

Chapter 2

CORE SAFETY CONCEPTS

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

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

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

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

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

(2) Allegations of child sexual abuse.

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

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

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

(6) The present danger may not include maltreatment.

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

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

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

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

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

d. Danger Threats may manifest as Present Danger when:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Definitions.

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

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

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

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

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

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

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

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

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

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

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

2. Child’s statements about the paramour.

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

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

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

c. Focus Household.

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

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

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

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

1. The FFA-I will focus on the household of the guardian or custodian.
2. If the child was placed in the current home as a result of a child protection investigation, regardless of whether the biological parent entered into and/or completed a case plan, the child's biological parent and household will be assessed in a separate FFA-Ongoing.
3. When there is no history of child welfare system involvement, the child's biological parent when in a different household will be assessed using the Other Parent Home Assessment.
4. When Termination of Parental Rights has occurred and a biological parent wishes to regain custody, requirements as described in 65C-16, Adoptions must be followed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Assessment of risk and safety for all minor children residing in the household and any family household needs including documentation of any unmet need such as food, clothing, or services not included in the case plan.

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

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

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

c. The completion or updating of the family functioning assessment at any point during a child welfare case requires child welfare professionals to obtain sufficient, current information about six

information domains: the extent of the maltreatment, circumstances surrounding the maltreatment, child functioning, adult functioning, approach to parenting and methods of discipline and managing their child's behavior.

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

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

- (1) Type of maltreatment;
- (2) Severity of maltreatment;
- (3) Description of specific events;
- (4) Description of emotional and physical symptoms;
- (5) Identification of the child and maltreating caregiver; and,
- (6) Condition of the child.

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

- (1) The duration of the maltreatment;
- (2) History of maltreatment;
- (3) Patterns of functioning leading to or explaining the maltreatment;
- (4) Parent/legal guardian or caregiver intent concerning the maltreatment (assessment of intent re: parenting/discipline vs. intent to harm);
- (5) Parent/legal guardian or caregiver explanation for the maltreatment and family conditions;
- (6) Unique aspects of the maltreatment, such as whether weapons were involved;
- (7) Caregiver acknowledgement and attitude about the maltreatment; and,
- (8) Other problems occurring in association with the maltreatment.

g. The “Child Functioning” domain is concerned with the child’s general behavior, emotions, temperament, development, academic status, physical capacity and health status. Refer to Appendix A of this operating procedure for information about child development at different ages. It addresses how a child functions from day to day and their current status rather than focusing on a specific point in time (contact during investigation, time of maltreatment event, case manager’s home visit). An assessment of child functioning must take into account the age of the child and/or any special needs or developmental delays. Among the areas to consider are trust, sociability, self- awareness and acceptance, verbal skills/communication, independence, assertiveness, motor skills, intellect and mental performance, self-control, emotion, play and work, behavior patterns, mood changes, eating and sleeping habits and sexual behavior. Additionally, the assessment of child functioning assesses the child’s physical capabilities including vulnerability and ability to make needs known. In terms of a child who is currently receiving ongoing case management, this information should reflect areas of current child need, such as a medical condition that must be managed, symptoms of depression or trauma, or poor academic performance. If the child is in out-of-home care, it should include information as to the child’s stability in the current placement. Information about child functioning includes:

- (1) General mood and temperament;
- (2) Intellectual functioning;
- (3) Communication and social skills;
- (4) Expressions of emotions/feelings;
- (5) Behavior;
- (6) Peer relations;
- (7) School performance;
- (8) Independence;
- (9) Motor skills;
- (10) Physical and mental health; and,
- (11) Functioning within cultural norms.

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

- (1) Communication and social skills;
- (2) Coping and stress management;
- (3) Self-control;

- (4) Problem solving;
- (5) Judgment and decision making;
- (6) Independence;
- (7) Home and financial management;
- (8) Income/Employment;
- (9) Citizenship and community involvement;
- (10) Rationality;
- (11) Self-care and self-preservation;
- (12) Substance abuse;
- (13) Mental health;
- (14) Family and/or domestic violence;
- (15) Physical health and capacity; and,
- (16) Functioning within cultural norms.

