Division of Children and Family Services Protection and Safety Procedure #27-2016	
Regarding:	Initial Assessment
Rescinds:	#14-2016 Initial Assessment
Date Effective:	September 20, 2016
Contact:	Connie Pfeifer at 402.471.9245 or connie.pfeifer@nebraska.gov
Issue by:	Douglas J. Weinberg, Director, Division of Children and Family Services

Philosophy:

One of the most important roles of a family is to protect and keep members of the family safe. At times, parents may not be able to keep their child safe. When this occurs, CFS Specialists will intervene to assure child safety, reduce the risk of harm in the household, and assist the parents to be able to provide for their child's safety, permanency and well-being.

Certain assumptions are at the core of CFS involvement:

1. Child and community safety will be the basis of each CFS Specialist intervention.
2. Parents do care and want to provide care for their children. Parents care about their children and want to keep them safe.
3. People can change their behaviors when provided adequate support and resources.
4. CFS Specialists and supervisors will provide trauma informed, compassionate, respectful, family driven, outcome focused, individualized, culturally competent and time limited intervention.
5. Families will be directly involved in the development of their Safety Plans, case plans and decisions about their family.
6. Case management services will be as minimally intrusive as possible, but will be provided at the level of effort needed to ensure safety.
7. CFS Specialists will conduct an assessment of safety and risk and an investigation on allegations of abuse or neglect to determine if the allegation occurred and if the alleged perpetrator's name should be placed on the Child Abuse and Neglect Central Registry.
8. CFS Specialists and supervisors will make every effort to prevent the unnecessary separation of children from their family. CFS Specialists and supervisors will help children remain in their homes and neighborhoods whenever child safety can be assured.
9. When children must be removed, CFS Specialists and supervisors will work with the family to safely reunify the child.
10. When children must be removed from their family, every effort will be made to place children with a family or kin when it is safe to do so. When children must be removed from their families, every effort will be made to keep the child in their home school.
11. When Indian (American Indian or Alaska Native) are removed from their home, the placement preferences (including good cause) of the child's tribe will be used.

Procedure:

I. INTAKE SCREENING UPDATE.

The Intake SDM® Screening Tool, within the Neglect category is changed to read: "Accept for assessment all intakes involving allegations of parent or custodian methamphetamine use if the report identifies one or more of the Physical, Behavioral, Cognitive, or Mental Health symptoms of methamphetamine use listed in the attached document "Methamphetamine Impact"". Intake CFS Specialist will continue to gather and document information about the impact of the parent/caregiver's substance use on their parenting ability

II. INITIAL ASSESSMENT PROCEDURES.

A. An initial assessment will be completed on all Intakes accepted for assessment, regardless of the case status determination. Even though the specific allegation of abuse or neglect is found to be untrue, or does not rise to the level of preponderance standard and is classified as unfounded for the Central Registry entry, the CFS Specialist will assess the child's situation to determine if threats to safety or risk of future maltreatment exist. Even though the allegation was unfounded, other identified threats to safety or risk future maltreatment cannot be ignored.

B. Once an Intake has been accepted by the Hotline, it will be assigned to a CFS Specialist to conduct an initial assessment which includes assessing for safety and risk and/or investigating to determine if maltreatment has occurred.

C. **Response Times:** The CFS Specialist will respond to Intakes by making contact with the alleged victim(s) within the following time frames:

1. Priority 1 Intakes have an expected response time to contact the alleged victim(s) 0-24 hours from the time the intake was accepted for assessment. These are Intakes that may be life threatening and require immediate response. If a CFS Specialist is unable to respond they must notify law enforcement of the emergency nature of the Intake and request that law enforcement respond immediately. The State Patrol may be contacted if local law enforcement is not available.
2. Priority 2 Intakes require a 0-5 calendar day response time to make contact with the alleged victim(s) from the date and time the intake was accepted for assessment.
3. Priority 3 Intakes require a 0-10 calendar day response time to make contact with the alleged victim(s) from the date and time the Intake was accepted for assessment.
4. All intakes will immediately be assigned to a CFS Specialist who is available to respond and coordinate the response with law enforcement per local area protocols. Contact with the victim(s) will be documented in Contact Detail in the Safety Assessment.

D. **Law Enforcement Involvement:** Law Enforcement may intervene with or without Department involvement.

1. If Law Enforcement contact occurred prior to the Intake accepted date and time, the CFS Specialist will make response time frames as defined above.
2. If Law Enforcement was the only contact the family had on the date the Intake was accepted:
   a. Priority 1: The CFS Specialist must make contact with the victim(s) and parent/caretaker within 24 hours of the Law Enforcement Contact.
   b. Priority 2: The CFS Specialist must make contact with the victim(s) and parent/caretaker within 0-5 calendar days of the Law Enforcement Contact.
   c. Priority 3: The CFS Specialist must make contact with the victim(s) and parent/caretaker within 0-10 calendar days of the Law Enforcement Contact.

E. **First Contact by Law Enforcement:** There are four situations where law enforcement may make the first contact with the family and later provide a written report to DHHS. All law enforcement reports will be date stamped and reviewed by a CFS Specialist within 24 hours of receipt. The CFS response to each report depends on the situation.
   1. Law enforcement is the first agency to receive a report of possible abuse or neglect and responds to protect the child.
   2. CFS receives an Intake and sends law enforcement out to respond prior to closing the intake by making a decision to accept for assessment or screen out the report. These reports will be processed through the Hotline as new Intakes, and will be accepted for assessment if:
      a. The report meets screening criteria; or
      b. The report indicates possible safety concerns that have not been addressed.
   3. DHHS receives the Child Abuse/Neglect report, accepts the Intake for assessment and sends law enforcement out for immediate contact with the child and family.
      a. The intake has been accepted for assessment and the assessment will be completed, regardless of information obtained by the law enforcement contact.
   4. DHHS receives the report of abuse and neglect and classifies the Intake as accepted for "Law Enforcement Only". Note: "Law Enforcement Only" is to be used as an Intake closing reason only in situations when the alleged perpetrator is not a parent/caretaker or household member.

F. **CFS Responsibility When Law Enforcement makes First Contact**
   1. The CFS Specialist will complete the assessment process if an assessment is required. The CFS Specialist may use the law enforcement contact date as the first contact with the victim if the law enforcement contact occurs after the date of the Intake and it is clear in the report that the child(ren) was seen and immediate safety concerns were addressed. The CFS Specialist will follow the procedures in the Program Guidance for the Central Registry Entries.
   2. Each Service Area will develop a protocol to enter findings on law enforcement only reports. The protocol will ensure that the appropriate notice letter is sent to the alleged perpetrator. The Service Area will provide continued follow-up as described in the Program Guidance for the Central Registry.

G. **Response Time Exceptions:** There are circumstances in which the CFS Specialist will not be able to meet the identified response time. These exceptions will be documented in N-FOCUS in the Exception Narrative based on the definitions below. It is expected that the CFS Specialist will use all skills and consult with the supervisor to locate and engage families.
   1. **Unable to Locate:** The CFS Specialist must make a "good faith" effort to locate the family before determining that the response time cannot be met. A "good faith" effort requires using all reasonable methods to locate the parties. This includes utilizing the following systems to obtain an address or location:
      a. The Department's computer information system;
      b. Nebraska Data Exchange Network (NDEN);
      c. Department of Motor Vehicles;
      d. Child Support Enforcement;
      e. Local Law Enforcement agency;
      f. Local utility companies;
      g. Post Office;
      h. Internet Search; and
      i. Schools and/or child care facilities the child may be attending based on information as to the family's address; speculation by others etc.

The CFS Specialist must consult with the supervisor as a mandatory consultation point to verify that no additional efforts are necessary. A determination must also be made if further efforts to locate the family must be made within the 30 day timeframe for completion of the assessment.

Note: The family's failure to respond to notes left on the door, letters, or phone messages is not evidence of sufficient effort to contact the family. If the child is located, but the parents decline contact, a safety and risk assessment must be completed using the available information.

2. **Unable to Identify:** The CFS Specialist has made 'good faith' efforts to identify the family. These actions can include contacting the reporting party or collaterals to obtain additional information that would provide additional sources of information to identify the family i.e. schools, day care, or employers.
3. **Parent Refusal:** Parents may refuse to be interviewed or allow their children to be interviewed. The CFS Specialist must make all attempts to engage the parent using family centered practice skills obtain parent agreement to conduct interviews. The CFS Specialist will make every effort to interview the child to determine if there is any safety or risk factors that require intervention by DCFS, law enforcement or the county attorney. The parent cannot prevent the CFS Specialist from contacting the child outside of the family home. The CFS Specialist may try to gain access to the child at locations outside the home, such as schools, day care, camps, etc. The CFS Specialist must consult with the supervisor to discuss next steps if the parent refuses to be interviewed or allow access to the child. The CFS Specialist and supervisor must assess whether it would be best to involve law enforcement and/or the county attorney regarding how to gain access to the child and parent to assess child safety. A determination about whether further efforts must be made within the 30 day timeframe for completion of the assessment must be made by the CFS Supervisor. If the child is located, but the parents decline contact, a safety assessment must be completed using the information available.
4. **Request by Law Enforcement:** There are times when law enforcement requests that the CFS Specialist temporarily delay contact with the alleged victim(s) and others involved in the report of child abuse and neglect. The CFS Specialist will document any Law Enforcement request to delay contact with the family in the intake narrative (Contact Exceptions), notify their supervisor and develop a plan to stay in communication with law enforcement to determine when contact can be made.
5. **Administrative Exception:** The CFS Specialist and supervisor may request a Response Time Exception from an Administrator in specific circumstances. These situations do not meet the Unable to Locate, Unable to Identify, Parent Refusal or Request by Law Enforcement exception criteria and were beyond the CFS Specialist's control.
   a. Exceptions will not be approved for the following situations. The CFS Specialist will conduct the assessment in the following circumstances:
      (1) Law Enforcement, doctors or others deem the injury as non-abusive;
      (2) Family Refuses to participate;
      (3) Inability to locate the alleged perpetrator;
      (4) Alleged perpetrator no longer in the home.
   b. The list is not exclusive and the Administrator may deny exceptions in other circumstances.

H. **Conflicts of Interest:**

1. **Law Enforcement**: If the intake alleges maltreatment by a member of the local law enforcement agency, the initial safety assessment will be completed with the assistance of the State Patrol. Requests for assistance from the State Patrol need to go through the Attorney General's Office. After informing the supervisor, the assigned CFS Specialist

will contact the Criminal Bureau Chief or a member of his staff at 402-471-2682 to request State Patrol assistance. The State Patrol has decision making authority about whether or not they will participate. If they agree to do so, the assigned officer will lead the investigation and determine how and when the alleged perpetrators will be contacted. The assigned patrol officer will also determine the timing and sequencing of interviews. If the CFS Specialist believes any planned delay will be unsafe for the children involved, he or she will consult with his or her supervisor. If the allegation of maltreatment involves an officer in the State Patrol, the State Patrol will be the investigating agency, either assigning an officer from Internal Affairs or an officer from another service area to investigate, in cooperation with the assigned CFS Specialist.

2. **CFS Specialist:** If the CFS Specialist has a conflict of interest in a specific case due to a personal relationship with parties in the case, the CFS Specialist will notify the supervisor immediately. The supervisor will make the decision about whether the assessment will be assigned to another CFS Specialist, or if necessary, to a CFS Specialist in another office within the Service Area or if a request will be made for assignment of a CFS Specialist from a different Service Area.

I. **Preparation for Initial Assessment:**

1. **Review available information:** The CFS Specialist assigned will thoroughly review information gathered at Intake and in any existing case record, specifically any prior abuse/neglect reports, or law violation reports involving the child, family and alleged perpetrator. It is critical that all previous reports and information be analyzed and taken into consideration. The history of the family is important because it provides critical information on the pattern of behaviors and provides indicators of past trauma that may impact the parent's ability to safely parent their child. The CFS Specialist will contact the reporter and collaterals for additional information as necessary.
2. **Coordinate with Law Enforcement:** The CFS Specialist will:
   a. Contact the appropriate law enforcement agency prior to initiating an assessment of child and family to request that a joint investigation be completed unless Investigative (1184) Team protocols have established a different response.
   b. Defer to law enforcement to schedule interviews if law enforcement plans to investigate the situation in cooperation with the CFS Specialist.
   c. Discuss any requested delays by Law Enforcement with the supervisor, if concerned that a delay will be unsafe for the children involved. This includes Law Enforcement requests for the CFS Specialist to have no contact with the child within the appropriate time frame based on the Priority response. Document the consultation in the N-FOCUS consultation point narrative.
   d. The CFS Specialist with the supervisor will consult with the CFS Administrator if there are concerns of child safety that CFS believes need to be addressed immediately. Based on the consultation, the CFS Administrator or supervisor may contact law enforcement with his or her concerns, consult with DHHS Legal staff, or discuss the situation with the local county attorney. Document the consultation in the N-FOCUS consultation point narrative.

J. **Gathering Information:**

1. The CFS Specialist will have face to face contact with the alleged child victim(s) within the established time frames as determined by the priority, unless requested by law enforcement to do something different. The CFS Specialist will interview each member of the household in the following order:
   a. The alleged child victim(s);
   b. Siblings and other children in the household or siblings who regularly visit;
   c. Non-maltreating parent/caretaker;

d. Other adults in the home; and
e. The alleged perpetrator.

2. If interviews cannot be conducted in this order, the CFS Specialist will clearly document the reason for variance in the N-FOCUS Contact Detail Narrative.
3. Face to face contact is required with all the children and all adults in the household to ensure a thorough assessment of safety and risk. It is possible to determine child safety without interviewing all adults in the household except for those egregious allegations when all household members need to be interviewed to determine safety.
4. In some situations, the CFS Specialist may not be able to interview everyone on the first contact with the child/family, but should make a good faith attempt to interview all parties the same day. If all interviews cannot be conducted initially the CFS Specialist must make a decision as to the child's safety based on the information they have available. The CFS Specialist must decide that the child is safe to remain in the home, or he/she must take additional action to ensure the child's safety.
5. Subsequent interviews (with others in the household) which are conducted after the CFS Specialist's initial determination of child safety will be analyzed to determine if the initial safety decision needs to be changed. If so, the CFS Specialist will complete and document a new safety assessment based on the additional information.
6. The CFS Specialist will utilize the narrative sections within the SDM safety assessment to document all supporting information regarding the decisions on each of the items.
7. Additional information gathered not related to the assessment being completed will be documented in Family Functioning narratives.
8. The CFS Specialist will observe the home environment and interactions between family members whenever possible.
9. The CFS Specialist will gather information from the non-custodial parent as a collateral contact. The non-custodial parent or relatives need to be contacted as they may be involved in the Safety Plan or considered for possible placement.
10. The non-custodial parent will be contacted as soon as possible to elicit information from him/her about their knowledge of the situation with the children and to determine the non-custodial parent's potential to be a Safety Plan participant or to care for the children should removal from the custodial parent's home be necessary.
11. The CFS Specialist will gather information from the custodial parent as a collateral contact in situations when an allegation is on the non-custodial parent.
12. Information will also be gathered about the non-custodial parent's involvement with the child, whether or not paternity has been established, legal rights if determined by a court, and parenting time schedule.
13. Information about the child's current situation may be shared with the non-custodial parent without a release of information form signed by the custodial parent. Non-custodial parents have the right to know what is happening with their children. The CFS Specialist can share basic facts about their child's situation, but should limit sharing of information about the custodial parent.
14. The CFS Specialist will gather and analyze information from sources other than the family. Written reports from law enforcement, therapists, school personnel and others will also be obtained, reviewed, and placed in the case file. For any assessment involving medical issues or where the alleged child victim is seen by a doctor or hospital, written information from medical providers will be obtained and placed in the case file.
15. The CFS Specialist will document these collateral contacts on the Family Functioning, Maltreatment Summary & Findings in N-FOCUS in chronological order. This includes noting the relationship of the individual to the case, all available contact information and the date of the contact.

16. Information gathered must be sufficient as evidenced by the following characteristics:
    a. Breadth: Is the CFS Specialist's understanding and analysis of the family based on information that covers the critical points (maltreatment, surrounding circumstances, child functioning, parenting, and adult functioning). The information gathered about the family is comprehensive;
    b. Depth: Is the CFS Specialist's understanding of the situation based on more than superficial information? Is the information pertinent and detailed?
    c. Reliable: Is the information trustworthy and dependable, reasonable, believable, and can be justified?
    d. Pertinent: Is the information relevant, significant and useful in determining the presence of safety threats or risk factors?
    e. Objective: Is the information factual, actual, and unbiased? Information exists without interpretation or value judgment;
    f. Clear: Is the information easily understood and unambiguous?
    g. Association: Does the CFS Specialist understand how the information is connected and inter-related? How the information is linked?
    h. Reconcile: Has the CFS Specialist resolved differing perspectives so that discrepancies are reconciled?
    i. Supported: Is the information confirmed or corroborated by reliable sources outside the immediate family?

III. INITIAL ASSESSMENT PROCESS.

The initial assessment is comprised of the SDM® Safety Assessment and the Initial Risk Assessment. In the case of Dependent Child cases, and Mentally Ill and Dangerous (3c) cases, the Prevention Assessment will be completed instead of the Risk Assessment.

IV. SDM HOUSEHOLDS.

A. SDM Assessments are completed on households. Do not consider employees (babysitter, nanny, etc.) to be household members. When a child's caregivers do not live together, the child may be a member of two households. If both households are involved in the report, both households should be assessed. In a situation in which multiple families share a home, consider the group to be one household if there is shared child care and/or shared access to children. For example, if two families share a house, and adults in both family groups have access to children in both families, assess the group as one household. However, if two families share a house with clear partitions of space and the ability to restrict access to children (e.g., locked doors between living area, separate entrances to the home, etc.), consider the families to comprise two separate households.

B. The CFS Specialist should keep in mind that during the course of an assessment, the number and configuration of households may change. For example, a case may begin with both parents living together with the child in the same household. At that point in time, they would be assessed as a single household, and the primary and secondary caregiver would be identified. If the parents separated while the child was in placement, and both parents were considered for reunification, then *two* assessments would become necessary, one for each household, with the legal parent as primary caregiver in each household.

There can be many family units in one household. When considering safety you assess everyone in the household.

C. **Caregivers:** The CFS Specialist should use the matrix below to assist in determining the primary and secondary caregivers.

Circumstance	Primary Caregiver	Secondary Caregiver
Two legal parents living together	Provides the most child care. May be 51% of care. • If care is divided precisely 50/50, select the alleged perpetrator. • If both are alleged perpetrators, select the caregiver contributing the most to abuse/neglect. • If there is no alleged perpetrator or both contributed equally, pick either.	The other legal parent
Single legal parent, no other adult in the household	The only parent	None
Single legal parent and any other adult living in the household	The only legal parent	Another adult in the household who contributes the most to care of the child. If none of the other adults contribute to child care, there is no secondary caregiver.
No legal parents Assess only if this household will be engaged in services or is the subject of initial assessment.	The household adult who provides the most child care.	Another adult in the household who contributes the most to care of the child. If there are no other adults, or none contributes to child care, there is no secondary caregiver.

D. When a **minor parent** is living with his/her parent and the minor parent retains legal care and custody of the child, the minor parent should be considered the primary caregiver of his/her child. The minor parent's parent may be considered a secondary caregiver of the infant/young child.

E. If both the Custodial Parent and the Non-custodial Parent have allegations of abuse or neglect the CFS Specialist will open separate households. **If there are no allegations against the non-custodial parent there is no reason to open a household to conduct SDM Assessments on the non-custodial parent.**

V. SDM SAFETY ASSESSMENT OVERVIEW.

A. The purpose of the safety assessment is to assess whether a household presents imminent **danger of serious harm** to any child, and if so, to determine what interventions should be

initiated or maintained to provide appropriate protection or if protective placement is necessary.

B. **Safety versus risk** assessment: It is important to keep in mind the difference between safety and risk when completing this assessment. The safety assessment focuses on the serious and imminent threat of harm to the child in the household and the interventions currently needed to protect the child. The risk assessment looks at the likelihood of **future** maltreatment in the next year to two years.

C. The CFS Specialist will conduct the safety assessment when a report of child abuse, neglect or dependency has been accepted for assessment. The first safety assessment is completed by the CFS Specialist assigned to conduct the initial assessment with the family. If subsequent new reports are accepted for assessment, the Service Area will develop protocols to determine if an Initial Assessment worker or the CFS Specialist responsible for the case will conduct a safety assessment. Safety reassessments are completed by the CFS Specialist responsible for the case at any time a change in safety status is noted.

D. During an initial assessment, more than one safety assessment may be required, due to changes in family circumstances. The safety assessment *process is required:*
   1. At the first face-to-face contact with the family in the initial assessment;
   2. When a new allegation of abuse or neglect involving the caregiver's household is received on an open case;
   3. Whenever new information becomes available or family conditions change; Prior to recommending case closure when the initial safety finding was unsafe or conditionally safe.

VI. <u>SAFETY ASSESSMENT PROCESS.</u>

A. The CFS Specialist will review and/or reference the safety threats during the safety assessment process and the assessment should be completed **immediately.**

B. The CFS Specialist is required to complete the initial safety assessment after same day contact with all victim(s) and parent(s). The CFS Specialist will complete one safety assessment [to be documented within 24 hours after the first contact was made with the victim(s)].

C. Additional safety assessments are only required when:
   1. There is a change in family conditions (ex: someone new moves into the home); or
   2. The original safety decision changes (safe to unsafe); or
   3. Not all victims are initially interviewed and the original safety decision changes; or
   4. A recommendation is made to close an ongoing case.

D. If the CFS Specialist was able to meet with the victim(s) but could not make contact with the parent, the CFS Specialist is required to complete a safety assessment after their contact with the victim(s). The CFS Specialist will utilize the safety assessment to determine and document the decision that the child(ren) could go home even though the CFS Specialist could not make contact with the parent until a later date. A new Safety Assessment is required on the subsequent date if the CFS Specialist gathers any **new** information that changes the safety decision. As the CFS Specialist continues to gather information that does not change the safety decision, a new safety assessment would not be required.

