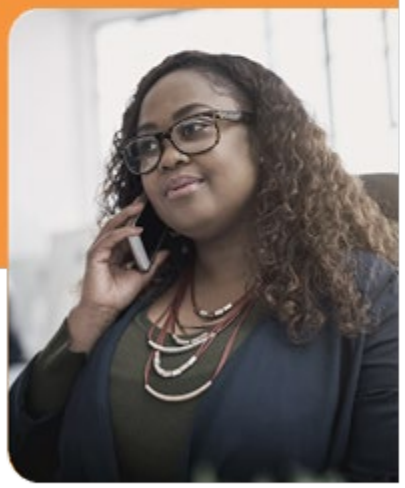
EVIDENT CHANGE
Inform Systems. Transform Lives.

POLICY AND PROCEDURES MANUAL



Newfoundland and Labrador Department of Children, Seniors and Social Development

November 2017

Updated June 2024

ABOUT EVIDENT CHANGE

Evident Change promotes just and equitable social systems for individuals, families, and communities through research, public policy, and practice. For more information, call (800) 306-6223 or visit us online at EvidentChange.org. Find us on social media by visiting Linktr.ee/EvidentChange.

CONTENTS

APPENDICES

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
STRUCTURED DECISION MAKING® MODEL
GENERAL DEFINITIONS

Structured Decision Making® (SDM) assessments are completed on households. *Always* assess the household of the alleged perpetrator. This may be the child's primary residence if it is also the residence of the alleged perpetrator, or the household of a non-custodial parent if it is the residence of the alleged perpetrator. SDM® assessments are not to be used to assess persons who are alternate care providers (foster parents) or third parties (e.g. child care provider, babysitter, teacher, athletic coach).

1. **Household:** All persons who live in the home and interact with the child. An individual who does not live in the home, but who has an intimate relationship with a parent in the home and interacts with the child, can be considered a member of that household.

2. Child refers to a person actually or apparently under the age of 16 years (subsection 2(1)(d) of the Children Youth and Families Act (CYFA Act). When a child's parents do not live together, the child may be a member of two households.

3. Parent refers to:

    - The custodial mother or father of a child;
    - A custodial stepparent;
    - A non-custodial parent who regularly exercises/attempts to exercise rights of access;
    - A person to whom custody of a child has been granted by a written agreement or by a court order; or
    - A person who is responsible for the child's care and with whom the child resides, except a foster parent. (Subsection 2[1][x][viii] of the CYFA Act)

Circumstance	Primary Parent	Secondary Parent
Two legal parents living together	The parent who provides the most child care. May be 51% of care. TIE BREAKER: If precisely 50/50, select alleged perpetrator. If both are alleged perpetrators, select the parent contributing the most to abuse/neglect. If there is no alleged perpetrator or both contributed equally, pick either.	The other legal parent
Single parent, no other adult in household	The only parent	None
Single parent and any other adult living in household	The only legal parent	Another adult in the household who contributes the most to care of the child. If none of the other adults contribute to child care, there is no secondary parent.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® MODEL OVERVIEW

See policy and procedures sections for complete details regarding each tool.

Decision	SDM® Assessment	Which Cases	Who	When
Should referral for child protection be investigated?	Screening and response time	All child protection referrals (CPR) created in the Integrated Service Management (ISM) system	Social worker receiving referral	Upon receipt of CPR
How quickly should social worker respond?	Response priority	All CPRs assigned an in-person response	Social worker receiving referral	Immediately after assigning
Can the child remain safely at home?	Safety*	All assigned child protection referrals	Assigned social worker	Always: For same-day referrals, the safety assessment form must be completed within 48 hours of receipt of referral, following the first face-to-face contact with the child/family. For referrals within seven days, the safety assessment form must be completed by the end of the eighth day after receipt of referral, following the first face-to-face contact with the child/family. However, for referrals actioned prior to day 7, it is best practice to complete the safety assessment form as soon as possible after the first face-to-face contact with the child/family rather than waiting until the eighth day to complete the form.

Decision	SDM® Assessment	Which Cases	Who	When
				Additional requirements: See Policy and Procedures for the Safety Assessment.
Should case be transferred to ongoing protective intervention? If so, at what contact level?	Risk	All assigned child protection referrals	Assigned social worker	Within 30 days of receipt of the child protection referral
Focus of family centred action plan (FCAP)	Family strengths and needs	All cases open for ongoing protective intervention	Social worker responsible for FCAP	Initial: Prior to initial FCAP and within 60 days of receipt of the CPR Review: Within 30 days of subsequent FCAP
Can child be returned home? Should reunification efforts continue? Should permanency goal be changed?	Reunification	Ongoing protective intervention cases with at least one child in out-of-home care with goal of return home	Assigned social worker	Every four months after the completion of the initial FCAP and prior to completion of FCAP
Can ongoing protective intervention case be closed? If not, what level of contact?	Risk reassessment	All ongoing protective intervention cases where ALL children are in the home	Assigned social worker	Every four months after the completion of the initial FCAP and prior to completion of FCAP

*Standard safety assessment is used for all referrals except alternate care providers. The alternate care provider safety assessment is used when the referral alleges maltreatment by an alternate care provider.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® SCREENING AND RESPONSE TIME ASSESSMENT
POLICY AND PROCEDURES

WHICH CASES

The screening and response time assessment (SRTA) is completed on all child protection referrals (CPR). This includes new referrals of child abuse and neglect on ongoing protective intervention cases.

WHO

The social worker who receives the information completes the assessment, and the supervisor reviews and approves the screening and response time decision.

WHEN

The SRTA is completed upon receipt of CPR. This generally occurs while the social worker is speaking with the referral source making a referral (either over the phone or in person). Occasionally, the social worker may need to gather information from additional sources as part of the screening process. For these referrals, the screening assessment is completed as soon as all necessary information is gathered and within 24 hours. In exceptional circumstances, the social worker may need additional time to obtain the information to make a screening decision. In this case, the decision is made within 72 hours of receipt of referral.

DECISION

The SRTA determines whether a referral requires an investigation and determines the required response time. If an investigation is required, the same-day response criteria identify whether a same-day response is required. All other referrals assigned for investigation require a response within seven days.

APPROPRIATE COMPLETION

Section 1. Maltreatment Type

If the referral meets all elements of a referral for child abuse or neglect (the alleged victim is a child, as defined by the CYFA Act; the family is located within the region's jurisdiction, and the alleged perpetrator is the parent of the child victim), proceed with review of screening criteria and select all applicable maltreatment types, using the definitions to ensure that the referral information meets criteria.

Section 2. Recommendation and Overrides
If any maltreatment type in Section 1 is present, check "Screen in: One or more maltreatment type is present." If no maltreatment is present, check "Screen out: No maltreatment type is present."

If the initial screening recommendation is "screen in," the worker should review only the override reasons for "screen out" to see if any apply. Likewise, if the initial screening recommendation is "screen out," the worker should review only the override reasons for "screen in." Check any override reasons that apply.

Record the final screening decision based on the impact of any overrides.

Section 3: Response Time Decision
For all referrals in which the final screening decision is to investigate, the same-day response criteria must be reviewed. If any of the same-day response criteria are present in a given referral, the response time for the referral is always same day.

Referrals that do not include criteria that meet the need for same-day response will always be assigned a response time of within seven days.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® SCREENING AND RESPONSE TIME ASSESSMENT

SECTION 1. MALTREATMENT TYPE

Physical Abuse

☐ Suspicious death of a child due to abuse and another child in care of parent.
☐ Non-accidental physical injury.
☐ Unexplained or suspicious physical injury.
☐ Parent giving the child toxic chemicals, alcohol, or drugs.
☐ Parent has acted or threatened to act in a way that is likely to cause injury.
☐ Propensity to violence.

Emotional Abuse

☐ Parental action has or is likely to emotionally harm the child.
☐ Exposure to violence in the home or between parents.

Sexual Abuse

☐ Parent engaging in or attempting to engage in a sexual act or sexual contact with child.
☐ Sexual exploitation of a child by a parent.
☐ Exposure to sexually explicit conduct or sexually explicit materials.
☐ Physical, behavioural, or suspicious indicators consistent with sexual abuse.
☐ Threat of sexual abuse.

Neglect

☐ Failure to protect child against neglect, physical, emotional and sexual abuse.
☐ Suspicious death of a child due to neglect, and another child is in care of parent.
☐ Abandonment or unwilling/unable/unavailable parent.
☐ Inadequate supervision.
☐ Failure to thrive.
☐ Inadequate medical, dental, and/or mental health care.
☐ Inadequate clothing or hygiene.
☐ Inadequate food/nutrition.
☐ Exposure to unsafe home and immediate environment.
☐ Child under 12 years committing serious offence.
☐ Inadequate response to child, under 12 years, committing a pattern of serious offences.
☐ Exposure to illegal drug activity.
☐ Involving child in criminal activity.
☐ Newborn exposure or risk of exposure to drugs or alcohol.
☐ Other high-risk birth.

No Maltreatment

☐ Referral does not include an allegation of abuse or neglect.

SECTION 2. RECOMMENDATION AND OVERRIDES

Initial Screening Recommendation

○ Screen out: No maltreatment type is selected.
○ Screen in: One or more maltreatment types are selected.

Overrides

○ Screen out: One or more maltreatment types are selected, but referral will be screened out. (*Select all that apply.*)
- ☐ Insufficient information to locate child/family.
- ☐ Duplicate referral; information will be included with referral assigned for investigation.
- ☐ Referral already investigated, no new allegations.
- ☐ Other (specify): _____

○ Screen in: No maltreatment type is present, but referral will be screened in and assigned for investigation. (*Select all that apply.*)
- ☐ Court request or order for an investigation.
- ☐ Other (specify): _____

○ No overrides apply.

Final Screening Decision *(after consideration of overrides)*

○ Screen out: No maltreatment type is selected AND no screen-in overrides apply; or referral was screened out based on an override.

○ Screen in: At least one maltreatment type selected AND no screen-out overrides are selected; or the referral was screened in based on an override. **Complete Section 3, Response Time Decision.**

SECTION 3. RESPONSE TIME DECISION *(Complete for all screened-in reports.)*

○ **Same-day response required based on one or more criteria below.** (*Select all that apply.*)
- ☐ Child death is suspicious or unexplained, and another child is in the home.
- ☐ Child requires same-day medical attention, AND abuse/neglect is suspected, OR parent is unwilling/refusing to obtain needed treatment.
- ☐ Child is demonstrating self-harmful behaviours, and the parent is not providing an adequate or appropriate response.
- ☐ Child age 12 or younger has killed or seriously injured another person, and there is concern that the parent has not or will not respond appropriately.
- ☐ Child has a visible injury that is suspicious, unexplained, or consistent with abuse, and the parent who is alleged to have either caused the injury or failed to protect will have access to the child today OR the perpetrator is unknown and may have access to the child today.
- ☐ Child is currently alone and requires immediate care.
- ☐ Child is inadequately supervised and likely to be exposed to harm or unsafe conditions today.
- ☐ Child is likely to be exposed to sexual harm or abuse today.
- ☐ Failure to protect child from serious harm.
- ☐ Physical conditions of the home or environment are immediately unsafe, and the child will be in the home today.
- ☐ The likelihood that a child has been or will be exposed to violence today is high, AND no parent is demonstrating protection of the child.
- ☐ A parent who allegedly killed or seriously injured (caused hospitalization of) another person through violent acts will have access to their child today.
- ☐ Other (specify): _____

○ **No same-day response criteria; response within seven days is required.**

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® SCREENING AND RESPONSE TIME ASSESSMENT
DEFINITIONS

SECTION 1. MALTREATMENT TYPE

Maltreatment is an action or lack of action by a parent resulting in the abuse and/or neglect of a child. A social worker will consider child's age, developmental status, and other vulnerabilities when assessing referrals for allegations of abuse or neglect. Parental action or lack of action may be caused or exacerbated by substance abuse, mental health concerns, developmental delays, etc.

When third-party maltreatment referral information is received, please refer to Practice Standard 1 to assess the parent's protectiveness in relation to the third-party maltreatment information. Assessing a parent's protectiveness in third-party maltreatment cases is directly linked with our legislative requirement to investigate situations of child maltreatment when it involves acts of parental omission or commission.

Physical Abuse

Physical abuse is action on the part of the parent in which a child sustained or is likely to sustain a physical injury. Injury to the child may be current or may have occurred in the past.

Suspicious death of a child due to abuse and another child in care of parent.
Report of child death and concern that abuse contributed to or caused the child's death. Examples include but are not limited to:

- Death of a child due to head trauma or internal injuries that appear suspicious; and/or
- Death of a child due to suffocation or physical restraint that prevented adequate respiration.

Non-accidental physical injury.
Infliction of physical injury on a child **by a parent.** Injury or injuries may be current or may be in different stages of healing. Include physical injuries to a child that resulted from a domestic violence incident or excessive discipline. Examples of non-accidental injuries include but are not limited to:

- Bruises and/or lacerations;
- Burns or bites;
- Injuries to bone, muscle, cartilage, or ligaments;
- Head injuries; and/or

- Internal injuries.

Unexplained or suspicious physical injury.
Injury to a child for which the parent and/or child can give no plausible explanation, and the perpetrator is unknown. Injury or injuries may be current or may be in different stages of healing. Examples include but are not limited to situations in which the child has an injury and:

- Parent and/or child provides details of the causes of the injury that are inconsistent with the injury;
- Parent has no explanation for the injury; and/or
- The injury appears suspicious, and the referral source has no information about circumstances that caused injury.

Parent giving the child toxic chemicals, alcohol, or drugs.
The chemicals, alcohol, or drugs given to the child caused or could cause harm, such as alcohol, illegal drugs, or an inappropriate dosage of medication, including medication prescribed to another individual. Also include any allegations of a parent giving a child poison, gasoline, kerosene, bleach, or cleaning agents.

Parent has acted or threatened to act in a way that is likely to cause injury.

- Parental threat of harm that if carried out is likely to cause injury to child, and it is likely that without intervention the parent will carry out the threat;
- Parents' action/behaviour toward child is escalating, and there is a history of parent causing physical injury when this occurs; and/or
- It is not necessary for a referral source to determine that an injury occurred. Consider the child's age and development in combination with the parent action.

Examples of parent action that could cause injury include but are not limited to:

- Striking a child with a closed fist or implement;
- Striking or using physical discipline on a child younger than 3 years;
- Striking a child on the head, including a face slap or hair pull;
- Shaking, kicking, or throwing a child;
- Interfering with a child's breathing;

- Parent has previously physically abused a child and that child is no longer in the care of the parent due to the abuse, and a child is currently living in the household.

Note: If the child has been injured, check one of the applicable physical injury definitions (i.e. suspicious death of a child due to abuse, and another child in care of parent; non-accidental physical injury; OR unexplained or suspicious physical injury) above.

Propensity to violence.
A parent with whom the child is living or who exercises access has allegedly killed or seriously injured another person, or their actions show a propensity to violence. Propensity to violence is defined as a natural inclination or tendency to frequently or almost always respond to situations using violence (e.g. a parent who has a repeated pattern of violent actions against an individual, such as death threats or assaults). Examples include but are not limited to:

- A parent allegedly attempted to, or killed, another person; or

- A parent recently seriously injured another person and that person required hospitalization for injuries that are considered serious or life threatening.

Emotional Abuse
Emotional abuse is a **pattern** of negative behaviour, **repeated destructive** interpersonal interactions or a single, significant destructive interaction by a parent toward the child. The impact on the child of being exposed to these emotionally harmful behaviours may include depression, significant anxiety or withdrawal, self-destructive or aggressive behaviour, or delayed development.

Parental action has or is likely to emotionally harm the child.
Parent has a pattern of negative behaviour; repeated destructive interpersonal interactions; OR a single, significant destructive interaction toward the child that has or likely will have an impact on the child's emotional well-being. The child may exhibit harm through symptoms of depression, significant anxiety or withdrawal, self-destructive or outwardly aggressive behaviour, or delayed development. Parental behaviour that constitutes emotional maltreatment may include but is not limited to repeated and/or extreme episodes of the following actions.

- The parent is exhibiting persistent or severe symptoms of mental illness. The child is worried that the parent will harm themself, child must care for a chronically depressed parent, or child worries about their own safety due to parent's symptoms.

- Rejecting or degrading the child. This may include singling one child out to criticize or punish, belittling the child, or shaming the child for expressing normal emotions such as affection or grief.

- Withholding affection or cognitive stimulation, failing to express care and love for the child, and/or using affection as a reward.

- Terrorizing the child. This may include threatening harm or actually harming self or a child's loved ones, including pets; intentionally placing the child in dangerous situations; or otherwise intentionally causing the child to experience extreme fear.
- Isolating the child. This may include intentionally denying the child opportunities for interacting with peers or other adults.

- Exploiting the child. Parent uses child for their own gain, such as talking negatively about the other parent in an effort to sabotage the child's relationship with that parent.

- Corrupting the child. Parental actions encourage the child to develop self-destructive, antisocial, criminal, or deviant behaviours.

Exposure to violence in the home or between parents.
Child is exposed to or is living in a situation where there are one or more incidents of violence between parents or between an adult household member and another adult, OR the child is known to experience the buildup of tension or aftermath of the assault (e.g. observing victim depression, bruises, or other injuries). Exposure is indicated by the *child seeing, hearing, or trying to intervene* in the incident of violence. Incidents of violence include but are not limited to *physical conflict; sexual assault; verbal altercations* that include coercion, intimidation, or threats; manipulation or control of children; isolation; or unreasonable control of the adult victim.

Exposure to violence can include circumstances in which parents are separated but continue to share parenting responsibilities and directly expose their child to violence.

When assessing referrals for exposure to violence, consider that some conflict between parents or partners is a normal part of a relationship, may occur during and following a parental separation, and **is not necessarily** a child protection concern.

Sexual Abuse
Sexual abuse includes any sexual contact between a parent and a child regardless of whether the sexual contact occurs by force, coercion, duress, and deception or whether the child understands the sexual nature of the activity. Sexual contact includes sexual penetration, touching, harassment, invitation to sexual touching, sexual acts such as exposure, voyeurism, or sexually exploiting the child by involving the child in the sex trade or pornography.

Parent engaging in or attempting to engage in a sexual act or sexual contact with child.
This is based on disclosure (verbal, written, drawing) and/or medical evidence, or credible witness account. This includes allegations that a parent made sexual advances toward a child and/or asked a child to perform sexual acts.

Sexual exploitation of a child by a parent.
The parent involves the child in obscene acts; engages the child in prostitution; or allows, permits, encourages, or engages in obscene or pornographic display, photographing, filming, or depiction of the child as prohibited by law.

Exposure to sexually explicit conduct or sexually explicit materials.
Parent has intentionally or recklessly exposed or allowed child to be exposed to actual or simulated sex acts; sexually explicit materials; sexual contact; bestiality; masturbation; purposeful exhibition of the genitals, anus, or pubic area; or other sexually explicit conduct.

Physical, behavioural, or suspicious indicators consistent with sexual abuse.
Basis exists for concern; the parent is suspected to have sexually harmed the child, or at this time the perpetrator is unknown and the parent cannot be ruled out. Indicators should be considered in the context of the child's age and developmental level. Examples include but are not limited to the following.

- A pre-adolescent child has a sexually transmitted infection, symptoms of a sexually transmitted infection, or otherwise unexplained injuries to their genital or anal area.

- Child has initiated sexual acts or activities that are outside age-appropriate exploration or development, and this has led to a concern that they are a victim of sexual abuse, including toddler or elementary school-aged child displaying highly sexualized, aggressive behaviours.

- Child complains of pain in the genital or anal area AND other indications of sexual abuse exist as referenced in preceding bullets.

Threat of sexual abuse.
No sexual act or exploitation has occurred; however, household conditions create substantial likelihood that the child will be sexually abused. This includes but is not limited to the following.

- A parent has a history of sexual abuse (including credible allegations) against a child.

- A parent views or possesses child pornography.

Neglect
Neglect is the lack of action by a parent in providing for the adequate care and attention of the child's needs, resulting in harm to the child or substantial risk of harm to the child.

Failure to protect child against neglect, physical, emotional, and sexual abuse.
The child is being harmed or likely would be harmed by a person other than the parent (including siblings or another parent not living in the household), AND the parent is aware of this or reasonably should have this knowledge, AND nothing indicates that the parent has acted to protect the child. Examples may include but are not limited to the following.

- Child is left with grandparent or other third party, despite the fact that grandparent or other third party abused/neglected parent as a child or caused harm in the past.
- Parent expresses disbelief and/or demonstrates lack of support for a child who has disclosed sexual, emotional, or physical abuse by the other parent, a family member, or another person.
- Parent allows individual with known history of sexual or physical abuse or neglect to have unsupervised access to child.
- Parent witnesses a third party abusing their child (striking, shaking, shoving, threatening, intimidating, berating, exposing to sexually explicit acts or pornography) and does not intervene to protect the child or prevent further exposure to harmful individual.
- Parent is aware of or reasonably should be aware of third party exploiting their child by encouraging or demanding that child participate in criminal acts, and parent does not intervene to protect child or prevent further exposure to harmful individual.

Suspicious death of a child due to neglect, and another child is in care of parent.
Report of child death is unexplained, or concern exists that parental neglect contributed to or caused the child's death such as:

- Unattended infant drowning in a bathtub or other body of water; or
- Death of an infant in an unsafe sleeping arrangement such as sleeping on a sofa, on a bed surrounded by pillows, or with an intoxicated adult.

Abandonment or unwilling/unable/unavailable parent.
A parent is unavailable or unwilling/unable to provide care and supervision to the child. Examples include but are not limited to:

- Death of parent and adequate arrangements have not been made;
- Parent has abandoned the child with no apparent plans for return;
- Parent has abandoned the child or has left the child alone with no adult supervision and without appropriate arrangements for the child's care;
- Parent is unable to care for the child due to arrest, hospitalization, or unavoidable absence, and no safe adult is available to care for the child; or
- Parent is demonstrating or expressing significant struggles in parenting the child to the extent that the likelihood is high that in the near future the parent will ask the child to leave the home and will refuse to parent/care for the child.

Inadequate supervision.
A child has been left unsupervised with responsibilities beyond their capabilities and/or without a support system that should include phone numbers of parents, other family members, or neighbours; information about personal safety; and what to do in an emergency. Consider length of time unsupervised, time of day, and age/ability of child.

OR

Parent is present but inattentive to actions or needs of the child to the extent that the child has been injured or could have been injured due to a parent's lack of attention or supervision. An example of this may include a parent being present but under the influence of OR a parent is misusing substances and/or unable to care for the child to the extent that an injury has or may occur without interventions.

Failure to thrive.
The child has been diagnosed with failure to thrive or allegedly has symptoms suggestive of failure to thrive such as being dehydrated, emaciated, underweight, or physically underdeveloped, and it is suspected that the child's diagnosis or symptoms are related to a parent's actions or lack of action to care for the child.

Inadequate medical, dental, and/or mental health care.
Parent unreasonably delays; refuses; or does not seek, obtain, and/or maintain necessary medical, dental, or mental health care when parent knows, or should reasonably be expected to know, that such actions may cause an adverse impact or will cause an adverse impact without intervention on the child's health and well-being. Such actions may include but are not limited to:

- Withholding or failing to obtain/maintain medically necessary treatment for a child with life-threatening, acute, or chronic medical conditions;

- Withholding or failing to obtain/maintain necessary mental health treatment for a child with suicidal or self-harming behaviours or threats, psychosis, severe depression or anxiety, or other severe mental health conditions; and/or

- Failing or refusing to obtain dental care for a child with dental problems that causes chronic pain or interferes with routine eating.

Inadequate clothing or hygiene.
Parent has failed to meet a child's basic needs for clothing and/or hygiene to the extent that the child's daily activities have been or will be adversely impacted without intervention. Examples include but are not limited to the following.

- Child experiences hypothermia or frostbite due to inadequate clothing.

- Child develops or suffers worsening of an injury or illness (e.g. sores, infection, severe diaper rash) due to poor hygiene.

- Schoolmates refuse to play with or sit next to child because of body odour, dirt, or other indicators of poor hygiene. (*Note*: Chronic lice infestation alone is not an indicator of poor hygiene.)

Inadequate food/nutrition.
Parent has not and/or does not provide sufficient food or hydration to meet minimal requirements for the child; child experiences significant lack of food or complains of unmitigated hunger due to lack of food. Exclude fasting for religious reasons. Examples may include but are not limited to the following.

- Neighbour states that child frequently comes over, asking for food.

- Parent is not meeting nutritional needs of the child, e.g. feeding infant something other than formula or breast milk.

Exposure to unsafe home and immediate environment.
The child's physical living conditions are significantly unsanitary and/or contain hazards that have led or could lead to a child's injury or illness if not resolved. Consider child's age and developmental stage when assessing the chances of injury or illness: Infants/toddlers are more vulnerable due to lack of understanding about avoiding physical hazards in the home. Examples may include but are not limited to:

- Housing that is an acute fire hazard or has been condemned;
- Exposed heaters;
- Gas fumes;
- Exposed electrical wiring;
- Broken windows or stairs;

- Vermin, human, or animal excrement uncontained in the home;
- Unguarded weapons;
- Accessible hazardous chemicals;
- Accessible drugs and/or paraphernalia; and/or
- Production of illegal drugs.

Child under 12 years committing serious offence.
It is alleged that a child under 12 years of age killed or seriously injured another person or caused serious damage to another person's property (e.g. arson, vehicle theft, and/or damage).

Inadequate response to child, under 12 years, committing a pattern of serious offences.
A child under 12 years has harmed or threatened to physically harm another person or animal or has caused serious damage to another person's property (e.g. arson, vehicle theft, and/or damage) on more than one occasion, AND there is concern that the parent has not or will not respond appropriately or has encouraged the behaviour.

Exposure to illegal drug activity.
Illegal drugs or drug paraphernalia are sold, distributed, or manufactured in the child's home, or parent exposes the child to this drug activity in another setting such as taking the child to a home where drugs are manufactured or where people congregate for the purpose of drug use (i.e. known drug house).

Involving child in criminal activity.
The parent causes the child to perform or participate in illegal acts that could, but are not limited to:

- Create danger of serious physical or emotional harm to the child;
- Lead the child to being arrested; or
- Force a child to act against their wishes.

Newborn exposure or risk of exposure to drugs or alcohol.
Newborn or birth mother has a positive toxicology screen at birth; OR mother or reliable source acknowledges that mother used drugs, alcohol, or solvent during pregnancy; AND there are concerns for child's safety (e.g. parent's ability to provide consistent care and supervision).

Other high-risk birth.
No acts or omissions constituting neglect have yet occurred with this child; however, conditions are present that suggest that the external supports of the hospitalization or the limited time since birth are the only reasons neglect has not occurred.

Examples may include but are not limited to the following.

- Parents have not attended to the newborn in the hospital.

- Behaviour of young parent with an inadequate support system suggests parent will be unable to meet the newborn's basic needs.

- A parent of any age with apparent physical, emotional, or cognitive limitations has an inadequate support system and may be unable or unwilling to meet the newborn's basic needs.

- A child is born with medical complications and parent response suggests parent will be unable to meet the child's exceptional needs (e.g. parent does not participate in medical education to learn necessary care or indicates denial of the diagnosis).

- Prior history of neglectful behaviour with other child(ren) suggests a high-risk birth.

*Please refer to the most recent Services to Expectant Parent Policy, where information is received regarding an expectant parent.

SECTION 2. RECOMMENDATIONS AND OVERRIDES

Initial Screening Recommendation

Screen out: No maltreatment type is selected.
Select this decision if "No Maltreatment" in Section 1 is selected, which means that the referral does not meet statutory requirements for an investigation.

Screen in: One or more maltreatment types are selected.
Select this decision if any maltreatment type in Section 1 is selected, which means that at least one reported allegation meets statutory requirements for an investigation.

Overrides

Screen out: One or more maltreatment types are selected, but referral will be screened out. *(Select all that apply.)*
Indicate the reason.