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

- (1) Reasons for being a caregiver;
- (2) Satisfaction in being a caregiver;
- (3) Parent/legal guardian or caregiver knowledge and skill in parenting and child development;
- (4) Parent/legal guardian expectations and empathy for a child;
- (5) Decision making in parenting practices;
- (6) Parenting style;
- (7) History of parenting behavior;
- (8) Cultural practices; and,
- (9) Protectiveness.

j. The “Discipline or Behavior Management” domain includes the broader context of socialization, teaching and guiding the child. It includes methods of discipline as well other ways that the caregiver provides direction, manages behavior, teaches, and directs a child. This domain includes the parent's methods, the source of those methods, purpose or reasons for, attitudes about, context of, expectations of discipline, understanding, relationship to child and child behavior, and the meaning of discipline. Information that answers this question includes:

- (1) Disciplinary methods;
- (2) Approaches to managing child behavior;
- (3) Perception of effectiveness of utilized approaches;
- (4) Concepts and purpose of discipline;
- (5) Context in which discipline occurs; and
- (6) Cultural practices.

2-5. Information Sufficiency.

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

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

- (1) Separate information domains are developed for each parent/legal guardian in the household as well as any significant caregiver.
- (2) Separate information domains are developed for each child.
- (3) Descriptions are provided in the relevant domains for other household members **and** members of the family resource network and their role in the family’s daily life is understood.
- (4) Information provides a clear picture of current family conditions. Information from the last completed and approved FFA or Progress Update will pre-fill the domains. It is the case manager’s responsibility to edit and modify the information that pre-fills the domains to provide:
 - (a) New information learned about the family.
 - (b) Document any changes that have occurred since the date of the last FFA.
 - (c) Additional information that supports the specific caregiver protective capacity and child strengths and needs ratings.
 - (d) Describe how a child is adjusting to or coping with in-home or out-of-home providers in a safety plan.

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

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

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

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

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

(10) Information supports the impending danger threshold criteria.

(11) Information supports protective capacity assessment.

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

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

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

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

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

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

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

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

2-6. Definition of “Least Intrusive.”

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

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

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

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

(4) Child’s need for routines and surroundings which are “normal” to the extent possible.

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

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

2-7. Caregiver Protective Capacities.

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

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

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

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

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

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

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

d. Protective capacities must be assessed and rated for the parent(s)/legal guardians and other persons in the household with significant responsibility for the care and protection of child(ren). The accurate identification of Caregiver Protective Capacities is informed by knowledge of a child's specific abilities given his/her age, whether they are in a normal range, and whether the parent(s)' interactions and expectations are appropriate given the child's age. When a child has any special medical, mental health or physical condition, the appraisal of protective capacities assesses whether the parent is able to understand and provide for such special needs. See Appendix A of this operating procedure, Child Development Stages Matrix, for summary descriptions of child behaviors that are within a normal range as to physical, socio-emotional, and cognitive development; indicators of developmental concern, and associated positive parenting characteristics.

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

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

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

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

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

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

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

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

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

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

(a) Examples may include:

1. People who do not act on their urges or desires.
2. People that do not over-react as a result of outside stimulation.
3. People who think before they act.
4. People who are able to plan.

(b) Case Management Scaling Guide.

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

B. Parent/Caregiver regularly is acts thoughtfully regardless of their on their urges or desires, avoids acting as a result of outside stimulation, avoids whimsical responses, thinks before they take action, and are able to plan when caring for children and making life choices. When parent/caregiver does act on urges/desires, they do not result in negative effects to their children or family.

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

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

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

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

1. People who perform when necessary.
2. People who proceed with a course of action.
3. People who take necessary steps.
4. People who are expedient and timely in doing things.
5. People who discharge their duties.

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

1. People who can move quickly when an unsafe situation presents (e.g., active toddlers who may dart out toward the street or water source, pool, canal, etc.).
2. People who can lift children.
3. People who are able to physically manage a child's behaviors.
4. People with physical abilities to effectively deal with dangers (e.g., a child with special needs who may be prone to 'running' away, a child who requires close supervision, etc.).