E. Each safety assessment is *documented* on N-FOCUS within 24 hours of the date/time the CFS Specialist makes contact with the victim(s), whether or not a Safety Plan is required. Documentation of narrative must be provided that supports and explains the rationale/reason related to child vulnerability; the existence of any safety threats; interventions; placement decisions and worker conclusions. The CFS Specialist will utilize the narrative sections within the SDM safety assessment to document this information. The safety assessment is used to guide decisions on whether or not the child may remain in the

home, the need for interventions to eliminate the threat of immediate harm, or if the child must be placed out of the home. ***A Safety Plan is required when any safety threat has been identified.***

VII. COMPLETING A SAFETY ASSESSMENT.

A. Child Vulnerabilities: The CFS Specialist will consider the vulnerability of each child throughout the assessment. Young children cannot protect themselves. For older children, the inability to protect themselves could result from diminished mental or physical capacity, or repeated victimization. The following conditions may result in a child's inability to protect self. The CFS Specialist will select all vulnerabilities that apply to any child.

1. Age 6 and under: Any child in the household is under the age of 7 years. Younger children are considered more vulnerable, as they are less verbal and less able to protect themselves from harm. Younger children also have less capacity to retain memory of events. Infants are particularly vulnerable, as they are nonverbal and completely dependent on others for care and protection.
2. Significant diagnosed medical or mental disorder that significantly impairs ability to protect self: Any child in the household who has a diagnosed medical or mental disorder that significantly impairs their ability to protect self from harm, or diagnosis may not yet be confirmed but preliminary indications are present and testing/evaluation is in process. Examples may include but are not limited to severe asthma, severe depression, severe ADHD, medically fragile (e.g., requires assistive devices to sustain life), etc. For developmental disabilities, mark the item for "diminished developmental/cognitive capacity."
3. Isolated or less visible in the community: Examples of children who are isolated or less visible in the community include but are not limited to any child of school age who is not currently enrolled in school or is enrolled but habitually absent, a child whose family lives in an isolated or remote community, a child who is not routinely involved in other activities within the community, etc.
4. Extreme allegiance to the alleged perpetrator: Any child in the household would be unable to protect him/herself or to assist others in acts of protection due to allegiance to the alleged perpetrator. Examples include children who prioritize protecting the caregiver over protecting themselves.
5. Diminished developmental/cognitive capacity: Any child in the household has diminished developmental/cognitive capacity, which impacts ability to communicate verbally or to care for and protect self from harm. Examples include but are not limited to autism, language disability, fetal alcohol effect, etc.
6. Diminished physical capacity: Any child in the household has a physical condition/disability that impacts ability to protect self from harm (e.g., cannot run away or defend self, cannot get out of the house in an emergency situation if left unattended).
7. Prior history of abuse/neglect as a victim that impacts child's ability to protect self: Any child in the household has previously been the victim of abuse or neglect AND this prior experience negatively affects that child's ability to protect him/herself in the current situation. Include either substantiated prior assessments or credible report.

B. **Section 1: Safety Threats:**

The CFS Specialist will use the definitions below to assess the following behaviors or conditions in the household that may place a child in immediate danger of serious harm. The CFS Specialist will analyze and answer each safety threat as it relates to the most vulnerable child.

1. **Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm, as indicated by any of the following:**

a. Current serious injury or abuse to the child other than accidental. Caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child (e.g., suffocating, shooting, bruises/welts, bite marks, choke marks) and requires medical treatment. Medical treatment is defined as going to a doctor or hospital. Include serious child injuries that result from domestic violence. Treatment that can be accomplished by a lay person in the home such as bandaging or icing should not be included as medical treatment. This threat is not met if the parent takes the child to the doctor/hospital but it was not necessary (such as the child has a scratch).
b. Caregiver fears he/she will physically harm the child and/or requests placement.
c. Current threat to cause serious harm or retaliate against the child. Threat of action that would result in serious harm, or household member plans to retaliate against the child for DHHS investigation or intervention.
d. Current excessive discipline or physical force. Caregiver has used torture or physical force, or has acted in a way that bears no resemblance to reasonable discipline; or he/she punished the child beyond the child's endurance. Examples include but are not limited to having the child kneel on rice or hold phone books with extended arms as punishment.
e. Drug-exposed infant. There is evidence that the mother used alcohol or other drugs during pregnancy AND this has created imminent danger to the infant.
   (1) Indicators of drug use during pregnancy include drugs found in the mother's or child's system, mother's self-report, diagnosed high risk pregnancy due to drug use, efforts on mother's part to avoid toxicology testing, withdrawal symptoms in mother or child, and pre-term labor due to drug use.
   (2) Indicators of imminent danger include the level of toxicity and/or type of drug present; the infant is diagnosed as medically fragile as a result of drug exposure; the infant suffers adverse effects from introduction of drugs during pregnancy.
f. Domestic violence likely to physically injure child. Domestic violence involves physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult. Include situations in which a child has already been injured, even if the intended victim of harm was not the child. Threat of physical harm to a child includes child behaviors that increase the risk of injury (e.g., attempting to intervene during violent dispute, participating in a violent dispute, clinging to an adult involved in the violent dispute), and the use of weapons or other instruments in a violent, threatening, and/or intimidating manner.

2. **Child sexual abuse is suspected and circumstances suggest that the child's safety may be of immediate concern.** To mark this safety threat, TWO conditions must be present: 1) suspicion and 2) circumstances. Consider the vulnerability of the alleged child victim, vulnerability of other children in the home, and the relationship of alleged perpetrator to other children in the home.

Suspicion of sexual abuse may be indicated by any of the following:	**AND** An immediate concern for child safety may be characterized or indicated by the following:
• The child discloses sexual abuse either verbally or behaviorally (e.g., age-inappropriate sexualized behavior toward self or others).	• Non-offending caregiver has expressed disbelief that sexual abuse occurred and appears unable or unwilling to prevent access to child by alleged perpetrator.

• Medical findings are consistent with molestation. • A possible or confirmed sexual perpetrator has access to any child in the household. Include any person (household member or not) who has been convicted, investigated, or accused of any sexual crime, or who has had other sexual contact with any child. • Caregiver or another household member has forced or encouraged any child in the household to engage in or observe sexual performances or activities.	• Alleged perpetrator refuses to leave the home or limit contact with alleged victim and siblings. • Child expresses fear that maltreatment will recur.

3. **Caregiver does not/is unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.** The CFS Specialist will select this threat when there is current harm or an identified current threat of harm to a child **and** the caregiver does not take action.

Current harm or an identified threat may be indicated by the following: • An alleged perpetrator of abuse who is not the caregiver. • An individual with known violent criminal behavior/history resides in the home, or caregiver allows access to the child. Caregiver may or may not know about the individual's history. • Include homes where gang activity occurs or where there is criminal activity in the home.	**AND** Caregiver does not or is unable to protect the child from serious harm or threatened harm by other family members, other household members, or others having access to the child. Caregiver does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age, emotional or physical disability, or developmental stage.

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

Evidence of questionable or inconsistent explanation includes the following: • Medical evaluation indicates that the injury is a result of abuse; however, caregiver denies, or attributes injury to accidental causes. • Caregiver's explanation for the observed injury is inconsistent with the type of injury. • Caregiver's description of the injury or cause of the injury minimizes the extent of harm to the child. • Caregiver does not or cannot explain injury when there is a reasonable expectation that the caregiver should	**AND** When determining if the nature of the injury suggests that safety is of immediate concern, consider the vulnerability of the child, location and/or severity of injury, physical or emotional disability of the child, and chronicity of injuries.

know (e.g., caregiver is sole person caring for the infant; caregiver states that child has not been out of his/her supervision during time that injury occurred).	

5. **The family actively impedes assessment by denying access to the child, coercing or coaching the child, or fleeing with the child.** Do not include families who are uncooperative or non-compliant with assessment requests and/or court orders or a caregiver who is uncooperative with safety planning. In such cases, consider other threats to child safety.
   a. Family currently refuses or does not provide access to the child, or cannot or will not provide the child's location.
   b. Family has removed the child from a hospital against medical advice to avoid assessment/investigation.
   c. Family has previously fled in response to a CPS investigation, or has previously fled with a child during visitation.
   d. Family has a history of keeping the child at home or away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding assessment.
   e. Caregiver intentionally coaches or coerces the child or allows others to coach or coerce the child in an effort to hinder the assessment.

   If the family will not allow the CFS Specialist to see the child at all or if the family coaches the child to give false information, the threat is present.

   The threat is NOT present if:
   a. The caregiver denies that maltreatment is occurring (despite evidence to the contrary);
   b. The caregiver is reluctant to allow the child to be interviewed but relents during the contact and permits it;
   c. The caregiver refuses to allow the CFS Specialist to take a follicle sample for testing;
   d. The caregiver refuses to participate in safety planning regarding another safety threat;
   e. The caregiver repeatedly delays efforts to contact and/or evaluate the family but the child is seen.

6. **Caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care. Needs may be basic or exceptional.**
   a. Caregiver does not attend to the child to the extent that the need for care goes unnoticed or unmet (e.g., caregiver is present but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).
   b. Caregiver leaves the child alone (time period varies with age, physical or emotional disability, and developmental stage).
   c. Caregiver makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.
   d. Minimal nutritional, clothing, and/or supervisory needs of the child are not met, resulting in danger to the child's health and/or safety.
   e. Child appears malnourished (e.g., child is listless and has difficulty concentrating; child or caregiver discloses inadequate nutritional practices).

f. The child is without minimally acceptable clothing for the weather and environment.
g. Caregiver does not seek treatment for the child's immediate, chronic, and/or dangerous medical/mental health condition(s) or does not follow prescribed treatment for such conditions, and lack of treatment presents an imminent and serious threat to child safety.
h. The child has exceptional needs, such as being medically fragile, which caregiver does not or cannot meet.
i. The child is violent, assaultive, or suicidal and caregiver will not/cannot take protective action.
j. The child shows effects of maltreatment such as serious emotional symptoms, lack of behavioral control, or serious physical symptoms.

Situations of abandonment or desertion are included in safety threat 7 and should not be marked as part of item 6.

7. **Caregiver is not available, is unwilling to provide care, or has deserted the child.** Examples of desertion include but are not limited to the following:
   a. Caregiver is unavailable (incarceration, hospitalization, abandonment, whereabouts unknown).
   b. The caregiver left a child unattended, the child is unable to identify him/herself, and there is no evidence with which to identify the child's family.
   c. The caregiver left the child unattended or in the temporary care of an adult caregiver, and it is not known where the caregiver is or if the caregiver will return.
   d. There is evidence that the caregiver will no longer parent and will not assume further responsibility for the child (e.g., does not pick up child who is ready to be discharged from hospital or juvenile detention, the caregiver demands a child removal, child "evicted" from family home). For whatever reason, the parent ceases parental responsibilities.

   This threat does not include educational neglect.

8. **The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.** Based on the child's vulnerability, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:
   a. Leaking gas from stove or heating unit;
   b. Substances or objects accessible to the child that may endanger his/her health and/or safety (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities; unsecured weapons);
   c. Lack of water or utilities (heat, plumbing, electricity), and no alternate, safe provisions are made;
   d. Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows;
   e. Exposed electrical wires;
   f. Excessive garbage or rotted or spoiled food that threatens health;
   g. Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites, severe infestation of pests including cockroaches and bedbugs causing negative medical/health effects);
   h. Evidence of human or animal waste throughout living quarters.

9. **Child shows signs of significant emotional harm that present an imminent threat to child safety <u>and</u> concerning caregiver behaviors are currently present.**
   Note: Child behaviors that indicate mental health or disability concerns that are not being addressed should be addressed under safety threat 6.

Indicators of significant emotional harm to the child include the following:
• The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations in household.
• The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of conditions in the home.
• Child is a danger to self or others, is acting out aggressively, is suicidal, or otherwise exhibits severe emotional disturbance.
	AND Examples of caregiver behaviors include the following (indicate all that apply):
	• <u>Domestic violence among adults is present in the household.</u> Domestic violence may involve physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult.
	• <u>Caregiver behavior towards the child.</u> The caregiver may do any of the following:
	  • Describe the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly);
	  • Curse at the child and/or repeatedly put the child down;
	  • Scapegoat a particular child in the family;
	  • Blame the child for a particular incident or for family problems;
	  • Place the child in the middle of a custody battle; or
	  • Choose his/her own relationships with an intimate partner above child's emotional safety.

10. **Child behaviors place the child at imminent threat of serious harm, in spite of appropriate response by caregiver(s).**
    To mark this threat, all three of the following conditions **<u>must</u>** be present:

The child is currently engaging in or habitually engages in behaviors that place him/her at imminent risk of serious harm. Examples include but are not limited to children who run away from home and place themselves in unsafe living/sleeping situations, children who engage in prostitution, and children who engage in self-harming behaviors, such as cutting,	**AND** The child's caregiver(s) have responded appropriately and made reasonable efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child, and increasing direct supervision and monitoring of the child.	**AND** The caregiver's current efforts, although appropriate, are insufficient to prevent the child from engaging in the behavior in the future.

that require medical intervention.		

11. **There is a pattern of prior CPS investigations of household members as alleged perpetrators, protective placements, or caregiver behavior <u>and</u> current circumstances are near the definition for any other safety threat.**

A pattern may be established by any of the following: • Prior death of a child as a result of action or inaction of current household members. • Prior serious harm to a child: Previous maltreatment by caregiver or other household adult that was serious enough to cause severe injury (e.g., fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks, and/or physical findings consistent with sexual abuse based on medical exam). • Termination of parental rights: Caregiver had parental rights terminated as a result of a prior CPS investigation. • Prior removal of the child from caregiver: Removal/placement of the child by DHHS or other responsible party was necessary for the safety of the child. • Prior CPS substantiation: Prior CPS investigation involving current household adults substantiated for maltreatment. • A pattern of unsubstantiated CPS investigations for any household adult. • Prior threat of serious harm to child by any household adult: Previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against the child for previous incidents; or prior domestic violence that resulted in serious harm or threatened harm to a child. • Prior service failure: Caregiver previously failed to successfully complete court-ordered or previously recommended services.	**AND** Current circumstances are concerning, but not sufficiently imminent or serious to warrant the marking of another safety threat. Examples include but are not limited to the following: • Child has a physical injury that is not serious or that does not warrant medical attention. • Child sometimes does not have sufficient nutrition, but malnourishment is not yet a concern.

12. **Other.** If, after careful review of the definitions for the other 11 safety threats, the CFS Specialist feels there is something unique in this family that was not captured in any

other safety threat, the CFS Specialist should select "other" and document the identified unique safety threat that, if not resolved immediately, would lead to removal of a child in this home. When methamphetamine or heroin use by the parent or caregiver has been identified, the CFS Specialist will utilize this safety threat.

If the CFS Specialist is unable to identify the perpetrator and there is a severe injury, there is an active safety threat. The CFS Specialist should start to rule out people that they know did not cause the injury and then safety plan from there.

Safety Assessment decisions are based on what the CFS Specialist knows at a point in time, so the CFS Specialist will make the best informed decision they can with the information they have available to them. Safety decisions can/may change as more information becomes available.

C. **Section 2: Safety Interventions:**

A. If no safety threats are present, the CFS Specialist can proceed to the Decision Section of the Safety Assessment. The CFS Specialist will complete Section 2 – Safety Interventions whenever one or more safety threats are present. For each safety threat identified, the CFS Specialist will consider the resources available in the family and the community that might help to keep the child safe. This section is intended to assist the family and the CFS Specialist in developing a strategy to allow a child to remain safely in the home.

B. Safety interventions are actions that will be taken by the family to allow the child to remain safely in the home. The interventions, either singly or in combination/sequence, will allow a Safety Plan to be written that will adequately and effectively mitigate all identified safety threats.

C. The process of writing a Safety Plan and selecting safety interventions should be a collaboration between the CFS Specialist and the family, starting with consideration of the least intrusive interventions that make use of the family's strengths, and ending with a plan that is both feasible and effective while taking into account the family's view.

D. The CFS Specialist will identify all types of safety interventions that will be implemented. If there are no available safety interventions that would allow the child to remain in the home, the CFS Specialist will indicate the need for protective placement.

E. **Interventions that utilize family strengths:**
Interventions marked with an asterisk (*) **must** be combined with frequent monitoring and oversight by the CFS Specialist or a person who has passed suitability.

a. **Use of family, kin, neighbors or other individuals in the community as safety resources.** Applying the family's strengths as resources to mitigate safety concerns, or using extended family members, kin, neighbors, or other individual to mitigate safety concerns. Examples include engaging a grandparent to assist with child care; agreement by a neighbor to serve as a safety net for an older child; commitment by 12-step sponsor to meet with caregiver daily and call the CFS Specialist if caregiver has used or missed a meeting; or caregiver's decision that the child will spend a night, a few days, or the duration of the initial assessment with a friend or relative/kin. An Assessment of Safety Plan Participants is REQUIRED for each person who will be engaged in this safety intervention.

b. ***The caregiver will appropriately protect the child from the alleged perpetrator.**
A non-offending caregiver has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator. Examples include agreeing that the child will not be left alone with alleged perpetrator or preventing alleged perpetrator from physically disciplining the child. When there are concerns about

the non-offending caregiver, this intervention should be used in combination with other interventions and increased monitoring of the Safety Plan.

c. ***The non-offending caregiver will move to a safe environment with the child.**
A caregiver not suspected of harming the child has taken or plans to take the child to an alternate location where the alleged perpetrator will not have access to the child. Examples include a domestic violence shelter, the home of a friend or relative, or a hotel.

d. ***The alleged perpetrator will leave the home, either voluntarily or in response to legal action.**
Another caregiver is available and the alleged perpetrator will be temporarily or permanently removed from the home. Examples include non-perpetrating caregiver "kicking out" alleged perpetrator who has no legal right to residence, or perpetrator agreeing to leave. When there are concerns about the reliability of either caregiver or perpetrator, this intervention should be used in combination with other interventions and increased monitoring of the Safety Plan.

F. **Intervention's that utilize community and agency resources:**

a. **Intervention or direct services by worker.**
Actions taken or planned by the CFS Specialist that specifically address one or more safety threats. Examples include providing information about nonviolent disciplinary methods, child development needs, or parenting practices; providing emergency material aid such as food; and advocacy and support in obtaining restraining orders. DOES NOT INCLUDE the assessment itself or services provided to respond to family needs that do not directly affect safety.

b. **Use of community agencies or services as safety resources.**
Involving a community-based organization, faith-related organization, or other agency in activities to address safety concerns, e.g., using a local food pantry, community mental health crisis intervention. DOES NOT INCLUDE long-term therapy or treatment or being put on a waiting list for services.

c. **Legal action planned or initiated; the child may remain in the home.**
A legal action has already commenced or will commence that effectively mitigates identified safety concerns. This includes family-initiated (e.g., restraining orders, protection orders, mental health commitments, change in custody/visitation/guardianship) and/or DHHS/agency-initiated (file petition and the child remains in the home) actions. When there are concerns about enforcement, this intervention should be combined with another intervention.

d. **Other.** The family and/or CFS Specialist identified a unique intervention for an identified safety concern that does not fit within the items above, and this intervention allows child(ren) to return to the home or remain in the home.

G. **Intervention to remove a child from the home is necessary to adequately ensure the child's safety.**
Indicate the removal action taken:

a. The parent or legal guardian has chosen to utilize an Informal Living Arrangement;
b. Request emergency protective custody;
c. Other court action.

D. **Safety Decision:**
The safety decision is the result of careful consideration of the safety threats present and any available safety interventions taken or immediately planned by the family, community partners, or agency to protect the child. The CFS Specialist will identify the safety decision based on the CFS Specialist's independent assessment of all safety threats, safety

interventions, and any other information known about the case.
The CFS Specialist will determine if the child is:

1. **Safe.** No safety threats were identified at this time. Based on currently available information, there are no children likely to be in imminent danger of serious harm.
2. **Conditionally safe.** One or more safety threats are present, and protective safety interventions have been identified and agreed to by caregiver(s). An in-home Safety Plan is required.
3. **Unsafe.** One or more safety threats are present, and an out-of-home placement is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in imminent danger of serious harm. An out-of-home Safety Plan is required.

E. **Informal Living Arrangement:** Informal Living Arrangement is a safety intervention that can be considered when the child has been determined unsafe. The child's living arrangement is considered to be an Informal Living Arrangement, when the parent has made arrangements prior to or during CFS involvement for a temporary and alternative place for their child to reside until child safety can be managed in the parental home.

A. Informal Living Arrangements should be for a temporary period of time that is agreed upon by the parent and temporary alternative caregiver.
B. There are two types of Informal Living Arrangements:
   1. The first type of Informal Living Arrangement is when the parent arranges for a temporary alternative caretaker to care for the child due to the parent's hospitalization, incarceration or other situation resulting in the parent being unable to care for the child prior to any CFS involvement. Subsequently CFS becomes involved based on the report of child abuse or neglect accepted for assessment. In these situations, the CFS Specialist should follow the steps described below in item #3a-i to approve the living arrangement.
   2. The second type of Informal Living Arrangement occurs when there is a child abuse or neglect report and CFS accepts the intake for assessment. Completion of the safety assessment indicates that the child(ren) cannot safely remain in the parental home. The CFS Specialist will ask the parent if there are any individual(s), including the non-custodial parent, relatives, and others known to the child(ren) who the parent could contact to make temporary placement arrangements for the child(ren).
C. The CFS Specialist will assist the parent, if needed, in contacting individuals identified that may help care for the child(ren). The CFS Specialist must complete an assessment of the potential temporary alternative caregivers to determine that there are no safety concerns if the child(ren) should reside with them.
   a. The CFS Specialist will assess the parent's level of agreement to cooperate with a plan for the child(ren) to temporarily reside out of the home. Once the parent has made an informal living arrangement, the CFS Specialist will take the following steps in order to approve this arrangement. The CFS Specialist will:
   b. Advise the parent that DCFS does not consider this foster care, and therefore, the parent is still legally and financially responsible for the child(ren).
   c. Advise the informal living caretaker that DCFS does not consider this foster care.
   d. Complete the Suitability of Safety Plan Participant Form for every adult in the proposed caretaker's home.
   e. Encourage the parent to provide a consent for the temporary alternative caretaker to obtain medical care and assist with meeting the educational needs of the child(ren).
   f. Document the child is "Unsafe" based on SDM Safety Assessment, and complete the Out of Home Safety Plan.

g. Document the Safety Plan and Risk or Prevention Assessment and document an "Approved Living Arrangement" on N-FOCUS.
h. Designate the child's legal status as "Non-Court Involved Child"; and
i. Develop guidelines within the Safety Plan for parent and child contact.