- *Insufficient information to locate child/family*. The caller was unable to provide enough information about the child's identity and/or location to enable an investigation. **Do not select this item if partial information is available.**

- *Duplicate referral; information will be included with referral assigned for investigation*. The information provided was reported previously and is being

investigated currently. No new facts (same alleged perpetrator, same incident, and same child) have been provided that constitute a new allegation.

- *Referral already investigated, no new allegations*. A report was received, investigated, and closed. The information reported matches the prior allegations in all respects.

- *Other (specify)*.

Screen in: No maltreatment type is present, but referral will be screened in and assigned for investigation. *(Select all that apply.)*
Select this decision if no maltreatment types in Section 1 are selected, which means that the referral does not meet statutory requirements for an investigation. However, a referral will be opened and assigned for investigation for:

- *Court request or order for an investigation*; and/or
- *Other (specify)*.

No overrides apply.

Final Screening Decision (after consideration of overrides)

Screen out: No maltreatment type is selected AND no screen-in overrides apply; or referral was screened out based on an override.
Select this decision if no maltreatment type in Section 1 is selected, which means that the referral does not meet statutory requirements for an investigation, AND no screen-in overrides in Section 2 are selected.

Screen in: At least one maltreatment type selected AND no screen-out overrides are selected; or the referral was screened in based on an override. **Complete Section 3, Response Time Decision**.

Select this decision if any criteria in Section 1 are selected, which means that at least one reported allegation meets statutory requirements for an investigation, or at least one screen-in criteria was identified AND no screen-out criteria were selected. For all referrals in which the final screening decision is to screen in, a response time must be identified.

SECTION 3. RESPONSE TIME DECISION

Same-day response required based on one or more criteria below. *(Select all that apply.)*

Child death is suspicious or unexplained, and another child is in the home.
Report of child death, which a medical or law enforcement professional or some other reliable source is concerned may have resulted from, or was caused by, a parent's action or lack of action to protect the child. Another child currently is in the care of the parent.

Child requires same-day medical attention, AND abuse/neglect is suspected, OR parent is unwilling/refusing to obtain needed treatment.
This includes situations where injuries or illnesses pose a danger of death/near fatality, physical impairment, disfigurement, or disability. Examples include but are not limited to the following.

- A child has symptoms associated with a failure to thrive diagnosis, and no medical attention is being provided currently; or the child's appearance and symptoms suggest that they should receive medical attention today.

- The parent is unwilling or refusing to obtain medical treatment; without such medical treatment, the child's condition may become life threatening or may result in permanent impairment (e.g. blood transfusions, insulin required at regular intervals for diabetes treatment).

- A child has a serious illness or injury that has not been medically assessed and the child's condition is worsening (e.g. young child experiencing prolonged vomiting or diarrhea, evidence of a worsening infection or chronic medical condition that affects child's breathing or ability to eat or drink).

Child is demonstrating self-harmful behaviours, and the parent is not providing an adequate or appropriate response.
Child has attempted or is threatening suicide, and the parent does not respond appropriately such as by seeking urgent medical or psychiatric attention or following recommendations of a mental health professional currently involved with the child's care.

Child age 12 or younger killed or seriously injured another person, and there is concern that the parent has not or will not respond appropriately.
Child either killed or seriously injured another person, and parent is not cooperating with the investigation, is hindering the investigation, or is not providing supervision to the child.

Child has a visible injury that is suspicious, unexplained, or consistent with abuse, and the parent who is alleged to have either caused the injury or failed to protect will have access to the child today OR the perpetrator is unknown and may have access to the child today.
Any of the following physical indicators of injury are currently present resulting from a parent's action or lack of action: bruising; broken bones; burns; fractures; injuries alleged to have been

caused by an object (e.g. imprint of a belt buckle); or superficial injuries such as cuts, welts, abrasions, etc.

Include situations in which the exact cause of an injury may be unknown, but it is suspected that a parent caused the injury; or the intent of the parent is unknown but there is a basis to suspect the injury was non-accidental. *Also consider situations in which the perpetrator is unknown and may have access to the child today, and an assessment is required to assess child safety and try to determine who caused the injury*.

Child is currently alone and requires immediate care.
The likelihood of the child being physically injured or becoming ill is high if a same-day response does not occur. The weather, age of child, clothing child is wearing, and the immediate environment are factors that should be considered when determining whether a same-day response is required. Examples may include but are not limited to the following.

- Parent has been arrested or hospitalized, or the parent left the child for some other reason and appropriate arrangements for the child's care either were not made or we are unsure if appropriate arrangements were made.
- Parent died and adequate arrangements for the child's care have not been made.
- Parent is currently unable or unwilling to parent their child, and no safe adult has agreed to care for the child beyond the same day. Parent may be unable due to mental illness, physical illness, or substance use/abuse.
- Parent stated that the child cannot remain in the home today or is forcing the child to leave the home today and is not making appropriate alternative arrangements for the child's care.
- Parent abandoned or has immediate plans to abandon a child, meaning the parent voluntarily surrendered or relinquished the child and their rights as a parent.

Child is inadequately supervised and likely to be exposed to harm or unsafe conditions today.
The likelihood of the child being physically injured or becoming ill is high if a same-day response does not occur. The weather, age of child, clothing child is wearing, and the immediate environment are factors that should be considered when determining whether a same-day response is required. Examples may include but are not limited to the following.

- Child is currently locked out of the home and has no safe alternate arrangements.
- Child was inadequately supervised and was injured, or the child avoided injury only due to intervention by a third party. The probability of another injury is high if no response occurs today because the circumstances that led to the inadequate

supervision have not changed (e.g. a parent was sleeping and the young child turned on the stove and burned their hand).

- Parent is currently caring for a child and is under the influence of drugs or alcohol or is experiencing symptoms suggestive of suicidal, homicidal, or psychotic behaviour or an intellectual impairment (e.g. hearing commands to hurt the child, does not recognize the need to feed a baby every two to four hours, is incoherent or passed out with a preschooler in their care). As a result, the child is at immediate risk of injury.

Child is likely to be exposed to sexual harm or sexual abuse today.
The likelihood that the child will be sexually abused or suffer sexual harm is high if a same-day response does not occur. This is due to the following.

- Allegations include current concerns of sexual abuse, and parent of concern will have access to the child today.

- Parent allegedly views or possesses child pornography and has/will have unsupervised access to the child today.

Failure to protect child from serious harm.
There is concern that, because of the parent's inability to protect the child from dangerous behaviours of others, the child may be injured today. Examples may include but are not limited to the following.

- Parent left child with a third party and knew or reasonably should have known that the third party was physically or sexually abusing the child.

- Allegations of sexual abuse exist, and non-perpetrating parent is disbelieving of the allegation or is otherwise demonstrating a non-supportive response.

- Parent allows access to the child by a person who is known to the agency as having seriously harmed a child or as having a significant history of violence to adults or children.

Physical conditions of the home or environment are immediately unsafe, and the child will be in the home today.

- Objects accessible by child present a concern for child's safety due to child's age, behaviour, or developmental ability (e.g. drug paraphernalia, power tools, weapons, etc.).

- Child is residing in a home that has been condemned or infested by rodents.

- Electrical wires in the home are exposed.
- Drug manufacturing/production takes place in the home.
- Uncontained feces are present in the home and accessible by child.

The likelihood that a child has been or will be exposed to violence today is high, **AND no parent is demonstrating protection of the child**.
Due to the nature of the violence, same-day response is required both to assess and ensure the physical safety of the child. Examples of exposure to violence that require same-day response may include but are not limited to circumstances described below.

- Child has been physically harmed during an incident of violence in the home (e.g. child intervened in a dispute or one parent was holding child during the dispute).
- An adult required medical attention as a result of a violent incident, and the child was present in the home when the assault occurred.
- Evidence shows that weapons or objects were used to physically assault or threaten the adult in the home, and the child was present.
- Police called child protection during or immediately after their response to report a violent incident in the home. Upon arrival, evidence that an assault occurred was present, the children were present in the home, and both adult parties indicated a desire to remain in the home tonight.
- Information is received (e.g. from a transition house) that a parent and their child are planning to return to a partner who has a history of abusing them. No information suggests that circumstances have changed, and child protection has:
    - » Previously responded on the same day to a referral involving violence;
    - » New information to suggest that the partner was seriously injured (required hospitalization) during the violent dispute; or
    - » Information that a child was previously injured during a violent dispute.

A parent who allegedly killed or seriously injured (caused hospitalization of) another person through violent acts will have access to their child today.

Other (specify).
This includes circumstances that require a same-day response to assess the safety of the child, and are not captured in any of the above items. This may include child expressing extreme fear of parent, including somatic symptoms of fear/anxiety.

No same-day response criteria; response within seven days is required.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
CHILD PROTECTION REFERRAL
POLICY AND PROCEDURES

The purpose of the Child Protection Referral form (CPR) is to:

1) Document allegations of child maltreatment
2) Document the screening decision
3) Document the response time decision

Which Cases
The Child Protection Referral form is completed for all information of alleged child maltreatment that is received by the Department of Children, Seniors and Social Development.

Who
The social worker who receives the information of alleged child maltreatment or the social worker assigned to the active protective intervention case.

When
The Child Protection Referral is completed within 24 hours of receipt of information of alleged child maltreatment.

Appropriate Completion
Please refer to *Standard #1: Engaging the Referral Source: Screening the Information* and *Standard #2: Assessing a Screened In Referral: Determining the Response Time and Developing the Protection Investigation Plan* in the Structured Decision Making® Practice Standards Manual for standards and practice considerations.

Referral Number
Referral number will indicate the assigned number to this referral.

Referral Type
Referral type will reflect one of the three options; New, Re-Opened or New Referral on Active Case. “New” indicates there has never been a protective intervention program on this client. “Reopened” indicates there has been a previous protective intervention program and it is closed. “New Referral on Active” indicates there is currently an active protective intervention program for this client.

General
Indicate the file number and any relevant cross referenced file numbers. For file numbers, there may be a file prior to ISM that has been stored in registry that has a file number assigned. For new programs that have never been assigned a file number, workers should follow office procedures to obtain a file number. Cross reference numbers are numbers that indicate other involvement for families. For example, an in-care/custody file number for an individual.

Information Received
Select the date presented, time when the information was received, who the referral is being registered by and who took the referral. Sometimes the referral will be registered by someone other than the person who took the referral. Ensure to indicate this correctly in this section. Select the appropriate office from the drop down list.

Child/Children:
Enter the name of the child(ren), the sex, date of birth, present location, school/daycare, name of person with whom living, and ethnicity. Role and the relationship of the person with whom living can be added by selecting the appropriate description from the drop down box that is available.

Details of Current Incident/Child Protection Concern
Include information which currently places the child at risk of abuse or neglect. This includes relevant information that has been provided to indicate child protection intervention is warranted. Capture all information that relates to the allegation. Please refer to *Standard #1: Engaging the Referral Source: Screening the Information* and *Standard #2: Assessing a Screened In Referral: Determining the Response Time and Developing the Protection Investigation Plan* in the Structured Decision Making® Practice Standards Manual for standards and practice considerations around taking a referral.

Parent/Guardian
Enter the name of the parent/guardian, address, contact telephone numbers, ethnicity, date of birth and age. Relationship to child and marital status can be added by selecting the appropriate description from the drop down box that is available.

Details Regarding Other Witnesses/Sources of Information
Enter in any other sources of information that are available and any potential witnesses who may have additional information about maltreatment of the child(ren). For example, you may have spoken with a school principal who stated the classroom teacher has additional information. This additional information can be captured here.

Current Caregiver/Foster Parent
There are some situations whereby referrals are received on parents/guardians when the children are residing with other caregivers (e.g. on a safety plan) or foster parents. Capture this information by entering the name(s), address, contact telephone numbers, ethnicity, date of birth and age. Marital status can be added by selecting the appropriate description from the drop down box that is available.

Referral Source
Referral sources are kept confidential, unless otherwise stated by the referral source. Social workers should discuss with the referral source if they wish to remain confidential. Indicate the referral source's choice in this section. Also enter the referral source's relationship to the child, if applicable. Enter the referral source's name, address, phone number(s) and any additional

comments about the referral source. If there is more than one referral source, this information may be captured in the Additional Source Comment Section.

Translator
In this section, select whether a translator is required, if known. If unknown, select that item in this section. If a translator is required, indicate the specific language, if known.

Assessment of Motivation of Referral Source
Please include any information you may have about the motivation of the referral source. For example; the referral source's relationship to the child, how they know the child or family, reasons for reporting, if there was a delay in reporting; why, have they made other reports, etc. There is a complete list of items to consider found in Standard #1: *Engaging the Referral Source: Screening the Information* in the Structured Decision Making® (SDM) Practice Standards Manual.

Initial Record Check
The date records are checked must be noted and whether or not there is a previous record. Where a child protection record exists, relevant information shall be included on the CPR and minimally include: the date of the referral, the verification decision and whether the child required protective intervention.

Service Response

Investigation
Use the Screening and Response Time Assessment (SRTA) to determine an initial screening recommendation and document it here.

If the initial screening recommendation is to screen in, select which maltreatment types are applicable by selecting from the drop down menu. If the initial screening recommendation is to screen out, select "no maltreatment."

If there is an override, select the appropriate override from one of the drop down menus determined by whether there is an override to screen out or screen in.

Final Screening Decision
Indicate the final screening decision.

Response Time Decision
Use the SRTA to determine a response time decision. If a same day response is selected, please select the applicable criteria from the drop down menu.

Social Worker Assigned
Select the appropriate worker from the list that is available, as well as the date and time the referral was assigned.

Investigation Plan
If an investigation plan has been developed at the time of the referral being received, please indicate the plan and the person responsible in this section.

Referral to Police
Police involvement is determined according to the Police/Department Protocol outlined in the Memorandum of Understanding (MOU). Police involvement is required in all cases of reported sexual abuse, physical injury and where a crime may have been committed against a child; in these cases, referrals must be sent to police which will be indicated in this section. In this section, you will indicate the date the referral was sent and how it was sent. Please reference Policy 1.5: *Police Involvement* in the Protection and In-care Policy and Procedures manual for more information.

Alleged Offender
This section is only completed if a referral has been sent to police. It should include the name, address, phone number, date of birth and relationship to child where possible. See the Structured Decision Making® Practice Standards Manual for areas to explore when obtaining this information.

Consultation: Verbal Approval of Screening and Response Time Decision
This section is where social workers will document the date of consultation and the name of the supervisor consulted with regard to the referral. When this section is completed, the case will convert from an intake case to an assessment case.

Supervisory Review and Approval of Screening and Response Time Decision
All information that has been captured on a Child Protection Referral must be reviewed and approved by a supervisor. Once the information has been reviewed, supervisors are able to agree or disagree with the decision of the social worker. If a supervisor does not agree with the assessment that has been completed, they can send the referral back to the social worker for further assessment. Supervisors will have the ability to make comments on this decision in this section. If a referral has been sent back for further assessment, social workers will document the additional information in the Details of Current Incident/Child Protection Concern section.

Supervisory Signature
All Child Protection Referrals must be reviewed and approved by a supervisor within 24 hours of completion of the Child Protection Referral. In cases where a supervisor has provided "verbal approval" for a decision, the CPR shall be approved within 72 hours of receipt of referral.

Newfoundland Labrador
Children, Seniors and Social Development

Child Protection Referral

(Pursuant to Section 11 *Children, Youth and Families Act*)

Referral Number:

Client File Number:

File Name:

Referral Type:

Cross Reference File #

Information Received

Date Presented:

Office:

Registered By:

Taken By:

Child/Children

Name	Sex	Date of Birth (YYYY-MM-DD)	Age	Present Location (Community/ Address)	School/ Daycare	Name of Person with Whom Living	Relationship	Indigenous	Current/ Absent

Parent/Guardian and Other Members in the Household

Name	Address	Relationship to Child	Contact Telephone Numbers	Marital Status	Indigenous	Date of Birth (YYYY-MM-DD)	Current/ Absent

Current Caregiver/Foster Parent

Name	Address	Contact Telephone Numbers	Marital Status	Ethnicity	Date of Birth (YYYY-MM-DD)	Age

Details Regarding Other Witnesses/Sources of Information

Name	Address	Relationship to Children	Agency	Telephone	Date of Birth (YYYY-MM-DD)	Age

Details of Current Incident/Child Protection Concern as Provided by Referral Source

Added By:

Date:

Description of Maltreatment Concerns:

Referral Source Information

Does the referral source wish to be kept confidential?

○ Yes ○ No

First Name:

Last Name:

Referral Source ☐ Other

Relationship to Child, if any

Method of Contact:

Address ☐ Same as Previous Address

Street:

Community/City: ☐ Other

Country: ☐ Other

Province/Territory ☐ Other

Newfoundland and Labrador

Postal Code:

Home Phone Number:

(__)__-__

Cell Phone Number:

(__)__-__

Work Phone Number:

(__)__-__

Additional Referral Source Comments:

Assessment of Motivation of Referral Source

Assessment of Motivation of Referral Source Comments:

Translator

Is translator required?

○ Yes ○ No ○ Unknown

If yes, Please Specify Language: ☐ Other

Initial Records Check

Departmental Records Date Checked:

Previous Record:

○ Yes ○ No

Comments:

Service Response: Investigation

Maltreatment Type

Please fill out the following:

- ☐ Physical Abuse
  - ☐ Non-accidental physical injury
  - ☐ Parent giving the child toxic chemicals, alcohol or drugs
  - ☐ Parent has acted or threatened to act in a way that is likely to cause injury
  - ☐ Propensity to violence
  - ☐ Suspicious death of a child due to abuse and another child in care of parent
  - ☐ Unexplained or suspicious physical injury

- ☐ Emotional Abuse
  - ☐ Exposure to violence in the home or between parents
  - ☐ Parental action has or is likely to emotionally harm the child

- ☐ Sexual Abuse
  - ☐ Exposure to sexually explicit conduct or sexually explicit materials
  - ☐ Parent engaging or attempting to engage in a sexual act or sexual contact with child
  - ☐ Physical, behavioral, or suspicious indicators consistent with sexual abuse
  - ☐ Sexual exploitation of a child by a parent
  - ☐ Threat of sexual abuse

- ☐ Neglect
  - ☐ Abandonment or unwilling/unable/unavailable parent
  - ☐ Child under 12 years of age committing serious offence
  - ☐ Exposure to illegal drug activity
  - ☐ Exposure to unsafe home and immediate environment
  - ☐ Failure to protect child against neglect, physical, emotional and sexual abuse
  - ☐ Failure to thrive
  - ☐ Inadequate clothing or hygiene
  - ☐ Inadequate food/nutrition
  - ☐ Inadequate medical, dental, and/or mental health care
  - ☐ Inadequate response to child, under 12 years of age, committing a pattern of serious offences
  - ☐ Inadequate supervision
  - ☐ Involving child in criminal activity
  - ☐ Newborn exposure of risk of exposure to drugs or alcohol
  - ☐ Other high risk birth
  - ☐ Suspicious death of a child due to neglect, and another child is in the care of parent

No Maltreatment

☐ Referral does not include an allegation of abuse or neglect

Initial Screening Recommendation:

○ Screen In ○ Screen Out

Please indicate if an override is being applied:

○ No Overrides Apply ○ Override Screened In ○ Override Screened Out

If "Override Screened In" (no maltreatment type present, but referral will be screened in assigned for investigation), please check all that apply:

○ Court Request or Order for an investigation

○ Other

If other, please specify:

If "Override Screened Out" (one or more maltreatment types are checked, but the referral types will be screened out), please check all that apply:

○ Insufficient information to locate child/family

○ Duplicate referral; information will be included with the referral assigned for investigation

○ Referral already investigated; no new allegations

○ Other

If other, please specify:

Final Screening Decision

○ Screen In

○ At least one maltreatment type is checked AND no screen out overrides apply

○ Referral was screened in based on an override

○ Screen Out

○ No maltreatment type is checked AND no screen in overrides apply

○ Referral was screened out based on an override

Response Time Decision

Same Day

- ○ Same day response required based on one or more of the criteria below. Check all that apply.
- ☐ Child death is suspicious or unexplained, and another child is in the home
- ☐ Child requires same day medical attention, AND abuse/neglect is suspected, OR parent is unwilling/ refusing to obtain needed treatment
- ☐ Child is demonstrating self-harmful behaviors, and the parent is not providing an adequate or appropriate response
- ☐ Child age 12 or younger has killed or seriously injured another person, and there is concern that the parent has or will not respond appropriately
- ☐ Child has a visible injury that appears suspicious, unexplained, or consistent with abuse or neglect
- ☐ Child is currently alone and requires immediate care
- ☐ Child is inadequately supervised and likely to be exposed to harm or unsafe conditions today
- ☐ Child is likely to be exposed to sexual harm or abuse today
- ☐ Failure to protect child from serious harm
- ☐ Physical conditions of the home or environment are immediately unsafe, and the child will be in the home today
- ☐ The likelihood that a child has been or will be exposed to violence today is high, AND no parent is demonstrating protection of the child
- ☐ A parent who has allegedly killed or seriously injured (caused hospitalization of) another person through violent acts will have access to his/her child today
- ☐ Other

If other, please specify:

Seven Day

- ○ No same-day response criteria; response within seven days is required

Investigation Plan

Steps to be Taken:

Person Responsible:

Referral to Police

Is a referral to police required?

○ Yes ○ No

Has referral been sent to the police?

○ Yes ○ No

Date Sent:

If yes, indicate how it was sent:

☐ Verbal ☐ Email ☐ Fax

Alleged Offender (only complete this section if making a referral to police)

First Name:

Last Name:

○ Date of Birth ○ Age (approximate)

Sex:

Relationship to child:

Address

Street:

Community/City: ☐ Other

Country: ☐ Other

Province/Territory ☐ Other

Newfoundland and Labrador

Postal Code:

Assigned To

Name: | Work Phone Number | Region | Office | Date Assigned

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® SAFETY ASSESSMENT
POLICY AND PROCEDURES

The purpose of the safety assessment is to: 1) help assess whether any child is likely to be in immediate danger of serious harm/maltreatment that requires intervention, and 2) determine what interventions should be initiated or maintained to protect the child.

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

WHICH CASES

All child protection referrals that are assigned for investigation, including a screened-in referral on an ongoing protective intervention case. If referral alleges maltreatment by a foster parent, use the alternate care provider safety assessment (ACPSA).

A review safety assessment is required when circumstances change including:

- Family circumstances (e.g. birth of a baby, unknown adult moves into home, person leaves the household);
- Information that is known about the family; and/or
- Ability of safety interventions to mitigate safety threats.

A change in family circumstance may not necessarily require a new child protection referral.

WHO

The social worker who is responding to the referral.

WHEN

For new referrals, including those on ongoing protective intervention cases, the child's safety is assessed before leaving the child in the home or returning the child to the home during the investigation. **This is typically during the first face-to-face contact with the child and parents.**

For same-day referrals, the safety assessment form must be completed within 48 hours of receipt of referral, following the first face-to-face contact with the child/family. For referrals within seven days, the safety assessment form must be completed by the end of the eighth day after receipt of referral, following the first face-to-face contact with the child/family. However, for referrals actioned prior to day seven, it is best practice to complete the safety assessment form as soon as possible after the first face-to-face contact with the child/family rather than waiting until the eighth day to complete the form.

If, during the course of investigation, any safety assessment identified a safety threat and led to a safety plan, a review safety assessment must be completed prior to closing the file (including the safety assessment form). If safety threats remain unresolved, an ongoing protective intervention case should be opened. A closing safety assessment is included in the risk reassessment for ongoing protective intervention files, and a stand-alone safety assessment is not required prior to closing.

DECISION

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

APPROPRIATE COMPLETION

Social workers should familiarize themselves with the items that are included on the safety assessment and the accompanying definitions. SDM assessments ensure that every worker is assessing the same items in each case and that the responses to these items lead to specific decisions. Once a worker is familiar with the items that must be assessed to complete the tool, the worker should conduct their initial interviews/contact as they normally would—using good social work practice to collect information from the child, parent, and/or collateral sources. The specific items that comprise the safety assessment shall be assessed at some point during the initial child/family contact.

Header Information

Enter the name of the household assessed. Typically, this would be the last name of the primary parent in the household.

Some referrals may involve more than one household with a safety assessment. If two such households have the same last name, also include the first name. Record the name of the primary parent, and if present, the secondary parent.

Also select whether allegations exist in the household being assessed. If at least one alleged perpetrator resides in the household, there are allegations in that household.

Enter the type of safety assessment, which is one of the following.

- Initial. Each household in the referral should have one, and only one, initial assessment. This should be completed during the first face-to-face contact with the child and parent when there are allegations in that household.

- Review. After the initial assessment, any additional safety assessment is most likely a review, unless it is completed at the point of closing a referral or ongoing protective intervention case.

- Case closing. This is a specialized review that is completed prior to closing an investigation where safety threats are still outstanding if the file is not transferred to ongoing protective intervention.

Record the date of the safety assessment. This should be the date that the worker made initial face-to-face contact with the child to assess safety, which may be different than the date that the form is being completed.

The safety assessment consists of four sections plus subsections:

Section 1. Child Vulnerability
Indicate (select) whether any child vulnerabilities are present for any child in the household in need of protective intervention. The vulnerability of each child is considered throughout the assessment of safety threats and safety planning. Typically young children cannot protect themselves. For older children, inability to protect themselves could result from diminished mental or physical capacity or repeated victimization. Indicate (select) whether any child vulnerabilities are present. Note that these vulnerability issues provide a context for safety assessment. The presence of one or more vulnerabilities does not automatically mean that the child is unsafe or that a safety threat is present.

Section 1A. Safety Threats
This is a list of 12 critical threats that must be assessed by every worker in every case. These threats cover conditions that would place a child in danger of immediate, serious harm. Because not every conceivable safety threat can be anticipated or listed on a form, a 13th "other" option is included.

Rely on information available at the time of the assessment. Social workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is expected that not all facts about a case can be known immediately. Some information is inaccessible, and some is deliberately hidden from the worker. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the safety threats and accompanying definitions. For each item, consider the most vulnerable child.

If the safety threat is present, based on available information, select that item "Yes." If the safety threat is not present, select that item "No." If circumstances that the worker determines to be a safety threat are not described by one of the existing items, the worker should select "other" and briefly describe the threat.

Section 1B. Protective Capacities

This section is completed only if one or more safety threats were identified. Select any of the listed protective capacities that are present for any child or parent. Consider information from the referral; from worker observations; interviews with children, parents, and collaterals; and review of records. For "other," consider any existing condition that does not fit within one of the listed categories but may support protective interventions for the safety threats identified in Section 1A.

Section 2. Safety Interventions

This section is completed only if one or more safety threats are identified and after a worker has determined whether or not protective capacities/abilities are present. The presence of one or more safety threats does not automatically mean that a child must be placed. In many cases, the child may remain in the home while the investigation continues if a short-term plan that mitigates the safety threat(s) sufficiently is initiated. Consider the relative severity of the safety threat(s), the parent's protective capacities/abilities, and the vulnerability of the child.

The safety intervention list contains general categories of interventions rather than specific programs. The worker should consider each potential category of interventions and determine whether that intervention is available and sufficient to mitigate the safety threat(s) and whether there is reason to believe the parent will follow through with a planned intervention. Simply because an intervention exists in the community does not mean it should be used in a particular case. The worker may determine that even with an intervention, the child would be unsafe; or the worker may determine that an intervention would be satisfactory but has reason to believe the parent would not follow through. The worker should keep in mind that any single intervention may be insufficient to mitigate the safety threat(s), but a combination of interventions may provide adequate safety. Also keep in mind that the safety intervention is not the case plan—it is not intended to "solve" the household's problems or provide long-term answers. A safety plan permits a child to remain home during the course of the investigation.

For each identified safety threat, review current protective capacities/abilities. Given these protective capacities/abilities, can in-home safety plan interventions adequately mitigate the threat? When assessing the appropriateness of safety interventions, it is critical to review the assessed protective capacities in Section 1B. If capacities 3, 4, and/or 5 are not present, consider whether any in-home intervention can be put into place to address threats.