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

1. People who are firm and purposeful.
2. People who are self-confident and self-assured.
3. People who are secure with themselves and their ways.
4. People who are poised and certain of themselves.

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

1. People who are alert and focused.
2. People who can move, are on the move, ready to move, will move in a timely way.
3. People who are motivated and have the capacity to work and be active.
4. People who express force and power in their action and activity.
5. People who are not lethargic to the point of incapacitation or inability to be protective.
6. People who are rested or able to overcome being tired.

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

1. People who get people to help them and their children.
2. People who use community public and private organizations.
3. People who will call on police or access the courts to help them.
4. People who use basic community services such as food and shelter.

(f) Case Management Scaling Guide.

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

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

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

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

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

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

1. People who do for themselves after they have done for their children.
2. People who sacrifice for their children.
3. People who can wait to be satisfied.
4. People who seek ways to satisfy their children's needs as the priority.

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

1. People who are flexible and can adapt.
2. People who accept things and can move with them.
3. People who are creative about caregiving.
4. People who come up with solutions and ways of behaving that may be new, needed and unfamiliar but more fitting.

(c) Case Management Scaling Guide.

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

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

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

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

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

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

1. People who can feed, care for, supervise children according to their basic needs.
2. People who can handle, manage, oversee as related to protectiveness.

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

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

1. People who are flexible and can adapt.
2. People who accept things and can move with them.
3. People who are creative about caregiving.
4. People who come up with solutions and ways of behaving that may be new, needed and unfamiliar but more fitting.

(b) Case Management Scaling Guide.

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

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

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

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

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

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

(a) Examples may include:

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

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

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

(b) Case Management Scaling Guide.

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

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

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

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

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

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

(a) Examples may include:

1. People who understand the cause – effect relationship between their own actions and results for their children.
2. People who are open to who they are, to what they do and to the effects of what they do.
3. People who think about themselves and judge the quality of their thoughts, emotions and behavior.
4. People who see that the part of them that is a caregiver is unique and requires different things from them.

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

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

safe.

children are safe.

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

1. People who recognize threatening situations and people.
2. People who are alert to danger from persons and their environment.
3. People who are able to distinguish threats to child safety.

(b) Case Management Scaling Guide.

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

B. Parent/Caregiver is aware of their surroundings and life situations.

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

C. Parent/Caregiver frequently is not aware of their surroundings and life situations.

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

D. Parent/Caregiver is not aware of their surrounding and life situations,

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

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

(a) Examples may include:

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

2. People who respect uniqueness in others.

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

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

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

6. People who appreciate uniqueness and difference.

7. People who are accepting and understanding.

(b) Case Management Scaling Guide.

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

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

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

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

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

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

(a) Examples may include:

1. People who possess an internal sense and appreciation for their protective role.
2. People who can explain what the "protective role" means and involves and why it is so important.
3. People who recognize the accountability and stakes associated with the role.
4. People who value and believe it is his/her primary responsibility to protect the child.

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

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

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

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

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

(b) Case Management Scaling Guide.

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

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

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

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

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

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

(a) Examples may include:

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

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

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

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

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

2. People who spring into action.

3. People who can withstand challenges and stress.

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

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

1. People who can let things pass;
2. People who have a big picture attitude, who don't overreact to mistakes and accidents; and,
3. People who value how others feel and what they think.

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

1. People who fully relate to, can explain and feel what a child feels, thinks and goes through.
2. People who relate to a child with expressed positive regard and feeling and physical touching.
3. People who are understanding of children and their life situation.

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

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

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

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

(b) Case Management Scaling Guide.

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

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

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

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

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

(a) Examples may include:

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

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

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

4. People who are properly attached to a child.

(b) Case Management Scaling Guide.

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

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

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

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

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

(7) The parent/legal guardian/caregiver is supportive and aligned with the child.

Supportive refers to actual, observable sustaining, encouraging and maintaining a child's psychological, physical and social well-being.

(a) Examples may include:

1. People who spend considerable time with a child filled with positive regard.
2. People who take action to assure that children are encouraged and reassured.
3. People who take an obvious stand on behalf of a child.