D. Families whose children are placed on a 48 hour hold by Law Enforcement cannot utilize the Informal Living Arrangement.

E. When the parent and child leave the parental home together to reside elsewhere, the CFS Specialist will take the following steps:
   a. Talk with the proposed caretaker to verify that s/he is willing and able to have the parent and child reside in his/her home;
   b. Advise the parent and the proposed caretaker that CFS does not consider this foster care and therefore, the parent is still financially responsible for the child(ren);
   c. Complete the Suitability of Safety Plan Participant Form for every adult in the proposed caretaker's home;
   d. Document the child is "Conditionally Safe" and complete the In Home Safety Plan. The child is "Conditionally Safe" because they remain with the parent who has a plan to keep their child safe, even though the family may temporarily not be residing in the parental home;
   e. Document the Safety Plan and Risk or Prevention Assessment on N-FOCUS; and
   f. Designate the child's legal status as "Non-Court Involved Child".

F. **Safety Concerns:**
   A. At the initial contact and every subsequent contact with the family, CFS Specialists must recognize immediate safety concerns. The CFS Specialist must start with a review of child vulnerabilities. No child is responsible for creating safety, but some children may have limited capacity to ask for help or escape maltreatment.
   B. The CFS Specialist will then consider threats to safety. When the CFS Specialist identifies a threat to safety using the definitions on the safety assessment, there is imminent risk of serious harm to a child, the CFS Specialist cannot leave the home without taking action to ensure the child will be safe.
   C. When safety threats are identified, the CFS Specialist must assess the parent's ability to protect the child and consider if any safety interventions will keep the child safe in the home. The safety decision is the interaction of threats and interventions. If the family and CFS Specialist can develop and implement a Safety Plan that will keep the child safe from the identified threats, the child is conditionally safe and may remain in the home. The CFS Specialist must follow up and monitor the family to ensure that the Safety Plan is followed.
   D. If safety threats are identified and no interventions are possible, the child is unsafe and must be **placed in out of home care.**

VIII. REASSESSING SAFETY.

A. Assessing child safety is a critical consideration throughout DCFS involvement with the family. Consideration of safety threats must be incorporated as part of each contact with the family. After the first safety assessment is completed, subsequent safety assessments will be completed whenever there is a change in the family's circumstances to determine if this poses a safety concern and the need for possible protective interventions. If the case will be closed, the CFS Specialist must document how all identified safety threats were resolved.

B. A new Safety Assessment is required on any subsequent day if the CFS Specialist gathers any new information that changes the safety decision. (I.e., if the CFS Specialist identifies a threat that was not apparent from their conversation with the child previously). As the CFS Specialist continues to gather information and the safety decision does not change, the

additional information gathered would be added and documented in the Family Functioning narrative section, but a new Safety Plan is not required.

IX. SAFETY PLAN.

A. When a safety threat is identified, a Safety Plan must be developed immediately. The CFS Specialist cannot leave the home without developing a Safety Plan if there are identified safety threats. The Safety Plan must document:
   1. The specific interventions that will be put in place immediately to ensure child safety in or out of the home;
   2. The person(s) responsible for monitoring compliance with the Safety Plan; and
   3. The anticipated completion date.

B. The Safety Plan must control and manage the identified safety threats and use the least intrusive services.

C. The Safety Plan is not intended to be a long-term solution to the household's needs, but rather a strategy for the short-term stabilization of the household to allow a child to safely remain/return home.

D. The Safety Plan must be implemented and active as long as threats to child safety exist and parents are unable to assure a child is protected.

E. Safety Plans may serve as the case plan during the initial safety assessment period, but there must always be a case plan developed.

F. The CFS Specialist must explore alternatives with law enforcement and the family to identify a Safety Plan that will be sufficient to assure the child's safety without removal from the home or family whenever possible. Removing a child from their home will be the last option, when it has been determined that there are no interventions available that can maintain the child safely in the home. At that point, the child is determined to be unsafe and action needs to be taken to place the child in protective custody for placement outside the home.

G. A Safety Plan must be completed in all cases in which a child is unsafe or conditionally safe. The Safety Plan must:
   a. Control or manage safety threats;
   b. Have an immediate effect;
   c. Be immediately available and accessible to the parents, child(ren), and Safety Plan participants;
   d. Have supports and services that have the immediate effect of controlling for identified threats;
   e. Be agreed upon by the parents, participants, and CFS Specialist as indicated by their signature on the Safety Plan; and
   f. Be monitored by the CFS Specialist.

H. When an In-Home Safety Plan is in place, the CFS Specialist will have face-to-face contact with the parent(s) and children no less than once a week, until the case plan is written and implemented.

I. Safety Plans for children in out of home care should address how safety will be monitored when the children are on visits with the biological parents; level of supervision; parent contact with the child outside of visits; etc.

J. Safety Planning always begins with the involvement of the parent/caregivers. Parents/Caregivers are important resources for contributing to the development of the Safety Plan. This does not mean parents/caregivers are responsible for the Safety Plan, nor do they have to agree that the Safety Plan that is created is the most suitable to them. The

CFS Specialist is responsible for the safety of the child. If the CFS Specialist and the family cannot develop and agree upon an appropriate in-home Safety Plan the CFS Specialist must:

1. Contact his/her supervisor about next steps; and
2. Contact law enforcement to discuss protective custody; and/or contact the County Attorney's office to discuss court ordered custody.

K. While the parents/caregivers do have a choice about whether or not to participate voluntarily with Safety Planning, they do not have a choice about whether some action will be taken to assure a child will be protected.

L. The CFS Specialist must consult with a supervisor as a mandatory consultation point when a safety threat is identified and a Safety Plan is necessary. Consultation must occur no later than one hour after the Safety Plan is initiated.

M. The Safety Plan must be completed with the family and documented on the SDM Safety Plan form and a copy left with the family. N-FOCUS documentation of the SDM Safety Plan must be made within 24 clock hours of determining that a Safety Plan is needed. The CFS Specialist will utilize the narrative sections within the Safety Plan to document all supporting information regarding all sections of the Safety Plan.

N. The Safety Plan is written at a point in time. It is not the final word in keeping a child safe. A Safety Plan should be in effect for no longer than a month at which time must be reevaluated to determine if the plan needs to be revised in any way.

O. The CFS Specialist will need to return to the home to reassess the viability of the Safety Plan at least weekly. The CFS Specialist will want to reduce the amount of assistance provided by others (both formal and informal supports) and increase the amount of safety provided by the parent/caregiver as parental capacity increases.

P. The CFS Specialist will ask the participants (and other collaterals) if any of the tasks can be removed or transferred to the parent/caregiver while maintaining child safety. As the CFS Specialist transfers these tasks there may be a need to increase the monitoring for a period of time. The Safety Plan should be allowed to evolve to the point that the family no longer needs a Safety Plan in order to achieve child safety.

Q. When reassessing for child safety, the CFS Specialist must assess the family as if none of the interventions are in place. The goal is to answer the question of whether a child is at imminent threat of serious harm in this household without interventions. Decisions and discussion regarding the re-evaluation of the Safety Plan must be documented in N-FOCUS in the Safety Plan Progress Narrative section.

X. UNCOPE.

The UNCOPE is a six item brief screening tool used to identify individuals who are at risk of substance addiction. The tool was developed in 1999 by Norman Hoffman, Ph.D.

A. The UNCOPE screening process does not drive safety and risk determinations. It is a stand-alone process to assist the CFS Specialist with gathering additional information about the family and about issues that may be contributing to child maltreatment or risk of maltreatment.

B. Information needed to utilize UNCOPE will be gathered during interviews with the family, collateral interviews, observations and review of records (i.e. law enforcement reports). The CFS Specialist will answer each question based on the information gathered. If the CFS Specialist receives conflicting information, the CFS Specialist must reconcile the information

by assessing the reliability and validity of the information and make a decision based on that analysis.

C. The CFS Specialist will complete the UNCOPE screening tool during the initial safety and risk assessment period on all household adults in child abuse and neglect accepted intakes.
D. A score of 2 or more on the UNCOPE tool means the individual(s) should be referred for a formal assessment or evaluation to determine if he/she would benefit from substance abuse treatment.
E. The CFS Specialist will discuss the findings of the UNCOPE screening and recommend further evaluation of the individual's substance use for individuals who are determined to be low or moderate risk on the SDM risk assessment tools. The CFS Specialist will provide information about available services in the community to access this evaluation.
F. The CFS Specialist will discuss the findings of the screening and request further evaluation for individuals whose household risk level is high or very high with an UNCOPE score of 2 or more when:
    a. Substance use was a factor in the intake findings;
    b. Substance use was a factor in any maltreatment;
    c. Substance use was a factor in any identified safety threat; or
    d. The individual scored higher than zero on the substance abuse related questions on the SDM Risk Assessment (R12 and R13).
G. The CFS Specialist will provide resource information and assist the individual in locating an appropriate affordable clinical/agency to complete the substance abuse evaluation, including referrals to the Division of Behavioral Health if the individual is identified to within a priority population for an expedited assessment..
H. The CFS Specialist will document the UNCOPE on N-FOCUS within 30 days of the Intake being accepted for assessment. Documentation of narrative must support and explain the rationale/reason for each of the questions in the UNCOPE.

XI. ASSESSMENT OF PLACEMENT SAFETY & SUITABILITY OVERVIEW.

A. SDM Assessment of Placement Safety and Suitability (APSS) is the tool that is used to assess safety and care concerns of a child in a foster home placement. Foster home placements include agency based, traditional, relative, Developmental Disabilities (DD) Family homes, or adoptive homes.
B. The process for completion of the APSS will be consistent across the state. Individual Service Areas may assign staff to complete the APSS, based on Service Area needs and resources.
C. The APSS is to be used when an Intake report with allegations of abuse or neglect is accepted on a licensed or approved foster home where foster children are placed. Refer to the Program Guidance Memo on Placement Concerns for Intake reports not accepted for assessment on a foster home regarding the care of the foster children.
D. The APSS will be completed by staff in the service area in which the foster or approved home is located, even though there may be children placed in the home from other Service Areas.
E. The CFS Specialists will share any information they may have about the child and the home with the CFS Specialist completing the assessment.
F. The APSS will not be used for:
    1. Congregate care placements (i.e., group homes and institutions); or
    2. Foster homes with no current placement and the allegation relates to a former foster child in their care.
G. The CFS Specialist will investigate alleged maltreatment reported in congregate care placements and foster homes with allegations of abuse or neglect specific to a former foster

child in their care as an Out of Home Care Assessment. The Organization Related Investigation on N-FOCUS will be used to assess and document complaints on these types of homes and facilities. This is also known as the Out-of-Home Care Assessment.

H. The APSS is not used for investigations of allegations of abuse or neglect in a facility. For those intakes, the Out of Home Assessment will be completed. The assigned worker will coordinate with the Licensure Unit, Medicaid, Managed Care Providers and Developmental Disabilities divisions as appropriate. The Out of Home Assessment will be documented using the Organization Related Investigation icon on N-FOCUS.

I. The CFS Specialist will conduct an investigation if the Intake report contains allegations of abuse or neglect. If there are no allegations of abuse or neglect in the Intake the Intake will be screened for placement concerns. Care concerns will be reviewed by DCFS Resource Development staff or Child Placing Agency Contractors.

J. There will be communication and collaboration between the assigned CFS Specialist, any ongoing CFS Specialists, and the child placing agency staff supporting the placement.

K. Completion of the APSS is accomplished in two parts. Information gathered must be comprehensive so that both parts of the assessment can be completed accurately.
   1. The investigation component must be completed to determine if there was maltreatment, which is important in assessing safety and risk, and so the appropriate case status determination or finding can be made.
   2. The second part is completion of the APSS and consideration of the placement decision.

L. The APSS looks at possible safety threats to the child in placement. Placement resources are held to a higher standard of care than a parental home. A situation in the foster home does not have to rise to the level of a safety threat before an intervention is put in place. The APSS placement decision guides the CFS Specialist to the final decision of assuring safety and suitability of the placement for the child. If a safety threat is identified, the CFS Specialist assigned will assess if an intervention can be implemented. The placement decision is based on identified safety threats and available interventions.

M. The APSS will be documented in N-FOCUS on the Organization in Home Details by completing the SDM Assessment for Placement Safety and Suitability. Family Functioning Narratives are available for documentation for Intakes with allegations, but can also be used for documentation by other CFS Specialist and Resource Development (RD) staff cooperating with the assigned worker while the case is in draft status. Documentation must support and explain the rationale/reason for each of the questions in the APSS.

N. The CFS Specialist completing the APSS assessment will take the lead in completing the investigation of abuse/neglect allegations and will collaborate with the assigned ongoing CFS Specialist (s), RD staff and child placing agency staff supporting the placement.

XII. APSS PROCESS.

A. Accepted Intakes must have initial face-to-face contact within the time frame established based on the priority of the intake.
   1. The APSS will be documented on N-FOCUS within 30 days from the date the Intake was Accepted for Placement Assessment.
   2. The APSS must be closed no more than 30 calendar days from the date the service area was notified of the report by the Hotline. If a subsequent Intake is accepted within the 30 day time frame the CFS Specialist, in consultation with the CFS Supervisor will determine whether to include the information and decisions in the current APSS OR to conduct a new APSS because of the case circumstances. The 30 day time frame is not extended if a subsequent accepted Intake is received and included in the original Intake.

B. The CFS Specialist will familiarize themselves with the items in the placement safety and suitability assessment and the accompanying definitions. Use of the APSS ensures that every

CFS Specialist is assessing the same items when considering the safety and suitability of a placement, and that the responses to these items lead to specific decisions. Once a CFS Specialist is familiar with the items that must be assessed to complete the APSS, the CFS Specialist will conduct his/her first contact as he/she normally would, using good social work practice to collect information from the child, care provider, and/or collateral sources.

C. The CFS Specialists will begin the APSS by considering and identifying child vulnerabilities. These vulnerabilities are described in the Safety Assessment.

D. All individuals in the household have to be interviewed as part of the APSS. If all interviews cannot be conducted initially and the APSS is finalized, the CFS Specialist will need to document a subsequent APSS if new information, based on subsequent interviews with the other household members, indicates that the previous child safety determination must be changed.

E. Safety concerns must be assessed by every CFS Specialist in every investigation of alleged abuse/neglect in a placement, or when concerns for safety are raised related to the behavior among children in the home or any other change in the household. These concerns cover the kinds of conditions that, should they exist, would render a child in danger of harm. Because not every conceivable concern can be anticipated or listed, an "other" category permits a CFS Specialist to indicate that some other circumstance creates a concern for the safety or appropriate care of a child; that is, there is something other than the listed categories causing the CFS Specialist to believe that the child is in danger of being harmed.

F. The CFS Specialist will determine if the information gathered results in a reason to believe that a concern related to child safety or care is present for any foster/adoptive child currently residing in the household. The CFS Specialist should rely on information available at the time of the assessment. The CFS Specialist will make every effort to obtain sufficient information to assess these items during the first contact with the family.

G. It is expected that not all facts about a case can be known immediately. Some information is inaccessible, and some can be deliberately hidden from the CFS Specialist. Based on reasonable efforts to obtain information necessary to respond to each item, the CFS Specialist will review each of the concerns and accompanying definitions.

H. The APSS will be documented in N-FOCUS in the Organization by selecting the Home Details push bar and then selecting the SDM Assessment for Placement Safety & Suitability icon.
   1. Information regarding the maltreatment will be documented under the APSS Family Functioning narrative Subject Area of "Maltreatment" in the item area of "Circumstances surrounding maltreatment".

I. For each item, the CFS Specialist will consider all children in the home. If the concern is present, based on available information, the CFS Specialist will mark that item. When the CFS Specialist identifies a concern that is not described by one of the existing items, the CFS Specialist should mark "other," and briefly describe the concern.

J. The CFS Specialist will document all required information in the APSS to support the safety, suitability and care decisions. Every APSS is documented on N-FOCUS whether or not an Intervention Plan is required. Documentation of narrative must be provided that supports and explains the rational or reason for decisions on each of the items.

XIII. COMPLETING THE APSS.

A. **Section 1A: Safety Concerns** – Safety concerns are circumstances in the placement that make a child less safe. They may or may not rise to the level of being a safety threat, but, because the child is in state custody, would represent a reason to consider changing the placement if the concern cannot be contained through a plan to increase safety.
   1. **Care provider caused physical harm to the child or made a plausible threat to cause physical harm in the current incident, as indicated by any of the following:**

a. Any non-accidental injury or abuse to any child in the household.
b. Care provider fears he/she will physically harm the child and/or requests removal.
c. Threat to cause harm or retaliate against the child: Threat of action that could result in harm, or plans to retaliate against the child for CPS investigation.
d. Excessive discipline: Care provider has acted in a way that bears no resemblance to appropriate discipline, considering the previous experiences of child. Consider any discipline that is not in compliance with DHHS or agency policy.
e. Use of physical force or corporal punishment.

2. **Current circumstances, combined with prior allegations of abuse/neglect and/or incident reports, suggest that the child's safety may be of immediate concern.** There must be both current concerns **and** related previous allegations/incidents that represent an emerging or unresolved pattern.

Current circumstances include any behaviors or conditions that diminish child safety without rising to the level of concern as defined here. Examples include but are not limited to the following: • Child sometimes does not have sufficient nutrition, but malnourishment is not yet a concern. • Child sometimes has imperfect hygiene that does not rise to the level of a concern.	**AND** Previous incidents may include any of the following: • Prior incident reports, including any licensing complaints or citations. • Prior referrals of abuse/neglect to the child. • Evidence of prior unreported injuries or incidents.

3. **Child sexual abuse is suspected and circumstances suggest that the child's safety may be of immediate concern.** To select this threat, two conditions must be present: suspicion and circumstances.

Suspicion of sexual abuse may be based on indicators such as the following: • The child discloses sexual abuse either verbally or behaviorally (e.g., age-inappropriate, sexualized behavior toward self or others). • Medical findings consistent with sexual abuse. • Care provider or others in household have been convicted, investigated, or accused of sexual misconduct with the child. • Indications of poorly defined or questionable sexual boundaries between household members, and/or care provider engages in or permits other household members to engage in behaviors that infringe upon appropriate sexual	**AND** • Access to the child by possible or confirmed sexual abuse perpetrator exists.

boundaries. Based on age, gender, and developmental status of household members, examples of inappropriate and/or poorly defined sexual boundaries may include such things as non-gender-specific sleeping arrangements or showering/bathing practices, exposure to nudity or sexually explicit materials, etc.	

4. **Care provider does not/is unable to protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, neglect, or emotional abuse.** The CFS Specialist will select this item when there is current harm or an identified current threat of harm to a child **and** the care provider does not take action.

Current harm or an identified threat may be indicated by the following: • An individual(s) with known violent criminal behavior/history resides in the household or frequents the home, and care provider allows access to the child. • The care provider does not or cannot comply with orders to prevent contact between the child and birth parent or other family members. • Include homes where gang activity occurs or where there is criminal activity in the home.	**AND** Care provider does not/is unable to protect the child from harm or threatened harm as a result of physical abuse, neglect, sexual abuse, or emotional abuse by other family members, other household members, or others having regular access to the child. Based on the child's age or developmental stage, care provider does not provide supervision necessary to protect the child from potential harm by others.

5. **Care provider's explanation for the injury to the child is questionable or inconsistent with the type of injury.** Factors to consider include age and vulnerability of the child, location of injury, exceptional needs of the child and chronicity of injuries.
   a. Medical evaluation indicates injury is consistent with abuse; care provider denies, or attributes injury to accidental causes.
   b. Care provider's explanation for the observed injury is inconsistent with the type of injury.
   c. Care provider's description of the injury or cause of the injury minimizes the extent of harm to the child.

6. **Care provider actively impedes assessment by denying access to the child, coercing or coaching the child, or fleeing with the child.** Do not include care providers who are uncooperative or non-compliant with assessment requests and/or court orders or if the care provider is uncooperative with safety planning. In such cases, consider other safety concerns.
   a. Care provider currently hinders or refuses access to the child.
   b. Care provider has removed the child from a hospital against medical advice.

c. Care provider keeps the child at home, away from peers, school, and other outsiders for extended periods of time.
d. Care provider intentionally coaches or coerces the child, or allows others to coach or coerce the child, in an effort to hinder the investigation.

7. **Care provider does not, cannot, or will not meet the child's need for supervision, food, clothing, and/or medical or mental health care.**
Note: If the care provider's limitations in this regard are directly related to substance abuse, select item 8.
   a. Care provider does not attend to the child to the extent that the child's need for care goes unnoticed or unmet (e.g., care provider is present but the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).
   b. Care provider leaves the child alone (time period varies with age, developmental state, and vulnerability).
   c. Care provider is unavailable (e.g., incarceration, hospitalization, abandonment, whereabouts unknown) or incapacitated (e.g., injured, ill).
   d. Care provider makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.
   e. Nutritional needs of the child are not met, resulting in danger to the child's health and/or safety; the child appears malnourished; or there is insufficient food in the home.
   f. The child is without appropriate clothing for the weather.
   g. Care provider does not seek treatment for the child's medical/dental/vision conditions(s) or does not follow prescribed treatment for such conditions.
   h. The child has a special need, such as being medically fragile, which care provider does not or cannot meet.
   i. The child has serious emotional symptoms, lack of behavioral control, or psychosomatic symptoms (e.g., sleep/appetite disturbance) and care provider will not/cannot seek or provide appropriate interventions.

8. **Care provider's current use of a legal or illegal substance impairs his/her ability to supervise, protect, or care for the child.**
Care provider uses legal or illegal substances, including alcohol, to the extent that control of his or her actions is impaired. As a result, care provider was/is unable to care for the child, has harmed the child, or is likely to harm the child.