Safety interventions 1–9 are considered to be in-home interventions and are incorporated into a safety plan where a threat has been identified; protective capacities/abilities are present and, in combination with one of these interventions, will allow all children to remain in the home while the investigation continues.

If one or more safety threats are identified, and the worker determines that in-home interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will be protectively placed in care via a protective care agreement (PCA) or removal process. If safety interventions 10 or 11 are used, the safety decision must be unsafe. Safety interventions 10 and 11 are used when only a placement can ensure safety.

If one or more interventions will be implemented, select each category that will be used. If an intervention will be implemented that does not fit into one of the categories, select 9 ("other") and briefly describe the intervention.

Section 3. Safety Decision

In this section, the worker records the result of the safety assessment. Select one of the choices based on identification of threats, capacities/abilities, and interventions:

1. **SAFE.** No safety threats have been identified. Based on current information, no children are likely to be in immediate danger of serious harm. The SDM system guides the worker to leave the child in the home for the present time.

2. **SAFE WITH PLAN.** One or more safety threats are identified. In-home safety interventions have been initiated and the child will either remain in the home or temporarily stay with a relative or significant other with consent of the parent, as long as the safety interventions mitigate the safety threat(s). A safety plan has been developed with and signed by the parents.

   Safety Plan. Any safety plan must include:

   - Each safety threat identified in Section 1A, written in a family-friendly manner that also describes the threat and child impact;
   - Detailed information for each planned safety intervention;
   - Information that describes how the safety plan will be monitored (e.g. who is responsible for each intervention action); and
   - Signature lines for family members, the worker, and their supervisor.

   The safety plan MUST be completed with the family, and a copy left with the family.

If safety threats have not been resolved by the end of the investigation, all remaining interventions will be incorporated into the FCAP.

3. **UNSAFE.** One or more safety threats are identified, and the signing of a PCA or removal is the only protecting intervention possible for one or more children. Without placement, one or more children are likely to be in danger of immediate serious harm.

Section 4. Location of Child's Placement

If the safety decision is "unsafe," the name and placement status of each child assessed should be recorded in this section in the same order the information is listed on page 1 of the assessment tool. **If the safety decision for the household is "unsafe" and any child will remain in the home, provide an explanation in the analysis below.**

PRACTICE CONSIDERATIONS

While safety is the prevailing concern for the first face-to-face contact, the manner of engaging the family will depend upon social work clinical skills. Whenever possible, the worker should use a strength-based approach to initiate the contact, while remaining observant for the presence or absence of safety threats. Most safety threats are salient and can be discerned without invasive questioning. Others will benefit from candor, which will be more forthcoming when the family is approached with respect. The first face-to-face contact may be limited to assessing safety if there are significant safety issues. At other times, the worker will also begin to gather information regarding risk and/or strengths and needs items as well as additional clinical information.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® SAFETY ASSESSMENT

r: 8/20

Household Name: _____ **Referral #:** _____ **File #:** _____

Primary Parent: _____ **Secondary Parent:** _____

Worker: _____ **Region:** _____

Date of Assessment: _____ **Assessment Type:** ○ Initial ○ Review ○ Case Closing

Select whether the child was observed, interviewed, or was not available for an observation or interview.

	Child Name	Observed	Interviewed	Unavailable	Date
1.		○	○	○	
2.		○	○	○	
3.		○	○	○	
4.		○	○	○	

For each child unavailable, please describe the reasons and the plan to see the child.

SECTION 1: CHILD VULNERABILITY

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

- ☐ Age 0–5 years
- ☐ Significant diagnosed medical or mental disorder
- ☐ Not visible in the community
- ☐ Diminished mental capacity (e.g. developmental delay, non-verbal)
- ☐ Diminished physical capacity (e.g. non-ambulatory, limited use of limbs)

SECTION 1A: SAFETY THREATS

Assess household for each of the following safety threats. Indicate whether currently available information results in reason to believe any safety threat is present. Select all that apply.

Yes	No	Safety Threat	Safety Threat Description (Parent action/inaction and impact on child)
1. ○	○	Parent caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by: ☐ Serious injury or abuse to the child other than accidental ☐ Parent fears they will maltreat the child ☐ Threat to cause serious harm or retaliate against the child ☐ Excessive discipline or physical force ☐ Propensity to violence ☐ Drug-exposed infant	
2. ○	○	Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.	
3. ○	○	Parent does not protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, emotional abuse, or neglect.	
4. ○	○	Parent does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.	
5. ○	○	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.	
6. ○	○	Parent's current substance abuse seriously impairs their ability to supervise, protect, or care for the child.	
7. ○	○	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.	
8. ○	○	Parent's emotional, developmental, or cognitive functioning or physical condition/disability seriously impairs their current ability to supervise, protect, or care for the child.	
9. ○	○	Parent describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.	

Yes	No	Safety Threat	Safety Threat Description (Parent action/inaction and impact on child)
10. ○	○	Parent's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.	
11. ○	○	Parent refuses access to the child or hinders the investigation, or there is reason to believe that the family is about to flee.	
12. ○	○	Current circumstances, combined with information that the parent has or may have previously maltreated a child in their care, suggest that the child's safety may be of immediate concern.	
13. ○	○	Other (specify)	

SECTION 1B: PROTECTIVE CAPACITIES

(If no safety threats are identified, skip to Section 3 and indicate that the household is safe.)

Select all that apply to at least one child or parent in the household.

Child

☐ 1. Child has the cognitive, physical, and emotional capacity to participate in safety interventions.
☐ 2. Child has, on more than one occasion, successfully acted in a way to protect themself from the safety threat.

Parent

☐ 3. Parent has the cognitive, physical, and emotional capacity to participate in safety interventions.
☐ 4. Parent recognizes problems and safety threats placing the child in imminent danger and is willing to participate in safety planning.
☐ 5. Parent is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.
☐ 6. Parent is aware of and committed to meeting the needs of the child.
☐ 7. There is evidence of a healthy relationship between parent and child.
☐ 8. At least one parent in the home is willing and able to take action to protect the child, including asking offending parent to leave.
☐ 9. Parent has the ability to access resources to provide necessary safety interventions.
☐ 10. Parent has supportive relationships with one or more persons who may be willing to participate in safety planning, AND parent is willing and able to accept their assistance.
☐ 11. Parent can articulate strategies that, in the past, have been successful in mitigating the identified safety threats to the child.
☐ 12. Other: _____

SECTION 2: SAFETY INTERVENTIONS

(If no safety threats are identified, skip to Section 3 and select that the child is safe.)

Select all that apply:

In-Home Interventions

☐ 1. Intervention or direct services by social worker. (DO NOT include the investigation itself.)
☐ 2. Use of family, neighbours, community elders, traditional healers, or other individuals in the community as safety resources.
☐ 3. Use of community agencies or services as safety resources.
☐ 4. Parent appropriately protects the victim from the alleged perpetrator.
☐ 5. Alleged perpetrator leaves the home, either voluntarily or in response to legal action.
☐ 6. Non-offending parent moves to a safe environment with the child.
☐ 7. Legal action planned or initiated—child remains in the home.
☐ 8. Parent makes arrangements for the child to stay with a relative or significant other.
☐ 9. Other (specify): _____

Placement Interventions

☐ 10. A child is in need of protective intervention, and a protective care agreement (PCA) is used/signed as an alternative to removal.
☐ 11. Child removed because interventions 1–10 do not adequately ensure the child's safety.

SECTION 3: SAFETY DECISION

Identify the safety decision by selecting the appropriate line below. Check one response only.

○ 1. **SAFE**. No safety threats were identified at this time. Based on currently available information, no children are likely to be in immediate danger of serious harm.

○ 2. **SAFE WITH PLAN**. One or more safety threats are identified. Safety interventions have been initiated and the child will either:

  ○ Remain in the home or

  ○ Will temporarily stay with a relative or significant other with consent of the parent, as long as the safety interventions mitigate the safety threat(s).

  Please check which arrangement applies. **A SAFETY PLAN IS REQUIRED.**

○ 3. **UNSAFE.** One or more safety threats are identified, and the signing of a PCA or removal is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate serious harm.

SECTION 4: LOCATION OF CHILD'S PLACEMENT

This section is completed only if the safety decision is *unsafe*. Record information in the same order as on page 1 of the safety assessment tool.

Record the name and status of each child assessed. If the safety decision for the household is "unsafe" and any child will remain in the home, ensure an explanation is provided in the analysis below.

Last Name	First Name	File Number	Birth Date	Removed	Remain in Home/Placed With Kin
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Supervisory Consult With	Date of Consult	Social Worker Name	Date Safety Assessment Form Completed	Supervisor Name	Date of Supervisory Approval

SECTION 5: ANALYSIS

Briefly summarize child vulnerabilities, protective capacities, and safety interventions to support the safety decision.

If the safety decision for the household is "unsafe" <u>and any child will remain in the home</u>, an explanation must be provided below.

While an explanation is not mandatory if the safety decision is "safe," "safe with plan," or "unsafe" (and no child remains in the home), an explanation is recommended. If this section is left incomplete, enter this information in a case note.

Supervisory Consult With: _____ **Date of Consult:** _____

Social Worker Name: _____ **Date Safety Assessment Form Completed:** _____

Supervisor Name: _____ **Date of Supervisory Approval:** _____

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® SAFETY ASSESSMENT
DEFINITIONS

SECTION 1: CHILD VULNERABILITY

Factors influencing child vulnerability (conditions resulting in child's inability to protect self; select all that apply to **any** child):

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

- **Significant diagnosed medical or mental disorder.** Any child in the household has a diagnosed medical or mental disorder that significantly impairs ability to protect self from harm; or diagnosis may not yet be confirmed but preliminary indications are present and testing/evaluation is in process. Examples may include but are not limited to severe asthma, severe depression, medically fragile (e.g. requires assistive devices to sustain life), etc.

- **Not visible in the community.** The child is isolated or less visible within the community (e.g. family lives in an isolated community, child may not attend school and is not routinely involved in other activities within the community, child has little to no interaction with community members or extended family, etc.). Children ages 0–5 may not be attending a daycare or enrolled in school and should not be automatically assumed to be not visible in the community.

- **Diminished mental capacity.** Any child in the household has diminished developmental/cognitive capacity, which impacts ability to communicate verbally or to care for and protect themselves from harm.

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

SECTION 1A: SAFETY THREATS

1. Parent caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by:

- Serious injury or abuse to the child other than accidental. Parent caused serious injury or abused the child as indicated by brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, and/or severe cuts; AND the child requires medical treatment.

- Parent fears they will maltreat the child. Parent expressed this fear directly to the social worker.

- Threat to cause serious harm or retaliate against the child. Parent threatened action that would result in serious harm, parent plans to retaliate against child for child protection investigation, or child expresses a credible fear that they will be maltreated by the parent and suffer serious harm.

- Excessive discipline or physical force. Parent used physical methods to discipline a child that resulted in or could easily result in serious injury, OR parent injured or nearly injured a child by using physical force. This could include using physical force with an object, such as a belt, to discipline the child.

- Propensity to violence. Parent has demonstrated a propensity to violence, through either a specific action or a pattern of actions, AND this creates imminent threat of harm to children.

  Indicators of propensity to violence include the parent:

  » Demonstrating a pattern of using violence or implied violence in response to situations; and/or

  » Being alleged to have killed or intentionally seriously injured another person through a violent assault.

- Drug-exposed infant. Evidence shows that the mother used alcohol, other drugs, or solvents during pregnancy, AND this has created imminent danger to the newborn child.

  » Indicators of drug use during pregnancy include drugs found in the mother's or child's system, mother's self-report, diagnosis of high-risk pregnancy due to drug use, efforts on mother's part to avoid toxicology testing, withdrawal symptoms in mother or child, and pre-term labor due to drug use.

» Indicators of imminent danger include the level of toxicity and/or type of drug present, diagnosis of the infant as medically fragile as a result of drug exposure, and suffering of adverse effects by the infant due to introduction of drugs during pregnancy.

2. Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.

Suspicion of sexual abuse may be based on the following indicators.

- Child discloses sexual abuse verbally or child's behaviour indicates possibility of sexual abuse (e.g. age-inappropriate or sexualized behaviour toward self or others).

- Medical findings consistent with child sexual abuse.

- Sexual abuse allegation has been made against parent in the household, AND they have been or are being investigated for, charged with, or convicted of a sex offence (including a Registered Sex offender); has had other sexual contact with the child; or has been previously verified by the department or other child protection agencies. Investigations for a sexual offence include those by child protection or other child protection agencies.

- Parent or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).

  AND circumstances suggest that the child's safety may be of immediate concern, based on the following indicators.

  » An alleged or convicted sexual abuse perpetrator, or an individual suspected of perpetrating, has access to a child.

  » Parent blames child for the sexual abuse or the results of the investigation.

  » Parent does not believe that the sexual abuse occurred.

3. Parent does not protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, emotional abuse, or neglect.

- Parent does not protect the child from serious harm or threatened harm as a result of physical abuse, sexual abuse, emotional abuse, or neglect by other family members, other household members, or others having access to the child. The parent does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage. This includes a parent not taking protective action following a disclosure of harm from the child.

- An individual with known physical or sexual violent criminal behaviour/history resides in the home, and current circumstances (e.g. no change in individual's behavioural pattern over time) suggest that the child's safety may be of immediate concern.

- Parent takes the child to dangerous locations where drugs are manufactured, regularly administered, and/or sold (e.g. amphetamine labs, drug houses, or locations used for prostitution or pornography), and this is likely to recur.

  If domestic violence (DV) exists in the home, the DV threat for violence between adults, as outlined in 7, may be more appropriate to select as a threat.

4. Parent does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.

- Nutritional needs of the child are not met, AND this results in danger to the child's health and/or safety including malnutrition.

- Child's clothing is inappropriate for the weather to the extent that the child is in danger of hypothermia or frostbite.

- Parent does not seek treatment for the child's immediate, chronic, and/or dangerous medical condition(s) or does not follow prescribed treatment for such conditions.

- Child appears malnourished.

- Child has exceptional needs, such as being medically fragile, which the parent does not or cannot meet.

- Child is suicidal and/or seriously self-harming, and the parent will not/cannot take protective action.

- Child exhibits signs of serious emotional symptoms, lack of behavioural control, or serious physical symptoms as a result of maltreatment.

- Parent does not attend to the child to the extent that need for care goes unnoticed or unmet (e.g. parent is present but the child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).

- Parent leaves the child alone in circumstances that create opportunities for serious harm (time period and opportunity for harm is dependent on age and developmental stage, e.g. young child left unattended in vehicle on a hot day).

- Parent is currently unavailable/unwilling to care for the child and no arrangements have been made (incarceration, hospitalization, abandonment, unknown location).

5. **The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.**
Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to:

- Leaking gas from stove or heating unit;

- Substances or objects accessible to young child that may endanger their health and/or safety (e.g. drug paraphernalia, scissors/knives, cleaning supplies);

- Lack of water or utilities and no alternate or safe provisions;

- Open/broken/missing windows accessible to young children;

- Exposed electrical wires;

- Excessive mould, garbage, or rotted or spoiled food that threatens child's health;

- Serious illness or significant injury due to living conditions that have not been remediated (e.g. lead poisoning, rat bites);

- Evidence of human or animal waste uncontained throughout living quarters;

- Unlocked and accessible guns and other weapons; and

- Drug production or sales from the home.

6. **Parent's current substance abuse seriously impairs their ability to supervise, protect, or care for the child.**
Parent has abused legal or illegal substances or alcoholic beverages to the extent that the parent is currently unable, or will likely be unable, to supervise, protect, or care for the child, which is likely to harm the child. Examples include but are not limited to:

- Co-sleeping with an infant or young child whilst under the influence of drugs, alcohol, or solvents;
- Driving under the influence of alcohol and/or other drugs with a child in the car; and
- Being unable to provide immediate care and/or supervision to a child in the event of an emergency or other essential need while under the influence of substances or alcohol.

7. **Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.**
There is evidence of domestic violence in the home, AND child's safety is of immediate concern. Examples include the following.

- Child was previously injured in domestic violence incident and violence is occurring in the home now.
- Child exhibits severe anxiety (e.g. nightmares, insomnia) related to situations associated with domestic violence.
- Child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of domestic violence in the home.
- Child's behaviour increases risk of injury (e.g. child attempted to intervene during violent dispute or participated in the violent dispute in an effort to protect a parent or stop the violence).
- Individuals in the home use guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.
- Evidence of serious, frequent, or escalating property damage resulting from domestic violence is apparent.
- Other indicators exist of highly dangerous domestic violence situations such as a perpetrator threatening or attempting to kill an adult, perpetrator harming household pets, and/or recent separation that is resisted by a violent partner.

8. **Parent's emotional, developmental, or cognitive functioning or physical condition/disability seriously impairs their current ability to supervise, protect, or care for the child.**
Evidence exists that the parent is mentally ill, developmentally delayed, cognitively impaired, or has a physical condition/disability, AND as a result, one or more of the following situations are observed.

- Parent's refusal to seek evaluation/treatment and/or to follow prescribed medications seriously impedes their ability to supervise, protect, or care for the child.

- Parent's inability to control emotions seriously impedes their ability to supervise, protect, or care for the child.

- Parent acts out or exhibits a distorted perception that seriously impedes their ability to supervise, protect, or care for the child.

- Parent's depression seriously impedes their ability to supervise, protect, or care for the child.

- Parent's current physical health/illness seriously impedes their ability to supervise, protect, or care for the child.

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

- Due to cognitive delay, the parent lacks basic knowledge and understanding related to parenting. Examples include:

    » Not knowing that infants need regular feedings;
    » Not accessing and obtaining basic/emergency medical care;
    » Not understanding proper diet; or
    » Not providing adequate supervision.

9. **Parent describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.**
Examples of parent actions include:

- Describing the child in a demeaning or degrading manner (e.g. as evil, stupid, ugly);

- Cursing and/or repeatedly putting the child down;
- Scapegoating a particular child in the family;
- Blaming the child for a particular incident or family problems; and
- Including the child in a custody dispute and expecting them to act as an intermediary or choose sides between parents, etc.

10. **Parent's explanation for child's injury is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.**
Factors to consider include the child's age, location of injury, developmental needs of the child, and chronicity or severity of injuries. The child's safety may be of immediate concern when:

- The injury requires medical attention, AND medical assessment indicates the injury is likely to be the result of abuse; OR
- A suspicious injury that did not require medical treatment was located on an infant; or, for older children, on the torso, face, head, and/or covered multiple parts of the body; appeared to be caused by an object; or is in different stages of healing;

  AND

- One of the following is true:
  - » Parent denies abuse or attributes injury to accidental causes; OR
  - » Parent's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury; OR
  - » Parent's description of the injury or cause of the injury minimizes the extent of harm to the child.

11. **Parent refuses access to the child or hinders the investigation, or there is reason to believe that the family is about to flee.** This may be indicated by any of the following situations.

- Family currently refuses access to the child or cannot/will not provide the child's location.

- Family has removed the child from a hospital against medical advice to avoid investigation.

- Family has previously fled in response to a child protection investigation.

- Family has a history of keeping the child at home, away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.

- Information exists that suggests the parent is intentionally coaching or coercing the child, or allowing others to coach or coerce the child, in an effort to hinder the investigation.

12. Current circumstances, combined with information that the parent has or may have previously maltreated a child in their care, suggest that the child's safety may be of immediate concern.

Current immediate threats to child safety and related previous maltreatment that was severe and/or represents an unresolved pattern must exist in order for this safety threat to be selected.

Previous maltreatment includes any of the following situations.

- Death of a child as a result of maltreatment.

- Serious injury or abuse to a child other than accidental. The parent caused serious injury defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child *and required medical treatment*.

- Unsuccessful reunification in connection with a prior child protection case opening.

- Prior removal/placement of a child by the department or other responsible child welfare agency or concerned party for the safety of the child.

- Prior child protection verification of maltreatment.

- Prior threat of serious harm to a child that involved the parent maltreating the child in a way that could have caused severe injury, retaliation or threatened retaliation against a child for previous incidents, or domestic violence that resulted in serious harm or threatened harm to a child.

- Department-recommended services were unsuccessful regarding changes in behaviour.

13. Other (specify).
This option is for circumstances or conditions that pose an immediate threat of serious harm to a child and are not already described in safety threats 1–12.

SECTION 1B: PROTECTIVE CAPACITIES

Child

1. Child has the cognitive, physical, and emotional capacity to participate in safety interventions.

   - The child has an understanding of their family environment in relation to any real or perceived threats to safety.
   - The child can identify how to obtain immediate assistance if needed (e.g. calling emergency responders, running to neighbor, telling an adult significant to the child).
   - The child is emotionally capable of overcoming allegiance to their parent in order to protect their own safety.
   - The child has sufficient physical capability to protect themself and/or remove themself from the situation if necessary.

2. Child has, on more than one occasion, successfully acted in a way to protect themself from the safety threat.
   Including but not limited to:

   - Child reached out to a member of their support network in response to the safety threat, and that network member was able to keep the child safe.
   - Child has demonstrated an ability to successfully protect themselves from the safety threat.

Parent

3. Parent has the cognitive, physical, and emotional capacity to participate in safety interventions.

    - The parent has the ability to understand that the current situation poses a threat to the safety of the child.
    - They are able to follow through with any actions required to protect the child.
    - They are willing to put the emotional and physical needs of the child ahead of their own.
    - They possess the capacity to physically protect the child.

4. Parent recognizes problems and safety threats placing the child in imminent danger and is willing to participate in safety planning.

    - The parent is cognizant of the problems that necessitated child protection intervention to protect the child.
    - The parent expresses a willingness to identify and/or discuss strategies that will ensure the child's safety.
    - The parent is able and willing to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child.
    - The parent accepts feedback and recommendations from the social worker.

5. Parent is willing to accept temporary interventions offered by social worker and/or other community agencies, including cooperation with continuing investigation/assessment.

    - The parent accepts the involvement, recommendations, and services of the social worker or other individuals working through referred community agencies.
    - The parent expresses that they will cooperate with the continuing investigation/assessment, allows the social worker and intervening agency to have contact with the child, and agrees to support the child in all aspects of the investigation or ongoing interventions.

6. Parent is aware of and committed to meeting the needs of the child.

- The parent is able to express the ways in which they have historically met the child's needs for:

  » Supervision;
  » Stability;
  » Basic necessities;
  » Mental/medical health care; and
  » Developmental/education.

- The parent is able to express their commitment to the continued well-being of the child.

7. There is evidence of a healthy relationship between parent and child.

- The parent displays appropriate behaviour toward the child, demonstrating that a healthy attachment with the child has been formed.

- There are clear indications through both verbal and non-verbal communication that the parent is concerned about the emotional well-being and development of the child.

- The child interacts with the parent in a manner evidencing that an appropriate relationship exists and that the child feels nurtured and safe.

8. At least one parent in the home is willing and able to take action to protect the child, including asking offending parent to leave.

- The non-offending parent understands that continued exposure between the child and the offending parent poses a threat to the safety of the child, **AND** the non-offending parent is able and willing to protect the child by ensuring that the child is in an environment in which the offending parent will not be present.

- If necessary, the non-offending parent is willing to ask the offending parent to leave the residence.

- If the situation requires, then the non-offending parent will not allow the offending parent to have other forms of contact (telephone calls, electronic correspondence, mail, or correspondence through third-party individuals, etc.) with the child.

9. Parent has the ability to access resources to provide necessary safety interventions.

   - The parent has the ability to access resources to contribute toward safety planning.

   - Community resources are available to meet identified needs in safety planning (e.g. able to obtain food, provide safe shelter, provide medical care/supplies).

10. Parent has supportive relationships with one or more persons who may be willing to participate in safety planning, AND parent is willing and able to accept their assistance.
    The parent has a supportive relationship with another family member, neighbor, or friend who may be able to assist in safety planning. Assistance includes, but is not limited to, the provision of child care or securing appropriate resources and services in the community.

11. Parent can articulate strategies that, in the past, have been successful in mitigating the identified safety threats to the child.

    - The parent has historically sought to solve problems and resolve conflict using a variety of appropriate strategies and resources, including assistance offered by friends, neighbors, and community members.

    - The parent has shown an ability to identify a problem, outline possible solutions, and select the best means to resolution in a timely manner.

12. Other:
    This option is for circumstances or conditions that are not already described in protective capacities 1–11.

SECTION 2: SAFETY INTERVENTIONS

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety threats rather than long-term changes. If protective capacities 3, 4, and/or 5 are not identified, consider whether an in-home safety intervention can be put into place, leaving the child in the home. Please refer to child protection policies whenever applying any of the safety interventions for safety planning.

In-Home Interventions

1. Intervention or direct services by social worker.
   Investigating worker or other child protection staff takes or plans actions, accepted by the parents, that specifically address one or more safety threats. Examples include:

- Providing information about non-violent disciplinary methods, child development needs, or parenting practices;
- Providing emergency material aid such as money, food, and infant formula;
- Planning return visits to the home to check on progress;
- Providing information on obtaining peace bonds and/or emergency protection orders; and
- Providing information on child abuse and neglect and discussing the legal implications of abusive and neglectful behaviour.

Intervention DOES NOT INCLUDE the investigation itself or services provided to respond to family needs that do not directly affect safety.

2. Use of family, neighbours, community elders, traditional healers, or other individuals in the community as safety resources.
This can include applying the family's own strengths as resources to mitigate safety concerns, accompanied by the use of extended family members, community elders, neighbours, or other individuals to mitigate safety concerns. Examples include:

   - Family's agreement to use non-violent means of discipline;
   - Engaging community resources (e.g. elders and/or traditional healers) to assist with safety planning such as agreeing to serve as a safety net or meet with the parent in crisis;
   - Engaging a grandparent to assist with child care or contact supervision;
   - Agreement by a neighbour to serve as a safety net for an older child; and
   - Commitment by a 12-step sponsor to meet with the parent daily and call the worker if the parent has used or missed a meeting.

3. Use of community agencies or services as safety resources.
Involving community-based organizations, faith-related organizations, or other agencies in activities to address safety concerns (e.g. using a local food bank). DOES NOT INCLUDE long-term therapy or treatment or placement on a waiting list for services.

4. Parent appropriately protects the victim from the alleged perpetrator.
A non-offending parent has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator. Examples include:

- Agreement that the child will not be alone with the alleged perpetrator; and

- Agreement that the parent will prevent the alleged perpetrator from physically disciplining the child.

5. Alleged perpetrator leaves the home, either voluntarily or in response to legal action.
Temporary or permanent removal of the alleged perpetrator. Examples include:

   - Arrest of alleged perpetrator;
   - Non-perpetrating parent requires alleged perpetrator to leave; or
   - Perpetrator agrees to leave.

6. Non-offending parent moves to a safe environment with the child.
Parent who is not suspected of harming the child has taken, or plans to take, the child to an alternate location where there will be no access to the suspected perpetrator. Examples include:

   - Domestic violence shelter or transition house;
   - Home of a friend or relative; or
   - Hotel.

7. Legal action planned or initiated—child remains in the home.
A legal action has commenced, or will be commenced, that will effectively mitigate identified safety factors. This includes family-initiated actions (e.g. peace bond, mental health commitments, changes in custody/visitation/guardianship) and caseworker-initiated actions (e.g. application for a protective intervention order, emergency intervention order, and child remains in the home). *May only be used in conjunction with other safety interventions*.

8. Parent makes arrangements for the child to stay with a relative or significant other.
The parent agrees to have the child temporarily stay with a relative or other suitable person while safety threats are being addressed. This should only include short-term voluntary agreements made between the parent and the relative or significant other. Examples include but are not limited to:

   - Child staying with a relative or significant other while environmental hazards are addressed;

   - Child staying with a relative or significant other while the offending parent moves to another location; or

   - Child staying with a relative or significant other to deescalate parent-child conflict.