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

1. People who strongly think of themselves as closely related to or associated with a child.
2. People who think that they are highly connected to a child and therefore responsible for a child's well-being and safety.
3. People who consider their relationship with a child as the highest priority.

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

1. People who show compassion through sheltering and soothing a child.
2. People who calm, pacify and appease a child.
3. People who physically take action or provide physical responses that reassure a child, that generate security.

(d) Case Management Scaling Guide.

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

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

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

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

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

2-8. Impending Danger.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (a) Extreme lack of hygiene with potential to cause serious illness.
- (b) Toxic chemical or materials easily within reach of child.
- (c) Unsecured, loaded firearms/ammunition in child's presence.
- (d) Illicit or prescription drugs accessible by children.

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

- (a) Parent is not maintaining child's medical regimen or meeting treatment needs despite the seriousness of the injury/illness.
- (b) Parent has not called 911 to seek emergency medical response.

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

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

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

- (a) Multiple injuries or singular severe injury that could not have occurred accidentally.
- (b) Despite seriousness of injury, parent reportedly does not know how child was injured.
- (c) Explanation for how child was injured changes over time.

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

- (a) Family is intentionally avoiding contact with CPI.
- (b) Caregiver is hiding the child with relative or family friend and refuses to disclose location.

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

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

- (a) Child is self-injurious.
- (b) Child is setting fires.
- (c) Child is sexually acting out.
- (d) Child is addicted to drugs or alcohol.

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

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

- (a) Child is being sexually abused and perpetrator has ongoing access to child.
- (b) Caregiver is physically assaultive/threatening.
- (c) Caregiver is brandishing a weapon.
- (d) Domestic violence dynamics are present in the household.
- (e) Caregiver is involved in substance misuse.
- (f) Caregiver is violating "no contact" supervision restrictions by order of the

court.

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

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

- (a) Child is unsupervised in a dangerous environment or condition.
- (b) Lack of basic, essential food, clothing, or shelter that result in child needing medical care or attention.
- (c) Child needs to be hospitalized for non-organic failure to thrive.

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

- (a) Parent expresses intent or desire to harm child.
- (b) Parent makes statements about the family's situation being hopeless.
- (c) Child describes extreme mood swings in parent, drug or alcohol use that exacerbate parent's volatility and frustration with child.

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

- (a) Parent describes the child as evil or has singled the child out for being responsible for the family's problems.
- (b) Child expresses fear of being left with caregiver.
- (c) Child describes being subjected to confinement or bizarre forms of punishment.

2-9. Child Strengths and Needs.

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

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

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

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

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

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

- (1) An "A" or "B" rating for any indicator reflects that a child is doing well in that area.
- (2) A "C" or "D" rating reflects that a child is not doing well and requires attention.

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

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

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

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

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

d. Specific Child Strength and Need Definitions and Ratings.

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

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

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

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

OR

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

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

OR

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

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

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

OR

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

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

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

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

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

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

OR

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

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

OR

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

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

OR

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

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

OR

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

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

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

OR

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

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

OR

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

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

OR

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

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

OR

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

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

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

OR

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

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

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

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

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

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

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

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

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

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

A. Child is demonstrating excellent overall health.

OR

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

B. Child is demonstrating an adequate level of overall physical health status.

OR

If child has a chronic condition, it is responding adequately to medical treatment.

C. Child is demonstrating an inconsistent or inadequate level of overall physical health. The child's physical health may be outside normal limits for age, growth and weight range.

OR

If child has a chronic condition, the symptoms are becoming problematic.

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

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

A. Child identifies with his/her culture, has a sense of cultural awareness, and/or is motivated to explore his/her culture. Child has an identified support network to assist in exploring and/or identifying with his/her culture.

OR

Child is of an age where they are not aware of their culture; however, they have a support network that will cultivate the child's sense of cultural identity.

B. Child identifies with his/her culture, has a sense of cultural awareness. Child shows some motivation to explore his/her culture.

OR

Child is of an age where they are not aware of their culture; however, their support network shows some motivation to cultivate the child's sense of cultural identity.

C. Child does not identify with his/her culture, but does have a sense of cultural awareness. Child does not have a support network to assist in exploring and/or identifying with his/her culture.