9. **The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.**
Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to the following:
   a. Leaking gas from stove or heating unit.
   b. Substances or objects accessible to the child that may endanger the health and/or safety of the child (hot or sharp objects; dangerous objects that can be swallowed, including medications, drugs, and household cleaners in injurious quantities).
   c. Lack of water or utilities (heat, plumbing, electricity) and no alternate, safe provisions have been made.
   d. Structural inadequacies: Caved-in roof, exterior doors that do not open/close, holes in floors, broken/missing windows.
   e. Exposed electrical wires.

f. Excessive garbage or rotted or spoiled food that threatens health.
g. Serious illness or significant injury has occurred due to living conditions and these conditions still exist (e.g., lead poisoning, rat bites).
h. Evidence of human or animal waste throughout living quarters.
i. Guns and other weapons are not locked.
j. Unrestricted access to pool or other body of water.
k. Blocked exits or unmarked exit routes.
l. Missing or non-functioning smoke detectors.
m. Un-gated stairways in home with young children, as licensing regulations apply.
n. Unsafe sleeping arrangements (e.g., infants sleeping on their stomachs, sleeping arrangements for infants that include pillow and comforters that may present a SIDS risk).

10. **Child behaviors raise concerns regarding child safety, in spite of appropriate response by care provider(s).**

To mark this threat, the following three conditions MUST be present:		
The child is currently engaging in or habitually engages in behaviors that place him/her at imminent risk of serious harm. Examples include but are not limited to children who run away from placement and place themselves in unsafe living/sleeping situations, children who engage in prostitution, and children who engage in self-harming behaviors, such as cutting, that require medical intervention.	**AND** The care provider(s) have responded appropriately and made reasonable efforts to help the child modify his/her behavior. Examples include but are not limited to seeking counseling, treatment, and/or other services for the child, and increasing direct supervision and monitoring of the child.	**AND** The care provider's current efforts, although appropriate, are insufficient to prevent the child from engaging in the behavior in the future

11. **Other.** If, after careful review of the definitions for the other 10 safety threats, the CFS Specialist feels there is something unique in this care provider that was not captured in any other safety threat, the CFS Specialist should select "other" and document the identified unique safety threat that, if not resolved immediately, would lead to removal of a child in this home.

B. **Section 1B: Care Concerns**

Care concerns are circumstances that do not diminish child safety, but that may indicate that a placement change should be considered if the concern cannot be addressed through a plan.

1. **Care provider's overall functioning impairs his/her current ability to supervise, protect, or care for the child.**
   a. Care providers refusal to take prescribed medications impedes his/her ability to care for the child.
   b. Care provider's inability to control his/her emotions impedes his/her ability to care for the child.

c. Care provider acts out or exhibits distorted perception that impedes his/her ability to care for the child.
d. Care provider's emotional stability, developmental status, or cognitive deficiency impedes his/her ability to care for the child.
e. Care provider expects the child to perform or act in a way that is impossible or improbable for the child's age or developmental stage (e.g., babies and young children expected not to cry, be still for extended periods, be toilet trained, eat neatly, or older children expected to care for younger siblings or stay alone).
f. Care provider lacks the basic knowledge related to parenting skills:
   1) Does not know that infants need regular feedings;
   2) Fails to access and obtain basic/emergency medical care;
   3) Does not understand what constitutes proper diet; or
   4) Does not understand what constitutes adequate supervision.

2. **Care provider routinely describes the child or family of origin in negative terms or acts toward the child in negative ways.**
   a. Care provider describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
   b. Care provider curses and/or repeatedly puts the child down.
   c. Care provider scapegoats a particular child in the household.
   d. Care provider blames the child for a particular incident or household problems.
   e. Care provider treats the child in markedly different ways that may stigmatize the child.
   f. Care provider interferes with the child's reunification or adoption (e.g., interferes with visitation or communication with birth parent, makes negative comments about the child's birth/adoptive family).
   g. Care provider undermines the child's identity (e.g., mocking the child for his/her background).

3. **Domestic violence currently exists in the household.**
   a. The child is or has been exposed to domestic violence in the household; OR
   b. Domestic violence among adults in the household is ongoing, and the child may or may not be aware of or involved in recent incidents.

C. **Section 2. Interventions to improve safety and care**

1. This section is completed only if one or more concerns are identified. If one or more concerns are present, it does not automatically follow that a child must be removed from the placement. In many cases, it will be possible to initiate a temporary plan that will mitigate the concern(s) sufficiently so that the child may remain in the home.
2. When there are safety concerns, the CFS Specialist completing the assessment must complete the interventions section.
3. The intervention list contains general categories of interventions rather than specific programs. The CFS Specialist should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the concern(s), and whether there is reason to believe the placement will follow through with a planned intervention. The CFS Specialist may determine that even with an intervention, the child would be unsafe, or the CFS Specialist may determine that an intervention would be satisfactory, but has reason to believe the placement would not follow through. The CFS Specialist must keep in mind that any single intervention may be insufficient to mitigate the concern(s), but a combination of interventions may provide adequate safety and care. Interventions are not intended to solve the

household's problems or provide long-term answers. A plan permits a child to remain in the home while further issues are resolved.

4. The process of writing a plan to improve safety and care and selecting interventions should be a collaboration between the CFS Specialist and placement family, starting with consideration of the least intrusive interventions that make use of the family's strengths, and ending with a plan that is both feasible and effective while taking into account the family's view.
5. Interventions marked with an asterisk (*) should be used in combination with monitoring by the CFS Specialist or another person who has passed suitability.
   a. **Interventions that utilize the families strengths:**
      1) **Use of family, neighbors or other individuals in the community as safety resources.** Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbors, or other individuals to mitigate safety concerns; agreement by a neighbor or relative to serve as a safety net for the child. An Assessment of Safety Plan Participants is REQUIRED for each person who will be engaged in this safety intervention.
      2) ***The care provider will appropriately protect the victim from the alleged perpetrator.** Care provider has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator.
      3) ***The alleged perpetrator will leave the household, either voluntarily or in response to legal action.** Removal of the allege perpetrator. Examples include arrest of alleged perpetrator, "kicking out" alleged perpetrator who has no legal right to residence, or perpetrator agrees to leave.
   b. **Interventions that utilize community or agency resources.**
      1) **Intervention or direct services by CFS Specialist.** Actions taken or planned by the CFS Specialist or other agency/DHHS staff that specifically address one or more safety threats. Examples include providing information about nonviolent disciplinary methods, the child's developmental needs, or parenting practices; providing emergency material aid such as food; planning return visits to the home to check on progress; providing information on obtaining restraining orders; and providing definition of child abuse laws and informing involved parties of consequences of violating these laws. DOES NOT INCLUDE services provided to respond to family needs that do not directly affect safety.
      2) **Use of community agencies or services as safety resources.** Involving community-based organizations, faith-related organization, or other agency in activities to address safety concerns. DOES NOT INCLUDE long-term therapy or treatment or being put on a waiting list for services.
      3) **Other.** The family or CFS Specialist identified a unique intervention for an identified safety concern that does not fit within the items above.
   c. **Placement change intervention.**
      Removal from current placement is necessary because interventions above do not adequately ensure the child's safety. One or more children are removed from the current placement resource.

D. **<u>Section 3: Placement Decision</u>**

1. The placement decision is the result of careful consideration of the safety concerns and care concerns present and any available interventions taken or immediately planned by the care provider, community partners, or agency to protect the child. The CFS Specialist will identify the placement decision based on the CFS Specialist's independent assessment of all safety concerns, care concerns, interventions, and any other information known about the case.

2. The CFS Specialist will determine if the home is:
   a. **Safe and suitable**. Based on currently available information, there are no child concerns in this placement.
   b. **Conditionally safe and suitable.** Based on interventions, the child will remain in the household at this time. An intervention plan is required.
   c. **Unsafe or unsuitable; removal from the household is the only protective intervention possible for one or more children.** Without removal, one or more children will likely be in danger of serious harm or in an unsuitable care arrangement.
3. The CFS Specialist will document their conclusion to include the following in N-FOCUS in the APSS narrative:
   a. **Concerns:** The CFS Specialist will identify the safety and/or care concerns identified and briefly describe the specific individuals, behaviors, conditions, and/or circumstances associated with each particular concern.
   b. **Interventions:** The CFS Specialist will identify all interventions identified and how the intervention(s) will adequately and effectively mitigate all identified concerns.
   c. **Placement Decision:** The CFS Specialist will identify the placement decision made and briefly describe why this decision was selected.

E. **Intervention Plan:**
1. An intervention plan is required whenever the decision is conditionally safe and suitable. The following should be included in any plan which is written in a family friendly manner:
   a. A description of each safety and care concern.
   b. A detailed description for each planned intervention.
   c. A description of how the plan will be monitored (e.g., who is responsible for each intervention action).
   d. The plan should be signed by the family members, the CFS Specialist, and his/her supervisor.
   e. The intervention plan MUST be completed with the care provider and a copy should be left with the family. The Intervention Plan is located on the last page(s) of the APSS, the CFS Specialist must print off the APSS in N-FOCUS in order to provide a copy with the family.

XIV. CASE STATUS DETERMINATION.

A. At the conclusion of the initial safety and risk assessments, the CFS Specialist will arrive at a finding regarding the maltreatment allegations based on information gathered and analyzed. The decision at this point is whether one or more allegations are classified as defined in Neb. Rev. Stat. 28-720 of Court Substantiated, Court Pending or Agency Substantiated or unfounded as defined in Neb. Rev. Statute 28-720.01. This finding is called the case status determination. The case status determination will be entered into N-FOCUS within 3 business days of a case status decision approved by the CFS Administrator. The CFS Specialist, supervisor and administrator will follow the two Central Registry Program Guidance memo's (1) Central Registry Entry and 2) Central Registry – Minors) when recommending the Case Status Determination. A case status determination of Court Pending does not mean the individual is on the Central Registry. No minors will be given a classification of Court Pending.

B. **Case Status Determination of "Law Enforcement" Reports**
1. The CFS Specialist will:
   a. Review the "Law Enforcement Only" report to determine if there is credible evidence that child abuse or neglect has occurred. In determining if credible

evidence exists, the CFS Specialist will consider observations, witness statements and/or other relevant information.

b. Make a case status determination using the statutory definitions provided in the Program Guidance on Central Registry Entries.

c. Send notification as explained below.

2. When DCFS has not received any reports from Law Enforcement, the CFS Specialist will follow the protocols outlined in the Program Guidance on Central Registry Entries.

C. **Case Status Determination Notification**

1. Person's Name Placed on Central Registry: The CFS Specialist will inform any person whose name will be entered on the Central Registry with a finding of "Court Substantiated", or "Agency Substantiated" in writing. When the case status determination is made that places the individual on the Central Registry, a letter of notification will be sent to the identified perpetrator. The notice letter will be sent by certified mail with return receipt requested, or if the actual address is uncertain, by first class mail to the last known address of the subject of the report. The notification letter generated by N-FOCUS includes the nature of the report, the classification of the report, and the subject's right to request that DHHS amend or expunge identifying information from the report, or to remove the substantiated report from the Central Registry.

2. Person with Court Pending Case Status Determination: The CFS Specialist will inform any person with a Court Pending determination in writing. The notice letter will be sent by certified mail with return receipt requested, or if the actual address is uncertain, by first class mail to the last known address of the subject of the report. The notification letter generated by N-FOCUS includes information that the County Attorney has initiated a court action and based on the final disposition, the Department will update the case status determination and issue the Department's decision.

3. Person's Name Not Placed on Central Registry: Individuals whose names will not be placed on the Central Registry (the report will be classified as Unfounded) will also be notified in writing. Written notification generated by N-FOCUS will be sent by first class mail.

4. Proof of Notification: The CFS Specialist document proof of notification to the alleged perpetrator. Proof of notification will include a copy of the signed notice letter, and the certified mail green return card or copy of electronic receipt. These documents can be scanned into N-FOCUS and categorized in Central Registry section.

D. **Changing Case Status Determination:** If the Case Status Determination was originally determined:

1. Agency Substantiated – The CFS Supervisor can update the Case Status determination to reflect the correct status of Court Substantiated with CFS Administrator Approval. Notice of the change will be sent to the alleged perpetrator through certified mail with the return receipt filed in the case record.

2. Court Pending – The CFS Supervisor can update the Case Status determination to reflect the correct status of Unfounded, Agency Substantiated or Court Substantiated with CFS Administrator Approval. Notice of the change will be sent to the alleged perpetrator through certified mail with the return receipt filed in the case record.

3. Unfounded – NO ONE can change this status. A new intake with allegations must be created and assessed/investigated.

E. **Tickets/Citations:** The issuance of a ticket or citation in and of itself does not automatically warrant a Court Pending Finding. The CFS Specialist needs to verify if the citation/ticket is actually filed with the court before determining whether the finding will be court pending. If the County Attorney chooses not to file criminal charges based on the citation/ticket the CFS Specialist will need to determine if the information available to the Department

warrants an agency substantiated finding or unfounded finding.

XV. DETERMINING SUITABILITY OF SAFETY PLAN PARTICIPANTS.

A. A Safety Plan participant refers to any formal or informal resource person including the non-custodial parent, who is selected to provide safety services within a Safety Plan. Safety Plans may involve relatives, friends of the family, volunteers, agency professionals, or others. Both the family and the CFS Specialist must be able to trust and depend on those involved in the Safety Plan. Making an informed decision about the suitability of potential Safety Plan participants must be completed quickly. In every case, a child's parents/caregivers will be the first source of information about people who can be considered for participation in the Safety Plan. Whenever possible, the child will be a source of information about people to participate in the Safety Plan. In all cases, the non-custodial parent will be considered for participation in the Safety Plan.

B. The CFS Specialist must conduct background checks on all Safety Plan participants, regardless of their level of involvement with the child. This includes all members of the household where the child will be spending time. Required checks include:
   1. Adult Protective Services (APS) Central Registry;
   2. Child Protective Services (CPS) Registry;
   3. Sex Offender Registry; and
   4. Local law enforcement.

C. Paid participants who are employees or licensed providers have completed background checks as part of their employment. It is not necessary to repeat those checks unless there is information that suggests a concern.

D. The CFS Specialist will complete the APS, CPS, and Sex Offender Registry Checks immediately; the law enforcement check will be completed within 48 hours. Background checks may be completed after hours and on weekends by contacting the Hotline at 1-800-652-1999.

E. The CFS Specialist can conduct background checks without a signed Release of Information form for internal DHHS use. However, Release of Information forms do need to be signed and dated by the parent/caregivers allowing the exchange of information between the CFS Specialist and the safety plan participants. If the parent/caregivers are unwilling to sign Release of Information forms for Safety Plan participants, those individuals cannot be part of the Safety Plan.

F. The CFS Specialist will discuss any entries on the APS Registry, CPS Registry or law enforcement check with the CFS Supervisor to decide if the facts of the situation should prevent the individual from being a Safety Plan participant. This discussion will explore how significant the event was, in relationship to the individual's role in the Safety Plan.
   1. If the supervisor approves the use of an individual with a central registry and/or criminal history to be a Safety Plan participant, approval must be requested and granted by the CFS Administrator and documented in the Program Case Consultation Point section of N-FOCUS.

G. The CFS Specialist will have face-to-face conversation with any potential informal Safety Plan participant, this includes non-custodial parent, kin, foster placements or other informal supports and/or have at least phone contact with formal Safety Plan participants.

H. The CFS Specialist will have face-to-face contact with foster parent Safety Plan participants unless the placement is currently licensed.

I. The CFS Specialist will have face-to-face contact the respite care providers, child care homes etc. unless the home or facility is licensed.

J. The CFS Specialist will discuss the expectations of the Safety Plan and the responsibilities of being a Safety Plan participant with potential Safety Plan participants. The discussion will

be documented in the Safety Plan Participant section of N-FOCUS. Discussion and assessment by the CFS Specialist will include the following. The Safety Plan participant:

1. Understands the safety threats;
2. Can ignore any influence made by the family;
3. Is committed to implement the Safety Plan, to follow the plan and report any concerns;
4. Is available to participate during the agreed upon day(s) and times;
5. Has accessible phone and transportation;
6. Has a keen sense of perception;
7. Is willing to work with CFS;
8. Understands the scheduled activities and expectations;
9. Has an appropriate view of the child and realistic and attitude toward the child and family situation;
10. Use of substances does not affect his/her ability to perform expected responsibilities;
11. Is not involved in criminal activity and does not have a history of criminal behavior that compromises his/her ability to keep the child safe;
12. Has sufficient resources to fulfill responsibilities, or needs only minimal assistance.
13. Is not involved in domestic violence; or in an active CFS case and does not have a history of being in a CFS case that would compromise his/her ability to keep the child safe;
14. Has a history of being protective of and providing acceptable care to children; understands/respects the family's culture and is willing to participate in a family team.
    a. The fact that the proposed Safety Plan participant does not meet one or more of the criteria does not automatically disqualify that person from participation in the Safety Plan unless the issue is clearly one of safety. In situations not clearly related to safety, the CFS Specialist will explore the issue further, discuss the situation with the CFS Supervisor, and determine how significant that issue is in the particular case given the individual's role in the Safety Plan.
    b. Summarize the Safety Plan and assure that schedules, time commitments, access, availability and the relationship with the CFS Specialist are clearly explained and understood. The CFS Specialist will know as much as possible about the proposed Safety Plan participant. The extent to which the criteria are applied to individuals participating in the Safety Plan is dependent on the person's role/activity specific to the Safety Plan (e.g., transportation, supervision, full time vs. part time care of the child) and their level of involvement with the child. The expectation is that individuals selected by the family to participate in the Safety Plan will be approved to do so, unless a safety concern is identified.

XVI. OUT OF HOME ASSESSMENTS/FACILITY ASSESSMENTS OVERVIEW.

A. CFS will conduct assessments of allegations of child abuse and neglect in day care homes (licensed and unlicensed), day care centers and child care facilities such as group homes and other residential care facilities where there is responsibility to provide for and to oversee the physical care of children.

B. Assessments of allegations of child maltreatment perpetrated by providers in day care homes, day care centers, foster homes or child caring institutions or facilities will be conducted by DCFS in conjunction with law enforcement, according to protocols established in each county. Law enforcement will focus primarily on conducting a criminal investigation.

C. The role of the CFS Specialist is to:
    1. Determine if abuse and neglect has occurred;
    2. Assess the safety of the children involved;
    3. Recommend action and follow through to assure child safety; and

4. Assess the cause of the problem and make recommendations to reduce risk of harm.

D. In cases of licensed child care homes or facilities:
   1. The CFS Specialist will ensure that the DHHS Licensing Unit has been notified so that a licensing review can also occur.
   2. The CFS Specialist will coordinate with all involved parties conducting reviews and investigations to maximize the opportunities to gain factual information, minimize the number of interviews and minimize the degree of intrusiveness. If interviews cannot be conducted jointly with licensing, then the law enforcement and CPS assessment will occur before any contact by the licensing authorities.

E. Allegations of child abuse and neglect of children perpetrated by teachers, school personnel, counselors, therapists, doctors, nurses and others not performing such care-giving responsibilities for children will not be assessed by DCFS and will be referred to Law Enforcement.

F. DCFS will assess reports of abuse/neglect on licensed or approved foster homes where NO children are currently placed.
   1. If a foster/approved home has children placed with them the CFS Specialist will conduct an APSS.

G. The Out-of-Home Assessment will be documented in N-FOCUS in the Organization Related Investigation narrative sections of N-FOCUS to document decisions and recommendations.

XVII. CONDUCTING THE OUT-OF-HOME ASSESSMENT.

A. To obtain the most accurate information it is the procedure of the Department to proceed in the following order. The CFS Specialist will:
   1. Review relevant Department and law enforcement records.
   2. Notify all CFS Specialists of children in care to discuss relevant case information and coordinate decision-making about the child(ren).
   3. In cases involving a licensed child caring agency, the investigating CFS Specialist request incident reports from the agency and documentation from the licensed facility that describes the action the facility has taken to ensure child safety. In cases involving foster homes, the licensing agent in consultation with his/her supervisor will determine when a Safety Plan is developed. The Out-of-Home Assessment is only conducted on foster homes when the foster family has no current placements and the allegations involve foster children previously placed in the foster home.
   4. Coordinate contact and consultation, as appropriate, with law enforcement, licensing, contracting, and resource development regarding placement and safety status.
   5. Conduct interviews in the following order:
      a. Reporting party to confirm details;
      b. Identified child victims;
      c. Other children in care who might have knowledge related to allegations;
      d. Anyone identified as present during incidents or who have knowledge of incidents;
      e. In the case of foster parents, the non-maltreating foster parent; and
      f. Alleged perpetrator
   6. If law enforcement is conducting a criminal investigation, the involved law enforcement officer will be responsible to determine how and when the interviews with the alleged perpetrator will occur. The Department will not interview the alleged perpetrator until approved by law enforcement.

B. **Notification of Parents of Children**.
   1. When conducting an assessment of alleged neglect, physical abuse or sexual abuse of a child in a child care home or facility, the CFS Specialist will make every effort to contact the parent or legal guardian of any suspected victims before interviewing the child.

a. If attempts to contact the parent or legal guardian are unsuccessful and there is reason to believe that interviewing the child is necessary to protect the child or other children, the CFS Specialist will interview the child without parental consent. Contact with the parent or legal guardian will occur as soon as possible following the interview with the child.
b. The following information will be provided to the parents or legal guardians of children alleged to have been abused or neglected in a child care home or facility:
(1) Notice that a report alleging neglect, physical abuse or sexual abuse has been received and information on the nature of the maltreatment;
(2) Notice that the DCFS is conducting an assessment of the allegations;
(3) The safety/protective or corrective measures taken; and
(4) The conclusions of the assessment along with any recommendations that will help protect the child from future maltreatment in the facility.