9. Other.
The family or worker identified a unique intervention for an identified safety concern that does not fit within items 1–7.

Placement Interventions

10. A child is in need of protective intervention, and a protective care agreement (PCA) is used/signed as an alternative to removal.
A PCA may be considered when:

- Supportive services and informal care by family or significant others are unavailable or inadequate to ensure the child's safety;
- The social worker and the parent agree that out-of-home care is necessary to ensure child's safety;
- Parent agrees to plan that includes maintaining regular contact and involvement with the child;
- A plan is developed with the parent to reduce the safety threats that cause the child to be in need of protective intervention; or
- Reunification is expected to occur within the six months allowed in the PCA.

11. Child removed because interventions 1–10 do not adequately ensure the child's safety.
One or more children are placed in the care of the manager of child protection pursuant to Section 20 of the CYFA.

SECTION 3: SAFETY DECISION

1. **SAFE.** No safety threats were identified at this time. Based on currently available information, no children are likely to be in immediate danger of serious harm.

2. **SAFE WITH PLAN.** One or more safety threats are identified. Safety interventions have been initiated and the child will either remain in the home or will temporarily stay with a significant other with consent of the parent, as long as the safety interventions mitigate the safety threat(s). **A SAFETY PLAN IS REQUIRED.**

3. **UNSAFE.** One or more safety threats are identified, and the signing of a PCA or removal is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.

SECTION 4. LOCATION OF CHILD'S PLACEMENT
If the safety decision is "unsafe," the name and placement status of each child assessed should be recorded in this section.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® ALTERNATE CARE PROVIDER SAFETY ASSESSMENT
POLICY AND PROCEDURES

The purpose of the Alternate Care Provider Safety Assessment (ACPSA) is to help assess whether any child/youth in care in a foster home placement, in kinship, or placed for the purpose of adoption is likely to be in immediate danger of harm/maltreatment, requiring intervention.

WHICH CASES
All allegations of child abuse and neglect assigned for investigation on a foster home or an adoption placement.

All allegations of child abuse and neglect assigned for investigation on a kinship home where reunification of the child with the parent is the plan.

WHO
The social worker who is responding to the referral.

WHEN
For a new allegation, the child's safety is assessed to determine whether or not the child can remain in the home or returned to the home during the investigation. **This is typically during the first face-to-face contact with the child and the Alternate Care Provider (ACP).**

The ACPSA tool is to be completed by the end of the next business day following the first face-to-face contact with the child/youth.

If needed, a subsequent ACPSA tool may be completed to assess changes in safety during the investigation such as resolution of identified safety threats or new information.

DECISION
The ACPSA tool outlines the safety threats that could be present and a way in which to structure this information to support decision making. This information guides the decision about whether the child may remain in the home with no intervention or must be moved to an alternate placement.

APPROPRIATE COMPLETION

Social workers should familiarize themselves with the items that are included on the ACPSA tool and the accompanying definitions. Social workers will notice that the items on this ACPSA tool are very similar to the items on the SDM safety assessment tool used for child protection investigations.

The ACPSA tool ensures that every social worker is assessing the same items when determining if a child can safely remain in the home during an investigation of abuse/neglect by an ACP and that the responses to these items lead to specific decisions. Once a social worker is familiar with the items that must be assessed to complete the tool, the social worker should conduct their initial interviews/contact as they normally would—using good social work practice to collect information from the child, ACP, and/or collateral sources. The specific items that comprise the ACPSA shall be assessed during the initial contact with child and ACP.

Header Information

Enter the name of the home assessed. Typically, this would be the last name of the primary ACP in the home.

Enter the type of ACPSA, which is either:

- Initial. The initial ACPSA is completed in response to the child abuse/neglect investigation. This should be completed during the first face-to-face contact with the child and ACP.

- Review. The review ACPSA is completed after the initial assessment, any additional ACPSA is a review of the original safety concerns and decision.

Record the date of the ACPSA. The date of the assessment should be the date that the social worker made initial face-to-face contact with the child to assess safety, which may be different than the date on which the form is being completed.

The ACPSA consists of two sections.

Section 1. Safety Threats

This is a list of critical threats that must be assessed by every social worker in every investigation of alleged abuse/neglect by an ACP. These threats cover conditions that would place a child in danger of harm. Because not every conceivable safety threat can be anticipated or listed on a form, an "other" option is included.

Rely on information available at the time of the assessment. Social workers should make every effort to obtain sufficient information to assess these items prior to terminating their initial contact. However, it is expected that not all details about a case can be known immediately. Some information is inaccessible, and some is purposefully hidden from the social worker. Based on reasonable efforts to obtain information necessary to respond to each item, review each of the safety threats and accompanying definitions. For each item, consider all children in care, children in kinship arrangements, or children in adoptive placements in the home. If the safety threat is present, based on available information, mark that item "Yes." If the safety threat is not present, mark that item "No." If circumstances that the social worker determines to be a safety threat are not described by one of the existing items, the social worker should mark "Other" and briefly describe the threat.

Section 2. Safety Decision

In this section, the social worker records the outcome of the ACPSA. Select one of the two choices based on identification of threats.

1. **SAFE.** No safety threats have been identified. Based on currently available information, no children are likely to be in immediate danger of harm.

2. **UNSAFE.** One or more safety threats are identified, and arrangement of alternate placement of child(ren) is the only protective intervention possible.

PRACTICE CONSIDERATIONS

While safety is the prevailing concern for the first face-to-face contact, the manner of engaging the family will depend upon social work clinical skills. Whenever possible, the social worker should use a strength-based approach to initiate the contact, while remaining observant for the presence or absence of safety threats. Most safety threats are salient and can be discerned without invasive questioning. Others will benefit from candor, which will be more forthcoming when the family is approached with respect.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® ALTERNATE CARE PROVIDER SAFETY ASSESSMENT

r: 8/20

Placement Provider Name: _____ **Referral #:** _____ **File #:** _____

Primary ACP: _____ **Secondary ACP:** _____

Worker: _____ **Region:** _____

Date of Assessment: _____ **Assessment Type:** ○ Initial ○ Review

☐ A new ACPSA is not required, as child(ren)/youth has already been removed from the home.

Check whether the child was observed, interviewed, or was not available for an observation or interview.

Child Name		Observed	Interviewed	Unavailable	Date
1.		○	○	○	
2.		○	○	○	
3.		○	○	○	
4.		○	○	○	

For each child unavailable, please describe the reasons and the plan to see the child.

SECTION 1: SAFETY THREATS
*Assess home for each of the following safety threats. Indicate whether currently available information results in reason to believe any safety threat is present. Mark all that apply***.**

Yes	No	Safety Threat	Safety Threat Description (Alternate care provider [ACP] action/inaction and impact on child)
1. ○	○	ACP caused physical harm to the child or made a plausible threat to cause physical harm in the current investigation, as indicated by: ☐ Any injury or abuse to the child other than accidental ☐ ACP fears they will maltreat the child ☐ Threat to cause harm or retaliate against the child ☐ Use of physical force or corporal punishment	
2. ○	○	Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.	

SECTION 1: SAFETY THREATS

Assess home for each of the following safety threats. Indicate whether currently available information results in reason to believe any safety threat is present. Mark all that apply.

Yes	No	Safety Threat	Safety Threat Description (Alternate care provider [ACP] action/inaction and impact on child)
3. ○	○	ACP does not protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, emotional abuse, or neglect.	
4. ○	○	ACP does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.	
5. ○	○	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.	
6. ○	○	ACP's current substance use seriously impairs their ability to supervise, protect, or care for the child.	
7. ○	○	Domestic violence exists in the home.	
8. ○	○	ACP's emotional, developmental, or cognitive functioning or physical condition/disability seriously impairs their current ability to supervise, protect, or care for the child.	
9. ○	○	ACP describes the child in predominantly negative terms or acts toward the child in negative ways that may result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.	
10. ○	○	ACP's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.	
11. ○	○	ACP refuses access to the child or hinders the investigation, or there is reason to believe that the family is about to flee.	
12. ○	○	Current circumstances, combined with information that the ACP has or may have previously maltreated a child in their care, suggest that the child's safety may be of immediate concern.	
13. ○	○	Other (specify)	

SECTION 2: SAFETY DECISION

Identify the safety decision by marking the appropriate box below. Check one response only.

○ **1. SAFE**. No safety threats were identified at this time. Based on currently available information, no children are likely to be in immediate danger of harm.

○ **2. UNSAFE.** One or more safety threats are identified, and arrangement of alternate placement of child(ren) is the only protective intervention possible.

Analysis

Briefly summarize child vulnerabilities and protective capacities to support the safety decision.

Supervisory Consult With: _____ **Date of Consult:** _____

Social Worker Name: _____ **Date Form Completed:** _____

Supervisor Name: _____ **Date of Supervisory Approval:** _____

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® ALTERNATE CARE PROVIDER SAFETY ASSESSMENT
DEFINITIONS

General Definitions

Alternate care provider (ACP):

1. A person, with whom a child is placed for care with the approval of a manager and who, by agreement with a manager, has assumed responsibility for the care of the child. An ACP includes a family member or a person significant to the child but does not include the parent of the child.

OR

2. Members of the extended family or a significant other approved to care for a child or youth under a Kinship Services Program whereby there is a goal of reunification with a parent.

OR

3. A person with whom a child (who is in the care or custody of a manager) is placed for the purpose of adoption and the adoption has not been finalized in court.

SECTION 1: SAFETY THREATS

1. ACP caused physical harm to the child or made a plausible threat to cause physical harm in the current investigation, as indicated by one or more of the following.

- Any injury or abuse to the child other than accidental. The ACP caused any injury or abused any child.
- ACP fears they will maltreat the child. ACP expressed this fear directly to the social worker and/or requested removal.
- Threat to cause serious harm or retaliate against the child. ACP threatened action that would result in harm; ACP plans to retaliate against child for CSSD investigation; or child expresses a credible fear that they will be maltreated by the ACP and suffer serious harm.

- Use of physical force or corporal punishment. ACP used physical methods to discipline a child that resulted in or could easily result in injury; OR ACP injured or nearly injured a child by using physical force. This could include using physical force with an object, such as a belt, to discipline the child.

2. Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.

Suspicion of sexual abuse may be based on the following indicators.

- The child discloses sexual abuse verbally, or the child's behaviour indicates possibility of sexual abuse (e.g. age-inappropriate or sexualized behaviour toward self or others).

- Medical findings consistent with child sexual abuse.

- ACP is alleged to, is being investigated for, is charged with, or is convicted of a sex offence (including a Registered Sex offender); has had other sexual contact with the child; or has been previously verified by CSSD or other child protection agencies. Investigations for a sexual offence include those by CSSD or other child protection agencies.

- ACP or others in the home have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).

AND circumstances suggest that the child's safety may be of immediate concern, based on the following indicators.

- An alleged or convicted sexual abuse perpetrator or those suspected of perpetrating has access to a child.

- ACP blames child for the sexual abuse or the results of the investigation.

- ACP does not believe that the sexual abuse occurred.

3. ACP does not protect the child from harm or threatened harm by others. This may include physical abuse, sexual abuse, emotional abuse, or neglect.

- ACP does not protect the child from serious harm or threatened harm as a result of physical abuse, sexual abuse, emotional abuse, or neglect by other family members, other household members, or others having access to the child.

- ACP does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage. This includes an ACP not taking protective action following a disclosure of harm from the child.

- An individual with known violent criminal behaviour/history resides in the home, and current circumstances suggest that the child's safety may be of immediate concern.

- If domestic violence exists in the home, the domestic violence threat for violence between adults, as outlined in 7, may be more appropriate to select as a threat.

4. ACP does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.

- Nutritional needs of the child are not met, AND this results in danger to the child's health and/or safety, including malnutrition.

- The child's clothing is inappropriate for the weather to the extent that the child is in danger of hypothermia or frostbite.

- ACP does not seek treatment for the medical condition(s) or does not follow prescribed treatment for such conditions.

- Child appears malnourished.

- Child has exceptional needs, such as being medically fragile, which the ACP does not or cannot meet.

- Child exhibits signs of serious emotional symptoms, lack of behavioural control, or serious physical symptoms and the ACP will not/cannot provide the appropriate interventions.

- ACP does not attend to the child to the extent that need for care goes unnoticed or unmet (e.g. ACP is present but the child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).

- ACP leaves the child alone in circumstances that create opportunities for serious harm (time period and opportunity for harm is dependent on age and developmental stage, e.g. young child left unattended in vehicle on a hot day).

- ACP is currently unavailable to care for the child and no arrangements have been made (incarceration, hospitalization, abandonment, unknown location).

5. **The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.**
Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to:

- Leaking gas from stove or heating unit;
- Substances or objects accessible to the child that may endanger their health and/or safety (e.g. drug paraphernalia, scissors/knives, cleaning supplies);
- Lack of water or utilities and no alternate or safe provisions;
- Open/broken/missing windows accessible to young children;
- Exposed electrical wires;
- Excessive mould, garbage, or rotted or spoiled food that threatens child's health;
- Serious illness or significant injury has occurred due to living conditions that have not been remediated (e.g. lead poisoning, rat bites);
- Evidence of human or animal waste uncontained throughout living quarters;
- Unlocked and accessible guns and other weapons; and
- Drug production or sales from the home.

6. **ACP's current substance use seriously impairs their ability to supervise, protect, or care for the child.**
ACP has abused legal or illegal substances or alcoholic beverages to the extent that the ACP is currently unable, or will likely be unable, to supervise, protect, or care for the child; which is likely to harm the child. Examples include but are not limited to:

- Co-sleeping with an infant or young child whilst under the influence of drugs, alcohol; or solvents;
- Driving under the influence of alcohol and/or other drugs with a child in the car; and
- Being unable to provide immediate care and/or supervision to a child in the event of an emergency or other essential need while under the influence of substances or alcohol.

7. Domestic violence exists in the home.

There is evidence of domestic violence in the home and the child/youth in care may have been exposed to violence between kinship providers or foster/adoptive parents and/or an adult household member and another adult. Incidents of violence include but are not limited to physical conflict; sexual assault; verbal altercations that include coercion, intimidation, or threats; manipulation or control of children/youth in care; isolation; or unreasonable control of the adult victim.

Examples include the following.

- Child/youth in care is exposed to one or more incidents of violence as indicated by the child seeing, hearing, or trying to intervene in the incident of violence against adults.

- Child/youth in care is known to experience the buildup of tension or aftermath of the assault (e.g. observing victim depression, bruises, or other injuries).

8. ACP's emotional, developmental, or cognitive functioning or physical condition/disability seriously impairs their current ability to supervise, protect, or care for the child.

Evidence exists that the ACP is mentally ill, developmentally delayed, cognitively impaired, or has a physical condition/disability, AND as a result, one or more of the following situations are observed.

- ACP's refusal to seek evaluation/treatment and/or to follow prescribed medications impedes their ability to supervise, protect, or care for the child.

- ACP's inability to control emotions seriously impedes their ability to supervise, protect, or care for the child.

- ACP acts out or exhibits a distorted perception that impedes their ability to supervise, protect, or care for the child.

- ACP's mental health/illness impedes their ability to supervise, protect, or care for the child.

- ACP's current physical health/illness impedes their ability to supervise, protect, or care for the child.

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

- Due to cognitive delay, the ACP lacks basic knowledge and understanding related to parenting. Examples include not:

  » Knowing that infants need regular feedings;
  » Accessing and obtaining basic/emergency medical care;
  » Understanding proper diet; or
  » Providing adequate supervision.

9. ACP describes the child in predominantly negative terms or acts toward the child in negative ways that may result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.

Examples of ACP actions include:

- Describing the child in a demeaning or degrading manner (e.g. as evil, stupid, ugly);
- Cursing and/or repeatedly putting the child down;
- Scapegoating a particular child in the family;
- Blaming the child for a particular incident or household problems; and
- Interfering with the child's reunification or adoption (e.g. interfering with visitation or communication with birth parent, making negative comments about the child's birth/adoptive family).

10. ACP's explanation for child's injury is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.

Factors to consider when assessing the injury or explanation of injury include the child's age, location of injury, developmental needs of the child, chronicity or severity of injuries. The child's safety may be of immediate concern when:

- The injury requires medical attention, AND medical assessment indicates the injury is likely to be the result of abuse; OR
- A suspicious injury that did not require medical treatment was located on an infant; or, for older children, on the torso, face, head, and/or covered multiple parts of the body; appeared to be caused by an object; or is in different stages of healing;

  AND

- One of the following is true:

» ACP denies abuse or attributes injury to accidental causes; OR

» ACP's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury; OR

» ACP's description of the injury or cause of the injury minimizes the extent of harm to the child.

11. ACP refuses access to the child or hinders the investigation, or there is reason to believe that the family is about to flee.

- The family currently refuses access to the child or cannot/will not provide the child's location.

- Information exists that suggests the ACP is intentionally coaching or coercing the child, or allowing others to coach or coerce the child, in an effort to hinder the investigation.

12. Current circumstances, combined with information that the ACP has or may have previously maltreated a child in their care, suggest that the child's safety may be of immediate concern.
Consider current circumstances and available information, how the kinship providers or foster/adoptive parents present upon initial contact, severity of previous allegations of abuse and neglect, or severity of prior reports regarding care of the child/youth in care. If the current circumstances appear to represent a pattern or continuation of behaviour observed in the past where there was harm or threatened harm, serious or not, this safety threat may be selected. This may include:

- Prior reports regarding care of the child/youth in care in the home;

- Prior allegations of child abuse/neglect to the child, as referrals on kinship providers or foster/adoptive parents do not exist; and

- Evidence of prior unreported injuries or incidents.

13. Other (specify). This option is for circumstances or conditions that pose an immediate threat of serious harm to a child and are not already described in safety threats 1–12.

SECTION 2: SAFETY DECISION

1. SAFE. No safety threats were identified at this time. Based on currently available information, no children are likely to be in immediate danger of serious harm.

2. UNSAFE. One or more safety threats are identified, and arrangement of alternate placement of the child(ren) is the only protective intervention possible.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SAFETY PLAN
POLICY AND PROCEDURES

The purpose of the safety plan is to:
1) Outline current safety threats in the household
2) Outline strengths/protective capacities in the household and
3) Outline all interventions required to address safety threats of the children in the household where one or more safety threats have been identified.

Which Cases
The safety plan is required on all cases where one or more safety threats have been identified and the safety assessment decision has concluded that the household is "safe with plan."

Who
The social worker who completed the safety assessment.

When
The safety plan is completed immediately following the completion of a safety assessment where one or more safety threats have been identified and when the safety decision is "safe with plan."

How long
A safety plan cannot exceed the 30-day investigation period. All plans should contain an end date and a review date. The plan should be reviewed with the social worker, the supervisor and the family.

Appropriate Completion

SECTION 1: Children's Names
Note all children's full names who will be included on the safety plan.

SECTION 2: Parent(s) Names
Note the parent(s) full names for whom the safety plan is being developed.

SECTION 3: Safety Threats
Indicate which safety threats were identified through the SDM Safety Assessment.

SECTION 4: Strengths/Protective Factors
Indicate any strengths/protective capacities that were identified through the SDM Safety Assessment.

SECTION 5: Safety Plan
Describe the action required, person(s) responsible (parents or other parties responsible to ensure child's safety), start date and review date. Please refer to *Standard #4: Assessing Child Safety and Safety Planning: Collaborating with the Family* in the Structured Decision Making® Practice Standards Manual for standards and practice considerations.

SECTION 6: Signatures
Obtain signatures from all parent(s) who are parties to the safety plan as well as any significant other who may be involved in the plan. The social worker developing the plan shall also sign in this section as well as a supervisor.

SECTION 7: Review of Safety Plan
This section is to be completed at the designated review date, if the safety plan is still in place at that time. Please indicate if a new safety plan is required and note any relevant commentary in this section. Please refer to Standard #4: *Assessing Child Safety and Safety Planning: Collaborating with the Family* in the Structured Decision Making® Practice Standards Manual for further information.

Newfoundland Labrador

Children, Seniors and Social Development

CSSD Safety Plan

File #

1 Child(ren)(s) Name(s) (Please Print)

2 Parent(s) Names (Please Print)

3 Safety Threats

4 Strengths/Protective Factors

5 Safety Plan

Action Required	Person Responsible	Start Date YYYY MM DD	Review Date YYYY MM DD

6 Signatures/Dates

Signature of Parent | Signature of Parent | Significant Other

Social Worker | YYYY MM DD | Supervisor | YYYY MM DD

7 Review of Safety Plan

Date of Review (YYYY MM DD) _____ Is new Safety Plan required? Yes ☐ No ☐ Date Ended (YYYY MM DD) _____

Signature of Parent | Signature of Parent | Significant Other

Social Worker | YYYY MM DD | Supervisor | YYYY MM DD

Commentary

White Copy - Client Yellow Copy - CSSD FIle Pink Copy - 2nd Review/Signficant Other Copy

Child, Youth and Family Services

CYFS Safety Plan

PRIVACY NOTICE

The Department of Child, Youth and Family Services collects personal information relating to children, youth and families, under the authority of the *Children and Youth Care and Protection Act*. This information may be collected for the provision of services and/or the operations of the Department. If you have any questions about the collection or use of this information, please contact the Information Management Division of the Department of Child, Youth and Family Services Provincial Office at Department of Child, Youth and Family Services, P. O. Box 8700 St. John's, NL A1B 4J6.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY RISK ASSESSMENT
POLICY AND PROCEDURES

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

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

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

WHICH CASES
All referrals that are assigned for investigation, including a screened-in referral on an ongoing protective intervention case.

WHO
The social worker who is responding to the referral.

WHEN
After the safety assessment has been completed AND prior to the conclusion of the protection investigation; this is before a decision to close with no further protective intervention or transfer to ongoing protective intervention. This is no later than 30 days from the date of the child protection referral (CPR).

DECISION
Identifies the level of risk of future maltreatment. The risk level guides the decision to close an investigation without services (in conjunction with the safety decision) or transfer a family to ongoing protective intervention services and to determine minimum contact standards for these cases. If the recommended response differs from the actual risk and safety assessment recommendation, provide an explanation in the investigation report and check the most appropriate reason.

Determination Recommendation	
Risk Level	**Recommendation**
Very High	Transfer to ongoing protective intervention services
High	Transfer to ongoing protective intervention services
Moderate	Close*
Low	Close*

*When unresolved safety threats are still present at the end of the investigation, ongoing service should be provided regardless of risk level.

APPROPRIATE COMPLETION
The risk assessment is completed based on conditions that exist at the time the incident is reported and investigated as well as the prior history of the family.

- Only one household can be assessed on the risk assessment form.
- Always assess the household in which the child abuse/neglect incident is alleged.
- If more than one referral is received in an investigative period, one risk assessment can be completed for multiple referrals received during that time.

Scoring Individual Items
A score for each assessment item is derived from the social worker's interview with household members and collateral persons, parent-child interactions, child protection record checks, and observations of the household members and physical conditions of the home; scores are based on the definitions for the items. The worker should refer to the definitions to determine their identification for each item.

Some characteristics are objective (such as prior child abuse/neglect history or the age of the child) and can be determined prior to contact in many cases. Others require the worker to ask questions, make observations, and use professional judgment based on their assessment of the family according to the item definitions. Sources of information used to determine the worker's

identification of an item may include statements by the child, parent, or collateral persons; worker observations; reports; or other reliable sources.
After all index items are scored, the worker totals the score and indicates the corresponding risk level for each index. Next, the scored risk level (which is the higher of the abuse or neglect risk scores) is entered.

Description of identified risk items. Provide narrative that describes the reason for the identification of all risk items on the neglect and abuse indices. This narrative will be completed as part of the Protection Investigation Summary form and should specify the reasons for scoring based on observation, results of interviews, and record reviews.

Overrides
After completing the risk assessment, the worker determines whether any of the override reasons exist. *Policy* overrides reflect incident seriousness and/or child vulnerability concerns and have been determined by the agency to warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. A *discretionary* override is applied by the worker to increase the risk level in any case in which the worker believes that the risk level set by the risk assessment is too low. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the risk assessment. Discretionary overrides may increase the risk level by one unit (e.g. from low to moderate OR moderate to high, but NOT from low to high).Selection of any override requires supervisory approval.

Final Risk Level
After completing the override section, indicate the final risk level, which is the highest of the scored risk level, policy override risk level (which is always very high), or discretionary risk level.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY RISK ASSESSMENT

Primary Parent Name: _____ **Secondary Parent Name:** _____
File #: _____ **Referral #:** _____
Worker: _____ **Region:** _____
Date of Assessment: _____

NEGLECT		**Score**
N1.	Current child protection referral (CPR) is for neglect	
	○ a. No 0	
	○ b. Yes 1	_____
N2.	Prior screened-in CPR (assign highest score that applies)	
	○ a. None 0	
	○ b. One or more, abuse only 1	
	○ c. One or two for neglect 2	
	○ d. Three or more for neglect 3	_____
N3.	Household has previously received ongoing child protection services	
	○ a. No 0	
	○ b. Yes 1	_____
N4.	Number of children in the household	
	○ a. One, two, or three 0	
	○ b. Four or more 1	_____
N5.	Age of youngest child in the home	
	○ a. Two or older 0	
	○ b. Under 2 1	_____
N6.	Primary parent provides physical care consistent with child needs	
	○ a. Yes 0	
	○ b. No 1	_____
N7.	Primary parent's mental health	
	○ a. No problems 0	
	○ b. Past or current problems 1	_____
N8.	Primary parent's alcohol or drug use (select applicable items and add for score)	
	☐ a. No problem 0	
	☐ b. Alcohol problem (current or historic) 1	
	☐ c. Drug problem (current or historic) 1	_____
N9.	Characteristics of children in household (select applicable items and add for score)	
	☐ a. No child exhibits characteristics below 0	
	☐ b. Medically fragile or failure to thrive 1	
	☐ c. Developmental, physical, or learning disability 1	
	☐ d. Positive toxicology screen at birth 1	_____
N10.	Housing (select applicable items and add for score)	
	☐ a. The family has physically safe housing 0	
	☐ b. Housing is physically unsafe 1	
	☐ c. Homeless at any time during investigation 2	_____
	TOTAL NEGLECT RISK SCORE	_____

ABUSE		**Score**
A1.	Current child protection referral (CPR) is for abuse	
	○ a. No 0	
	○ b. Yes 1	_____
A2.	Number of prior screened-in CPRs for abuse	
	○ a. None 0	
	○ b. One 1	
	○ c. Two or more 2	_____
A3.	Household has previously received ongoing child protection services	
	○ a. No 0	
	○ b. Yes 1	_____
A4.	Prior injury to a child resulting from abuse/neglect	
	○ a. No 0	
	○ b. Yes 1	_____
A5.	Primary parent's assessment of incident (select applicable items and add for score)	
	☐ a. Neither following characteristic applies 0	
	☐ b. Blames child for abuse/neglect 1	
	☐ c. Justifies abuse and/or neglect 2	_____
A6.	Domestic/family violence between any adult household member in the past year	
	○ a. No 0	
	○ b. Yes 2	_____
A7.	Primary parent's characteristics (select applicable items and add for score)	
	☐ a. None of following characteristics apply 0	
	☐ b. Provides insufficient emotional support 1	
	☐ c. Employs excessive/inappropriate discipline 1	
	☐ d. Overly controlling/bullying 1	_____
A8.	Primary parent has a history of abuse or neglect as a child	
	○ a. No 0	
	○ b. Yes 1	_____
A9.	Secondary parent's alcohol or drug use	
	○ a. No problem or no secondary carer 0	
	○ b. Alcohol and/or drug problem (select all applicable) 1	_____
	☐ Alcohol ☐ Drug	
A10.	Characteristics of children in household (select applicable items and add for score)	
	☐ a. No child exhibits characteristics below 0	
	☐ b. Child/youth in conflict with the law 1	
	☐ c. Developmental or learning disability 1	
	☐ d. Mental health or behavioural problem 1	_____
	TOTAL ABUSE RISK SCORE	_____

SCORED RISK LEVEL
Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart:

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

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

○ Yes ○ No 1. Child is likely to have access with an individual who, historically or presently, has allegedly sexually abused a child.
○ Yes ○ No 2. Non-accidental injury to a child younger than 3 years of age.
○ Yes ○ No 3. Severe non-accidental injury to a child of any age.
○ Yes ○ No 4. Parent action or inaction resulted in death of a child due to abuse or neglect (past or current).