OR

Child is of an age where they are not aware of their culture and their support network shows little motivation to cultivate the child's sense of cultural identity.

D. Child does not identify with his/her culture, lacks a sense of cultural awareness, and expresses no motivation in exploring and/or identifying their culture. Child has minimal supports to assist with motivation, exploration, and/or identification of culture.

OR

Child is of an age where they are not aware of their culture and their support network shows no motivation and/or support for cultivation of the child's cultural identity.

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

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

OR

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

OR

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

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

OR

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

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

OR

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

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

OR

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

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

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

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

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

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

OR

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

2-10. Stages of Change.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2-11. Family Time/Family Visitation.

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

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

- (1) Attend any type of school, sporting, or extracurricular activity;
- (2) Attend (in person or by phone) a doctor's appointment, medication management, therapy sessions (such as family, speech, vocational, or physical), or special needs training (such as nebulizers); and,
- (3) Participate in monitored telephone calls, face-time, skyping, e-mails, letters, exchange of photographs, etc.

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

- (1) Family time between the parent and child (s. [39.402\(9\)\(a\)](#), F.S.);
- (2) Family time among siblings who are separated in various placements (s. [39.402\(9\)\(b\)](#), F.S.); and,
- (3) Grandparent visitation (s. [39.509](#), F.S.).

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

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

- (a) Consistent. Caregiver regularly attends visits or calls in advance to reschedule (90-100% compliance).
- (b) Routine. Caregiver may miss visits occasionally and rarely requests to reschedule visits (65-89% compliance).
- (c) Sporadic. Caregiver misses or reschedules many scheduled visits (26-64% compliance).
- (d) Rarely or Never. Caregiver does not visit or visits 25% or fewer of the allowed visits (0-25% compliance).

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

- (a) Excellent. Parent/legal guardian/caregiver **consistently**:
 1. Demonstrates parental role.
 2. Demonstrates knowledge of child's development.
 3. Responds appropriately to child's verbal/non-verbal signals.

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

5. Shows empathy toward child.

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

1. Demonstrates parental role.

2. Demonstrates knowledge of child's development.

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

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

5. Shows empathy toward child.

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

1. Demonstrates parental role.

2. Demonstrates knowledge of child's development.

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

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

5. Shows empathy toward child.

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

1. Demonstrates parental role.

2. Demonstrates knowledge of child's development.

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

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

5. Shows empathy toward child.

2-12. Evaluation of Case Plan Outcomes.

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

(1) Specific;

(2) Measurable;

(3) Attainable;

(4) Reasonable; and,

(5) Timely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- values the effects.
- (e) The caregiver sees and accepts the effects of the changed behavior and values the effects.
 - (f) The caregiver indicates satisfaction about the changed behavior.
 - (g) The caregiver prefers the changed behavior over previous ways of behaving.
 - (h) The caregiver recognizes the possibility of relapse and the inevitable consequences.
 - (i) The caregiver can reflect on the positive benefits resulting from the changed behavior.
 - (j) The caregiver is motivated to work on other changes and adjustments in his or her life.
 - (k) There is evidence of secondary gains such as changes in life circumstances, changes in child behavior, changes in relationships, and so on.

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

- (a) The caregiver is actively participating in planned services.
- (b) The caregiver acknowledges the need to change.
- (c) The caregiver is committed to addressing what must change.
- (d) The caregiver acknowledges his or her responsibility for child protection.
- (e) The caregiver makes the correlation between his or her diminished protective capacities and threats to child safety.
- (f) The caregiver assertively takes action to address what must change.
- (g) The caregiver is beginning to demonstrate enhanced protective capacities associated with what must change to create a safe environment.
- (h) The caregiver demonstrates change in perceptions, attitudes, motives, emotions, and behaviors that are associated with his or her protective capacities.
- (i) The caregiver is purposively using services (i.e., counseling, skill building, education) to enhance protective capacities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The caregiver maintains that problems are unchangeable.

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

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

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

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

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

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

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

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

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

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

a. Substantially Compliant.

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

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

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

b. Partially Compliant.

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

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

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