C. **Case Status Determination in a facility**.
1. The CFS Specialist will follow the Program Guidance on Central Registry Entries to determine whether there is preponderance of evidence that child abuse, neglect or sexual abuse occurred.
2. The CFS Specialist will determine if there is risk to other children in care will determine if child abuse and neglect occurred and whether there is preponderance of the evidence.
3. The CFS Specialist may determine that risk of maltreatment to children exists without a substantiated finding that actual incidents of child abuse, neglect or sexual abuse has actually occurred. Recommendations about changes in practice or conditions that will reduce the likelihood of maltreatment will be made. Once these determinations have been made the following will occur:
a. The case status determination will be entered into the Child Abuse and Neglect Central Registry utilizing the Program Guidance on Central Registry Entries.
b. A summary of the assessment, findings and recommendations for action will be sent to the appropriate licensing staff, resource development staff, CFS Specialists with children in placement and the county attorney.
c. The case findings will be shared with the alleged perpetrator and facility director.
4. Recommendations about changes in practice and conditions that would reduce the likelihood of maltreatment will be provided to the child care provider, the parents involved and the child care director in cases of a child care facility.

D. **Substantiated Reports.**
1. When reports of child maltreatment are substantiated, the Department will:
a. Assess present risk to the child(ren) involved and assure steps are taken to protect the child(ren).
b. Inform the child's parent or legal guardian as soon as possible.
c. Notify the agency responsible for the child's placement when an incident involves a child placed by another child caring agency.
d. Immediately notify the appropriate licensing and contracting authorities of the substantiated abuse or neglect.
2. When neglect or abuse is substantiated the parents of the victim(s) and subject of the report in that home or child care facility will be notified.
3. Information on the status of the investigation cannot be shared with the parent/caretakers of children who are not identified victims or witness of abuse/neglect in the facility.
4. Requests for information from others who are not subjects in the report will be referred to Law Enforcement to make a request for information.

5. When Licensing determines that children are not safe in the care of home or facility, licensing staff will make recommendations to the parent or legal guardian to make alternative child care arrangements.

XVIII. RISK ASSESSMENT OVERVIEW.

A. The risk assessment informs the CFS Specialist of the risk of harm and if ongoing services are needed. The risk assessment is only valid for families where maltreatment has been alleged in the current referral.

B. The risk assessment identifies families who have very high, high, moderate, or low probabilities of abusing or neglecting their children in the future. By completing the risk assessment, the CFS Specialist obtains an objective appraisal of the likelihood that children in a household will experience maltreatment in the next 12-18 months. The difference between risk levels is substantial. High risk families have significantly higher rates of subsequent referral and substantiation than low risk families, and they are more often involved in serious abuse or neglect incidents.

C. The risk instrument is based on research of abuse/neglect cases that examined the relationships between family characteristics and the outcomes of subsequent confirmed abuse and neglect. The instrument does not predict recurrence; it simply assesses whether a family is more or less likely to have another abuse/neglect incident without intervention by the agency. One important result of the research is that a single index should not be used to assess the risk of both abuse and neglect. Different family dynamics are present in abuse and neglect situation. Hence, separate indices are used to assess the future probability of abuse or neglect, although both indices are completed for every family.

D. The Risk Assessment will be completed in situations where the parent does not share information or when parents will not accept services or will not be in the state to receive services. The CFS Specialist will utilize information gathered from other sources and behavioral observations in answering the items.

E. The CFS Specialist will conduct a risk assessment on all accepted reports of abuse and neglect. Case status determination is a separate decision and is not linked to the Risk Assessment.

   1. The CFS Specialist must obtain approval from the CFS Administrator if a risk assessment will not be completed. This a mandatory consultation point. The reason why the request is being made and the approval must be documented in N-FOCUS Consultation Point narrative.

F. The CFS Specialist will conduct the risk assessment prior to the decision to recommend ongoing services or to close the case. The CFS Specialist has 30 days to complete this process from the date the intake was accepted for assessment.

G. The risk level informs the decision to open an ongoing services case. If an ongoing service case is opened, the risk level helps the CFS Specialist prioritize the intensity of service coordination provided to each family.

H. The CFS Specialist will document the Risk Assessment on N-FOCUS within 30 days of the Intake being accepted for assessment. Documentation must support and explain the rationale/reason for each of the items in the Risk Assessment regardless of the risk level.

I. Collateral contacts refers to a person that provides information. Supporting Evidence is information gathered through what the CFS Specialist has personally observed; heard, etc., records reviewed (NDEN, Other program records).

J. The CFS Specialist will utilize the Family Functioning narratives to document any additional information not captured in the risk assessment.

XIX. COMPLETING THE RISK ASSESSMENT.

A. The risk assessment is completed based on conditions that exist at the start of the initial assessment.

B. The CFS Specialist will refer to the definitions to determine his/her selection for each item.

C. **Section 1: Neglect/Abuse Index**

1. **R1. Current report is for.**
   The CFS Specialist will determine if the report that led to the current referral or DHHS investigation is for abuse, neglect, or both. Neglect includes general neglect, abandonment, and caregiver absence/incapacity. Abuse includes physical abuse, emotional maltreatment and/or exploitation, or sexual abuse/sexual exploitation. *Neither category includes dependency.*

   Include reported allegations as well as allegations added by DHHS during the course of the initial assessment.

R1. Current report is for	Neglect Score	Abuse Score
[ ] a. Neglect	1	0
[ ] b. Abuse	0	1
[ ] c. Both	1	1

2. **R2. Prior investigations of any household adult**
   Assess prior DHHS or other CPS history. Determine if there are any prior intakes, excluding those accepted as dependency, alternative response, duplicate/multiple reports, information only, and law enforcement only, involving any adult members of the current household as alleged perpetrators for any type of neglect or abuse, regardless of finding. One intake may involve multiple allegations and/or multiple children, but will still be counted as one intake. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect. Where possible, history from other jurisdictions should be included.

   If yes, answer both R2a and R2b, indicating the number of prior neglect investigations and the number of prior abuse investigations.
   a. Neglect includes general neglect or abandonment, and if the caregiver is absent or incapacitated.
   b. Abuse includes physical abuse, emotional abuse, and sexual abuse/sexual exploitation.

R2. Prior investigations of any household adult	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	1	0
R2a. Prior Neglect		
[ ] a. None	0	0
[ ] b. One	1	0
[ ] c. Two	1	0
[ ] d. Three or more	2	0
R2b. Prior Abuse		
[ ] a. None	0	0

[ ] b. One	0	1
[ ] c. Two or more	0	2

3. **R3. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)**
   The CFS Specialist will mark "Yes" if this household previously had or currently has an open family preservation or foster care case as a result of a prior investigation. Include voluntary or court-ordered family services or foster care services; do not include delinquency, status offense, alternative response or dependency cases.

R3. Household previously had an open ongoing service case due to child abuse or neglect (non-court (voluntary) or court-ordered)	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	1	1

4. **R4. Number of child victims involved in the current child abuse or neglect incident**
   Determine the number of children under 19 years of age for whom abuse or neglect was alleged or substantiated in the current investigation. Only include the number of children listed on the intake who have allegations. If it is discovered that other children are victims, they would need to be added to the intake and counted.

R4. Number of child victims involved in the current child abuse or neglect incident	Neglect Score	Abuse Score
[ ] a. One, two, or three	0	0
[ ] b. Four or more	1	0

5. **R5. Prior injury to any child in household resulting from child abuse or neglect**
   The CFS Specialist will mark "Yes" if any child sustained an injury resulting from abuse and/or neglect prior to the referral that resulted in the current investigation. Injury sustained as result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn. Prior injury may or may not have been subject to a child protection investigation. Include prior substantiated injuries and credible report of prior injuries, but exclude accidental injuries.

R5. Prior injury to any child in household resulting from child abuse or neglect	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	1

6. **R6. Age of youngest child in the home**
   The CFS Specialist will determine the current age of the youngest child presently in the household where the child abuse or neglect incident reportedly occurred. If a child was removed as a result of the current investigation, count the child as residing in the home.

R6. Age of youngest child in the home	Neglect Score	Abuse Score
[ ] a. 2 or older	0	0
[ ] b. Under 2	1	1

7. **R7. Characteristics of children in the household**
   The CFS Specialist will assess each child in the household and determine the presence of

any of the following characteristics. These characteristics are separate and distinct from the child vulnerabilities on the safety assessment. Diagnoses are required where indicated. Diagnoses must be listed as a current Diagnostic and Statistical Manual (DSM) diagnosis.

a. **Medically fragile/failure to thrive.** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention, or is diagnosed as failure to thrive. Requires medical documentation or credible report of professional diagnosis.

The following characteristics may be present during the initial assessment, or may have been true for any child in the household at any time in the past.

b. **Positive toxicology,** any child had a positive toxicology report for alcohol or another drug at birth or at any time in the past. The child need not have been born in the current incident or during the initial assessment.
c. **Physical disability,** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include any credible information).
d. **Developmental disability,** as evidenced by intellectual disability, learning disability, or other developmental problem including ADHD, that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
e. **Delinquency history.** A child has been referred to juvenile court for delinquent or status offense behavior. Status offenses that are not brought to court attention but that create stress within the household should also be scored, such as children who run away or are habitually truant.
f. **Current or previous mental health/behavior problems.** These are problems not related to a physical or developmental disability. This could be indicated by a current Diagnostic and Statistical Manual (DSM) diagnosis, received or receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking psychotropic medication. Exclude ADHD and use of related medications, which would be included in item "d".
g. **None of the above.** No characteristics are exhibited by any child in the household.

R7. Characteristics of children in the household	Neglect Score	Abuse Score
[ ] a. Medically fragile/failure to thrive	1	0
[ ] b. Positive toxicology screen at birth	1	1
[ ] c. Physical disability	1	0
[ ] d. Developmental disability	0	1
[ ] e. Delinquency history	0	1
[ ] f. Current or previous mental health/behavior problems	0	1
[ ] g. None of the above	0	0

8. **R8. Primary caregiver's assessment of incident**

The CFS Specialist will assess for each characteristic and mark all that apply.

a. **Blames child.** Blaming refers to caregiver's statement that the maltreatment incident occurred because of the child's action or inaction (e.g., claiming that the child seduced him/her, or the child's misbehavior forced caregiver to beat him/her). Exclude situations in which the caregiver claims that one child injured another child or in which the caregiver claims that the child injured him/herself.
b. **Justifies maltreatment of the child.** Justifying refers to caregiver's statement that his/her action or inaction, which resulted in harm to the child, was appropriate and

constitutes good parenting (e.g., claiming that this form of discipline was how the caregiver was raised, so it is all right).

c. **None of the above** characteristics are applicable.

R8. Primary caregiver's assessment of incident	Neglect Score	Abuse Score
[ ] a. Blames child	0	1
[ ] b. Justifies maltreatment of the child	0	2
[ ] c. None of the above	0	0

9. **R9. Primary caregiver provides physical care consistent with each child's needs**
The CFS Specialist will mark "Yes" if the caregiver is providing age-appropriate physical care that meets minimal standards for all children in the household. Examples may include the following:
   1. Obtaining standard immunizations. Do not mark cases in which the caregiver has made a choice not to immunize due to religious or philosophical convictions.
   2. Obtaining medical care for severe, chronic, or recurrent illness. Mark as "No" missed well-baby/child visits where there are concerns for infant/child health.
   3. Providing the child with adequate food.
   4. Providing the child with adequately clean, weather-appropriate clothing.
   5. Preventing or addressing rodent or insect infestations.
   6. Providing adequate housing with operative plumbing and electricity (heating and cooling).
   7. Ensuring that poisonous substances or dangerous objects are not within reach of a small child.
   8. Supporting or providing age/developmentally appropriate hygiene (bathing, brushing teeth, changing diapers).

R9. Primary caregiver provides physical care consistent with each child's needs	Neglect Score	Abuse Score
[ ] a. No	1	0
[ ] b. Yes	0	0

10. **R10. Primary caregiver characteristics**
Assess the primary caregiver for each characteristic and mark all that apply.
   a. **Provides insufficient emotional/psychological support** to the child, such as persistently berating/belittling/demeaning the child, not attempting to bond with the child, or depriving the child of affection or emotional support.
   b. **Employs excessive/inappropriate discipline** that caused or threatened harm to the child because the actions were excessively harsh physically or emotionally and/or inappropriate to the child's age or development. Examples may include the following:
      (1) Locking the child in a closet or basement;
      (2) Holding the child's hand over fire;
      (3) Hitting the child with dangerous instruments; or
      (4) Depriving a young child of physical and/or social activity for extended periods.
   c. **Domineering parent,** indicated by controlling, abusive, overly restrictive, bullying, or over-reactive rules. This may be characterized by a caregiver seeing his/her own way as the only way or by little two-way communication between the caregiver and child.
   d. **None of the above** characteristics are exhibited by the primary caregiver.

R10. Primary caregiver characteristics	Neglect Score	Abuse Score
[ ] a. Provides insufficient emotional/psychological support	0	1
[ ] b. Employs excessive/inappropriate discipline	0	1
[ ] c. Domineering parent	0	1
[ ] d. None of the above	0	0

11. **R11. Primary caregiver has a past or current mental health problem**
    The CFS Specialist will mark "Yes" if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:
    a. Current DSM diagnosis by a mental health clinician;
    b. Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; **or**
    c. Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.

    Do not include diagnoses of ADHD or learning disabilities (e.g., dyslexia).

    If the CFS Specialist selects "Yes", documentation must reflect details as to how the CFS Specialist made their determination (i.e., parent reported specific diagnosis and was able to provide information on the doctor, medications, treatment etc.)

    If the CFS Specialist selects "No", documentation must include references to collaterals or supporting evidence (e.g., spouse, parent, children, friends, NDEN) that no one indicated that mental health has been an issue.

R11. Primary caregiver has a past or current mental health problem	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes (mark all that apply)	1	0
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

12. **R12. Primary caregiver has past or current alcohol or drug problem that interferes with family functioning**
    The CFS Specialist will assess whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Include abuse of alcohol and/or illegal substances, and abusive use of prescription drugs. Legal, non-abusive prescription drug or alcohol use should not be considered an alcohol or drug problem. The CFS Specialist will assess for the following characteristics using the definitions and mark all that apply:

Interference in function may be evidenced by the following:

a. Substance use that affects or affected the following:
   (1) Employment;
   (2) Criminal involvement;
   (3) Marital or family relationships; or
   (4) to provide protection, supervision, and care for the child.
b. An arrest or citation for driving under the influence of drugs and/or alcohol, refusing breathalyzer testing, possession of a controlled substance or paraphernalia

(this includes situations when the individual was not charged or the charge was dismissed);

c. Self-report of a problem;
d. Treatment received currently or in the past;
e. Multiple positive toxicology screens;
f. Health/medical problems resulting from substance use; or
g. The child was diagnosed with fetal alcohol syndrome or exposure (FAS or FAE), or the child had a positive toxicology screen at birth and the primary caregiver was the birthing parent.

The CFS Specialist will select the following based on whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

R12. Primary caregiver has past or current alcohol or drug problem	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Alcohol (mark all that apply)	**1**	**0**
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] c. Drugs (mark all that apply)	**1**	**0**
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

13. **R13. Secondary caregiver has past or current alcohol or drug problem**
Applying the definition in R12 to the secondary caregiver, assess for the following characteristics and mark all that apply.

R13. Secondary caregiver has past or current alcohol or drug problem	**Neglect Score**	**Abuse Score**
[ ] a. No secondary caregiver	**0**	**0**
[ ] b. No	**0**	**0**
[ ] c. Yes	**0**	**1**
Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
Drugs (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

14. **Primary caregiver has a history of abuse or neglect as a child**
The CFS Specialist will mark "Yes" if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. The alleged abuse or neglect does not need to have happened by the adult's caregiver/parent. Include disclosure of incidents that would be screened in for assessment now.

R14. Primary caregiver has a history of abuse or neglect as a child	**Neglect Score**	**Abuse Score**
[ ] a. No	**0**	**0**
[ ] b. Yes	**0**	**1**

15. **R15. Two or more incidents of domestic violence in the household in the past year**
The CFS Specialist will mark "Yes" if credible statements by caregivers or others indicate that there have been two or more physical assaults and/or periods of intimidation/threats/harassment between caregivers, or between a caregiver and another adult, in the past year. Instances of domestic violence that occur outside the physical household structure (i.e. bar) or with any of the current household members will be included in the count. The CFS Specialist will use collaterals and/or supporting evidence in describing the item.

R15. Two or more incidents of domestic violence in the household in the past year	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	2

16. **R16. Housing**
The CFS Specialist will assess and determine the presence of any of the characteristics below and mark all that apply. If the agency or DHHS has already provided emergency services to address housing, assess housing as it was prior to the intervention. If the agency or DHHS helps the family move to a DV shelter as part of a Safety Plan, do not mark "a" or "b" in this item.
    a. **Current housing is physically unsafe,** such that it does not meet the health or safety needs of the child (e.g., exposed wiring; structurally unsafe conditions; unsafe/insufficient heating and cooling, and alternative safe arrangements have not been made; unsanitary plumbing; roach/rat infestations; human/animal waste on floors or other household surfaces; rotting food).
    b. **Homeless at time the investigation began,** or about to be evicted at the time the investigation began. Include families who are living in temporary shelter. If the caregiver is unsure of the family's living situation or family considers themselves homeless, endorse this item.
    c. **Family has housing that is physically safe.**

R16. Housing (mark all that apply)	Neglect Score	Abuse Score
[ ] a. Current housing is physically unsafe	1	0
[ ] b. Homeless at time the investigation began	2	0
[ ] c. Family has housing that is physically safe	0	0

D. **Supplemental Items**
Supplemental items are not used to calculate the scored risk level. These items are included to collect data to test hypotheses about possible risk factors. At this time, it is not known if any supplemental item contributes to the likelihood of future harm.

1. **S1. Primary caregiver provides mental health care consistent with each child's needs.**
The CFS Specialist will mark "Yes" if the caregiver is providing mental health care consistent with the needs of all children in the household. Also mark "Yes" if no child in the household has mental health care needs.
    a. No
    b. Yes
Examples of appropriate care for children with mental health care needs include the following:

a. Obtaining appropriate assessment, therapy, or counseling;
b. Ensuring that the child takes necessary medications on an appropriate schedule;
c. Advocating for resources to meet the child's needs from school or community clinic sources (even if resources have not yet been obtained);
d. Supporting child's integration into family, community, and school.

A child's mental health care needs may be indicated by any of the following:

a. Diagnosis of a DSM condition by a mental health clinician;
b. Repeated referrals for mental health/psychological evaluations; or
c. Recommendation for treatment/hospitalization.

2. **S2. Primary caregiver has a criminal arrest history.**
The CFS Specialist will indicate whether the primary caregiver has ever been arrested or convicted, either as an adult or as a juvenile. This includes DUI but excludes all other traffic offenses (consider citations for window tint, driving without insurance, and other non-moving violations as traffic offenses). This includes situations when the individual was not charged or the charge was dismissed.
   a. No
   b. Yes
3. **S3. Primary caregiver's partner is the biological parent of the victim child.**
The CFS Specialist will indicate if the primary caregiver has a partner. If so, indicate the gender of the primary caregiver's partner. Next, indicate if he/she is an alleged perpetrator in the current incident. Then, indicate if the partner is the biological parent of all of the child victims, one or more but not all child victims, or none of the child victims.
   Does the primary caregiver have a partner?
   a. No
   b. Yes (continue to answer remaining questions in this section).
   Gender of primary caregiver's partner
   a. Female
   b. Male
   Is the primary caregiver's partner an alleged perpetrator in the current incident?
   a. No
   b. Yes
   The primary caregiver's partner is the biological parent of:
   a. All child victims
   b. One or more, but not all child victims
   c. None of the child victims

E. **<u>Section 2: Scoring and Overrides</u>**

1. **<u>Scoring Individual Items</u>**:
   a. A score for each assessment item is derived from the CFS Specialist's observation of the characteristics it describes. Some characteristics are objective (such as prior child abuse/neglect history or the age of the child). Others require the CFS Specialist to use discretionary judgment based on his/her assessment of the family.
   b. Sources of information used to determine the CFS Specialist's endorsement of an item may include statements made by the child, caregiver, or collateral persons; CFS Specialist observations; reports; or other reliable sources. The CFS Specialist should refer to the definitions to determine his/her selection for each item.
   c. After all index items are scored, the CFS Specialist totals the scores and indicates the corresponding risk level of each index. Next, the scored risk level (whichever is higher of the abuse or neglect index) is entered.

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

2. **Policy Overrides:** After completing the risk assessment, the CFS Specialist determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns, and have been determined to warrant a risk level designation of very high regardless of the risk level indicated by the assessment. **Note: Mark each policy override that is present:**
   a. Sexual abuse case AND the perpetrator is likely to have access to the child. This override only applies if it happened within the review period.
   b. Non-accidental injury to a child under age 2. This override only applies if it happened within the review period.
   c. Severe non-accidental injury. This override only applies if it happened within the review period.
   d. Caregiver action or inaction resulted in death of a child due to abuse or neglect. This policy override is considered over the lifetime of the case. If the caregiver ever caused a child death either by action or inaction this policy override will be selected.

3. **Discretionary Override:** A discretionary override is applied by the CFS Specialist to increase the risk level in any case in which the CFS Specialist believes that the risk level set by the risk assessment is too low.
   a. This may occur when the CFS Specialist is aware of conditions affecting risk that are not captured within the items on the risk assessment.
   b. Discretionary overrides may increase the risk level by one unit (for example, from low to moderate risk OR moderate to high risk, but NOT from low to high risk).
   c. After completing the Override section, the CFS Specialist will indicate the final risk level, which is the highest of the scored risk level, policy override risk level (which is always very high), or discretionary risk level.
   d. The risk level informs the decision to open an ongoing services case.

Final Risk Level	Recommendation
Low	Close Case*
Moderate	Close Case*
High	Ongoing services needed
Very High	Ongoing services needed
**Low and moderate risk cases must be recommended for ongoing services if the most recent SDM safety assessment finding was conditionally safe or unsafe.*	

XX. DETERMINING RISK ASSESSMENT RESPONSE.

Following the completion of the safety and risk assessments, the CFS Specialist determines the DCFS response. The response by DCFS must be the least intrusive, most appropriate level of service necessary to meet the identified needs of the family.