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

○ Yes ○ No 5. If **yes**, override risk level (select one): ☐ Moderate ☐ High ☐ Very High

Discretionary override reason: _____

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

FINAL RISK LEVEL (select final level assigned):

○ Low
○ Moderate
○ High
○ Very High

Social Worker Name: _____ **Date Form Completed:** _____

Supervisor Name: _____ **Date of Supervisory Approval:** _____

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY RISK ASSESSMENT
DEFINITIONS

The risk assessment is composed of two indices: the neglect index and the abuse index. Both indices must be completed with every item answered, regardless of the current allegation. Only one household can be assessed on a risk assessment tool. If two households are involved in the alleged incident(s), separate risk assessment tools should be completed for each household.

In applying the definitions, consider conditions that existed AT THE BEGINNING of the assessment/investigation. Also select any risk items that emerged or occurred DURING the assessment/investigation unless otherwise stated in the definition.

NEGLECT INDEX

N1. Current child protection referral (CPR) is for neglect
The current referral includes any type of neglect allegation.

N2. Prior screened-in CPR (assign highest score that applies)
Where possible, history from other jurisdictions should be checked.

- Count prior screened-in referrals involving any adult members of the current household who were alleged perpetrators in this or any other household. Include prior screened-in referrals for children no longer in the household.

- Do not count prior referrals in which:

  » Allegations were perpetrated by an adult who is not part of the current household;

  » A child in the home was identified as a perpetrator of abuse/neglect; and/or

  » Reports were screened out.

a. None. No screened-in referrals prior to the current investigation/assessment.

b. One or more, abuse only. One or more screened-in referrals, verified or not, for any type of *abuse* prior to the current investigation/assessment AND no prior neglect referrals that were screened in for investigation. Abuse includes physical, emotional, or sexual abuse.

c. One or two for neglect. One or two screened-in referrals, verified or not, for any type of *neglect* prior to the current investigation/assessment, with or without prior abuse referrals.

d. Three or more for neglect. Three or more screened-in referrals, verified or not, for any type of *neglect* prior to the current investigation/assessment, with or without prior abuse referrals.

N3. Household has previously received ongoing child protection services
Where possible, history from other jurisdictions should be checked.

Any member of the current household, prior to this investigation, received or is currently receiving ongoing child protection services, AND that member was an alleged perpetrator. Service history includes voluntary or court-ordered intervention.

N4. Number of children in the household
Include children who are temporarily absent but expected to return (e.g. children who were removed from the home during the investigation, temporarily reside with kin, ran away but are expected to return, or are temporarily at boarding school or camp).

N5. Age of youngest child in the home
Age of the youngest child currently residing in the household where abuse/neglect allegedly occurred. If a child is removed as a result of the current investigation or otherwise is temporarily placed/residing outside of the household, count the child as residing in the household. If the child has permanently left the home as a result of a previous investigation (i.e. continuous custody, permanently residing with kin), do not count that particular child.

N6. Primary parent provides physical care consistent with child needs
Physical care of the child includes providing food, clothing, shelter, hygiene, and medical care. Consider the child's age/developmental status.

ANSWER NO IF:

- The current referral of neglect relates to physical care of child, AND concerns were verified.

- Whether or not a neglect verification is current, the child has been harmed or their well-being has been threatened because of unmet physical needs. Needs may be considered unmet regardless of whether the cause is neglectful or due to situations outside of the parent's control. This includes but is not limited to the following situations.

» Child has a significant medical/dental/vision condition that requires care and care is not being provided.

» Child persistently does not *have,* or parent does not ensure the child has, clothing that is appropriate for weather conditions, OR clothing is persistently unwashed.

» Living environment lacks adequate utilities or safe alternative provision (e.g. drinking water), has potentially dangerous conditions (e.g. unlocked poisons, dangerous objects in reach of small child), is unsanitary, or is infested with rodents, AND these conditions persist regardless of any attempt parents/carers have made to rectify problems. If living environment concerns are to the degree that it is *unsafe*, also score N10.

» Child frequently goes hungry or thirsty, has lost weight, or has failed to gain weight.

» A young child is not being bathed regularly, as evidenced by their physical appearance and/or resulting in a strong odour.

N7. Primary parent's mental health

Indicate if the primary parent or others have made credible and/or verifiable statements specifying that the primary parent:

- Has been diagnosed, or is currently being treated by a professional qualified to do so, for a mental illness/disorder other than substance-related disorders; and/or

- Has/had multiple referrals for mental health/psychological evaluations, treatment or hospitalizations.

If primary parent has never been diagnosed but appears to have (or have had) a mental health problem, consider obtaining an assessment prior to scoring. Do not count reports motivated solely by efforts to undermine the credibility of the primary parent or other ulterior motives.

N8. Primary parent's alcohol or drug use (select applicable items and add for score)

Do not score parent's legal, non-abusive prescription drug use.
Indicate if the primary parent has a past or current alcohol and/or drug abuse problem that interferes or interfered with their or the family's functioning. Include any illegal drugs, abuse of prescription medication prescribed or not, and other items such as solvents.

Any of the following may be true of the primary parent.

- A professional qualified to do so has diagnosed the primary parent with a substance-related disorder.

- If primary parent has never been diagnosed but appears to have (or have had) an alcohol or drug problem, consider obtaining an assessment prior to scoring. If parent is unwilling to participate in an assessment, or for other reasons an assessment cannot be completed, also count if the primary parent:

  » Self-identifies as an alcoholic or addict; and/or
  » Uses substances in ways that have negatively affected their:
    - Employment;
    - Marital or family relationships; or
    - Ability to provide protection, supervision, and care for the child.

- Parent has been arrested for use, possession, or distribution of illicit substances including solvents, crimes committed under the influence of substances, or crimes committed to obtain substances.

- Parent has been arrested for driving under the influence or refusing breathalyser testing.

- Parent has had multiple positive urine/blood/hair follicle samples.

- Parent has/had health/medical problems resulting from substance use.

- Parent has given birth to a child diagnosed with fetal alcohol syndrome disorder (FASD), or a child had a positive toxicology screen at birth.

N9. Characteristics of children in household (select applicable items and add for score)

a. No child exhibits characteristics below

b. Medically fragile* or failure to thrive. Any child in the household *has a diagnosis* of medically fragile or failure to thrive as evidenced by parent's statement of such a diagnosis, medical records, and/or doctor's report.

**Medically fragile*: Infant has a medical condition that requires technological intervention; the condition, if untreated, is likely to result in death or serious harm. For example, child requires a trach/vent or central line feeding.

c. Developmental, physical, or learning disability. Any child in the household who has a developmental, physical, or learning disability *that has been diagnosed by a professional* (e.g. doctor, school counsellor, psychologist, etc.) as evidenced by parent's statement of such a diagnosis, medical/school records, and/or professional's statement.

d. Positive toxicology screen at birth. Any child had a positive toxicology report at birth for alcohol or another drug/substance not used according to a doctor's prescription, and the primary or secondary parent is the birth mother.

N10. Housing (select applicable items and add for score)

a. The family has physically safe housing

b. Housing is physically unsafe. The family has housing but the housing situation is physically unsafe to the extent that it does not meet the health or safety needs of the child (for example, exposed wiring, lack of water or utilities, rat infestations, human/animal waste on floors, or rotting food).

c. Homeless at any time during investigation. The family was homeless or was about to be evicted at any time during the current investigation. Do not check this item if the family is living in transitional housing AND has a longer-term plan for housing.

ABUSE INDEX

A1. Current child protection referral (CPR) is for abuse
The current referral includes any type of abuse allegation, including:

- Physical abuse;
- Psychological/emotional abuse; or
- Sexual abuse.

A2. Number of prior screened-in CPRs for abuse
Where possible, history from other jurisdictions should be checked.

- Count prior screened-in referrals involving any adult members of the current household who were alleged perpetrators of abuse (physical, psychological, or sexual abuse/sexual exploitation). Include prior screened-in referrals for children no longer in the household.

- Do not count:

  » Prior screened-in referrals of abuse in which allegations were perpetrated by an adult who is not part of the current household;

» If child in the home was identified as the perpetrator of abuse/neglect; or

» Reports that were screened out.

a. None. No abuse investigations/assessments prior to the current investigation/assessment.

b. One. One investigation/assessment, substantiated or not, for any type of *abuse* prior to the current investigation.

c. Two or more. Two or more investigations/assessments, verified or not, for any type of *abuse* prior to the current investigation/assessment.

A3. Household has previously received ongoing child protection services
Where possible, history from other jurisdictions should be checked.

Any member of the current household, prior to this investigation, has received or is receiving ongoing child protection services, AND that member was an alleged perpetrator. Service history includes voluntary or court-ordered intervention.

A4. Prior injury to a child resulting from abuse/neglect

- An adult in the household was previously verified for child abuse or neglect that resulted in an injury to a child, whether or not the child is a member of the current household.

- Though not previously reported to the department or verified, credible information suggests that an adult in the household caused an injury to a child consistent with abuse or neglect, whether or not the child is a member of the current household.

A5. Primary parent's assessment of incident (select applicable items and add for score)

a. None of following characteristics apply. The parent neither blames nor justifies the current abuse/neglect or alleged abuse/neglect.

b. Blames child for abuse/neglect. An incident of abuse or neglect has occurred (whether verified or not) and the primary parent blames the child for the abuse or neglect. Blaming refers to the parent's statement/belief that their action or inaction was in response to something that the child did or did not do (e.g. child was hit by her stepfather because she talked back to him; parent claims that the child seduced them; parent says the child deserved to be hit because they misbehaved).

c. Justifies abuse/neglect. An incident of abuse or neglect has occurred (whether verified or not) and the primary parent justifies the abuse or neglect. Justifying refers to the parent's statement/belief that their action or inaction was appropriate and constitutes good parenting (e.g. claims that this form of discipline was how they were raised, states that kids these days are always in trouble because parents are too lenient).

A6. Domestic/family violence between any adult household members in the past year

In the previous year, there have/has been:

- Two or more physical assaults;
- One or more serious incidents resulting in serious physical harm and/or involving use of a weapon; or
- A pattern of intimidation, threats, or harassment between parents or involving an adult household member and another adult(s).

Incidents may be identified by self-report or by credible report by a family or other household member, credible sources, and/or police reports.

Do not include violence between any adult household member and a child where the child is the alleged perpetrator of the violence.

A7. Primary parent's characteristics (select applicable items and add for score)

a. None of the following characteristics apply. The primary parent does not exhibit characteristics listed below.

b. Provides insufficient emotional support. The primary parent provides insufficient emotional/psychological support to the child, such as persistently depriving the child of affection or emotional support.

c. Employs excessive/inappropriate discipline. The primary parent's disciplinary practices caused or threatened harm to a child because they were excessively harsh physically, excessively harsh emotionally, and/or inappropriate to the child's age or development.

Examples may include but are not limited to:

- Locking the child in room or closet;
- Holding the child's hand over fire;

- Hitting the child with dangerous object or fist; or

- Depriving a young child of physical and/or social activity for extended periods.

d. Overly controlling/bullying. The primary parent over-controls or bullies the child and/or expects immediate compliance. This may be characterized by persistent berating/belittling/demeaning of the child, a parent seeing their own way as the only way, or by little two-way communication between the parent and child.

A8. Primary parent has a history of abuse or neglect as a child

Based on credible statements by the primary parent or others, or any child protection history known to the agency, the primary parent was abused or neglected as a child (child protection history includes neglect and physical, sexual, or emotional abuse).

Note: Base your assessment of what the parent experienced as a child on *current* definitions of abuse/neglect regardless of what it was labelled at the time.

A9. Secondary parent alcohol or drug use

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

SELECT IF:

The secondary parent has a past or current alcohol and/or drug abuse problem that interferes or interfered with their or the family's functioning. Include any illegal drugs, abuse of prescription medication prescribed or not, and other items such as solvents.

Any of the following may be true of the secondary parent.

- A professional qualified to do so has diagnosed the secondary parent with a substance-related disorder.

- If secondary parent has never been diagnosed but appears to have (or have had) an alcohol or drug problem, consider obtaining an assessment prior to scoring. If parent is unwilling to participate in an assessment, or for other reasons an assessment cannot be completed, also count if the secondary parent:

  » Self-identifies as an alcoholic or addict; and/or
  » Uses substances in ways that have negatively affected their:
    - Employment;
    - Marital or family relationships; or
    - Ability to provide protection, supervision, and care for the child.

- Secondary parent has been arrested for use, possession, or distribution of illicit substances, crimes committed under the influence of substances, or crimes committed to obtain substances.

- Secondary parent has been arrested for driving under the influence or refusing breathalyzer testing.

- Secondary parent has had multiple positive urine/blood/hair follicle samples.

- Secondary parent has/had health/medical problems resulting from substance use.

- Secondary parent has given birth to a child diagnosed with FASD, or a child had a positive toxicology screen at birth.

A10. Characteristics of children in household (select applicable items and add for score)

a. No child exhibits characteristics below

b. Child/youth in conflict with the law. Any child in the household has been involved with the youth criminal justice system. Offending or antisocial behaviour not brought to court attention but that creates stress within the household should also be scored, such as child who runs away or is habitually truant.

c. Developmental or learning disability. Any child in the household who has a developmental or learning disability *that has been diagnosed by a professional* (e.g. physician, school counsellor, psychologist, etc.) as evidenced by parent's statement of such a diagnosis, medical/school records, and/or professional's statement.

d. Mental health or behavioural problem. Any child in the household who has mental health or behavioural problems (includes attention deficit disorders) not related to a physical or developmental disability. This could be indicated by:

- A mental health diagnosis by a qualified professional;
- Receiving mental health treatment;
- Individualized Education Plan due to behavioural problems;
- Attendance in a special classroom because of behavioural problems; or
- Currently taking psychotropic medication.

POLICY OVERRIDES

After completing the risk assessment, the worker determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns and have been determined by the agency to warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. Policy overrides require supervisory approval.

1. Child is likely to have access with an individual who, historically or presently, has allegedly sexually abused a child

Select this policy override in the following circumstances.

- Sexual abuse case AND the alleged perpetrator is likely to have access to the child they are alleged to have abused.
- An individual who is suspected to have sexually abused a child(ren) in the past will likely have access to children in the household. This is a concern as no information is available to suggest that circumstances have changed for the alleged perpetrator, increasing risk of sexual harm to other children.
- An individual is suspected to have sexually abused a child in the household, and the parent's actions indicate that the perpetrator is likely to have continued access to the child.

Note: If the social worker and supervisor's clinical assessment is that the perpetrator's access to children is no longer a current child protection concern, the policy override does not need to be selected. This can include parent's actions that are protective in nature.

2. Non-accidental injury to a child younger than 3 years of age

Any child in the household younger than the age of 3 has a physical injury resulting from actions or inactions of a parent.

3. Severe non-accidental injury to a child of any age

Any child in the household has a serious physical injury resulting from a parent's action or inaction. Severe injury includes brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that requires medical treatment and seriously impairs the health or well-being of the child.

4. Parent action or inaction resulted in death of a child due to abuse or neglect (past or current)

Any child in the household has died as a result of actions or inactions by the parent.

DISCRETIONARY OVERRIDE

A discretionary override is applied by the worker to increase the risk level in any case in which the worker believes that the risk level set by the risk assessment is too low. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the risk assessment. Discretionary overrides may increase the risk level by one unit (e.g. from low to moderate OR moderate to high, but NOT from low to high). Discretionary overrides require supervisory approval.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
PROTECTION INVESTIGATION SUMMARY
POLICY AND PROCEDURES

The purpose of the Protection Investigation Summary (PIS) is to:

1) Summarize the protection investigation
2) Identify whether or not the protection concerns were verified
3) Identify whether or not the children are in need of protective intervention

Which Cases
The protection investigation summary is completed for every investigation. If more than one referral is received in an investigative period, only one PIS is required.

Who
The social worker who completed the investigation.

When
At the conclusion of an investigation and following completion of required documents for an investigation (including safety assessment and risk assessment). The PIS shall be completed within 30 days of receipt of the CPR. The PIS is completed prior to the transfer of the case from assessment to ongoing protective intervention services.

Appropriate Completion
Please refer to *Standard #5: Concluding the Child Protection Investigation* in the Structured Decision Making® Practice Standards Manual for standards and practice considerations.

Header Information

Enter the case open start date, case number and ISM number.
Parent
Enter the name of the primary parent, address, date of birth and select role from a drop down menu. Enter the same for the secondary parent, if applicable.

Other Parent
If there is another parent who is not part of the household (e.g. biological parent who is not part of the household), please enter the date of birth, address and select the role from a drop down menu.

Child/Children:
Enter the name of the child(ren), date of birth, and select from a drop down menu to indicate with whom the children are living.

Additional Household Members Not Identified Above
Indicate the name and date of birth of other household members, if available, other than the primary parent, secondary parent and children. Select role from the drop down menu. There is space in this section to further describe the household member's relationship to the child and family.

SECTION 1: Verify the Protection Concerns
The information in this section will need to be completed for each referral that was received in the investigative period. Document the referral date and assigned number. From a drop down menu, select the protection concern and then indicate whether or not this concern was verified.

SECTION 2: Safety and Risk Assessment Outcomes
Identify the safety decision for the most recent safety assessment completed. If the investigation was discontinued and a safety assessment could not be completed, do not complete this section.

Identify the risk assessment outcome on the risk assessment completed during this investigation. If the investigation was discontinued and a risk assessment could not be completed, do not complete this section.

SECTION 3: Decision Regarding Child's Need for Protective Intervention
Please select ONE of the six options available for the decision regarding a child's need for protective intervention. If "Investigation Discontinued" was selected, please select the appropriate reason within that category. See Standard #5: *Concluding the Child Protection Investigation* in the Structured Decision Making® Practice Standards Manual for further information.

SECTION 4: Summarize the Investigation
Please refer to *Standard #5: Concluding the Child Protection Investigation* in the Structured Decision Making® Practice Standards Manual for information pertaining to summarizing the investigation.

The social worker shall sign this form and the clinical supervisor will approve it.

Newfoundland Labrador
Children, Seniors and Social Development

Protection Investigation Summary

Case Start Date:_____ File #:_____ ISM ID:_____

Parent

Primary Parent	Role	Date of Birth	Address

Secondary Parent	Role	Date of Birth	Address

Other Parent(s) Not in Household (i.e. biological parents who are not part of household)

Name	Role	Date of Birth	Address

Child/Children

Child's Name	Date of Birth	With Whom Living

Additional Household Members not Identified Above

Name	Role	Date of Birth

Describe household member's relationship to child and family:

_____

_____

_____

Section One - Verify the Protection Concerns

Please indicate, for each protection concern, if the concern was or was not verified during the investigation.

Referral Number	Referral Date	Protection Concern	Verified
			☐ Yes ☐ No
			☐ Yes ☐ No

Section Two - Safety and Risk Assessment Outcomes

Most Recent Safety Assessment Outcome:

◯ **Safe**
◯ **Safe with Plan**
◯ **Unsafe**

If there are outstanding safety threats and the child is unsafe, please discuss further in Section Four and indicate how safety threats will be addressed in a FCAP.

Most Recent Risk Assessment Outcome:

◯ **Low Risk**
◯ **Moderate Risk**
◯ **High Risk**
◯ **Very High Risk**

Section Three - Decision Regarding Child's Need for Protective Intervention

Please choose one:

☐ Child **is** in need of Protective Intervention - transfer to Ongoing Protective Intervention Services

☐ Child **is** not in need of Protective Intervention - close case.

☐ The court has determined a child is not in need of protective intervention and CSSD has determined that no further intervention is required - close case.

☐ Child is already on an active Ongoing Protective Intervention case. There are **new** protection concerns as a result of this investigation that need to be addressed in a FCAP.

☐ Child is already on an active Ongoing Protective Intervention case. There are **no new** protection concerns as a result of this investigation that need to be addressed in a FCAP.

☐ Investigation Discontinued

- ◯ Family moved out of province
- ◯ Family cannot be located
- ◯ Youngest child turned 16
- ◯ Child deceased
- ◯ Referral information does not match family

Section Four - Investigation Analysis

Social Worker: Date completed:

Supervisor: Supervisor approval date:

Supervisor comments, if required:

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT
POLICY AND PROCEDURES

The family strengths and needs assessment (FSNA) is used to evaluate the presenting strengths and needs of each family. This assessment tool is used to systematically identify critical family needs, and it helps plan effective service interventions. The strengths and needs assessment serves several purposes.

- It ensures that all social workers consistently consider each family's strengths and needs in an objective format when assessing need for services.
- It provides an important case planning reference for workers and supervisors.
- The initial strengths and needs assessment, when followed by periodic reassessments, permits social workers and their supervisors to easily assess changes in family functioning and thus assess the impact of Family Centred Action Plan (FCAP) goals and objectives on safety and risk in the household.
- In the aggregate, needs assessment data provide management with information on the problems families face. These profiles can then be used to develop resources to meet client needs.

WHICH CASES
All cases open for ongoing protective intervention services. If a removal occurs prior to the completion of the initial FSNA, consult with your supervisor to determine whether a FSNA will be completed prior to the Plan for the Child. If a removal occurs in between review periods, determine with your supervisor if an updated FSNA needs to be completed prior to the Plan for the Child.

The child assessment portion is completed for each child who is in need of protection and for whom a file is established in ISM.

May be used when a case closes following a child protection investigation. A community service referral may be made, which may benefit from the completion of a family strengths and needs assessment.

WHO
The social worker who is responsible for developing the FCAP in conjunction with the family or the Plan for the Child.

WHEN

- **Initial FSNA:** Within 60 days of the receipt of the CPR and before the FCAP or Plan for the Child.

- **Review FSNA:** Completed for every subsequent FCAP but no sooner than 30 days before any FCAP is due. When reviewing in-home cases, complete the risk reassessment first. If based on risk and safety, the case will be closed; it is not necessary to complete the strengths and needs assessment.

DECISION

Identifies the three most important priority needs of parents and all needs of children that must be addressed in the FCAP. Goals, objectives, and activities in a case plan should relate to one or more of the priority needs.

Identifies a family's priority areas of strength that should be incorporated into the case plan to the greatest extent possible as a means to address identified needs.

APPROPRIATE COMPLETION

If an FSNA is not required at the review period because it has been decided that a file will be closing, select "FSNA is not required because file is closing." The social worker will sign the form and the supervisor will approve it.

Social workers should familiarize themselves with the eleven parent categories and the ten child categories of the FSNA and definitions. Workers will notice that the items are areas they are probably already assessing. What distinguishes the SDM model is that it ensures that every worker assesses the same categories in each case, and that the responses to these items lead to specific case planning. Once a worker is familiar with the items that must be assessed to complete the FSNA, the worker should conduct their family assessment as they normally would—using good social work practice to collect information from the child, parent, and/or collateral sources. SDM assessments ensure that a specific set of categories are addressed at some time during the assessment.

Items SN1 to SN11 and CSN1 to CSN10

Using the definitions, determine the appropriate response for each item and enter the corresponding score on the line provided. Note that SN11 and CSN10 are used when a parent or child, respectively, has a unique strength or need not covered in other items.

- If an individual has a strength, select "a."

- If an individual does not have a unique area of strength or need, select "b."

- If an individual has a need, select "c" or "d," depending on the severity of the need.

- Use narrative section at the end of the assessment tool to briefly describe the rationale for scoring each domain.

Items CSN1 to CSN10 relate to children in the family/household. Use one column for each child who will be assessed. Briefly summarize strengths and needs to describe all responses for each child. All identified child needs must be addressed in the case plan if not adequately being addressed by the family.

Priority Strengths and Needs for Parents

To identify priority strengths and needs for parents, consider ratings for items SN1 through SN11 in Section A (parent) of the FSNA. All identified child needs must be addressed in the FCAP or Plan for the Child.

For priority needs, enter the item number and title of any "d" responses. All items with a "d" response should be a priority need. Up to three domains should be selected for priority needs. If fewer than three "d" items are selected as priority needs, enter the item number and title of all "c" responses and review these as possible priority needs. You may select fewer than three priority needs, but not more than three.

To determine whether items with a "c" rating should be selected as a priority need, consider whether the item contributed to any selected safety threat (from the SDM safety assessment) or would prevent the family from completing the action(s) required to ensure the child's safety as stated on their safety plan.

A domain may be a priority need for one or both parents.

For priority strengths, enter the item number and title of any "a" and "b" responses. To determine whether an item should be selected as a priority strength, consider whether the item could be used to mitigate any selected safety threat (from the SDM safety assessment) or would facilitate the family reaching their safety goal.

Select "p" if it is a strength for only the primary parent; a domain may be a priority need for one parent and a priority strength for another parent.

FCAP or Plan for the Child

A family case plan is to be written with goals and objectives that incorporate, where possible, the parent's priority strengths to address the parent's priority needs. The FCAP is also to include service to address the child's needs and take into consideration the child's strengths. It is the parent's responsibility to ensure that the child's needs are met through appropriate service

provisions. If a child is in out-of-home care and the parent is unable to meet the child's needs, the agency must meet the child's needs.

PRACTICE CONSIDERATIONS

Completion of the FSNA requires gathering information from all family members, collaterals, and a review of records. It may be completed or modified during the course of the family's involvement. The worker must be aware of culturally specific interpretations of appearances and must engage family in culturally appropriate ways to make an accurate assessment. Where it is difficult to distinguish between responses, additional assessment may be helpful (i.e. psychological, developmental, substance use assessments), particularly if the difference between one rating and another is likely to impact selection of priority needs.

The FSNA identifies priority needs to address in the case plan. Once those areas are identified, the worker may benefit from additional assessment within those areas to identify specific objectives, services, and activities most appropriate for the family. The family's history of service utilization and willingness to change in these areas should be considered. FCAP objectives need to be clear and measurable. If a safety plan was in place, any continuing safety intervention requirements should now be incorporated into the case plan.

When scoring, consider the entire scope of available information, including the family's perspective, information from collateral sources, existing records and documents, and worker observations. Often, different sources will suggest different responses (e.g. father states he has no problem with alcohol but has two DUIs in the last year; mother states she believes he is an alcoholic; a court-ordered assessment suggests alcohol dependency; and father's brother states father has no problem with alcohol). The worker must make a determination based on social work assessment skills and professional judgment, taking into account the merits of each perspective. The household is assessed by completing all items. If there are two parents, each is assessed and scored separately.

For children in out-of-home care, the case plan will also include information regarding visitation. While the SDM assessment does not guide the decision concerning visitation at the initial case plan, the worker is encouraged to consider the safety threats that led to removal, the risk level, and the specific needs of parent and child.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT

r: 8/20

☐ **FSNA is not required because file is closing**

Household Name: _____ **File Number:** _____

Initial or Reassess #: _____ **Worker:** _____ **Region:** _____

Child Name	Date of Birth
1.	
2.	
3.	
4.	

Primary Parent: _____ **Secondary Parent:** _____

The following items should be considered for each family/household member. Worker should base the score on their assessment for each item, taking into account the family's perspective, child's perspective where appropriate, worker observations, collateral contacts, and available records. Refer to accompanying definitions to determine the most appropriate response. Enter the score for each item.

