked about it:

- How has the perpetrator used violence and control to support the substance abuse, e.g., stealing rent money to use?
- Has the focus on the substance abuse eclipsed the focus on the domestic violence?
- Do practitioners believe that the domestic violence will automatically no longer be an issue if the substance abuse is addressed?
- How does recovery from substances change the perpetrator's pattern of coercive control? Do family members experience a greater feeling of safety and self-determination or do they feel the level of control is the same or worse?
- How does the domestic violence perpetrator interfere with the adult survivor's recovery efforts? How does the perpetrator support those efforts?

Similarly, mental health issues of the domestic violence perpetrator and its impact on adult functioning needs to be appropriately factored into the assessment and any case plan. The assessment of mental health issues is often not integrated into the overall assessment of domestic violence because it is perceived primarily as an adult functioning issue. Here are some of the questions that can be asked about it:

- Has the perpetrator been wrongly or incompletely diagnosed as having a mental health issue instead of being identified as being abusive? For example some abusers will be wrongly diagnosed as bi-polar. In other instances, veterans with PTSD will also not be identified as being abusive.
- Has the focus on the mental health eclipsed the focus on the domestic violence?
- Do practitioners believe that the domestic violence will automatically no longer be an issue if the mental health is addressed?
- How does treatment of the mental health issues change the perpetrator's pattern of coercive control? Do family members experience a greater feeling of safety and self-determination or do they feel that the level of control is the same or worse?
- How does the domestic violence perpetrator interfere with the adult survivor and child survivor's mental health treatment efforts? How does the perpetrator support those efforts?

PARENTING

When domestic violence is present in the hotline call or present in the history of the family: How does the overall intersection of the domestic violence and other factors shape parenting?

Racism and other forms of discrimination can increase the negative overall assessment of domestic violence perpetrator. For example, our overall assessment of a domestic violence perpetrator who is poor or a person of color is likely to be more negative than someone who comes from a higher socio-economic status or is Caucasian. The behavior focus of the Safe and Together model requires an articulation of the specific behaviors related to the domestic violence, making it less likely that assessment will be biased by cultural, racial or economic stereotypes.

Similarly the assessment of the parenting of the survivor can be influenced by the racism, homophobia or other forms of discrimination.

- Is the perpetrator playing on racial or gender stereotypes to increase their control over the adult survivor?
- Are service providers and others taking an overly pathologized view of the adult survivor because of racism or other forms of discrimination?
- When English is not the primary language is the overall adult functioning assessment incomplete or inappropriately being confused with lower intellectual levels or poorer parenting?
- Is culturally or circumstantially appropriate parenting misinterpreted as being limited or poor functioning? For example, are stricter limits on child outdoor play because of the dangers of violence in the neighborhood being confused for lack of knowledge about the child's needs?

Cultural factors may make it harder to label and identify the perpetrators overall patterns of coercive control and actions taken to harm the child. If a community identifies with strict norms it may be hard to see the perpetrator's pattern. Similarly within the context of home schooling it may be difficult to see a wider pattern of isolation. Cultural values that allow of extremely high expectations of women as parents and low expectations of men as parents will make it harder to identify control e.g., "he's not making her stay with the children. That's what women do" or "He's a good dad because he's never physically harmed them." Cultural norms about physical discipline of children may make it harder to identify the perpetrator's pattern of abuse as well.

DISCIPLINE AND BEHAVIOR MANAGEMENT

When domestic violence is present in the hotline call or present in the history of the family: How does the overall intersection of the domestic violence and other factors shape discipline?

Racism and other forms of discrimination can increase the negative overall assessment of domestic violence perpetrator. For example, our overall assessment of a domestic violence perpetrator who is poor or a person of color is likely to be more negative than someone who comes from a higher socio-economic status or is Caucasian. The behavior focus of the Safe and Together model requires an articulation of the specific behaviors related to the domestic violence making it less likely that assessment will be biased by cultural, racial or economic stereotypes. Similarly the assessment of the discipline by the survivor can be influenced by the racism, homophobia or other forms of discrimination.

- Is the perpetrator playing on racial or gender stereotypes to increase their control over the adult survivor?
- Are service providers and others taking an overly pathologized view of the adult survivor because of racism or other forms of discrimination?
- When English is not the primary language is the overall adult functioning assessment incomplete or inappropriately negative, e.g., being confused with lower intellectual levels or poorer behavior management?

DISCIPLINE AND BEHAVIOR MANAGEMENT (continued)

- Is culturally or circumstantially appropriate discipline misinterpreted as being limited or poor functioning? For example, is sending difficult children to be raised by extended family interpreted as lack of attachment and care?

Cultural factors may make it harder to label and identify the perpetrators overall patterns of coercive control and actions taken to harm the child. If a community identifies with strict norms it may be hard to see the perpetrator's pattern. Similarly within the context of home schooling it may be difficult to see a wider pattern of isolation. Cultural values that allow of extremely high expectations of women as parents and low expectations of men as parents will make it harder to identify control e.g., "he's not making her stay with the children. That's what women do" or "He's a good dad because he's never physically harmed them." Cultural norms about physical discipline of children may make it harder to identify the perpetrator's pattern of abuse as well.

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