A. An on-going case will be opened based on the following:
   1. Families with an unsafe or conditionally safe child; and/or
   2. Families at high or very high risk for future child abuse or neglect of their children; and/or

3. Families with court ordered DHHS involvement regardless of Safety/Risk Assessment determinations.

B. Ongoing cases may be court or non-court involved. All ongoing cases will be assessed to determine if a child or family is Native American. If a child is identified or is believed to be Native American, the CFS Specialist will send Non-Court or Court Notice to the Tribe(s) and follow all ICWA procedures described in the Indian Child Welfare Act Operations Manual.

XXI. REGISTERED SEX OFFENDER IN THE HOME.

A. If the intake concerns possible lack of proper supervision because the alternative caregiver is a convicted sex offender, the CFS Specialist will take the following steps, in addition to standard initial assessment protocol, to assess child safety and risk:
   1. Determine from the State Patrol Sex Offender Register (www.sor.nebraska.gov) what the individual was convicted of and the age of the previous victim;
   2. Determine from the interview with the child if there has been any inappropriate contact or grooming behaviors;
   3. Talk with the non-offending parent and provide information from the Sex Offender Registry about the conviction. This information is public record and not subject to confidentiality requirements;
   4. Talk with the offender and the non-offending parent about their responsibility to keep the child safe, and help them identify actions to protect the child.

XXII. PREVENTION ASSESSMENT OVERVIEW.

A. The prevention assessment informs the CFS Specialist as to risk of harm and if ongoing services are needed. The prevention assessment is used for families where there is no current child abuse or neglect alleged, with the goal of preventing future abuse or neglect. The prevention assessment is used for dependency cases, including Alternative Response, Mentally Ill & Dangerous (3c) and children identified as sex trafficking victims.
   1. For referrals that involve any allegations of child maltreatment, the CFS Specialist will use the **risk assessment.**

B. The prevention assessment identifies families who have very high, high, moderate, or low probabilities of abusing or neglecting their children in the future. By completing the prevention assessment, the CFS Specialist obtains an objective appraisal of the likelihood that children in a household will experience abuse or neglect in the next 12-18 months. The prevention assessment is used to estimate the likelihood of a future incident of child maltreatment when there has been no allegation in the current incident.

C. For dependency cases the prevention assessment needs to be completed prior to making the decision to transfer to ongoing services or close the case.

D. The prevention level informs the decision to open an ongoing services case. If an ongoing service case is opened, the prevention level helps the CFS Specialist prioritize the intensity of service coordination provided to each family.

E. The CFS Specialist will document the Prevention Assessment on N-FOCUS within 30 days of assignment for ongoing services. Documentation of narrative must be provided that supports and explains the rationale/reason for each of the questions in the Prevention Assessment regardless of the risk level.

F. The CFS Specialist will document the Prevention Assessment on N-FOCUS within 30 days of the Intake being accepted for assessment.

G. Documentation must be provided that supports and explains the response selected on the Prevention Assessment.

H. Collateral contacts refers to a person that provides information. Supporting Evidence is information gathered through what the CFS Specialist has personally observed; heard, etc., records reviewed (NDEN, Other program records, etc.

I. The CFS Specialist will utilize the Family Functioning narratives to document any additional information the family and others share that is not relevant to the Prevention Assessment but may be applicable in continued work with the family.

XXIII. COMPLETING THE PREVENTION ASSESSMENT.

A. The prevention assessment is completed based on conditions that exist at the start of the initial assessment or referral to ongoing services. An SDM prevention assessment must be completed on each household that is involved in the referral

B. The CFS Specialist should refer to the policy definitions to determine his/her selection for each item.

C. **Section 1: Neglect/Abuse Index**

1. **P1. Prior investigations of any household adult**
   Assess prior DHHS or other CPS history. Determine if there are any prior intakes, excluding those accepted as dependency, Alternative Response, duplicate/multiple reports, information only, and law enforcement only, involving any adult members of the current household as alleged perpetrators for any type of neglect or abuse, regardless of finding. Keep in mind that one intake may involve multiple allegations and/or multiple children, but will still be counted as one intake. Exclude investigations of out-of-home perpetrators (e.g., daycare) unless one or more caregivers failed to protect. Where possible, history from other jurisdictions should be included.
   Answer both P1a and P1b, indicating the number of prior neglect investigations and the number of prior abuse investigations.
   a. Neglect includes general neglect or abandonment, and if the caregiver is absent or incapacitated.
   b. Abuse includes physical abuse, emotional abuse, and sexual abuse/sexual exploitation.

P1. Prior investigations of any household adult	Neglect Score	Abuse Score
[ ] a. No	-1	0
[ ] b. Yes	0	0
P1a. Prior neglect (select one)		
[ ] a. None	0	0
[ ] b. One or Two	2	0
[ ] c. Three or More	3	0
P1b. Prior Abuse (select one)		
[ ] a. None	0	0
[ ] b. One	1	1
[ ] c. Two or More	1	2

2. **P2. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)**
   The CFS Specialist will mark "Yes" if this household previously had or currently has an open family preservation or foster care case as a result of a prior investigation. Include voluntary or court-ordered family services or foster care services; do not include delinquency, Alternative Response, status offense or dependency cases.

P2. Household previously had an open ongoing service case due to child abuse or neglect (voluntary or court-ordered)	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	3	2

3. **P3. Number of child victims involved in the current child abuse or neglect incident**
   Determine the number of children under 19 years of age who live in the home, related or not. Include the following:
   a. An unborn child if the mother is in the last trimester of pregnancy;
   b. Children who have been removed from the home in the current referral;
   c. The legal children of any caregiver, even if that caregiver does not have full custody (e.g., if those children reside in the household less than 50% of the time).

   Do not include children who are not the legal responsibility of a household caregiver if they do not reside in the home full-time (e.g., an unrelated child who frequently stays in the home but has a permanent residence elsewhere).

P3. Number of child children in the Household.	Neglect Score	Abuse Score
[ ] a. One, two, or three	0	0
[ ] b. Four or more	2	0

4. **P4. Prior substantiated physical abuse**
   The CFS Specialist will mark "Yes" if any prior physical abuse investigation was substantiated for any current adult member of the household. The CFS Specialist will mark "No" if there is no history of substantiated physical abuse.

P4. Prior substantiated physical abuse	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	0	2

5. **P5. Age of youngest child in the home**
   The CFS Specialist will determine the current age of the youngest child presently in the household. If a child was removed as a result of the current referral, count the child as residing in the home.

P5. Age of youngest child in the home	Neglect Score	Abuse Score
[ ] a. 2 or older	0	0
[ ] b. Under 2	1	0

6. **P6. Characteristics of children in the household**
   The CFS Specialist will assess each child in the household and determine the presence of any of the following characteristics:
   a. **Medically fragile/failure to thrive.** Any child in the household is medically fragile, defined as having a long-term (six months or more) physical condition requiring medical intervention (include also infants under six months of age with physical conditions requirement medical intervention if the condition is likely to persist for six months or more), or is diagnosed as failure to thrive. Requires medical documentation or credible report of professional diagnosis.

   The following characteristics may be present during the initial assessment, or may have been true for any child in the household at any time in the past.

b. **Drug or alcohol exposure.** A child was affected by drugs or alcohol in utero or at birth as evidenced by maternal alcohol or drug use during pregnancy, OR any child had a positive toxicology report for alcohol or another drug at birth or at any time in the past.
c. **Physical disability,** as evidenced by a significant physical handicap that has been diagnosed by a professional (e.g., physician) or is readily apparent (e.g., blindness, amputation, paralysis, etc.; include any credible information).
d. **Developmental disability,** as evidenced by intellectual disability, learning disability, or other developmental problem including ADHD, that has been diagnosed by a professional (e.g., physician, school social worker, psychologist).
e. **Delinquency history.** A child has been referred to juvenile court for delinquent or status offense behavior. Status offenses that are not brought to court attention but that create stress within the household should also be scored, such as children who run away or are habitually truant.
f. **Current or previous mental health/behavior problems.** These are problems not related to a physical or developmental disability. This could be indicated by a current Diagnostic and Statistical Manual (DSM) diagnosis, received or receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking psychotropic medication. Exclude ADHD and use of related medications, which would be included in item "d".
g. **None of the above.** No characteristics are exhibited by any child in the household.

P6. Characteristics of children in the household	**Neglect Score**	**Abuse Score**
[ ] a. Medically fragile/failure to thrive	**1**	**0**
[ ] b. Drug or alcohol exposure	**1**	**0**
[ ] c. Physical disability	**1**	**0**
[ ] d. Developmental disability	**0**	**1**
[ ] e. Delinquency history	**0**	**1**
[ ] f. Current or previous mental health/behavior problems	**0**	**1**
[ ] g. None of the Above	**0**	**0**

7. **P7. Primary caregiver provides physical care consistent with each child's needs**
The CFS Specialist will mark "Yes" if the caregiver is providing age-appropriate physical care that meets minimal standards for all children in the household. Examples may include the following:
a. Obtaining standard immunizations. Do not mark cases in which the caregiver has made a choice not to immunize due to religious or philosophical convictions.
b. Obtaining medical care for severe, chronic, or recurrent illness. Mark as "No" missed well-baby/child visits where there are concerns for infant/child health.
c. Providing the child with adequate food.
d. Providing the child with adequately clean, weather-appropriate clothing.
e. Preventing or addressing rodent or insect infestations.
f. Providing adequate housing with operative plumbing and electricity (heating and cooling).
g. Ensuring that poisonous substances or dangerous objects are not within reach of a small child.

h. Supporting or providing age/developmentally appropriate hygiene (bathing, brushing teeth, changing diapers).

P7. Primary caregiver provides physical care consistent with each child's needs service case due to child abuse or neglect (voluntary or court-ordered)	Neglect Score	Abuse Score
[ ] a. No	1	0
[ ] b. Yes	0	0

8. **P8. Primary caregiver characteristics**
   Assess the primary caregiver for each characteristic and mark all that apply.
   a. **Provides insufficient emotional/psychological support** to the child, such as persistently berating/belittling/demeaning the child, not attempting to bond with the child, or depriving the child of affection or emotional support.
   b. **Employs excessive/inappropriate discipline** that caused or threatened harm to the child because the actions were excessively harsh physically or emotionally and/or inappropriate to the child's age or development. Examples may include the following:
      (1) Locking the child in a closet or basement;
      (2) Holding the child's hand over fire;
      (3) Hitting the child with dangerous instruments; or
      (4) Depriving a young child of physical and/or social activity for extended periods.
   c. **Domineering parent,** indicated by controlling, abusive, overly restrictive, bullying, or over-reactive rules. This may be characterized by a caregiver seeing his/her own way as the only way or by little two-way communication between the caregiver and child.
   d. **None of the above** characteristics are exhibited by the primary caregiver.

P8. Primary caregiver characteristics	Neglect Score	Abuse Score
[ ] a. One or more apply	0	1
[ ] Provides insufficient emotional/psychological support		
[ ] Employs excessive/inappropriate discipline		
[ ] Domineering parent		
[ ] b. None of the above	0	0

9. **P9. Primary caregiver has a past or current mental health problem**
   The CFS Specialist will mark "Yes" if credible and/or verifiable statements by the primary caregiver or others indicate that the primary caregiver has a past or current mental health problem, not including substance abuse, as evidenced by the following:
   a. Current DSM diagnosis by a mental health clinician;
   b. Repeated referrals for mental health/psychological evaluations by professionals engaged with the family; or
   c. Recommendation for treatment/hospitalization, or if the caregiver has been treated/hospitalized for mental health problems at any time.
   Do not include diagnoses of ADHD or learning disabilities (e.g., dyslexia).

P9. Primary caregiver has a past or current mental health problem	Neglect Score	Abuse Score
[ ] a. No	0	0

[ ] b. Yes (mark all that apply)	1	0
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

10. **P10. Primary caregiver has past or current alcohol or drug problem that interferes with family functioning**
    The CFS Specialist will assess whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Include abuse of alcohol and/or illegal substances, and abusive use of prescription drugs. Legal, non-abusive prescription drug or alcohol use should not be considered an alcohol or drug problem. Assess for the following characteristics and mark all that apply:
    Interference in function may be evidenced by the following:
    a. Substance use that affects or affected the following:
       (1) Employment;
       (2) Criminal involvement;
       (3) Marital or family relationships; or
       (4) Ability to provide protection, supervision, and care for the child.
    b. An arrest or citation in the past for driving under the influence of drugs and/or alcohol, refusing breathalyzer testing, possession of a controlled substance or paraphernalia;
    c. Self-report of a problem;
    d. Treatment received currently or in the past;
    e. Multiple positive toxicology screens;
    f. Health/medical problems resulting from substance use; or
    g. The child was diagnosed with fetal alcohol syndrome or exposure (FAS or FAE), or the child had a positive toxicology screen at birth <u>and</u> the primary caregiver was the birthing parent.

The CFS Specialist will select the following based on whether the primary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

P10. Primary caregiver has past or current alcohol or drug problem	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	2	1
[ ] Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] Drugs (mark all that apply		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

11. **P11. Secondary caregiver has past or current alcohol or drug problem**
    Applying the definition in P10 to the secondary caregiver, the CFS Specialist will select

the following based on whether the secondary caregiver has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning.

P11. Secondary caregiver has past or current alcohol or drug problem	Neglect Score	Abuse Score
[ ] a. No secondary caregiver	0	0
[ ] a. No	0	0
[ ] b. Yes	0	1
[ ] Alcohol (mark all that apply)		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		
[ ] Drugs (mark all that apply		
[ ] During the last 12 months		
[ ] Prior to the last 12 months		

12. **P12. Primary caregiver has a history of abuse or neglect as a child**
The CFS Specialist will mark "Yes" if credible statements by the primary caregiver or others indicate that the primary caregiver was abused or neglected as a child, regardless of agency history/intervention. Include disclosure of incidents that would be screened in for assessment now.

P12. Primary caregiver has a history of abuse or neglect as a child	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	2	1

13. **P13. Primary caregiver has a criminal arrest history**
The CFS Specialist will indicate whether the primary caregiver has ever been arrested or convicted either as adult or as a juvenile. This includes DUI but exclude all other traffic offenses (e.g., willful-reckless driving, speeding, parking tickets; consider citations for window tint, driving without insurance and other non-moving violations as traffic offenses).

P13. Primary caregiver has a criminal arrest history	Neglect Score	Abuse Score
[ ] a. No	0	0
[ ] b. Yes	1	1

14. **P14. Two or more incidents of domestic violence in the household in the past year.**
The CFS Specialist will mark "Yes" if credible statements by caregivers or others indicate that there have been two or more physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult in the past year. Include domestic violence involving minor parents if they are the primary or secondary caregiver. Do not include violence among other household members that does not involve primary and/or secondary caregivers. The CFS Specialist will use collaterals and/or supporting evidence in describing the item.

P14. Two or more incidents of domestic violence in the household in the past year.	Neglect Score	Abuse Score

[ ] a. No	**0**	**0**
[ ] b. Yes	**0**	**1**

15. **P15. Housing**
    The CFS Specialist will assess and determine the presence of any of the characteristics below and mark all that apply. If the agency or DHHS has already provided emergency services to address housing, assess housing as it was prior to the intervention. If the agency or DHHS helps the family move to a DV shelter as part of a Safety Plan, do not mark this item.
    a. **Current housing is physically unsafe,** such that it does not meet the health or safety needs of the child (e.g., exposed wiring; structurally unsafe conditions; unsafe/insufficient heating and cooling, and alternative safe arrangements have not been made; unsanitary plumbing; roach/rat infestations; human/animal waste on floors or other household surfaces; rotting food); **or family is homeless** or has received an eviction notice at the time of the referral. Include families who are living in temporary shelter. If the caregiver is unsure of the family's living situation or family considers themselves homeless, endorse this item.
    b. **Family has housing that is physically safe.**

P15. Housing	Neglect Score	Abuse Score
[ ] a. Current housing is physically unsafe or family is homeless	**2**	**0**
[ ] b. Family has housing that is physically safe	**0**	**0**

D. Supplemental Items

Supplemental items are not used to calculate the scored prevention level. These items are included to collect data to test hypotheses about possible prevention factors. At this time, it is not known if any supplemental item contributes to the likelihood of future harm.

1. **S1. Prior injury to any child in the household resulting from child abuse or neglect.**
   The CFS Specialist will mark "Yes" if any child sustained an injury resulting from abuse and/or neglect prior to the referral that resulted in the current investigation. Injury sustained as a result of abuse or neglect may range from bruises, cuts, and welts to an injury that requires medical treatment or hospitalization, such as a bone fracture or burn. Prior injury may or may not have been subject to a child protection investigation. Include prior substantiated injuries and credible report of prior injuries, but exclude accidental injuries.
   a. No
   b. Yes

2. **S2. Primary caregiver provides mental health care consistent with each child's needs.**
   The CFS Specialist will mark "Yes" if the caregiver is providing mental health care consistent with the needs of all children in the household. Also mark "Yes" if no child in the household has mental health care needs. Examples of appropriate care for children with mental health care needs include the following:
   a. Obtaining appropriate assessment, therapy, or counseling;
   b. Ensuring that the child takes necessary medications on an appropriate schedule;

c. Advocating for resources to meet the child's needs from school or community clinic sources (even if resources have not yet been obtained);
d. Supporting child's integration into family, community, and school.

A child's mental health care needs may be indicated by any of the following:

a. Diagnosis of a DSM condition by a mental health clinician;
b. Repeated referrals for mental health/psychological evaluations; or
c. Recommendation for treatment/hospitalization.

E. Section 2: Scoring and Overrides

1. Scoring Individual Items:

a. A score for each assessment item is derived from the CFS Specialist's observation of the characteristics it describes. Some characteristics are objective (such as prior child abuse/neglect history or the age of the child). Others require the CFS Specialist to use discretionary judgment based on his/her assessment of the family.
b. Sources of information used to determine the CFS Specialist's endorsement of an item may include statements made by the child, caregiver, or collateral persons; CFS Specialist observations; reports; or other reliable sources. The CFS Specialist should refer to the definitions to determine his/her selection for each item.
c. After all index items are scored, the CFS Specialist totals the scores and indicates the corresponding prevention level of each index. Next, the scored prevention level (whichever is higher of the abuse or neglect index) is entered.

Neglect Score	Abuse Score	Prevention Level
-1-0	0-1	Low
1-3	2-4	Moderate
4-8	5-8	High
9+	9+	Very High

2. Overrides:

a. After completing the prevention assessment, the CFS Specialist determines if any of discretionary overrides exist. The prevention assessment does not have any policy overrides.
b. A discretionary override is applied by the CFS Specialist to increase the prevention level in any case in which the CFS Specialist believes that the prevention level set by the prevention assessment is too low. This may occur when the CFS Specialist is aware of conditions affecting the likelihood of future harm that are not captured within the items on the prevention assessment. Discretionary overrides may increase the prevention level by one unit (for example, from low to moderate OR moderate to high, but NOT from low to high).
c. After completing the Override section, the CFS Specialist will indicate the final prevention level, which is the highest of the scored level, or discretionary override level.
d. The prevention level informs the decision to open an ongoing services case.

Note: Alternative Response policy will be used in Alternative Response Cases regarding recommendations.

Final Prevention Level	Recommendation
Low	Recommend for referral*#
Moderate	Recommend for referral*#
High	Ongoing services needed

Very High	Ongoing services needed
**Low and moderate risk cases must be recommended for ongoing services if the most recent SDM safety assessment finding was conditionally safe or unsafe.*	

XXIV. DETERMINING PREVENTION ASSESSMENT RESPONSE.

A. Following the completion of the safety and prevention assessments, the CFS Specialist determines the DCFS response. The response by DCFS must be the least intrusive, most appropriate level of service necessary to meet the identified needs of the family.

B. An on-going case will be opened based on the following:

1. Families with an unsafe or conditionally safe child; and/or
2. Families at high or very high risk for future maltreatment of their children: and/or
3. Families with court ordered DHHS involvement regardless of Safety/Risk Assessment determinations.

C. Ongoing cases may be either court or non-court involved. All ongoing cases will be assessed to determine if a child or family is Native American. If a child is identified or is believed to be Native American, the CFS Specialist will send Non-Court or Court Notice to the Tribe(s) and follow all ICWA procedures described in the Indian Child Welfare Act Operations Manual.

XXV. DRUG FACTORS.

A. Based on information gathered during the Risk or Prevention Assessment, the CFS Specialist will document what drugs, if any, are factors when a child initially became involved in CFS. This information is based on the Risk or Prevention Assessment, not on what was alleged in the Intake.

B. This information is person specific and does not require a diagnosis. This is the CFS Specialists assessment of whether drug or alcohol use is a contributing factor related to the current CFS assessment of abuse or neglect.

C. The CFS Specialist will document the specific drug(s) that are a contributing factor in the family for each individual where drugs impact the family. The CFS Specialist will indicate which drug is the 'primary drug of choice' by the individual.

XXVI. ENGAGING FAMILIES WITH SERVICES.

A. CFS Specialists shall make efforts to engage the family and offer interventions prior to requesting the County Attorney to file a petition. However, if a safety threat is identified during the initial assessment or the family's risk level is high or very high and the evidence leading to those decisions is based on one of the five situations listed below, a mandatory staffing with an Administrator is required to determine whether a request to file should be forward to the County Attorney's office.

B. When a CFS Specialist has made efforts to engage a family in services and the family refuses to actively participate and/or their participation is such that child safety cannot be

managed, the CFS Specialist will consult with their supervisor to determine if a 'request to file' should be prepared.

C. A 'request to file' must be sent to the county attorney when the CFS Specialist determines the parent/custodian has been using methamphetamine, regardless of the parent's level of engagement with services.

D. A 'request to file' should be based on:

1. A presence of any safety threat(s) and the family is unwilling to engage in interventions.
2. There are no safety threat(s), but the family's risk level is high or very high and the evidence leading to those decisions is based on one of the five situations listed below. A mandatory staffing with an Administrator is required to determine whether a request to file should be forwarded to the County Attorney's office. These include:
   1) Domestic Violence;
   2) Previous Termination of Parental Rights;
   3) Serious Physical Abuse (i.e. head trauma, broken bones, multiple injuries); or
   4) Sexual Abuse by a Parent.
3. There are no safety threat(s), but the family's risk level is high or very high and the family is unwilling to engage with services. The CFS Specialists are encouraged to involve the Investigative and/or Ongoing (LB1184) Team in discussion of all cases in which the family's risk level is high or very high and the family is unwilling to engage in interventions.