A. PARENT
Rate each parent.

Primary	Secondary		
		SN1.	**Substance Use** (Substances: alcohol, solvents, illegal drugs, inhalants, prescription/over-the-counter drugs)
○	○		a. Teaches and demonstrates a healthy understanding of alcohol and drugs
○	○		b. Substance use or abuse does not negatively impact parenting and protection
○	○		c. Substance use or abuse sometimes impacts parenting and protection
○	○		d. Substance use or abuse significantly impacts parenting and protection
		SN2.	**Household Relationships/Domestic Violence**
○	○		a. Demonstrates healthy relationships
○	○		b. Minor or occasional conflict that does not negatively impact parenting and protection
○	○		c. Frequent conflict or some domestic violence that sometimes impacts parenting and protection
○	○		d. Chronic conflict or severe domestic violence that significantly impacts parenting and protection

Primary	Secondary		
		SN3.	**Social Support System**
○	○		a. Strong mutual support system
○	○		b. Support system does not negatively impact parenting and protection
○	○		c. Limited support system sometimes impacts parenting and protection
○	○		d. No support system or negative support system significantly impacts parenting and protection
		SN4.	**Parenting Practices**
○	○		a. Demonstrates effective parenting and protection
○	○		b. Demonstrates adequate parenting and protection
○	○		c. Demonstrates inadequate parenting and protection
○	○		d. Demonstrates parenting practices that have harmed or may seriously harm the child
		SN5.	**Mental Health/Coping Skills**
○	○		a. Strong coping skills
○	○		b. Adequate coping skills or mental health symptoms do not negatively impact parenting and protection
○	○		c. Mental health symptoms or coping skills sometimes impact parenting and protection
○	○		d. Mental health symptoms or coping skills significantly impact parenting and protection
		SN6.	**Cognition**
○	○		a. Strong cognitive ability
○	○		b. Cognitive ability does not negatively impact parenting and protection
○	○		c. Cognitive ability sometimes impacts parenting and protection
○	○		d. Cognitive ability significantly impacts parenting and protection
		SN7.	**Resource Management/Basic Needs**
○	○		a. Consistently provides adequate housing, food, and clothing
○	○		b. Resource management does not negatively impact parenting and protection
○	○		c. Management of resources sometimes impacts parenting and protection
○	○		d. Management of resources significantly impacts parenting and protection
		SN8.	**Cultural Identity**
○	○		a. Cultural identity strengthens parenting and protection
○	○		b. Cultural identity does not negatively impact parenting and protection
○	○		c. Cultural identity sometimes impacts parenting and protection
○	○		d. Cultural identity significantly impacts parenting and protection

Primary	Secondary		
¡	○	**SN9.**	**Physical Health**
○	○		a. Promotes overall health and prevention
○	○		b. Physical health does not negatively impact parenting and protection
○	○		c. Physical health sometimes impacts parenting and protection
○	○		d. Physical health significantly impacts parenting and protection
		SN10.	**Prior Trauma**
○	○		a. No trauma, or parent demonstrates skills learned through recovery from past trauma
○	○		b. Trauma does not negatively impact parenting and protection
○	○		c. Trauma sometimes impacts parenting and protection
○	○		d. Trauma significantly impacts parenting and protection
		SN11.	**Other Identified Parent Strength/Need (not covered in SN1–SN10)**
○	○		a. Supports parenting and protection
○	○		b. Has no negative impact on parenting and protection
○	○		c. Sometimes impacts parenting and protection
○	○		d. Significantly impacts parenting and protection

COMMENT:

B. CHILD

Rate each child according to the current level of functioning.

	Child 1 Score	Child 2 Score	Child 3 Score	Child 4 Score
CSN1. Emotional/Behavioural Health				
○ a. The child's emotional/behavioural health contributes to child safety and well-being.				
○ b. The child does not have an emotional/behavioural health concern, OR the child has an emotional/behavioural health concern but it is being addressed.				
○ c. The child has an emotional/behavioural health concern that requires intervention.				
○ d. The child has an emotional/behavioural health concern that contributes to the threat of harm to self or others.	_____	_____	_____	_____

	Child 1 Score	Child 2 Score	Child 3 Score	Child 4 Score

CSN2. Physical Health/Disability

- ○ a. The child has no health care needs or disabilities.
- ○ b. The child has minor health problems or disabilities that are being addressed with minimal intervention and/or medication.
- ○ c. The child has health care needs that require routine interventions.
- ○ d. The child has serious health/disability needs that require ongoing treatment and interventions by professionals or trained parents.

CSN3. Education

Does child have a specialized educational plan?

○ No ○ Yes, describe: _____

- ○ a. The child has outstanding academic achievement.
- ○ b. The child has satisfactory academic achievement, or the child is not of school age.
- ○ c. The child has academic difficulty.
- ○ d. The child has severe academic difficulty.

CSN4. Family Relationships

- ○ a. The child's relationships within their family are nurturing/supportive.
- ○ b. The child's relationships within their family are adequate.
- ○ c. The child's relationships within their family are strained.
- ○ d. The child's relationships within their family are harmful.

CSN5. Child Development

- ○ a. The child's development exceeds expectations.
- ○ b. The child's development is age-appropriate.
- ○ c. The child's development is limited.
- ○ d. The child's development is severely limited.

CSN6. Alcohol/Drugs

- ○ a. The child actively chooses a drug-free lifestyle.
- ○ b. No use, or experimentation only.
- ○ c. The child's alcohol or other drug use results in disruptive behaviour and conflict
- ○ d. The child's chronic alcohol or other drug use results in significant disruption of functioning.

CSN7. Trauma

- ○ a. The child's response to prior trauma contributes to child safety.
- ○ b. Child has not experienced trauma, OR the child has trauma concern, but it is being addressed.
- ○ c. The child's response to prior trauma is a concern, AND it is an ongoing unmet need.
- ○ d. The child's response to prior trauma is a concern that directly contributes to danger to the child.

	Child 1 Score	Child 2 Score	Child 3 Score	Child 4 Score

CSN8. Peer/Adult Social Relationships

- ○ a. The child has strong social relationships.
- ○ b. The child has adequate social relationships.
- ○ c. The child has limited social relationships.
- ○ d. The child has poor social relationships. _____ _____ _____ _____

CSN9. Criminal Behaviour

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

- ○ a. The child actively avoids criminal behaviour.
- ○ b. The child has no criminal behaviour in the last two years OR is under the age of 12.
- ○ c. Child arrested or placed on probation in the past two years.
- ○ d. The child is or has been involved in any violent or repeated non-violent delinquent behaviour. _____ _____ _____ _____

CSN10. Identified Child Strength/Need (not covered in CSN1 – CSN9)

- ○ a. Child indicator of strength.
- ○ b. Neutral or no need.
- ○ c. Child indicator of slight need.
- ○ d. Child indicator of significant need. _____ _____ _____ _____

COMMENT:

C. PRIORITY NEEDS AND STRENGTHS

Enter item number and description of up to three most serious needs (d and c) and greatest strengths (a and b) from Section A (items SN1–SN9) for each parent (P=Primary, S=Secondary, B=Both).

Parent Priority Areas of Need	P	S	B	Parent Priority Areas of Strength	P	S	B
1.				1.			
2.				2.			
3.				3.			

Rationale for selecting parent priority needs:

Rationale for selecting children's needs:

Note: All identified child needs must be addressed in the case plan if not adequately being addressed by the family.

Social Worker Name: _____ **Date Form Completed:** _____

Supervisor Name: _____ **Date of Supervisory Approval:** _____

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT
DEFINITIONS

For each category, there are four possible responses.

"a." This is a strength response. A parent/child with a response of "a" has exceptional skills or resources in this area, and these skills and resources have a positive impact on the child and on the parent's ability to parent and protect the child. The parent has demonstrated an ability to engage in actions that help to create or sustain safety for the child over time.

"b." This is an "average" or appropriate functioning response. There may not be perfect functioning in the domain, but functioning in general does not have a negative impact on the child or on the parent's ability to parent and protect the child and to keep them safe.

"c." A parent/child is experiencing increased need in the category's domain, and this increased need sometimes negatively impacts the parent's ability to parent and protect the child or impacts the child's ability to be safe.

"d." A parent/child is experiencing extraordinary need in the category's domain, and this need has a significant impact on the ability to parent and protect the child. The parent/child engages in actions that directly threaten the safety of the child. Needs in this area likely created a safety threat for the child.

PARENT

SN1. Substance Use

Include alcohol, solvents, illegal drugs, inhalants, prescription/over-the-counter drugs that are not used according to prescription.

a. <u>Teaches and demonstrates a healthy understanding of alcohol and drugs</u>
The parent may use alcohol or prescribed drugs; however, use does not negatively affect parenting skills and functioning, and the parent teaches and demonstrates an understanding of the choices made about use or abstinence and the effects of alcohol and drugs on behaviour and society.

b. <u>Substance use or abuse does not negatively impact parenting and protection</u>
Substance use or abuse does not impair parent's ability to create an environment in which the child experiences consistent safety and nurturance.

The parent does not have a history of substance use or abuse OR has a history of substance use or abuse but is in recovery and able to maintain recovery without formal support (may continue to participate in a self-help group).

Alcohol or drug use does not negatively affect parenting or other areas of the parent's life, such as family, social, health, legal, or financial.

c. Substance use or abuse sometimes impacts parenting and protection
The parent's alcohol or drug use results in behaviours that impede their ability to meet the child's basic needs or emotional well-being on a consistent basis or contributed to a current incident of child maltreatment. The parent continues to experience negative consequences in some areas such as family, social, health, legal, or financial.

OR

The parent is in recovery from drug or alcohol abuse and requires minimal to moderate continuing support to maintain child safety. For example, parent remains in a day treatment or outpatient intervention program.

d. Substance use or abuse significantly impacts parenting and protection
The parent's use of alcohol or drugs results in behaviours that consistently impede their ability to meet the child's needs to the extent that the child has been or may be seriously harmed. The parent experiences significant impairment and negative consequences in their life such as family, social, health, legal, or financial. The parent needs help to achieve or maintain abstinence.

SN2. Household Relationships/Domestic Violence
Include relationships between parent and other adults in the household, including intimate relationships.

a. Demonstrates healthy relationships
Internal or external stressors (e.g. illness, financial problems, divorce, special needs) may be present, but the household maintains positive interactions (e.g. mutual affection, respect, open communication, empathy) and shares responsibilities mutually agreed upon by the household members.

Household members mediate disputes and promote non-violence in the home. Individuals are safe from threats, intimidation, or assaults by other household members.

The parent may have a history of violent relationships, but the parent has developed new patterns of behaviour and is consciously choosing relationships that are healthy.

b. Minor or occasional conflict that does not negatively impact parenting and protection

Internal or external stressors are present, but the household is coping despite some disruption of positive interactions. Conflicts may be resolved through less adaptive strategies such as avoidance; however, household members do not control each other or threaten physical or sexual assault, and there is no current domestic violence.

c. Frequent conflict or some domestic violence that sometimes impacts parenting and protection

Internal or external stressors are present, and the household is experiencing increased disruption of positive interactions coupled with lack of cooperation and/or emotional or verbal abuse that impacts the child. This may be evidenced by the following situations.

- Custody and visitation issues are characterized by frequent conflicts.
- The parent's pattern of adult relationships creates significant stress for the child. Examples include frequent introduction of new intimate partners or the parent has ended a violent relationship but has not developed behaviours to prevent repeating either being a victim or aggressor.
- Adult relationships are characterized by occasional physical outbursts that may result in minor injuries to a parent and/or controlling behaviour that results in isolation or restriction of activities. Both the offender and the victim need to seek help in reducing threats of violence.
- The violence, threats/intimidation, or controlling behaviour is ongoing and increasing in frequency or severity.

d. Chronic conflict or severe domestic violence that significantly impacts parenting and protection

Internal or external stressors are present, the household experiences minimal positive interactions, and the child has been or may be seriously harmed. This may be evidenced by the following situations.

- Parent's relationship with child's other parent continues to involve child in conflict to the extent that child is seriously emotionally harmed and/or caused to experience repeated medical/legal examinations or child protection investigations due to repeated unfounded allegations against the other parent.
- The parent's pattern of adult relationships places the child at risk for maltreatment and/or contributes to severe emotional distress.

- One or more household members use regular and/or severe physical violence. Individuals engage in physically assaultive behaviours toward other household members. The violence has resulted in injury to a parent or involved the use of a weapon.

- The parent is in a relationship characterized by severe household violence, and the child has been seriously hurt, physically or emotionally, by the violence.

SN3. Social Support System

A social support system is a network of individuals (other than intimate partners or members of the household) or organizations (i.e. religious organizations, community organizations, community elders, professional providers) who provide or share concrete support (i.e. financial help, transportation, babysitting) or emotional support (i.e. listening, advice). Contact may include in-person or other means, including social media.

a. <u>Strong mutual support system</u>
The parent has frequent contact with an extensive MUTUAL support system;

AND

This contributes to child safety, well-being, and permanency by having many people who have worked together in mutual support for care of the child.

b. <u>Support system does not negatively impact parenting and protection</u>
The parent has a sufficient social support system and is able to get concrete or emotional support when needed. As needs arise, the parent uses extended family; friends; and cultural, religious, and community resources to provide support and/or services such as child care, transportation, supervision, role-modeling for parent(s) and child, parenting and emotional support, guidance, etc.

OR

The parent is able to maintain care of the child despite lack of social support.

c. <u>Limited support system sometimes impacts parenting and protection</u>
At times the parent needs concrete or emotional support and their social support system is not able to provide what the parent needs. As a result the child experiences some isolation or unmet needs, however this has not created a safety threat for the child. This may include:

- Lack of a sufficient social support system; or
- Not using the support that is available.

The support provided either contributes to child distress or adversely impairs the parent's ability to meet child's needs in the long term.

d. No support system or negative support system significantly impacts parenting and protection

The parent does not have a support system or has a negative support system, and this impacts their ability to resolve conditions that have seriously harmed or may seriously harm the child. This may include the following situations.

- No one is able to help provide the concrete support that is needed by the parent (e.g. transportation, food, child care).
- The social support system is negative and directly creates a safety threat for the child (e.g. support system encourages alcohol/drug use), placing the child at risk of maltreatment.

SN4. Parenting Practices

Parenting practices include knowledge, skills, and attitudes.

Safe and appropriate parenting may be demonstrated differently in different cultures. For example, in some cultures, overt displays of affection or a parent who engages in physical play with the child may be frowned upon. This should not be interpreted as inappropriate parenting unless there is evidence that this behaviour is harmful to the child.

a. Demonstrates effective parenting and protection

The parent displays strong parenting patterns, on a consistent basis, that are age-appropriate for the child in the following areas: expectations, discipline, communication, protection, and nurturing. The parent has basic knowledge and skills to provide care. Examples of such parenting include the following.

- Parent recognizes and expresses hope for child's abilities/strengths.
- Parent has the ability to recognize and respond to the child's cues.
- Parent has an understanding of age- and developmentally appropriate expectations for their child and promotes and encourages activities such as:
  - » Developmental play groups;
  - » Occupational therapy/physiotherapy or other developmental services; and/or

» School, church, or community-based activities appropriate for the child's age.

- The parent spends quality time with the child and supports the child when they are upset.

b. Demonstrates adequate parenting and protection

The parent displays adequate parenting patterns that are age-appropriate for the child in the following areas: expectations, discipline, communication, protection, and nurturing. The parent has basic knowledge and skills to provide care. Examples of such parenting include the following.

- When child errs, parent provides non-violent intervention. Communication of expectations and intervention may not be perfectly consistent, but, at a minimum, are generally effective in helping the child understand limits and self-regulate behaviour (as age appropriate).

- Child is growing to have a developmentally appropriate sense of behavioural expectations and is learning to manage their behaviour well.

- Parent provides adequately for child's basic needs.

- Minimally, parent periodically spends time with child, supports child when child is upset, and lets child know that they are loved and valued.

c. Demonstrates inadequate parenting and protection

The parent displays inadequate parenting patterns that are not age-appropriate for the child in at least one of the following areas: expectations, discipline, communication, protection, and nurturing. The parent lacks some basic knowledge and skills to provide care. Examples of such parenting include the following.

- Parent seldom sets limits or expectations for the child in advance or sets limits/expectations that are somewhat outside of the range of child's potential; and/or when child errs, parent often fails to respond at all or responds by blaming child, calling child names, physical discipline that does not injure, etc.

- Parent frequently does not notice or is unaware of the child's needs, to the extent that these needs are often unmet. Child displays some signs of anxiety over basic needs, such as lack of concentration, difficulty sleeping, hoarding, or stealing food.

- Parent seldom expresses love or value for the child. Child may worry about their place in the life of the parent and/or may frequently experience self-doubt. However, child is able to function on a daily basis in developmentally expected ways.

d. <u>Demonstrates parenting practices that have harmed or may seriously harm the child</u>

The parent displays inadequate parenting patterns that are not age-appropriate for the child in most of the following areas: expectations, discipline, communication, protection, and nurturing. The parent lacks basic knowledge and skills to provide care. Examples of such parenting practices include the following.

- Parent is unable or unwilling to protect the child from harm by another.
- Parent responds to child's needs or behaviour with physical or verbal violence, resulting in serious physical or emotional harm to the child.
- Parent sets unrealistic limits/expectations that are beyond the range of child's potential and result in or may result in serious physical or emotional harm to the child.
- Parent has not set limits/expectations for the child to the extent that the child has no sense of commonly acceptable behaviour and no ability to manage their own behaviour; child is already, or is likely to, engage in unlawful behaviours.
- Parent is unaware of child's needs to the extent that the child has become seriously ill or injured due to unmet basic needs.
- Parent rarely, if ever, expresses love or value for the child, AND the child is showing signs of severe emotional harm. Symptoms of severe emotional harm to the child include, but are not limited to: fear of the parent, nightmares, aggression toward siblings/peers, anxiety, developmental regression, and self-destructive behaviour.

SN5. Mental Health/Coping Skills

When assessing the parent's mental health and coping skills, consider if the parent has any diagnosed or suspected mental health conditions AND if these conditions affect their ability to parent and protect the child. **The presence of a diagnosed mental health condition does not necessarily mean that a need is present.**

Mental health also includes consideration of the parent's coping to the extent that some behaviours may not rise to the level of diagnosis but nonetheless affect parenting and protection of the child. For example, severe unmanaged stress may not indicate a mental health diagnosis, but may negatively impact the child. Similarly, a parent with exceptional coping skills may be able to parent and protect the child through extraordinarily stressful family conditions.

a. Strong coping skills

The parent demonstrates the ability to cope with adversity, crises, and long-term problems in a constructive manner. The parent demonstrates realistic, logical judgment and emotional responses that are consistent with circumstances.

Parent understands their own emotional needs and is effectively meeting them in ways that do not interfere with ability to provide care. Parent demonstrates ability to think about what child needs, and has/acquires knowledge needed to respond to child's needs most of the time.

b. Adequate coping skills or mental health symptoms do not negatively impact parenting and protection

The parent may or may not have a mental health diagnosis.

Parent may struggle from time to time, but parent is always able to manage sufficiently so that child does not experience significant stress, worry, or unmet needs. For example, parent may experience some depression or anxiety, but is managing through medication, therapy, or self-help so that while the child may be aware, the child is not significantly worried, and parent's condition does not interfere with caregiving.

c. Mental health symptoms or coping skills sometimes impact parenting and protection

The parent may or may not have a mental health diagnosis.

Parent displays periodic mental health symptoms or has occasional difficulty dealing with situational stress, crises, or problems, AND this sometimes impacts their ability to parent and protect the child.

Examples of impact on child include the following.

- Child may occasionally worry about how parent is coping but such worry does not interfere with participation in school or community life.
- Child may sometimes assume some parenting responsibilities for self or siblings but such responsibilities do not interfere with their emotional development.

- Child may have periodic sense of loss/grief when parent is not available.

- Child's basic needs may sometimes be unmet due to parent incapacity, but the child has not experienced injury and is not likely to experience serious harm.

d. Mental health symptoms or coping skills significantly impact parenting and protection

The parent displays chronic, severe mental health symptoms, has a diagnosis, or has been repeatedly hospitalized for mental health concerns, AND this leads to situations where the child has been or may be seriously harmed.

Examples of threats of serious harm to the child include the following.

- Parent could not meet child's needs for food, shelter, or supervision to the extent that the child has been or may be seriously harmed.

- Due to mental health or coping, parent acts in a dangerous or harmful manner toward the child

- Child is falling significantly behind developmentally due to prolonged parent unavailability/absence.

SN6. Cognition

When assessing the parent's cognition, consider any diagnosed or suspected cognitive conditions, including developmental disabilities, traumatic brain injury, or dementia/Alzheimer's disease AND the impact that such conditions have on the parent's ability to adequately parent and protect the child. If cognitive conditions are suspected, consider obtaining a professional assessment. **The condition itself does not necessitate the selection of "d."**

a. Strong cognitive ability

Parent demonstrates ability to think about what child needs and has/acquires knowledge needed to respond to child's needs. Parent is able to overcome challenges through the use of effective problem-solving techniques.

b. Cognitive ability does not negatively impact parenting and protection

Parent may struggle to understand some aspects of parenting but has always been able to work out solutions that meet child's needs. Parent may or may not have some cognitive limitations but is able to meet the child's basic needs with or without the assistance of family or other non-agency-provided help.

Parent may struggle from time to time, but manages sufficiently so that child does not experience significant stress, worry, or unmet needs.

c. Cognitive ability sometimes impacts parenting and protection

Parent has some difficulty understanding, generalizing, and/or retaining essential child care information, which makes it harder to parent effectively. Parent may require additional efforts (i.e. repetition, visual cues) to learn parenting skills. This has or may have some negative impact on the child but has never resulted in and is unlikely to result in serious harm. Examples of negative impact on child include the following.

- Child's basic needs may sometimes be unmet due to parent incapacity, but the child has not experienced injury and is not likely to experience serious harm.
- Child may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.

d. Cognitive ability significantly impacts parenting and protection

Parent has significant difficulty understanding fundamental parenting information, such as:

- How much to feed and how often;
- Appropriate discipline;
- How to decide when a child needs medical care; and/or
- Whether it is reasonable to expect a 6-month-old to be fully potty-trained.

Despite numerous efforts to help parent understand vital information, parent does not appear to comprehend and cannot apply information to parenting tasks, and the child has been or may be seriously harmed. Examples of threats of serious harm to the child include the following.

- Parent could not meet child's needs for food, shelter, or supervision.
- Child may assume parenting responsibilities for self or siblings in ways that are interfering with development or functioning. Child is falling significantly behind developmentally due to prolonged parent unavailability/absence.

SN7. Resource Management/Basic Needs

Consider the age and vulnerability of the child and assess how parental management of resources impacts children and other family members in the household.

a. Consistently provides adequate housing, food, and clothing
The parent has a history of consistently providing adequate housing, food, and clothing. The parent has adequate resources to meet the family's basic needs.

b. Resource management does not negatively impact parenting and protection
Parent may have limited resources, such as income, but is able to secure assistance independently to meet the family's basic needs (e.g. use of food banks, income support, Mother Baby Nutritional Supplement, etc.) that will be sufficient for the long term (e.g. has a plan for the next six months).

c. Management of resources sometimes impacts parenting and protection
The parent does not adequately manage available resources, which results in difficulty providing for basic care needs related to health and safety (e.g. getting to necessary medical appointments, purchasing needed medications). However, this condition is not chronic, and the child has not experienced harm or threat of harm.

- Parent may have limited/no income and is unable to secure assistance independently (e.g. food bank) OR has been able to secure only short-term assistance (e.g. motel vouchers, limited-time food bank, etc.)
- The parent provides housing, but it is in poor repair.
- Food and/or clothing may sometimes fail to meet child's basic needs.
- The family may be temporarily homeless (staying with relatives or in a shelter); however, there is no evidence of harm or threat of harm to the child.

d. Management of resources significantly impacts parenting and protection
Parent lacks resources or severely mismanages available resources, which results in unmet basic care needs related to health and safety. Parent may consistently leave child's basic needs unmet while using resources for other priorities.

Resource conditions exist in the household that have caused illness or injury to family members. Example include the following.

- Inoperable plumbing, heating, or wiring causes an imminent threat of harm to the child.
- Food is unavailable or spoiled, or family members are malnourished.

- Child chronically presents with clothing that is unclean, not appropriate for weather conditions, or is in poor repair to the extent that the child experiences physical harm (e.g. rash from soiled clothing, frostbite from inappropriate clothing).

- Family is homeless (living on the street), which results in harm or threat of harm to the child. The family was homeless or was about to be evicted at any time during the assessment. Consider the family to be homeless if the family is living in transitional housing AND has no longer-term plan for housing or is not developing a plan for housing.

SN8. Cultural Identity

Culture is a system of shared actions, values, beliefs, and traditions that guide the behaviour of families and communities. *For this item, cultural identity may refer to race, ethnicity, gender identity/expression, sexual orientation, religious/spiritual affiliation, disability, or social identity that reflects the unique characteristics of the family*.

Keep in mind that family members may identify with multiple cultures, and that a person's dominant cultural identification may shift with the context. For example, in some situations, it may be more important to the parent to identify as a disabled person than to identify with an ethnic group. Cultural identity is not limited to identification with a non-mainstream culture and may refer to the mainstream culture.

<u>Connecting culture, identity, and caregiving/parenting</u>

Consider how the family's culture, cultural identity, norms, and past/current experiences of discrimination/oppression may influence or shape parenting and caregiving.

In particular, consider:

- How the parent identifies themself (see culture and cultural identity above);

- Any historical experiences of oppression/discrimination that are important or relevant to this parent;

- Any current experiences of oppression/discrimination this parent might have; and

- Any coping skills, strengths, and survival skills this parent has developed or demonstrated in facing oppression/discrimination.

How do all of the above influence or shape the parent's beliefs about parenting or child rearing? How do all of the above influence or shape their actions with their children?

a. Cultural identity strengthens parenting and protection
The parent draws upon their culture and its associated community to respond to challenges in ways that create safety for the child.

b. Cultural identity does not negatively impact parenting and protection
The parent is connected to a culture and its associated community and/or identifies with a culture, and this has no impact on child safety.

c. Cultural identity sometimes impacts parenting and protection
The parent has no particular identification with a culture, and the absence of cultural identity is resulting in *some* conflict with family or community, which is having a negative impact on the child.

Parent experiences intergenerational and/or societal conflict surrounding values and norms related to cultural/community differences. The parent perceives services and supports as unavailable or access as limited, and this has a negative impact on parenting and protection.

Cultural beliefs may lead the parent to engage in behaviours that have a negative impact on the child but are unlikely to harm the child. Examples include the following.

- Parent's cultural expectations differ from larger societal norms and this causes conflict between parent and child.

- Parent ostracizes a child due to their sexual orientation, gender identity, or other cultural identity.

d. Cultural identity significantly impacts parenting and protection
The parent identifies with a culture and its connected community. They experience *significant* conflict related to cultural identity due to lack of understanding of cultural or language differences or of available support networks.

OR

The parent has no *particular* identification with a culture, and the absence of cultural identity is resulting in *significant* conflict with family or community, and this is having an adverse impact on the child due to isolation, lack of support, and/or lack of access to resources.

OR

Cultural beliefs may lead the parent to engage in behaviours that have harmed or may harm the child. Examples include:

- Refusal of life-saving medical treatment (e.g. blood transfusions, treatment for diabetes);
- Belief in use of extreme corporal punishment; and/or
- Abandoning a child due to their sexual orientation, gender identity, or other cultural identity.

SN9. Physical Health

When assessing the parent's physical health, consider any diagnosed or suspected conditions AND the impact such conditions may have on the parent's ability to adequately parent and protect the child. **The condition itself does not necessitate the selection of "d."**

a. Promotes overall health and prevention

The parent has no current health concerns that affect parenting and protection. The parent proactively seeks preventative health care for themself and the family. The parent promotes a healthy lifestyle including nutrition, physical activity, and recreational activities that promote overall health and well-being.

b. Physical health does not negatively impact parenting and protection

The parent has no current physical health concerns that affect parenting and protection. The parent accesses regular health resources for self-care (e.g. medical/dental), or parent is in good health and is physically able to meet most of child's needs.

Parent may have a medical condition but is consistently able to meet the child's needs (e.g. parent with lupus that is mild or well-controlled, parent is able to participate in most of child's activities, and child is not experiencing sense of loss).

c. Physical health sometimes impacts parenting and protection

The parent has health concerns or conditions that affect parenting, protection, and/or family resources, or parent may occasionally struggle to meet child's needs because of health limitations (i.e. chronic medical condition, physical disability). Child has not and is not likely to experience injury, but child experiences some negative impact. Examples of impact on child include the following.

- Child may sometimes assume some parenting responsibilities for self or siblings, but such responsibilities do not interfere with development.

- Child may occasionally worry or feel stress about parent's health, but such worry does not interfere with participation in school or community life (e.g. parent has chronic diabetes that is not well-managed, and the parent's related mood variations have some non-significant impact on the child; parent with lupus that makes it impossible to participate fully in child's activities).

d. Physical health significantly impacts parenting and protection
Parent has one or more health conditions that limit the parent's ability to meet the child's needs to the extent that a child has already experienced significant physical/emotional harm or harm is likely to occur. Examples of threats of serious harm to the child include the following.

- Parent cannot meet child's needs for food, shelter, or supervision (e.g. parent has severe lupus, parent has been unable to provide feeding for infant, and infant has been diagnosed with failure to thrive; so many episodes of missed feedings have occurred that infant would likely develop failure to thrive; or parent has diabetes that is not well-managed and becomes unable to notice or respond to child's needs.)

- Child may assume parenting responsibilities for self or siblings in ways that are interfering with development or functioning.

- Child may experience intense loss/grief when parent is not emotionally or physically available (e.g. repeated parent hospitalizations, a parent so incapacitated that they cannot respond to child).

SN10. Prior Trauma

Trauma may occur when a person has experienced or witnessed an event or events of actual or threatened death or serious injury. Trauma may be caused by many experiences, e.g. serious physical harm to themselves or others; intergenerational trauma; cultural deprivation; sexual abuse; bullying; domestic violence; natural disasters; and long-term exposure to extreme poverty, neglect, or verbal abuse.

a. No trauma, or parent demonstrates skills learned through recovery from past trauma
Parent has not experienced trauma, OR the parent has experienced prior trauma and demonstrates skills learned through recovery to create a consistently safe and nurturing environment for the child.

b. Trauma does not negatively impact parenting and protection
The parent has a prior experience of trauma, but that prior trauma does not affect daily functioning or parenting and protection of the child.

c. Trauma sometimes impacts parenting and protection
Parent has experienced trauma, AND the parent's response involved intense fear or helplessness, which sometimes impacts functioning and causes distress (child sometimes worries about parent's health), but does not harm the child. The parent has learned some strategies to manage these responses, and the parent sometimes uses them.

Parent sometimes experiences intrusive, distressing recollections of the event, including images, thoughts, or perceptions; has distressing dreams about the event; or acts or feels like the traumatic event is recurring; BUT parent has learned some skills and interventions to manage these thoughts, and parent sometimes utilizes them.

d. Trauma significantly impacts parenting and protection
Parent has experienced trauma, AND the parent's response involved intense fear or helplessness, causing impaired functioning and significant distress/harm for the child. For example, the parent has not accessed services and/or cannot use coping strategies or has not received intervention to help manage their responses, AND this has resulted in significant harm to the child. Parent may deny the traumatic experience or how it is affecting them or the child.

SN 11. Other Identified Parent Strength/Need (not covered in SN1–SN10)

a. Supports parenting and protection
A parent has identified an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas.

b. Has no negative impact on parenting and protection
The parent has no area of strength or need relevant for case planning that is not included in other categories.

c. Sometimes impacts parenting and protection
A parent has a need that has a moderate to significant impact on family functioning but that has not resulted in harm or threat of harm to the child. The family perceives they would benefit from services and support that address the need.

d. Significantly impacts parenting and protection
A parent has a need that has a serious impact on family functioning, placing the child at imminent threat of serious harm. The family perceives they would benefit from services and support that address the need.

CHILD DOMAINS

CSN1. Emotional/Behavioural Health

a. The child's emotional/behavioural health contributes to child safety and well-being.
The child displays coping skills/responses at or above the developmentally expected ability in dealing with crises, disappointment, and daily challenges, and contributes to the child's safety and well-being. Child routinely manages their own behaviour at or above developmentally expected ability.

b. The child does not have an emotional/behavioural health concern, OR the child has an emotional/behavioural health concern but it is being addressed.
The child's coping strategies do not interfere with school, family, or community functioning. The child is able to develop and maintain trusting relationships. The child may be able to identify the need for, seek, and accept guidance. The child may demonstrate some depression, anxiety, or withdrawal symptoms that are situationally related. However, the child maintains situationally appropriate emotional control.

OR

Child has emotional or behavioural concerns that are being effectively managed through supportive intervention or programming that does not require additional parent support (i.e. child receives limited in-school support and is not on medication).

c. The child has an emotional/behavioural health concern that requires intervention.
The child has periodic mental health symptoms/diagnoses (i.e. depression, somatic complaints, antisocial behaviour, hostile behaviour, or apathy) OR experiences some difficulties dealing with situational stress, crises, or problems, AND this is impacting the child in one of the following ways.

- Child's emotional/behavioural health concern is interfering with child's sense of well-being, development, and/or ability to form relationships.

  OR

- Child's emotional or behavioural condition is being managed through a treatment program that requires minimal to moderate parent support.

d. The child has an emotional/behavioural health concern that contributes to the threat of harm to self or others.
Child functioning is severely impacted in one or more areas due to chronic/severe mental health symptoms/diagnoses, OR behaviour is/may be harmful to self or others (e.g. self-injury, persistent violence toward others, inappropriate sexual behaviours, cruelty to animals, bullying), AND this is impacting the child in one of the following ways.

- Child is in danger of serious harm to self or others.

  OR

- Child's emotional or behavioural condition is being managed through a treatment program and/or frequent crisis intervention.

CSN2. Physical Health/Disability

a. The child has no health care needs or disabilities.
The child demonstrates good health and hygiene care, involving awareness of nutrition and exercise. The child receives routine preventive and medical/dental/vision care.

b. The child has minor health problems or disabilities that are being addressed with minimal intervention and/or medication.
Child has adequate health. Minimal interventions are those that typically require no formal training (e.g. oral medications).

c. The child has health care needs that require routine interventions.
Minor health/disability needs require routine interventions that are typically provided by lay persons after minimal instruction (e.g. glucose testing and insulin, cast care).

d. The child has serious health/disability needs that require ongoing treatment and interventions by professionals or trained parents.
Those who provide treatment/interventions have received substantial instruction (e.g. central line feeding, paraplegic care, or wound dressing changes).

CSN3. Education

Does child have a specialized educational plan?

(Specialized educational plan includes IEP, etc.)

a. The child has outstanding academic achievement.
The child is working above grade level and/or is exceeding the expectations of the specific educational plan.

b. The child has satisfactory academic achievement, or the child is not of school age.
The child is working at grade level, and/or is meeting the expectations of the specific educational plan, or the child is not of school age.

c. The child has academic difficulty.
The child is working below grade level in at least one, but not more than half of, academic subject areas, and/or child is struggling to meet the goals of the existing educational plan. The existing educational plan may need modification.

d. The child has severe academic difficulty.
The child is working below grade level in more than half of their academic subject areas, and/or child is not meeting the goals of the existing educational plan. The existing educational plan needs modification. Also, score "d" for a child who is required by law to attend school but is not attending.

CSN4. Family Relationships

Score only the child's family of origin. **This does not include the foster or kinship placement family.** Consider relationships with siblings as well.

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

b. The child's relationships within their family are adequate.
The child experiences positive interactions with family members and feels safe and secure in the family, despite some unresolved family conflicts.

c. The child's relationships within their family are strained.
Stress/conflict within the family interferes with the child's sense of safety and security. The family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own.

d. The child's relationships within their family are harmful.
Chronic family stress, conflict, or violence severely impedes the child's sense of safety and security. The family is unable or unwilling to resolve stress, conflict, or violence on their own and is not able or willing to obtain outside assistance.

CSN5. Child Development

For a chart of average development by age, go to the end of this section.

a. The child's development exceeds expectations.
The child's physical and cognitive skills are above their chronological age level.

b. The child's development is age-appropriate.
The child's physical and cognitive skills are consistent with their chronological age level.

c. The child's development is limited.
The child does not exhibit most physical and cognitive skills expected for their chronological age level.

d. The child's development is severely limited.
Most of the child's physical and cognitive skills are two or more age levels behind chronological age expectations.

CSN6. Alcohol/Drugs

Include alcohol, solvents, other illegal drugs, and prescription drugs that are not used according to prescription**.**

a. The child actively chooses a drug-free lifestyle.
The child does not use alcohol or other drugs and is aware of consequences of use. The child avoids peer relations/social activities involving alcohol and other drugs and/or chooses not to use substances despite peer pressure/opportunities to do so.

b. No use, or experimentation only.
The child does not use alcohol or other drugs, or the child may have experimented with alcohol or other drugs but there is no indication of sustained use. The child has no demonstrated history or current problems related to substance use.

c. The child's alcohol or other drug use results in disruptive behaviour and conflict.
Disruptive behaviour or conflict due to drug use may occur in school/community/family/work relationships. Use may have broadened to include multiple drugs or substances.

d. The child's chronic alcohol or other drug use results in significant disruption of functioning.
Disruption of functioning may be indicated by the loss of relationships or job, school suspension/expulsion/drop out, problems with the law, and/or physical harm to self or others. The child may require medical intervention to detoxify.

CSN7. Trauma

Trauma may occur when a person has experienced or witnessed an event or events of actual or threatened death or serious injury. Trauma may be caused by many experiences, e.g. serious physical harm to self or others; intergenerational trauma; cultural deprivation; sexual abuse; bullying; domestic violence; natural disasters; and long-term exposure to extreme poverty, neglect, or verbal abuse.

a. The child's response to prior trauma contributes to child safety.
The child has experienced prior trauma and demonstrates skills learned through recovery to contribute to their own safety.

b. Child has not experienced trauma, OR the child has trauma concern but it is being addressed.
The child has not experienced trauma, OR the child has a prior experience of trauma; however, any traumatic experiences do not impact care for the child (either because there is no impact on child's functioning or because the child has learned to manage the impact on their functioning effectively).

c. The child's response to prior trauma is a concern, AND it is an ongoing unmet need.
The child has experienced trauma, AND the child's response involved intense fear or helplessness, which sometimes impacts functioning and sometimes causes distress but not harm to the child. The child has learned some strategies to manage these responses, and the child sometimes uses them.

The child sometimes experiences intrusive, distressing recollections of the event, including images, thoughts, or perceptions; has distressing dreams of the event; or acts or feels like the traumatic event is recurring, BUT child has learned some skills and interventions to manage these thoughts and sometimes utilizes them.

d. The child's response to prior trauma is a concern that directly contributes to danger to the child.
The child has experienced trauma, AND the child's response involved intense fear or helplessness, causing impaired functioning and significant distress/harm for the child. For example, the child has not accessed services and/or cannot use coping strategies or has not received intervention to help manage their responses, AND this has resulted in significant harm to the child. Child may deny the traumatic experience or how it is affecting them.

CSN8. Peer/Adult Social Relationships

Social relationships include relationships with adults and peers.

When considering adult relationships, consider the child's relationships with adults who are not immediate family members or foster family members. This domain would include coaches, neighbours, child protection workers, club leaders, mentors, etc. Please specify who these adults are in your comments.

When considering peer relationships, consider the child's relationships with other children in school and the community. Exclude relationships with siblings.

a. The child has strong social relationships.
The child enjoys and participates in a variety of constructive, age-appropriate social activities. The child enjoys reciprocal, positive relationships with others.

b. The child has adequate social relationships.
The child demonstrates adequate social skills. The child maintains stable relationships with others; occasional conflicts are minor and easily resolved.

c. The child has limited social relationships.
The child demonstrates inconsistent social skills; the child has limited positive interactions with others. Conflicts are more frequent and serious, and the child may be unable to resolve them.

d. The child has poor social relationships.
The child has poor social skills, as demonstrated by frequent conflictual relationships or exclusive interactions with negative or exploitive peers, or the child is isolated and lacks a support system.

CSN9. Criminal Behaviour

Criminal behaviour includes any action that would constitute a crime. Consider this domain to include both offences for which the child has been arrested/charged and those which have not yet come to the attention of law enforcement.

a. The child actively avoids criminal behaviour.
There is no indication of criminal behaviour. The child may be involved in community service and/or crime prevention programs and takes a stance against crime.

b. The child has no criminal behaviour in the last two years OR is under the age of 12.
There is a history of delinquent behaviour but the child has successfully completed extra-judicial sanctions/probation and has committed no criminal behaviour in the past two years.
OR

The child is under the age of 12 (score concerning behaviours under item CSN6).

c. Child arrested or placed on probation in the past two years.
The child may have been arrested or placed on probation within the past two years.

d. The child is or has been involved in any violent or repeated non-violent delinquent behaviour.
This behaviour has or may have resulted in consequences such as arrests, incarcerations, or probation.

CSN10. Identified Child Strength/Need (not covered in CSN1–CSN9)

a. Child indicator of strength.
A child has an exceptional strength and/or skill that has a positive impact on family functioning. The family perceives this strength as something they can build on to achieve progress in identified need areas.

b. Neutral or no need.
Not applicable. A child has no area of strength or need relevant for case planning that is not included in CSN1–CSN9.

c. Child indicator of slight need.
Child has a need that has a moderate impact on family functioning. The family perceives they would benefit from services and support that address the need.

d. Child indicator of significant need.
Child has a serious need that has a significant impact on family functioning. The family perceives they would benefit from services and support that address the need.

CHILD DEVELOPMENTAL MILESTONES CHART

**Note: These milestones represent overall age trends. Individual differences exist in the precise age at which each milestone is attained.*

Physical	Cognitive	Emotional/Social	Sexual	Possible Impacts of Maltreatment
Infant-Toddler (0-3 years)				
0-3 mo: random, uncoordinated, reflexive movements (e.g. sucking, grasping); moves arms and legs actively; is able to follow objects and focus 3-6 mo: uses arms to prop self; head at 90-degree angle; rolls over; holds head up when in sitting position; crawling motions; reaches for objects 6-9 mo: grasps purposefully; transfers objects from hand to hand; sits unaided; spends more time in an upright position; learns to crawl; pushes head and torso off the floor; supports weight on legs; sits in "tripod" 9-15 mo: crawls and pulls to standing; eye-hand coordination; gets to and from sitting; beginning to walk; learns to grasp with thumb and finger; feeds self 15- 24 mo: more complex motor skills (e.g. walks, runs); drinks from cup alone; turns pages of book; walks backwards; stacks two to three blocks 2-3 yr: has sufficient muscle control for toilet training; is highly mobile (e.g. learns to climb up stairs); increased eye-hand coordination (e.g. can do simple puzzles, string cheerios, throw and kick a ball); climbs over furniture; walks along a line	0-3 mo: looks at faces; smiles selectively at parent's voice; cries undifferentiated; vocalizes sounds (coos) 3-6 mo: interested in the environment; recognizes primary parent; babbles and imitates sounds; follows moving objects 6-9 mo: discriminates between parents and others; begins to respond to select words (e.g. name); puts everything in mouth; drops objects repeatedly 9-15 mo: points to pictures in books and in response to verbal cues; may use single words; interested in and understands words; says words (e.g. mama, dada); stares for long periods of time to gain information; object permanence present 15-24 mo: imitates complex behaviours; increased vocabulary (e.g. names parts of body); resistant to changes in routine; uses language to serve immediate needs (e.g. cookie, mine); imitates words readily and understands a lot more than verbally expressed 2-3 yr: uses more complex toys; becoming more verbal (e.g. 2-word phrases and counting); sleeps through the night; can sort objects by color, size etc.; names one or more colors; counts three objects; says name	0-3 mo: learns trust in self and others; settles when comforted by parent; turns head to sounds; wants to have needs met; likes movement, to be held and rocked 3-6 mo: facial expressions of emotion; responds to social stimuli; makes loud vocalizations; responds to tickling. 6-9 mo: socially interactive; plays games with parents; responds to affection; prefers primary parent 9-15 mo: exhibits separation anxiety and stranger anxiety; engages in solitary play; is willful and has tantrums; becomes aware of self; copies gestures and words 15-24 mo: "no" stage; begins to exert independence and tests limits; tends to stay near primary parent and makes overtures to parent seeking approval and asking for help 2-3 yr: engages in parallel play;; emotionally attached to toys or objects; begins toilet training; takes turns in a song or game; has difficultly sharing; displays affection, especially for parents; developing interest in peers; can get frustrated and bite, hit or pull hair; shows fear and is able to be settled; beginning to understand and follow simple requests/rules	5 mo: touches genitals and rocks on stomach for pleasure 2 yrs: no sense of privacy; openly curious about other's body parts and functions; talking to peers about "poop" and "pee"; beginning to develop gender identity	Chronic malnutrition: growth delays, brain damage, cognitive issues Chronic illness from medical neglect Head injury or shaking: skull fractures, paralysis, blindness, deafness, death Internal injury to organs Passive, withdrawn, apathetic, unresponsive "Frozen watchfulness", fearful, anxious, depressed Attachment problems, insecure or disorganized attachment: overly clingy, cannot use parent as source of comfort, no discrimination of significant people Behavioural regression Delayed developmental milestones (e.g., language and speech delays, toileting) Regressive behaviours (loss of skills); resistance to change in routines; changes in eating; sleeping or other routines based on habits

Physical	Cognitive	Social/Emotional	Sexual	Possible Impacts of Maltreatment
Preschool (4-6 years)				
Physically active; cannot sit still for long Rule of 3s (3 yrs, 3 ft, 33 lbs) Weight gain of 4-5 lbs per year Complex gross motor skills: jumping, climbing, hopping, running, riding tricycles Fine motor skills: refined coordination; eye-hand coordination, draws shapes, cuts with scissors; improved finger dexterity; able to hold and use pencil Most are toilet trained; washes hands and face; brushes teeth and dresses independently	Drastic increase in vocabulary; answers simple questions Magical and illogical thinking; difficulty separating fantasy from reality; good imagination Poor understanding of time and sequence of events; beginning understanding of yesterday, tomorrow, etc. Understands opposites and consecutive concepts; can count objects past ten; name five colors; attend to an activity for 20 minutes if interested Does not realize people have different perspectives Expresses ideas, asks questions, engages in discussions Knows basic rules of grammar; increased attention span; accurate memory, but suggestable Knows and can name members of family and friends	Imaginative and cooperative play; shows social skills of giving, sharing and receiving; can play cooperatively with two to five children Social skills, and fine and gross motor skills are further developed Wants to please adults; self-esteem based on what others tell them Feels guilty when disobedient; development of conscience Increased ability to control emotions; increased frustration levels Delayed gratification is increasing; shows a wide range of emotions Displays independence; protects self and stands up for rights Unreasonable fears are common; nightmares are prominent May have an imaginary friend	Curious about self and others' bodies; may touch self and others' genital areas to explore differences between male and female Sense of privacy is emerging; becomes embarrassed to be seen nude May masturbate Plays house, acts out roles of Mommy and Daddy Sexual behaviour among children at this stage is mutual and is easily redirected Is developing sexual identification	Poor muscle tone and coordination Malnutrition; underweight; small stature; eating difficulties Excessive fearfulness, anxiety, night terrors; reminders of traumatic experiences Cognitive delays; poor concentration Lack of curiosity; absent imaginative play-enactment of trauma themes in play or art Superficial attachments; little to no distress when separated from parents Lack of impulse control; poor self-esteem; lack of confidence Regression Delayed developmental milestones Overall poor physical health; somatic complaints begin

Physical	Cognitive	Social/Emotional	Sexual	Possible Impacts of Maltreatment
School Age (6-11 years)				
Slow and steady growth in height and weight (3-4 inches per year) Fine and gross motor skills developed with physical activity Increased coordination and strength Body proportions are becoming similar to adults; energetic and has large appetite 10-11 yrs: puberty begins for some children	Dramatic changes in cognition ("developmental leap"): 6-8 yrs: recognizes others' perspectives; 8-10 yrs: recognizes difference between behaviour and intent; 10-11 yrs: accurately recognizes and consider others' perspectives and viewpoints Accurate perception of events; rational thought; concrete thinking; understands concepts of space and time Language is used as a communication tool; actively listens to others and considers ways of communicating with others; has mutual conversations Can remember events from months or years earlier Understands how behaviours impact others Asks questions that are fact oriented; wants to know how, why, and when	Believes rules are important and must be followed: 6 yrs: believes rules can be changed; 7-8 yrs: strict adherence to rules; 9-10 yrs: rules can be negotiated Develops understanding of social roles; can adapt behaviour to fit different situations; understands concepts of right and wrong; begins to experience conflict between parents' values and those of peers Less fantasy play, more team games Good self-control; frustration tolerance is increasing Acts very independent and self-assured, but at times can act childish and silly Has a strong group identity; increasingly defines self through peers; increase in friendships Self-esteem based on ability to perform and produce; sensitive to others' opinions Morality: avoids punishment	Questions about pregnancy, intercourse, birth; looking at nude pictures Game playing with sexual activity (e.g. truth/dare); flirting; reenactment of intercourse with clothes on Experiences sexual arousal; has erections; masturbates Beginning to understand sex-role differentiation, attraction to and interest in peers Talks about sex with same gender peers Seeks privacy when in bathroom and changing clothes	Seeks immediate gratification Experiences extreme emotions; increased anxiety, easily frustrated; lacks impulse control Poor social adjustment in school: emotional outbursts, difficulty concentrating, being overly reliant on teachers Extreme reaction to perceived danger Acting out: hitting, fighting, lying, stealing, verbal outbursts, swearing May speak in unrealistically positive terms about parents Feels inadequate around peers, over-controlling May not be able to trust; tests commitment of foster parents and adoptive parents with negative behaviours Role reversal to please parents Risk for behaviour and mood disorders (e.g. depression, anxiety, conduct disorders); risk for emotional and behavioural attachment issues Regression Impaired academic performance; learning and developmental problems; problems with decision making, attention, control of emotions and impulses

Physical	Cognitive	Social/Emotional	Sexual	Possible Impacts of Maltreatment
Adolescence (12-21 years)				
Dramatic growth spurts: females 10-12 yrs; males 12-14 yrs Typical onset of puberty: females 11-14 yrs; males: 12-15 yrs Anxious about physical changes to the body Changes at puberty promote rapid growth, maturity of sex organs, and development of secondary sex characteristics Achieves sexual maturity and increased sexual drive	Thinking hypothetically: consequences of thoughts and actions without experiencing them; plans behaviour accordingly Thinks logically Insight and perspective taking; understand and consider others' perspectives; introspection and self-analysis; social system perspectives Cognitive development is impacted by emotion Show increased and decreased interest in school, or loss of interest in academic studies Begins to consider and sometimes makes vocational choices; is interested in making money	Main task is identity formation Need help in dealing with most changes taking places in order to retain a strong sense of identity and values 12-14 yr: distance themselves from parents; identify with peer group; social status based on group membership; need to be independent from all adults; self-conscious about physical appearance; emotionally liable; engages in activities for intense emotional experience; risky behaviour; rejection of parental standards 15-17 yr: friendships are based on loyalty and trust; conscious choices about which adults to trust; respect and honesty sought from adults; forms identity by organizing perceptions of attitudes, behaviours, and values Mood swings; often does not know how to express anger Less dependent on family for affection and emotional support Strives to define self as a separate individual (e.g. hairstyles, clothes) Morality: golden rule; conforming with the law is good for society	12-14 yrs: ambivalent about sexual relationships; sexual behaviour is exploratory 15-17 yrs: may become sexually active Struggles with sexual identify formation Onset of menstruation for females; unexpected and unexplained erections for males Achieve sexual maturity and increased sex drives	Poor self-esteem; expect to fail; pervasive feelings of guilt, overly rigid expectations of self, inadequacy; overcompensate for negative self-esteem by being narcissistic, self-complementary, grandiose Lack capacity to manage intense emotions; frequent mood swings; difficulty expressing emotion; flashbacks Poor peer relationships; problems with teachers Risk for behaviour and mood disorders (e.g. depression, anxiety, PTSD); risk for emotional and behavioural attachment issues, conduct disorder; risk of addiction; risk of suicide attempts and eating disorders Impaired academic performance; learning and developmental problems; problems with decision making, attention; frequent absences from school Internalized behavioural problems (e.g. sad, depressed, withdrawn, isolated); externalized behavioural problems (e.g. aggressive, hyperactive) Increased risk of aggression, violence and criminal activity; Inappropriate sexual behaviour; higher risk of teenage pregnancy

Adapted from California Department of Social Services, 2013; Eastern Health, 2015; Government of NL, 2015; 2018; and University of Pittsburgh, 2005.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
CONTACT STANDARDS FOR ONGOING PROTECTION INTERVENTION
POLICY AND PROCEDURES

PURPOSE

1. To outline the minimum contact standard requirements for all households in receipt of ongoing protection intervention services

2. Contact standards are determined by the risk level classification resulting from the completion of the SDM Family Risk Assessment tool.

WHICH CASES

All cases that have been transferred to ongoing protection intervention services.

These contact standards do not apply for ongoing protection intervention cases where a child or children has an In-Care or Kinship status. Please refer to the Protection and In Care Policy and Procedures manual for contact standards relative to these services.

Refer to *Practice Considerations* for additional practice prompts relative to contact with families.

WHO

The social worker assigned to the case.

WHEN

1. Contact refers to in person contact with parent(s) and all children. The nature and intent of this contact with children and families is a clinical decision that must be discussed between the social worker and the clinical program supervisor in accordance with policy 1.7 of the Protection and In Care Policy Manual.

2. Minimum contact requirements for a family receiving ongoing protective intervention services are determined by the classification of risk level in the household. Contact standards are as follows:

Effective March 19, 2018, the contact standards are outlined as follows:

a) Low – once every two months
b) Moderate – once every two months
c) High – once per month
d) Very High – once per month

Effective October 1, 2018, the contact standards are outlined as follows:

a) Low – once every two months
b) Moderate – once every two months
c) High – once per month
d) Very High – twice per month

APPROPRIATE COMPLETION:

1. A social worker shall complete, at minimum, the above noted in person contact(s) with the parent(s) and all children as part of the ongoing assessment of safety and risk.

2. The social worker shall adhere to the minimum contact standards at the location(s) outlined in the following chart:

MINIMUM CONTACT STANDARDS FOR ONGOING PROTECTIVE INTERVENTION CASES EFFECTIVE MARCH 19, 2018		
Risk Classification	**Parent and Child Contacts**	**Location**
Low	**ONE** face-to-face contact every two months with parent(s) and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
Moderate	**ONE** face-to-face contact every two months month with parent(s) and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
High	**ONE** face-to-face contact per month with parent(s)and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
Very High	**ONE** face-to-face contact per month with parent(s) and all children.	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.

Contact Content:

1. Assess for change in safety (vulnerability, safety threats, protective capacities, interventions)

2. Progress toward case plan objectives:
   a) Participation in services
   b) Demonstration of skills

3. Change in needs (identification of new needs/needs reduction)

4. Visitation Quality (if applicable)

MINIMUM CONTACT STANDARDS FOR ONGOING PROTECTIVE INTERVENTION CASES EFFECTIVE OCTOBER 1, 2018		
Risk Classification	**Parent and Child Contacts**	**Location**
Low	**ONE** face-to-face contact every two months with parent(s) and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
Moderate	**ONE** face-to-face contact every two months month with parent(s) and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
High	**ONE** face-to-face contact per month with parent(s)and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
Very High	**TWO** face-to-face contacts per month with parent(s) and all children. One contact must include both parents and all children. The second contact must include all children but it will be the social worker and supervisor's discretion as to whether both parents should be seen; at least one parent shall be seen.	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.