XXVII. REASONABLE EFFORTS.

A. "Reasonable efforts" are those supports and services, both informal and formal, that are needed to preserve and reunify families. The CFS Specialist must review the existing threats to child safety and determine what actions are necessary to reduce the threat to allow the child to remain at home safely or to make it possible for the children placed in out-of-home care to be reunited with his or her family.

B. The CFS Specialist will document the "reasonable efforts" considered and why those efforts are not sufficient to maintain the safety of the child before out-of-home placement is made or why the child cannot be reunified. The CFS Specialist will document that in his/her opinion, no additional efforts could have prevented removal or allowed the child to be reunited.

1. For court involved cases, the CFS Specialist will document reasonable efforts in the court report reasonable efforts narrative.
2. For non-court involved cases reasonable efforts will be documented in the intervention section of the safety assessment.

C. Reasonable efforts to preserve and reunify the family are not required when a court of competent jurisdiction has determined that:

a. The parent of the juvenile has subjected the juvenile to aggravated circumstances, including but not limited to, abandonment, torture, chronic abuse or sexual abuse; or
b. The parent of the juvenile has (i) committed first or second degree murder to another child of the parent, (ii) committed voluntary manslaughter to another child of the parent, (iii) aided or abetted, attempted, conspired, or solicited to commit murder, or aided or abetted voluntary manslaughter of the juvenile or another child of the parent, or (iv) committed a felony assault which results in serious bodily injury to the juvenile or another minor child of the parent; (v) been convicted of felony sexual assault of the other parent of the juvenile under Neb. Rev. Stat. 28-319.01 or 28-320.01 or a comparable crime in another state; or

c. The parental rights of the parent to a sibling of the juvenile have been terminated involuntarily.

XXVIII. ACTIVE EFFORTS.

A. The Indian Child Welfare Act (ICWA) establishes a minimum standard for preventing the breakup of the family, removal of an Indian child from their home and guidelines for placement in foster or adoptive homes. Active efforts must be made to keep the Indian family together. Active efforts means that everything possible must be performed to help the family resolve the problems that led to neglect or abuse, including referral to services that are sensitive to the family's culture. The CFS Specialist must involve and use the available resources of the extended family, the tribe, Indian social service agencies and individual Indian caregivers.

B. The CFS Specialist will provide active efforts to provide remedial services and rehabilitative programs to prevent the breakup of the Indian family. The CFS Specialist must consider services available through tribal social services, Native American service providers, and service providers with appropriate cultural components, experience or knowledge as well as individual Indian caregivers (traditional healers, spiritual leaders, etc.) and extended family members.

C. The CFS Specialist will provide Active efforts as described below. This list is not exhaustive and the CFS Specialist can and should take any action necessary to prevent removal and to help the family resolve the problems that led to the alleged abuse or neglect.

1. Collaborative casework that includes the family and the tribe(s), both prior to and after the removal of an Indian child, exceeding the level that is required under reasonable efforts to preserve and reunify the family that is consistent with the current social and cultural conditions and way of life of the Indian child's tribe or tribes to the extent possible under the circumstances;
2. A request to the Indian child's tribe or tribes and extended family known to DCFS to convene traditional and customary support and services;
3. Actively engaging, assisting, and monitoring the family's access to and progress in culturally appropriate and available resources of the Indian child's extended family members, tribal service area, Indian tribe or tribes, and individual Indian caregivers;
4. Identification of and provision of information to the Indian child's extended family members concerning appropriate community, state, and federal resources that may be able to offer housing, financial, and transportation assistance and actively assisting the family in accessing such community, state, and federal resources;
5. Identification of and attempts to engage tribally designated Nebraska Indian Child Welfare Act representatives;
6. Exhaustion of all available tribally appropriate family preservation alternatives.

D. At every court hearing involving an ICWA child, the CFS Specialist will provide a written report of DCFS attempts to provide or provision of active efforts based on Neb. Rev. Stat. 43-1503. This report will be sent to the Indian child's tribe or tribes within three (3) days after being filed with the court regardless of the decision of the tribe to intervene or efforts made to be involved in the case. The CFS Specialist may contact the DCFS ICWA Program Specialist to consult on the provision of Active Efforts.

E. When the Court or Court Order does not find that active efforts have been made, the CFS Specialist and CFS Supervisor will contact the DCFS ICWA Program Specialist for consultation.

F. Additional details on Active Efforts are in the Program Guidance on ICWA.

XXIX. EMERGENCY REMOVAL.

A. If safety cannot be controlled with supports and services in the home, then placement out of the home must be considered.
   1. For Native American children the CFS Specialist will follow provisions of the Indian Child Welfare Act (ICWA). The CFS Specialist will contact the appropriate tribe for placement options and recommendations, and will document the contacts and information received in the ICWA narrative on N-FOCUS.
   2. The non-custodial parent will be the first placement option considered, prior to a relative or foster care, in the event the child must be removed from his/her home due to safety concerns.
      a. If the non-custodial parent is not available, or is not appropriate, relatives will be considered before foster care.
   3. Whenever possible, children will be consulted about possible placement options.

B. Supervisors must pre-approve all requests to place a child(ren) in foster care. Documentation must include the reasons why the non-custodial parent or relatives were not available or suitable.

XXX. NOTICE TO THE EARLY DEVELOPMENT NETWORK.

A. It is important to have children assessed early for any educational needs. Federal law requires a referral to the Early Development Network (EDN) for early intervention services in substantiated cases involving children under the age of three (3). Upon referral, the EDN Service Coordinator will contact the family to determine if they are interested in having their child evaluated for services. Parents can refuse to participate in this evaluation. The CFS Specialist must let the child's parents know about the referral and discuss all the possible benefits of EDN services. Early intervention services may include physical therapy, occupational therapy, speech therapy, vision and hearing services, and social emotional supports/services.

B. An automatic referral will be generated to EDN when a case status determination of Agency Substantiated or Court Substantiated is entered on N-FOCUS on a parent/caretaker with a child under the age of three (3).

C. At any time, the CFS Specialist must refer a child under that age of three (3) to EDN if there is a suspected delay in the child's development. This can be done at any time during CFS involvement. Referring for EDN services early in the child's development may prevent or minimize negative effects of exposure to risk factors such as abuse and neglect. The CFS Specialist will complete the EDN Referral from N-FOCUS correspondence and send that

form to the local EDN service provider. EDN service providers can be identified by calling 1-888-806-6287.

D. The CFS Specialist may be contacted by EDN staff to provide additional information about the child and family. The EDN Service Coordinator will make a decision to contact the family or provide services based upon the information they have gathered.

XXXI. SDM CASE REVIEWS.

A. At a minimum, the CFS Supervisor will conduct the following reviews of SDM Assessments. The CFS Supervisor will utilize discretion and the work performance of individual CFS Specialists to determine the frequency of additional SDM Reviews.

B. The CFS Supervisor will review every SDM Assessment in which an Override is utilized;

C. The CFS Supervisor will review every SDM Assessment for New Workers for the first 6 months;

D. The CFS Supervisor will conduct a random sample of SDM Assessments. One SDM Assessment will be selected each month for each CFS Specialist. The CFS Supervisor will conduct an in-depth review of one SDM Assessment for each CFS Specialist.

XXXII. CASE CLOSURE.

A. The decision to close a case is not based on safety alone. The CFS Specialist must also consider risk which looks at the likelihood of any harm over the long-term. High and very high risk cases should not be closed if the family can be engaged in services.

B. The CFS Specialist cannot close a case with a safety a plan still in place. If a Safety Plan is still needed, the child is not safe and the case cannot be closed. This is different from saying that the family has a plan to keep the child safe over the long term. If the Safety Plan depends on the case monitoring and/or resources of agencies contracted with CFS, the CFS Specialist cannot close the case.

C. The Initial Assessment case closes when:

1. There are no active safety threats **and** the risk level is low or moderate **and** there is no juvenile court intervention.
2. The family is unable to be located or moved and the CFS Supervisor has determined that a good faith effort was made to locate the family.
3. A child has been determined safe **and** a high or high risk family refuses services **and** the supervisor and CFS Administrator have determined that the county attorney should not be contacted **or** the County Attorney has determined that there will be no court intervention.
4. There is an active safety threat, the family will not engage in services and after assistance from CFS Administration, the county attorney will not file a petition.

GLOSSARY

Abandonment means a parent's intentionally withholding from a child, without just cause or excuse, the parent's presence, care, love, protection and maintenance and the opportunity for the display of parental affection for the child.

Abandoned Child means a child who is without an appropriate caregiver due to the intentional act and conscious decision of the parent not to care for the child.

Active efforts means and includes and includes, but is not limited to:

1. A concerted level of casework, both prior to and after the removal of an Indian child, exceeding

the level that is required under reasonable efforts to preserve and reunify the family described in section 43-283.01 in a manner consistent with the prevailing social and cultural conditions and way of life of the Indian child's tribe or tribes to the extent possible under the circumstances;

2. A request to the Indian child's tribe or tribes and extended family known to the department or the state to convene traditional and customary support and services;
3. Actively engaging, assisting, and monitoring the family's access to and progress in culturally appropriate and available resources of the Indian child's extended family members, tribal service area, Indian tribe or tribes, and individual Indian caregivers;
4. Identification of and provision of information to the Indian child's extended family members known to the department or the state concerning appropriate community, state, and federal resources that may be able to offer housing, financial, and transportation assistance and actively assisting the family in accessing such community, state, and federal resources;
5. Identification of and attempts to engage tribally designated Nebraska Indian Child Welfare Act representatives;
6. Consultation with extended family members known to the department or the state, or a tribally designated Nebraska Indian Child Welfare Act representative if an extended family member cannot be located, to identify family or tribal support services that could be provided by extended family members or other tribal members if extended family members cannot be located; and
7. Exhaustion of all available tribally appropriate family preservation alternatives.

Adjudication means the process of rendering a judicial decision as to whether the facts alleged in a petition or other pleadings are true.

Administrative Hearing is a due process hearing held to appeal a decision made by a state agency.

Adoption means the method provided by law to establish the legal relationship of parent and child with the same mutual rights and obligations that exist between children and their birth parents.

Adoption Disruption means termination of an adoptive placement prior to finalization of the adoption.

Adoption Dissolution means legal termination of an adoption that has been finalized, including legal termination of the adoptive parent(s)' rights.

Adoption Exchange means a listing of children with special needs for whom an adoptive family is being sought, and of families approved for adoption of special needs for children. Some exchanges also list children needing a legal risk placement.

Adoption Registry means a central repository of profiles for all families approved for adoption or fos-adopt by the Department and available for such a placement.

Adoptive Placement means a type of placement that has not been finalized by a Decree of Adoption issued by a county or juvenile court.

Adult means an individual 19 years or older.

Affidavit is a written statement of facts signed under penalty of perjury, often before a court clerk or notary public who administers the oath to the signing party, who is called the affiant or declarant.

Affidavits are routinely required for the procurement of warrants and are used in some jurisdictions to initiate juvenile court proceedings. They may be admitted into evidence.

Aftercare means the control, supervision, and care exercised over youth who have been paroled. It also means the outpatient treatment program for persons who have completed inpatient substance abuse treatment.

Age of Majority means the age at which, by statute, an individual is considered an adult and responsible for his/her own care, support and actions.

Agency Substantiated means that the Department's determination of child abuse or neglect against the subject of the report of child abuse or neglect was supported by a preponderance of the evidence and based upon an investigation pursuant to Neb. Rev. Stat. 28-713.

Allegation means a charge or claim of fact in a petition or other pleading which must be proven if the petition or other pleading is to be found true.

Approval study means a process which includes results of a home visit, a Child Protective Services check, a law enforcement check, and responses from references completed by the Department of a relative or person known to a child prior to placement occurring.

Beginning of foster care means the first 60 days after a placement in out-of-home care is made.

Beyond a reasonable doubt means the highest standard of proof, most often used in criminal cases. The evidence must, by virtue of their probative force, prove guilt. This standard of proof is applied when a court terminates the parental rights of Indian and non-Indian parents to an Indian child.

Caregiver means a parent or guardian, or in some cases, other adult in the household who provides care and supervision for the child. The primary caregiver provides the most child care. The primary caregiver is considered to provide at least 51% of care. The secondary caregiver is the other legal parent or another adult in the household who cares for the children.

Case Closure
Case closure means the 1) safety and risk does not rise to the need for court intervention; or the children are safe and the risk is low to moderate; or the family is unable to be located or 2) decision and process on the successful achievement of goals and outcomes of a child/family that eliminate the need for services and supervision.

Case Plan means a written agreement developed by the CFS Specialist with input from the family members and other team members that identifies the agreed upon goals and objectives. Case Plans are developed for both court involved and non-court involved families.

Case Planning means the family-centered strengths-based process of engaging family members to ensure services are tailored to best address the family's strengths and needs. For Indian children/youth, case planning includes contacting and involving the tribe at the earliest opportunity.

Central Registry means the list of records maintained by the Department containing records of all reports of child abuse or neglect opened for investigation which have been classified as Court Substantiated or Agency Substantiated.

Child means an individual who by reason of minority, is legally subject to parental, guardianship, or similar control. In the state of Nebraska child means an individual less than 19 years of age.

Child and Families Services Specialist means the case manager, initial assessment or ongoing case manager assigned to work with a child or their family who is employed by the Department of Health and Human Services.

Child Caring Agency means an agency incorporated to provide care for children in residential settings maintained by the organization for that purpose.

Child custody proceeding for an Indian child means and includes:

1. "Foster care placement" means any action removing an Indian child from its parent or Indian custodian for temporary or emergency placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian custodian cannot have the child returned upon demand, but where parental rights have not been terminated;
2. "Termination of parental rights" means any action resulting in the termination of the parent-child relationship;
3. "Preadoptive placement" means the temporary placement of an Indian child in a foster home or institution after the termination of parental rights, but prior to or in lieu of adoptive placement;
4. "Adoptive placement" means the permanent placement of an Indian child for adoption, including any action resulting in a final decree of adoption; and
5. "Voluntary foster care placement" means a non-court-involved proceeding in which the department or the state is facilitating a voluntary foster care placement or in-home services to families at risk of entering the foster care system. **This includes cases that are identified as non-court involved and Alternative Response.** An Indian child, parent, or tribe involved in a voluntary foster care placement shall only be provided protections as provided in Neb. Rev. Statute 43-1505(4) and sections 43-1506 and 43-1508

Child Placing Agency means an organization authorized by its articles of incorporation to place children with a foster family or in adoptive homes.

Child Pornography means any visual depiction (live performance or photographic representation) and includes undeveloped film or video tape or data stored on a computer disk or by other electronic means which is capable of conversion into a visual image and also includes any photograph, film, video, picture, digital image or computer-displayed image, video or picture, whether made or produced by electronic, mechanical, or other means of an individual under 18 years of age of sexually explicit conduct.

Clear and convincing evidence means the amount of evidence needed to convince ordinarily prudent minded people that the evidence is strongly in favor of one of the parties. It is more than a preponderance of evidence. Clear and convincing evidence is the standard of proof needed to place an Indian child in foster care.

Closed Adoption means an adoptive situation in which there is no contact or exchange of information between birth relatives(s) and adoptive parent(s) after a decree of adoption.

Commitment means an order by the court committing a child to the care and custody of the

Department of Health and Human Services.

Commitment Date means the date that a child is made a Department ward via court order or voluntary relinquishment.

Concurrent Planning means the process of developing and implementing plans simultaneously to reach the primary permanency objective and an alternative objective. Concurrent planning may occur at any time in a case regardless of adjudication, including status offense and delinquency.

Conditionally Safe means that one or more safety threats are present, and protective safety interventions have been identified and agreed to by caregiver(s). An in-home safety plan is required.

Continuance means the postponement of a hearing, trial or other scheduled court proceeding, at the request of one or both parties, or by the judge without consulting them.

Conviction means the finding that an individual is guilty beyond a reasonable doubt of committing a crime.

Court Appointed Special Advocate (CASA) means a lay volunteer appointed by the court to assist in representing the child's interest in a juvenile court proceeding.

Court Involved Case means a case in which the County Attorney has filed a petition in the interest of the child and the court has assigned responsibility of the child to DHHS or the court has taken jurisdiction of the child and family to address identified safety threats, risk of harm to the child or community safety.

Court Pending means that a criminal complaint, indictment, or information or a juvenile petition under Neb. Rev. Stat. § 43-247(3)(a) has been filed in District Court, County Court, or separate Juvenile Court, and that the allegations of the complaint, indictment, information, or juvenile petition relate or pertain to the same subject matter as the report of abuse or neglect.

Court Report means a written document that contains information about the child and the family and the progress towards achieving the goals in the case plan.

Court–Substantiated means that a district court, county court, or separate juvenile court has entered a judgment of guilty on a criminal complaint, indictment, or information, or an adjudication of jurisdiction on a juvenile petition pursuant to Neb. Rev. Stat. § 43-247(3) (a), and the judgment or adjudication relates or pertains to the same subject matter as the report of abuse or neglect.

Courtesy Assessment means an assessment completed at the request of another state jurisdiction without continuing involvement of DHHS.

Courtesy Supervision means a cooperative arrangement between two or more counties, states or tribes to provide, or continue to provide, services to children and their families who are the subject of a dispositional order.

Criminal History means a county, state, or federal criminal history of conviction or pending indictment of a misdemeanor or felony.

Cruel Punishment means any type of discipline that results in injury, cuts, extreme bruising; withholding food, water, or required care, or requiring child to consume non-food items or inappropriate amounts of food, water or non-food items; a parent/caregivers' use of sadistic measures or weapons.

Cultural Plan means a written plan to ensure a life-long process of encouraging and fostering the Indian child's awareness and understanding of their Native American and tribal heritage and the development of a positive cultural identity. Key components of this plan include, but are not limited to, educating the child about his/her tribal history; initiating and maintaining connections and contact with extended family and other tribal members; exposing the child to positive Native American role models, literature, music, and art; recognizing and addressing racism at the child's current age and in the future, planning for the child to be a part of tribal events and ceremonies, etc.

Custody means the right to or responsibility for a child's care and control, carrying with it the duty of providing food, shelter, medical care, education and discipline.

Dependent Child means a child whose parent is or will be unable to care for the child through no fault of the parent, when no maltreatment has been identified. The parent may be incapacitated or absent due to illness, death, incarceration, or otherwise unavoidably unable to provide care, the child has extraordinary mental health, emotional, or physical needs which the parent does not have the ability or capacity to meet.

Discharge means the termination of Department guardianship or custody of the child.

Disposition means the court's determination of a case in which there is an issuance of a final order or opinion.

Dispositional Hearing means the hearing used for the purpose of determining what will occur with or by a child and/or parents who have been adjudicated within the juvenile court's jurisdiction. A dispositional hearing is when the juvenile court judge will order implementation of a treatment plan.

Domestic Violence means the establishment of control and fear in a relationship through the use of violence and other forms of abuse between spouses, persons living as spouses or adult members of the same household. The offender may use physical abuse, emotional abuse, sexual abuse, economic oppression, isolation, threats, intimidation, and maltreatment of the children to control the other person. Relationships involving domestic violence may differ in terms of the severity of the abuse, but control is the primary goal of all offenders.

Emotional Abuse means the parent/caregiver demonstrates a pattern of criticizing, rejecting, insulting, isolating, terrorizing, or humiliating the child, resulting in serious emotional or behavioral issues.

Emotional Neglect means a parent/caregiver's pattern of failure to seek ongoing or emergency mental health services for a child who has suicidal, homicidal, or severe self- harming behaviors. Severe self-harming behaviors include cutting, burning, or other self- mutilation that requires medical treatment OR risk-taking behaviors likely to result in serious physical harm.

Escapee means a youth who has made an unauthorized flight from a facility to which he/she has been committed by the court or placed by lawful authority.

Evidence means any sort of proof submitted to the court for the purpose of influencing the court's decision on a case.

Expungement Review means the process for an individual, whose name has been entered on the Child and/or Adult Abuse Central Registry, to request that their name be removed.

Failure to Thrive means a serious medical condition in which a child's weight and motor development are significantly below average for his/her age. Usually, though, not always, found in children less than one year old, the syndrome may have an organic cause or it may be caused by severe emotional or physical neglect.

Family means a biological, adoptive or self-created unit of people residing together consisting of adult(s) and child(ren) with the adults(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, cultural practices and a significant relationship. Biological parents, siblings, and others with significant attachments to a child living outside of the home are included in the definition of a family.

Family/Person Centered Practice means a process that is based on a core set of values, beliefs, and principles that recognize that families can and should contribute to all aspects of services through their active participation.

Family Preservation means the efforts being made to safely keep the family together. Family Preservation is also the permanency objective whenever a decision is made that indicates the child can be safely maintained in the home

Family Strength means areas of a family's life where they exhibit power and decision making that is an asset to the family. Identified family strengths are used when developing safety interventions and strategies to achieve case plan goals.

Family Team means a group comprised of individuals selected by the family (including children), including, but not limited to family, friends, relatives, peers, providers, teachers, etc. who come together both formally and informally to form a circle of support around a person and/or family. . Children must be involved in all family team meetings unless they are younger than age 9 or not developmentally appropriate to participate.

Family Team Meeting: A meeting that is convened for the purpose of creating, implementing, evaluating, and updating a Safety Plan and/or Case Plan that furthers an individual's/family's achievement of their goals and the child safety concerns. The team meeting must include the family (unless reunification is not the permanency goal), the Case Manager, and may include other formal and informal supports selected by the family (or others if the family is no longer involved).

Formal Resource People/Participants/Supports means individuals who participate as members of the Family Team due to their paid relationship with the child and family. Examples of this include foster parents, teachers, therapists, community treatment aides, family organization advocates (mentors paid to provide support who are not chosen by the family), and agency staff.

Foster Care means engaged in the service of exercising 24-hour daily care, supervision, custody, or control over children, for compensations or hire, in lieu of the care of supervision normally exercised by parents in their own home. Foster care will not include casual care at irregular intervals or programs as defined in Neb. Rev. Stat. §71-1910. The Indian Child Welfare Act expands the definition

of foster care to include guardianships and placements in which the parent or Indian custodian cannot have the child returned upon demand.

Foster Care Placement means (a) all types of placements of juveniles described in Neb. Rev. Stat. 43-245 and 43-247, (b) all types of placements of neglected, dependent, or delinquent children, including those made by the Department of Health and Human Services, by the court, by parents, or by third parties, (c) all types of placements of children who have been voluntarily relinquished pursuant to Neb. Rev. Stat. 43-106.01 to the department or any child-placing agency as defined in Neb. Rev. Stat. 71-1926 licensed by the department, and (d) all types of placements that are considered to be a trial home visit, including those made directly by the department or office.

Foster family means the placement in which a child is residing other than with their biological parent(s) or legal guardians.

Foster Home means a private single-family living unit, under one roof, housing no more than nine children/youth under the age of 19 including foster children and children of the provider that provides 24-hour parenting to all of the children. No more than six children can be under the age of 12.

Group Home means a home operated under the auspices of an organization that is responsible for providing social services, administration, direction, and control for the home and that is designed to provide 24-hour care for twelve or fewer foster children in a residential setting.

Guardian means an individual appointed by a court who has the powers and responsibilities of a parent. The guardian is empowered to facilitate education, authorize medical care, consent to marriage or adoption of the ward. Under Nebraska law a guardian is not legally required to provide financial support for the ward and is not liable for acts of the ward.

Guardian ad Litem means an attorney appointed by the court to act in the minor's or an incompetent adult's behalf in a lawsuit and protect the minor's or adult's best interests in court.

Guardianship means that the court has appointed an individual to become a child's guardian. Guardianship is one of the permanency objectives available to children if reunification or adoption cannot occur.

Household means all persons who have significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. A person considered as a member of the household if he/she spends 50% or more of his/her time in the home OR if the home is his/her only permanent residence (e.g., deployed members of the military, temporarily incarcerated individuals).

Household Violence means violence within the household which can include child to child; child and parent; parent to parent; or other caretakers or relatives in the home.

Independent Living means the establishment of a residence for a foster youth to reside outside of a foster placement or his/her family. The youth would reside in an apartment, house, dorm or other type of living arrangement and is responsible for taking care of their needs i.e., paying rent, buying and preparing food, managing a budget). It is also a term used as a permanency objective or concurrent plan for a youth 16 years of age or older when it appears reunification may not occur and adoption or legal guardianship are not appropriate and the youth's best interest is served by self-

sufficiency.

Indian Child Welfare Act means the federal and state law that provides direction in working with Indian Children and their families. Refer to the Indian Child Welfare Act Operations Manual for specific direction in working with children and families that may be Indian.

Informal Living Arrangement means that the parent has made arrangements prior to or after DCFS involvement for a temporary and alternative place for their child to reside until child safety can be managed in the parental home.

Informal Resource People/Participants/Supports means individuals who participate as members of the Family Team and do not receive payment for their responsibility with respect to the family. Examples of this may be relatives, neighbors, spiritual leaders, volunteer mentors, friends, etc.

Initial Assessment means the process the Department utilizes to assess for child safety, risk and to determine if maltreatment occurred.

Injury means tissue damage such as welts, bruises, or lacerations that last more than 24 hours, resulting from trauma.

Intake means the stage of the CPS case process where the CPS caseworker screens and accepts reports of child maltreatment.

Interstate Compact on Juveniles (ICJ) means the law which provides (1) for the return from one state to another of delinquent juveniles who have absconded; (2) for the return of non-delinquent juveniles who have run away from home; (3) for the cooperative supervision of delinquent juveniles on probation or parole; and, (4) for additional cooperative measures to the protection of juveniles and of the public.

> ICJ Compact Administrator means the individual in each compacting state appointed by the appropriate state authority for the administration and management of the state's supervision and transfer of juvenile delinquents.

Interstate Compact on the Placement of Children (ICPC) means the law which controls the movement of children from one state to another for the purposes of placement.

> ICPC Administrator or designee means a person designated by the executive head of each jurisdiction that is party to this compact who shall be general coordinator of activities under this compact in his/her jurisdiction and who, acting jointly with like persons of other party jurisdictions, shall have the power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact. In Nebraska this person is located in the Policy Unit of the Division of Children and Family Services. Interstate Compact on ICPC and ICPC Administrator designee definitions are out of alphabetical order and should be moved to where Interstate Compact on Juveniles definition is located.

Juvenile Offender means (1) any juvenile who has committed an act other than a traffic offense which would constitute a misdemeanor or an infraction under the laws of the state or violation of a city or village ordinance; or (2) any juvenile who has committed an act which would constitute a felony under the laws of this state; or (3) any juvenile who has committed an act which would constitute a traffic offense as defined in Neb. Rev. Stat section 43-245.

Kinship Home means a home where a child or children receive foster care and at least one of the primary caretakers has previously lived with or is a trusted adult that has a pre-existing, significant relationship with the child or children or is a sibling of such child or children pursuant to Neb. Rev. Stat. 43-1311.02.

Law Enforcement means the police department or town marshal in incorporated municipalities, the office of the sheriff in unincorporated areas, the Nebraska State Patrol, or tribal law enforcement.

Law Enforcement Check means a review of computer information or contact with a law enforcement agency to determine all felony or misdemeanor filings, including any charges filed, the dates filed, the level of charges, disposition date and final disposition.

Least restrictive means a child in a placed in a setting that is most comparable to his/her home.

Legal custody means a legal relationship that is established by court order, in which one individual, referred to as the Custodian, if given legal authority over, and the corresponding legal responsibility for, another individual. Physical custody may or may not be simultaneous with legal custody.

Maltreatment means parenting behavior that is harmful or destructive to a child's (age birth through age seventeen (17)) cognitive, social, emotional, and/or physical development.

Medical Neglect means the parent/caregiver's pattern of refusing or failing to seek/obtain medical treatment or rehabilitative care for the child's conditions that have potential life-threatening or long-term health effects, including failure to thrive. This includes appropriate medication, medical or dental care, or speech or physical therapy when there is potential for lifelong negative impact.

Medical Neglect of Handicapped Infant means the withholding of medically indicated treatment (including appropriate nutrition, hydration, and medication) from disabled infants with life-threatening conditions. Exceptions include those situations in which:

1. The infant is chronically and irreversibly comatose;
2. The provision of this treatment would merely prolong dying or not be effective in improving or correcting all the life-threatening conditions; or
3. The treatment would be virtually futile in terms of the survival of the infant and the treatment itself in such a situation be inhumane. Food and water must always be provided regardless of the extent of disabilities, and "quality of life" cannot be used as a criterion for deciding upon appropriate medical treatment.

Missing Child/Family Alert means the process whereby CFS agencies can attempt to locate families who have left their jurisdiction by notifying other parts of the state or other state CFS agencies that the children are under the jurisdiction of the court or may be in danger.

Near Fatality means a case in which an examining physician determines that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment (Neb. Rev. Stat. 81-3126).

Non-Court Involved Case means a case in which the family agrees to work with DHHS without involving the juvenile court system, to address the identified safety threats and/or reduce the potential for risk of future maltreatment to children. Non-court involved cases are also described as Voluntary Cases.

Non-custodial Parent means any individual recognized as the parent legally through marriage, adoption, or biology; a man named by the mother or other relative as the father, who agrees he is the father; or in some cases, an individual who has acted in the role of parent for a significant period of time who does not have placement of the child the majority of the time.

Parenting Time means the quality and quantity of time a parent spends with their child who is in out of home care.

Permanency is both a process and a result that includes involvement of the child as a participant or leader in finding a permanent connection with at least one committed adult who provides a safe, stable and secure parenting relationship, love, unconditional commitment and lifelong support in the context of reunification, a legal adoption, or guardianship, where possible, and in which the child/youth has the opportunity to maintain contacts with important persons including brothers and sisters.

Permanency Plan means the systematic process of carrying out (within a brief, time-limited period) a set of goal-directed activities designed to help children live in permanent families. This process has the goal of providing the child continuity of relationships with nurturing parents or caretakers and the opportunity to establish lifetime family relationships.

Permanency Objective means an anticipated result of all efforts and services, which will result in permanency for the child or his/her discharge from Department custody.

Petition means a document filed by a county attorney in a juvenile court at the beginning of a maltreatment, status offense, and/or delinquency case. The petition states the allegations that, if true, form the basis for court intervention.

Physical Abuse means the non-accidental infliction of injury or an act the poses substantial likelihood of inflicting bodily injury.

Physical Custody means the individual with whom the agency places a child for provision of physical care, or in the case of children who are not wards of DHHS, or the individual(s) physically caring for the child.

Physical Neglect means the failure of the caregiver to provide basic needs, for example food, clothing, shelter, medical care, supervision and a safe and sanitary living environment for the child.

Placement means the arrangement for the care of a child in a licensed or approved foster family or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic or any institution primarily education in character, and any hospital or other medical facility. For purposes of the Indian Child Welfare Act, the definition of placement can include an institution caring for the mentally ill, mentally defective or epileptic or any institution primarily educational in character, and any hospital or other medical facility.

Prevention Assessment means a process to evaluate the probability (likelihood, chance, potential, prospect) that a family involved with DHHS for Dependency or Status Offense will experience maltreatment in the next 12 to 18 months.

Primary Caregiver means the person in the household who provides the most child care. The primary caregiver is considered to provide at least 51% of the care.

Preponderance of Evidence means that an event is more likely to have occurred than not by a greater weight of the evidence. As the term "preponderance of the evidence" suggests, there must be credible evidence of maltreatment documented in the case record to support a finding of agency substantiated.

Protective Placement means that safety threats are identified and no interventions are possible, the child is unsafe and must be taken into protective placement. Protective placement is defined as: 1) the family voluntarily placing their child out of the home in a residence approved by the Department; or 2) the Department initiating court action.

Putative Father: A person alleged to be the biological father with no legal establishment of paternity. Also referred to as the alleged parent.

Reasonable efforts mean those supports and services both informal and formal that may allow the child to remain in his/her home safely or to be returned home.

Relative means a person connected to the child by blood, marriage, adoption or tribal law or custom. A person related through legal guardianship will be deemed to be a relative for the purpose of these regulations. For Native American children, relative will be defined either by the law or custom of the tribe, or, in the absence of tribal law or custom, as defined by the Indian Child Welfare Act.

Reunification means a permanent plan for the child that involves the return of the child to any individual who retains parental or legal rights to the child after removal for child abuse, neglect, or both, regardless of the custody arrangement prior to the child entering out-of-home care.

Reunification Assessment means a process to assess whether a child(ren) can be safely returned to the family home based on an evaluation of safety, risk and parenting time.

Risk means the probability (likelihood, chance, potential, prospect) that any harm will occur in the next year to two years.

Risk Assessment means an objective appraisal of the likelihood that children in a household will experience abuse or neglect in the future.

Risk Re-assessment means the process of reassessing for risk to determine if change has been made in the family that has reduced or increased the probability of future harm.

Runaway means there is reasonable evidence to suggest that the child has runaway or has been absent from home for at least 12-14 hours without parent/caregiver consent, and the parent/caregiver does not know where to locate the child.

Safe child means no safety threats were identified at the present time. Based on currently available information, there are no children likely to be in imminent danger of serious harm.

Safety means actions of protection, demonstrated by a caregiver, that mitigate the danger, demonstrated over time.

Safety Assessment means an immediate (here and now) observation and investigation of whether there are serious and imminent threats to a child. Safety is about the short term.

Safety Intervention means involvement to mitigate safety threats which utilizes family strengths whenever possible through the use of family, kin, neighbors or other individuals in the community as safety resources. It may also include direct services by the case manager and community and agency resources. Action to remove a child from the home may be necessary to ensure child safety through court action, a Voluntary Placement Agreement or the family and DHHS agreement to an informal out-of-home placement with relatives.

Safety Plan means there is a written agreement created with the family that describes the safety threats and how those safety threats will be managed to ensure child safety. The plan may remain in effect as long as needed and must be continuously evaluated and modified as long as it is in effect.

Safety Threat means there are circumstances in the family situation that could result in serious harm to the child. "Serious" means that the harm would require medical or mental health attention or emergency services, and that if DHHS staff do not think they could contain the threat, staff could not leave the child in the home. Imminent means that there is a reasonable expectation that the harm will occur in the next week or month.

Secondary Caregiver is a person residing in the household and provides care for children. They are usually a legal parent or another adult that provides less than 50% of care to the child.

Sexual Abuse means any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, the child, or other person.

Sexual Exploitation means, but is not limited to, causing, allowing, permitting, inflicting or encouraging, or forcing a minor child to solicit for or engage in voyeurism, exhibitionism, or prostitution, or in the production, distribution or acquisition of pornographic photography, films or depictions of the child when the child is unable to give consent due to the child's age or incapacity.

Status Offender means any juvenile who, by reason of being wayward, or habitually disobedient, is uncontrolled by his or her parent, guardian, or custodian; who deports himself or herself so as to injure or endanger seriously the morals or health of himself, or others; or who is habitually truant from home or school.

Torture means the infliction of intense pain to punish, coerce, or afford sadistic pleasure.

Trial Home Visit means a placement of a court-involved juvenile who goes from a foster care placement back to his or her legal parent or parents or guardian but remains as a ward of the state.

Transitional Living Proposal means there is a Transitional Living Proposal/Plan developed by identifying knowledge and skills of a youth related to their ability to live on their own with limited supports and providing them with education, support and training to develop and improve those skills and knowledge. This term has also been referred to as an Independent Living Plan

Unable to Locate means the subjects of the maltreatment report have not been located after a good faith effort on the part of the Department.

Unfounded means all reports not classified as court substantiated, court pending, agency substantiated, or unable to locate.

Unreasonable use of Confinement/Restraints means the use of restraints without a physician's order; the parent/caregiver using confinement to a chair, bed, corner or similar environment for unreasonable periods of time is considered physical abuse.

Unsafe child means a child for whom one or more safety threats are present and placement is the only protective intervention possible. Without placement, the children will likely be in imminent danger of serious harm.

Violence means the exertion of physical force so as to injure, abuse, or control.

Vulnerable Child means a child/youth that does not have sufficient capacity for self-protection.

References:

Neb. Rev. Statute 28-457 Methamphetamine; prohibited acts; violation; penalties
Methamphetamine Impact (attached)
Reasonable Efforts: Neb. Rev. Statute 43-283.01
Early Development Network: Neb. Rev. Statute 43-1501-43-1516
Child Abuse Prevention and Treatment Act (P.L. 111-310)

Attachment:

Summary of Initial Assessment Program Guidance Changes

Methamphetamine Impact

Meth use during pregnancy may result in:

- Lack of prenatal care
- Nutritional neglect
- Increase complications of pregnancy
- Low birth weight
- Prematurity
- Birth defects and brain lesions

Newborns and young children may exhibit:

- Addiction withdrawal symptoms that can continue for months
- Irritability, excessive crying
- Slow weight gain or failure to thrive
- Difficulty sucking or swallowing, feeding issues
- Poor sleep patterns
- Hypersensitivity to touch
- Extreme muscle tension, shaking of arms or legs
- Respiratory problems
- Developmental delays or disorders
- Neurological abnormalities
- Learning disabilities, speech problems
- Temper tantrums, aggressive behaviors

Breastfeeding is <u>Not</u> Recommended:

- Babies exposed to meth in breast milk may have insomnia, jitteriness, irritability, slower weight gain, poor sleep patterns, inconsolable crying

School age children may demonstrate:

- Attention Deficit Hyperactivity Disorder
- Social maladjustment
- Academic difficulties

Environmental Exposure:

- Chemicals in lab environments can create life-threatening illnesses or death
- Exposure in environments where meth is used is caused by ingestion from household surfaces, inhaling, and skin penetration.
- Elevated heart rate and agitation

Other impacts on children:

- Lack of stimulation impacts brain and neurological development resulting in academic difficulties and delays
- Lack of consistent interaction and care impacts the child's ability to trust others and to form relationships
- Chaos in home environment causes stress and trauma for children impacting social, psychological and emotional development.
- Exposure to weapons, dangerous animals, violence, physical and sexual assault
- Sporadic school attendance
- Low self-esteem, shame, embarrassment
- Poor role models

Physical symptoms of meth use include:

- Weight loss, anorexia
- Rapid facial aging

- Abnormal sweating
- Shortness of breath
- Sores that do not heal
- Dilated pupils
- Burns on lips or fingers
- Track marks on arms, and legs
- Teeth loss and dental deterioration
- Kidney, heart, brain, and liver damage
- Positive drug screen
- Parent/caregiver admission of use

Behavioral symptoms of meth use include:

- Withdrawal from friends and family
- Change in friends
- Increased activity
- Long periods of sleeplessness
- Long periods of sleep
- Incessant talking
- Irritability
- Twitching and shaking
- Decreased appetite
- Erratic attention span
- Repetitious behavior, such as picking at skin, pulling out hair, compulsive cleaning, grooming, or assembling and disassembling objects
- Aggression or violent behavior
- Convulsions
- Carelessness about appearance
- Deceit or secretiveness
- Increase risk of hepatitis, HIV, sexually transmitted diseases

Cognitive effects include decreased ability to:

- Recognize and recall words and pictures
- Manipulate information
- Ignore irrelevant information
- Make inferences
- Learn from experience

Mental health symptoms of meth use include:

- Increased confidence, good mood, talkativeness, alertness
- Increased sex drive
- Decreased boredom, loneliness
- Paranoia
- Anxiousness
- Nervousness
- Agitation
- Aggression
- Confusion
- Extreme moodiness
- Severe depression
- Psychotic behavior such as hallucinations, homicidal or suicidal thoughts
- Delusions of insects crawling under the skin

Paraphernalia observed may include:

- Rolled up paper or short straws
- Pieces of glass, mirrors
- Razor blades
- Burned spoons
- Plastic tubing
- Syringes/needles

Signs of a meth lab include:

- Unusual strong chemical odors such as ether, ammonia (smells like cat urine) and acetone (smells like nail polish remover)
- Large numbers of empty pill bottles or blister packs, especially of cold or asthma medication
- Propane tanks with blue corrosion on fittings, or with bent or tampered valves
- Heating sources such as hotplates/torches
- Stripped lithium batteries
- Cookware coated with white residue
- Mason jars or other glassware
- Plastic tubing
- Hoses leading outside for ventilation
- Soft drink or milk bottles with hoses attached
- Drain cleaner, paint thinner, denatured alcohol, ammonia, starter fluid, antifreeze, hydrogen peroxide, rock salt, iodine.
- Lantern or camp stove fuel
- Iodine or chemical stained bathrooms or kitchen fixtures
- Excessive amounts of trash, especially chemical containers, coffee filters with red stains, red stained cloth, and empty duct tape rolls.
- Secretive or unfriendly occupants
- Extensive security measures or attempts to ensure privacy
- Curtains drawn or windows blackened or covered
- Increased activity, especially at night
- Frequent visitors at unusual times
- Renters who pay their landlords in cash

The above lists are suggestive of meth use, but are not definitive. While the more symptoms that are present the higher the likelihood of meth use, the CFS Specialist must consider any of the above items in the context of the entire family situation.

Treatment:

Meth addiction is difficult to overcome because the drug causes the brain to lose its ability to process dopamine, leaving the user less and less able to feel enjoyment without the drug. Withdrawal creates a crushing depression. Recovery rates are associated with the severity and length of usage. Studies have shown improved cognitive ability after 3 months of abstinence, and full recovery of attention, memory, learning, executive and motor functioning after 4 years. One study showed successful recovery rates for users able to remain drug free for 9 months.

References:

Methamphetamine Exposures in Young Children, Michael Matteucci, MD et al, Pediatric Emergency Care, Vol.23, Number 9, September 2007

The Methamphetamine Home: Psychological Impact on Preschoolers in Rural Tennessee, Comfort B. Asanbe, PhD. et al, National Rural Health Association, Summer 2008

Meth Gives Rise to a New Tide of Child Endangerment, Diana Riggs, Adoptalk, Fall 2004

Parenting Children Who Have Been Exposed to Methamphetamine, Oregon Post Adoption Resource Center, not dated.

Methamphetamine Health Concerns: Children, Utah Department of Health, not dated.
The Partnership at Drugfree.org
National Institute of Drug Abuse Research Report, Methamphetamine Abuse and Addiction, September 2006
National Institute on Drug Abuse Topics in Brief: Methamphetamine Addiction, November 2011
National Survey on Drug Use and Health Report, Methamphetamine Use January 26, 2007

Summary of Initial Assessment Program Guidance Changes
Pages where changes have been made are noted below.

- Move Glossary to the End of the Document (pg. 61)
- Update Glossary terms:
  - Added Putative Father (pg. 72)
  - Removed Alleged Father
  - Removed Adjudicated Father
  - Updated Abandonment (pg. 61)
- I. Intake Update – added in language regarding methamphetamine.
- II. Initial Assessment Procedures
  - Added language on using the custodial parent as a collateral contact when there are allegations on the non-custodial parent. (pg.6)
- III. Initial Assessment Process
  - Added language regarding the mentally ill and dangerous population. (pg. 7)
- VI. Safety Assessment Process
  - Removed C.4. The language was unclear and provided no additional direction. (pg. 9)
- VII. Completing a Safety Assessment
  - Removed C.7.c. The language was duplicative. (pg. 18)
  - Changed E. Informal Living Arrangement and corrected E.2 to reference the correct section in assessing an Informal Living Arrangement. (pg.19)
- XI. Assessment of Placement Safety & Suitability Overview (pg. 23-24)
- XII. APSS Process (pg. 24-25)
- XXII. Prevention Assessment Overview
  - A. Added reference to conduct the prevention assessment on cases with children identified as mentally ill and dangerous. (pg. 48)
  - C. Removed language regarding the initial assessment as it did not add clear direction to staff. (pg. 48)
- XXV. Drug Factors. Guidance added. (pg. 57)
- XXXII. Case Closure (pg. 61)
- References. Added Methamphetamine attachment