Contact Content:

1. Assess for change in safety (vulnerability, safety threats, protective capacities, interventions)

2. Progress toward case plan objectives:
   i. Participation in services
   ii. Demonstration of skills

3. Based on the above contact standards, the social worker shall meet, in accordance with the designated standards, with the household members to assess and monitor:
   a) Safety (e.g. vulnerabilities, safety threats, protective capacities, interventions)
   b) Progress with activities, goals, and objectives outlined in the case plan, including but not limited to:
      i. Participation in services
      ii. Demonstration of new skills

   c) Supports and services in place for the parent(s) and/or child or children, using the *Family Centered Action Plan (FCAP)* as a guide.
   d) Any change in family strengths and/or needs, e.g. have new needs been identified in the household? Have previously identified needs been reduced? Using the *Family Strengths and Needs Assessment (FSNA)* as a guide.
   e) Parent-child interactions; quantity and quality of family visitation (if applicable)
   f) Whether additional activities, interventions or services may be required to enhance child safety and reduce risk; and
   g) Factors that may impact on the parent's ability to meet the need of their child and jointly develop a plan with the parent to address these factors.

4. Please refer to the Observing and Interviewing Children Policy (1.7) when completing private interviews with children as part of contact standards visits.

PRACTICE CONSIDERATIONS:

- Households in receipt of ongoing protection services require regular, ongoing intervention from the assigned social worker. Depending on the household circumstances, members may be visited more often than the minimum required contact standard outlined above. The social worker, in consultation with the supervisor, shall assess if additional contact is required and determine the type and frequency of that contact.

- When a child is returning home from an out of home placement, the social worker, in consultation with the supervisor, shall determine the frequency of contact required based on the needs of the family.

  At a minimum, monthly contact with children and parents should occur. When children are returned home, the Reunification Assessment risk rating will be low or moderate because that tool is determining if it is safe for the child to return home. The

risk rating on the Reunification Assessment should not be used when determining ongoing contact standards, once the child is returned home, as this tool is solely designed to determine if it is safe for a child to return home. Once the child is returned home, a clinical determination needs to be made regarding frequency of contact with the family in the interim until the Risk Reassessment is completed at the next case review period. Often when a child is returned home, an increased level of contact is needed to support the child safely remaining home.

- For cases where a child or children have an In-Care or Kinship status, there are no contact standards to outline the minimum required contact with the child's originating household. It is however, expected that contact with the child's family will be regular to monitor progress and achieve permanency. As a guideline, these households should have monthly contact, preferably in their own home. The social worker, in consultation with the supervisor, shall determine the frequency, type, and location(s) of this contact. The requirement for additional contact, dependent upon case specific information, is a clinical decision that should be made between the social worker and clinical program supervisor. In cases where the family's social worker and the child's social worker are not the same, the social worker for the family is not required to see the child as this responsibility remains with the child's in care social worker.

RELEVANT DOCUMENTS:

- ***Protection and In Care Policy and Procedure Manual, 2019***

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
CONTACT STANDARDS EFFECTIVE OCTOBER 1, 2018

MINIMUM CONTACT STANDARDS FOR ONGOING PROTECTIVE INTERVENTION CASES		
Risk Level	**Parent and Child Contacts**	**Location**
Low	**ONE** face-to-face contact every two months with parent(s) and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
Moderate	**ONE** face-to-face contact every two months month with parent(s) and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
High	**ONE** face-to-face contact per month with parent(s)and all children	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.
Very High	**TWO** face-to-face contacts per month with parent(s) and all children One contact must include both parents and all children. The second contact must include all children but it will be the social worker and supervisor's discretion as to whether both parents should be seen; at least one parent shall be seen.	Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor.

Contact Content:

1. Assess for any change in safety (vulnerability, safety threats, protective capacity, interventions).
2. Progress toward case plan objectives:
   a) Participation in services
   b) Demonstration of skills
3. Change in needs (identification of new needs/needs reduction).
4. Visitation Quality (if applicable)

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
FAMILY CENTRED ACTION PLAN
POLICY AND PROCEDURES

The purpose of the Family Centred Action Plan (FCAP) is to:
1) outline current family needs;
2) outline strengths in the household;
3) outline the services/supports to be provided to the family;
4) outline the case plan for the family

Which Cases
All cases that have been transferred to ongoing protective intervention services. FCAPs are not required for cases that need a *Plan for the Child.*

Who
The social worker assigned to the case.

When
Initial FCAP: Within 60 days of the receipt of the CPR and after the Family Strengths and Needs Assessment (FSNA) has been completed.

Review FCAP: Four months after the initial FCAP. Subsequent reviews will be every four months following the completion of the *Case Summary* form.

When a child is returning home from an out-of-home placement: Notwithstanding the four-month case review process, when a Reunification Assessment recommends a child return home, an FCAP needs to be reviewed and revised/updated, as needed, prior to or shortly after a child has returned home.

Appropriate Completion

If an FCAP is not required due to the case requiring a *Plan for the Child*, select "FCAP is not required because Plan for the Child is required." The social worker will sign the form and the supervisor will approve it.

If an FCAP is not required because it was completed in the assessment phase or in between review periods as a result of a Protective Care Agreement (PCA), the social worker can select "FCAP is not required as an FCAP was completed with a Protective Care Agreement" at the time of the review following the implementation of the PCA. An FCAP will be required for subsequent review periods. The social worker will sign the form and the supervisor will approve it.

If an FCAP is not required at the review period because it has been decided that a file will be closing, select "FCAP is not required because file is closing." The social worker will sign the form and the supervisor will approve it.

Please refer to *Standard #6: Transitioning a Case to Ongoing Protective Intervention Services* in the Structured Decision Making® Practice Standards Manual for standards and practice considerations.

Parent(s) Names
Document the names of parent(s) who will be included in the FCAP

Children's Names
Document all children's full names who will be included in the FCAP.

File Number and ISM Number
Indicate the applicable numbers in these sections.

Identified Needs
The FSNA identifies up to three priority needs for parents and up to three priority needs for each child. The social worker shall determine, in consultation with their supervisor, which needs to address on the FCAP. Document the identified needs in this section.

Please note: All identified child needs must be addressed in the case plan if not adequately being addressed by family.

Identified Strengths
The FSNA identifies strategies for parents and strengths for each child. Document the relevant strengths in this section.

Change Required (Objectives)
Using the S.M.A.R.T. objectives found in the Structured Decision Making® Practice Standards Manual, social workers shall work with families to identify the change required/objectives for the FCAP. Please refer to *Standard #6: Transitioning a Case to Ongoing Protective Intervention Services* in the Structured Decision Making® Practice Standards Manual for further information on completing this section.

Activities, Person Responsible, Start Date and Completion Date
Use this section to identify the specific activities, person(s) responsible, start date and completion date of activities. Please refer to the S.M.A.R.T. Objectives and *Standard #6: Transitioning a Case to Ongoing Protective Intervention Services* in the Structured Decision Making® Practice Standards Manual for further information on completing this section.

Date of Review
Indicate the date when the FCAP will be reviewed.

Signatures
When an FCAP is required, the following individuals shall sign the document: parent(s), significant other, social worker and clinical supervisor.

If an FCAP is not required, the social worker shall select one of the three boxes found at the top of the form and the form must be then signed by the social worker and clinical supervisor.

Newfoundland Labrador
Children, Seniors and Social Development

Family Centered Action Plan (FCAP)

- ☐ **FCAP is not required because Plan for the Child is required**
- ☐ **FCAP is not required as an FCAP was completed with a Protective Care Agreement**
- ☐ **FCAP is not required because file is closing**

Parent(s) Name(s):

Child(ren)(s) Name(s):

Case #:

ISM #:

Identified Needs:

Identified Strengths:

Change Required (Objectives):

Activities	Person Responsible	Start Date (YYYY-MM-DD)	Completion Date (YYYY-MM-DD)

Date of Review (YYYY-MM-DD)

Signatures:

Parent	**Date (YYYY-MM-DD)**
Parent	**Date (YYYY-MM-DD)**
Significant Other	**Date (YYYY-MM-DD)**
Social Worker (please print)	**Date (YYYY-MM-DD)**
Social Worker's Signature	**Date (YYYY-MM-DD)**
Clinical Supervisor (please print)	**Date (YYYY-MM-DD)**
Clinical Supervisor's Signature	**Date (YYYY-MM-DD)**

Privacy Note

The Department of Children, Seniors and Social Development collects personal information relating to children, youth and families, under the authority of the *Children and Youth Care and Protection Act*. This information may be collected for the provision of services and/or the operation of the Department. If you have any questions about the collection or use of this information, please contact the Information Management Division of the Department of Children, Seniors and Social Development, Provincial Office at:
Department of Children, Seniors and Social Development
P.O Box 8700
St. John's, NL
A1B 4J6

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® REUNIFICATION ASSESSMENT
POLICY AND PROCEDURES

The purpose of the reunification assessment is to structure critical case management decisions for children in out-of-home placements who have a goal of reunification. This is accomplished by:

1. Assisting social workers to routinely monitor critical case factors that affect goal achievement; and

2. Helping social workers to organize and structure the information gathered in preparation for the case review process.

The reunification assessment process considers:

1. The risk level within the family to whom the child is to be returned;

2. The quality and frequency of visitation that has occurred during the out-of-home placement period;

3. The safety of the environment to which the child may be returned; and

4. The need for continued reunification efforts, ongoing planning and permanency.

WHICH CASES
All cases receiving Ongoing Protective Intervention Services **in which at least one child is in an out-of-home placement**. If more than one household is receiving reunification services, complete one reunification assessment on each household. A reunification assessment must also be completed if CSSD has determined that, due to any present safety threat(s), the child cannot safely remain in the household.

If the child is residing with another parent or relative/significant other as part of a 30-day safety plan, a reunification assessment is not required. A review safety assessment must be completed, prior to the child returning home, to determine whether safety threats remain present. If so, a reunification assessment must be completed within the next review period.

WHO
The social worker responsible for the case.

WHEN
Every four months after the completion of the initial FCAP and prior to the completion of an FCAP form and Case Summary.

Should be completed prior to any reunification if a reunification assessment has not been completed within the last 30 days. If the transition plan extends beyond a 30-day timeframe, consider whether or not a reassessment is needed.

DECISION
The reunification assessment guides decision making to:

1. Return a child home;
2. Maintain out-of-home placement; and/or
3. Terminate reunification services and develop new permanency goal.

APPROPRIATE COMPLETION
The reunification reassessment is completed and based on information gathered during the review period. There are four sections to the reunification assessment.

1. The reunification risk reassessment, including consideration of policy and discretionary overrides

2. The visitation plan evaluation for all children in the household

3. The safety threats that are present and whether possible interventions exist

4. Placement/permanency plan guidelines tree

Each section of the reunification assessment process is dependent on the findings of the previous section and is supported by a tool. The social worker is encouraged to share with the family, the FCAP/Plan for the Child and the criteria that will be used to evaluate progress and to assist the family to understand the relationship between each of the phases of the reunification considerations.

In the first section, the social worker assesses the household's reunification risk level based on the most recently determined risk level identified in the Risk Assessment. The second section is the evaluation of the quality and frequency of visitation between the child and parent with whom reunification is being considered. Where risk is low or moderate and visitation is assessed to be acceptable, the social worker then completes the third section, which is to assess the safety of the household. The result of each of these sections is then analyzed prior to a final consideration regarding the child's return or consideration of the fourth phase, which is guidelines for placement and the permanency planning goal.

To gather all of the information required to assess the risk level, quality and frequency of visitation, and safety of the family environment and permanency plans, the social worker gathers input from the family and considers their progress. The social worker also seeks input from other professionals providing services to the child, collaterals, and other supports who have participated in the case plan. This information is used to determine the appropriate responses to the questions by applying the definitions in the reunification assessment. The outcome of each reunification assessment tool is then considered along with cultural and contextual information and clinical analysis.

Narrative supporting the evaluation of risk, visitation, safety, and permanency decision incorporated into the case summary during the formal review process, and shared with family

PRACTICE CONSIDERATIONS

The reunification assessment should be shared with and explained to the household at the beginning of the case so that the household may understand how the worker will evaluate risk of subsequent harm, visitation and child safety, and the role of each in coming to a recommendation for reunification, maintenance of placement, and the permanency goal. Specifically:

- Discuss their original risk level, explaining that services, activities and behavioural changes in the FCAP or Plan for the Child are intended to reduce risk, and how risk and progress are evaluated. Explain that a new verification or failure to progress toward case plan goals increases risk and that progress toward plan goals will reduce their risk level.

- Explain that both the quantity and quality of their visitation are evaluated and how that is done. Explain that acceptable visitation may allow consideration of a return home and that unacceptable visitation may block consideration of a return home.

Explain that if risk and visitation suggest that reunification should be considered, safety is assessed to determine if the threats leading to placement have been resolved and that no other threats are identified; or if identified, can be controlled with in-home services.

OVERRIDES

After determining the scored risk level, the worker determines whether any of the override reasons exist for the review period. If a policy override was selected in a previous review period but has since been addressed and/or the social worker's and supervisor's clinical assessment is that sufficient progress has been made, during the current case review period, to adequately mitigate risk to the child, the policy override does not need to be selected.

Policy overrides reflect incident seriousness and/or child vulnerability concerns and have been determined by the agency to warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. A **discretionary override** is used by the ongoing worker whenever the worker believes that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment in which the worker could only *increase* the risk level, the risk reassessment section of the reunification assessment permits the worker to *increase* or *decrease* the risk level by one step.

The reason a worker may decrease the risk level is that after a minimum of four months, the worker has acquired significant knowledge of the family. If a discretionary override applies, select yes, indicate the reason, and select the override risk level. Selection of any overrides require supervisory approval.

After completing the override section, indicate the final risk level.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® REUNIFICATION ASSESSMENT[1]

r: 02/24

☐ Reunification assessment is not required at this time as the child is living at home

Household Name: _____ **File #:** _____

Worker: _____ **Region:** _____

Primary Parent: _____ **Secondary Parent:** _____

Date of Assessment: _____

Is this the removal household? ○ Yes ○ No **Reunification Assessment # (select):** _____

A. REUNIFICATION RISK REASSESSMENT **Score**

R1. Risk level on most recent protection investigation (not reunification risk level or risk reassessment)

○ a. Low.....0
○ b. Moderate.....3
○ c. High.....4
○ d. Very high.....5
○ e. No initial risk level.....4 _____

R2. Has there been a new verification of protection concerns since the initial risk assessment or last reunification reassessment?

○ a. No.....0
○ b. Yes.....2 _____

R3. Parent's progress with FCAP objectives or Plan for the Child desired outcomes since the last assessment/reassessment (*score based on the parent demonstrating the least progress*)

○ No secondary parent

P	**S**	
○	○	a. Demonstrates new skills consistent with all FCAP objectives/Plan for the Child desired outcomes and is actively engaged to maintain objectives/desired outcomes.....-2
○	○	b. Demonstrates some new skills consistent with all FCAP objectives/Plan for the Child desired outcomes and is actively engaged to maintain objectives/desired outcomes;.....-1
○	○	c. Minimally demonstrates new skills and behaviours consistent with FCAP objectives/Plan for the Child desired outcomes and/or has been inconsistently engaged in obtaining the objectives/outcomes.....0
○	○	d. Does not demonstrate new skills and behaviours consistent with FCAP objectives/Plan for the Child desired outcomes and/or refuses engagement.....4 _____

TOTAL SCORE _____

[1] To be completed for each household to which a child may be returned (e.g. father's home, mother's home).

REUNIFICATION RISK LEVEL
Assign the risk level based on the following chart.

Score	Risk Level
○ -2 to 1	○ Low
○ 2 to 3	○ Moderate
○ 4 to 5	○ High
○ 6+	○ Very High

OVERRIDES

Policy Overrides: *(increases risk level to very high)* Indicate if any of the following are true in the current review period.

☐ 1. Child is likely to have access with an individual who, historically or presently, has allegedly sexually abused a child.
☐ 2. Non-accidental physical injury to a child younger than 3 years of age..
☐ 3. Severe non-accidental injury to a child of any age.
☐ 4. Parent action or inaction resulted in death of a child due to abuse or neglect (past or current).

Discretionary Override: (risk level may be adjusted up or down one level.)

Override Risk Level: ☐ Lower ☐ Higher

Reason: _____

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

FINAL REUNIFICATION RISK LEVEL (select one)

○ Low
○ Moderate
○ High
○ Very High

B. VISITATION PLAN EVALUATION

Evaluate compliance with the planned visitation frequency and the quality of visits, based on social worker's direct observation whenever possible; supplemented by observation of child, reports of foster parents, etc. Divide the visits that were made by the parents by the number of planned visits for the parents. (*score based on the parent demonstrating the least progress*)

Child's Name	Visitation Frequency	Quality of Face-to-Face Visits
1.	○ Regular (90–100%) ○ Routine (65–89%) ○ Sporadic (24–64%) ○ Rare or Never (0–23%)	○ Strong/adequate ○ Limited/destructive
2.	○ Regular (90–100%) ○ Routine (65–89%) ○ Sporadic (24–64%) ○ Rare or Never (0–23%)	○ Strong/adequate ○ Limited/destructive
3.	○ Regular (90–100%) ○ Routine (65–89%) ○ Sporadic (24–64%) ○ Rare or Never (0–23%)	○ Strong/adequate ○ Limited/destructive
4.	○ Regular (90–100%) ○ Routine (65–89%) ○ Sporadic (24–64%) ○ Rare or Never (0–23%)	○ Strong/adequate ○ Limited/destructive

Overrides

☐ Policy: If visitation is currently supervised for safety, visitation is not considered acceptable.
☐ Discretionary (reason): _____

IF RISK LEVEL IS LOW OR MODERATE AND VISITATION IS ACCEPTABLE, COMPLETE A REUNIFICATION SAFETY ASSESSMENT. OTHERWISE GO TO SECTION D, PLACEMENT/PERMANENCY PLAN GUIDELINES.

C. SAFETY THREATS

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

○ a. No, describe how the initial safety threat(s) was ameliorated or mitigated after the child's removal below.
○ b. Yes, please describe safety threat(s) as it currently exists below.

1a. If yes, is there a safety intervention that can and will be incorporated into the case plan to mitigate these safety threats?

☐ No; no safety interventions are available and appropriate to mitigate safety threats if the child were to be reunified at this time.

☐ Yes; one or more safety interventions have been identified to mitigate safety threats and allow reunification to proceed with an in-home safety plan in place.

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

○ a. No

○ b. Yes

2a. If yes, is there a safety intervention(s) that can and will be incorporated into the Plan for the Child to mitigate these safety threats?

☐ No; no safety interventions are available and appropriate to mitigate safety threats if the child were to be reunified at this time.

☐ Yes; one or more safety interventions have been identified to mitigate safety threats and allow reunification to proceed with an in-home safety plan in place.

SAFETY DECISION

Identify the safety decision by selecting the appropriate option below. This decision should be based on the assessment of all safety threats, safety interventions, and any other information known about the case. Select one line only.

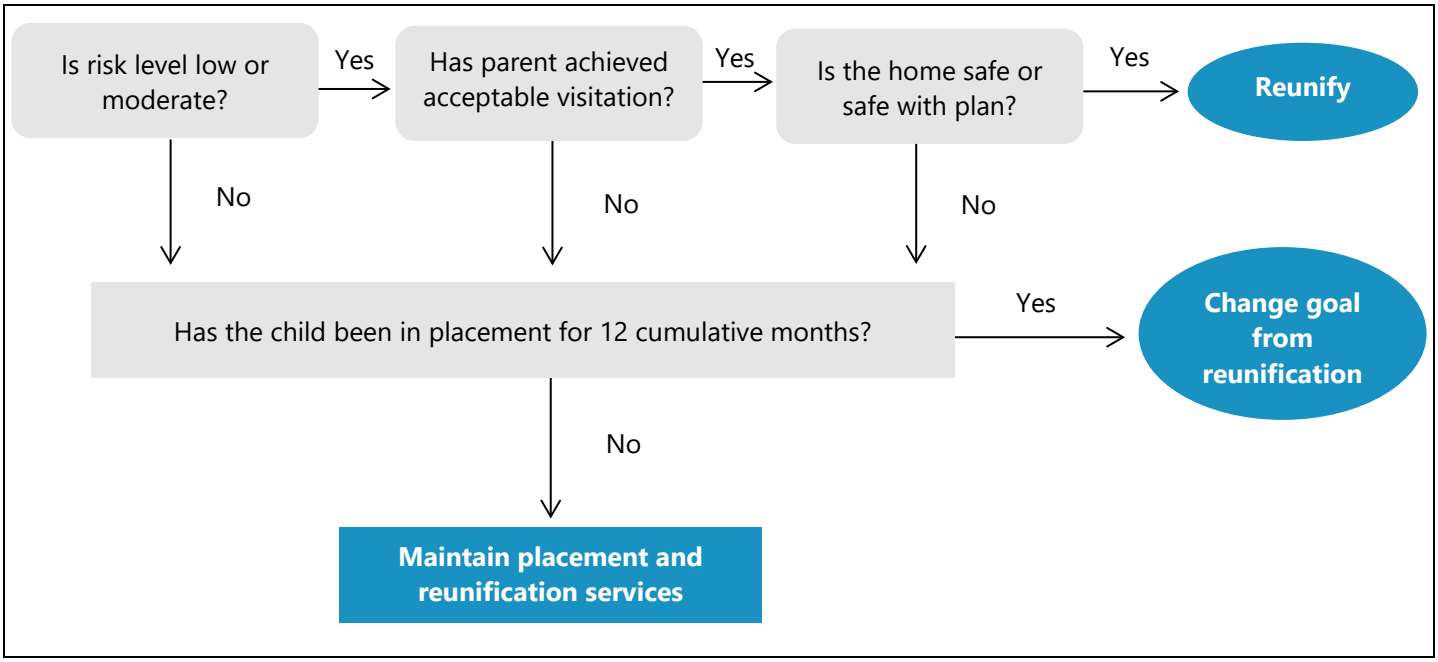
○ 1. **SAFE:** No safety threats were identified at this time. Based on currently available information, no children are likely to be in immediate danger of serious harm.

○ 2. **SAFE WITH PLAN:** One or more safety threats are identified, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be safe with plan upon return home. SAFETY PLAN REQUIRED.

○ 3. **UNSAFE:** One or more safety threats are identified, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm.

D. PLACEMENT/PERMANENCY PLAN GUIDELINES TREE

Complete for **each child** receiving family reunification services and enter results in Section E. Consult with supervisor and appropriate regulations.



Is risk level low or moderate:	○ Yes	○ No
Has parent achieved acceptable visitation:	○ Yes	○ No
Is the home safe or safe with plan:	○ Yes	○ No
Has the child been in placement for 12 cumulative months:	○ Yes	○ No

Recommendation

○ Return home
○ Maintain placement and reunification services
○ Change goal from reunification

Overrides (select one)

○ No override applicable.
○ The placement/permanency plan guidelines tree recommends maintaining placement and reunification services, but conditions exist to recommend termination of reunification services.
○ The placement/permanency plan guidelines tree recommends changing the goal from reunification, but there is probability of reunification within the next four months.
○ The placement/permanency plan guidelines tree recommends changing the goal from reunification, but other extenuating factors or circumstances require continuation of reunification services for the next four months.
○ The placement/permanency plan guidelines tree recommends maintaining placement and reunification services but conditions exist to return the child home with services. *If selected, please complete a safety assessment.*

Provide a description of the reasons for any override that are specific to the case:

E. RECOMMENDATION SUMMARY

If recommendation is the same for all children, enter "all" under child # and complete row 1 only. If the recommendation is not the same for all children, provide an explanation below.

Child #	Recommendation		
	Return Home	Maintain Placement and Reunification Services	Change Goal From Reunification
1.			
2.			
3.			
4.			

Provide explanation if the recommendation is not the same for all children:

Social Worker Name: _____ **Date Form Completed:** _____

Supervisor Name: _____ **Date of Supervisory Approval:** _____

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® REUNIFICATION ASSESSMENT
DEFINITIONS

A. REUNIFICATION RISK REASSESSMENT

R1. Risk level on most recent protection investigation (not reunification risk level or risk reassessment)

Identify the final risk level from risk assessment completed for the most recent investigation. This is either the investigation that led to case opening or placement, or the most recent subsequent assigned investigated referral. Choose and record the final risk level on the most recent referral (low, moderate, high, or very high). If there is not an initial risk assessment for this case, choose "No initial risk level" for a score of 4, equivalent to high risk.

Do not use a prior risk reassessment or a reunification assessment risk level.

R2. Has there been a new verification of protection concerns since the initial risk assessment or last reunification assessment?

Identify whether there has been a new verified investigation since either the initial risk assessment that led to case opening or, if at least one reunification assessment has been completed, the most recent reunification reassessment.

a. Choose a if there has not been a verified investigation in the review period
b. Choose b if there has been at least one verified investigation

R3. Parent's progress with FCAP objectives or Plan for the Child desired outcomes since the last assessment/reassessment

Simple compliance with/attendance at services is not sufficient to indicate behavioural change.

Identify whether a parent is actively engaged in achieving the case plan objectives specified in the Plan for the Child and is demonstrating the skills/behaviours (e.g. ability to manage substance use/abuse; ability to resolve conflict constructively and respectfully; uses age-appropriate, non-physical discipline in conjunction with appropriate boundary setting; develops a mutually supportive relationship with partner) that will enable the parent to create and maintain safety for the child(ren).

"Case plan objectives" specifically refers to the service objectives in the Plan for the Child identifying changes in parent behaviour necessary to create and maintain safety.

If there is not a secondary parent, check the box and only rate the primary parent.
If there are two parents, rate progress for each. If progress differs between parents, score based on the parent demonstrating the least amount of participation/progress.

a. Demonstrates new skills consistent with all FCAP objectives/Plan for the Child desired outcomes and is actively engaged to maintain objectives/desired outcomes.
Choose "a" if the parent is regularly demonstrating all behavioural changes identified in the FCAP objectives and Plan for the Child desired outcomes and is able to create long term safety for children in the household. The parent is actively engaged in activities to maintain the objectives.

b. Demonstrates some new skills consistent with all FCAP objectives/Plan for the Child desired outcomes and is actively engaged to maintain objectives/desired outcomes.
Choose "b" if the parent is demonstrating some new skills and behavioural change consistent with objectives/desired outcomes, is actively engaged in achieving the objectives but is not regularly demonstrating the behaviours necessary to create long term safety in all areas.

c. Minimally demonstrates new skills and behaviours consistent with FCAP objectives/Plan for the Child desired outcomes and/or has been inconsistently engaged in obtaining the objectives/outcomes.
Choose "c" if the parent is demonstrating minor behavioural change consistent with FCAP objectives and Plan for Child desired outcomes but has made little progress toward changing their behaviour and is not actively engaged in achieving the objectives. Parent behaviour continues to make it difficult to create safety or may contribute to immediate danger of serious harm.

d. Does not demonstrate new skills and behaviours consistent with FCAP objectives/Plan for the Child desired outcomes and/or refuses engagement.
Choose "d" if the parent has not demonstrated behavioural change consistent with FCAP objectives and Plan for the Child desired outcomes. The parent refuses services, sporadically follows the plan, or has not demonstrated the necessary skills/behaviours due to a failure or inability to participate. The parent is unable to create or maintain safety and behaviour is likely to contribute to immediate danger of serious harm.

POLICY OVERRIDES

After completing the risk assessment, the worker determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns and have been determined by the agency to warrant a risk level designation of very high

regardless of the risk level indicated by the assessment tool. Policy overrides require supervisory approval.

If a policy override was selected in a previous review period but has since been addressed and/or the social worker and supervisor's clinical assessment is that sufficient progress has been made, during the current case review period, to adequately mitigate risk to the child, the policy override does not need to be selected.

1. Child is likely to have access with an individual who, historically or presently, has allegedly sexually abused a child
Select this policy override in the following circumstances.

- Sexual abuse case AND the alleged perpetrator is likely to have access to the child they are alleged to have abused.
- An individual who is suspected to have sexually abused any child(ren) in the past will likely have access to children in the household. This is a concern as no information is available to suggest that circumstances have changed for the alleged perpetrator, increasing risk of sexual harm to other children.
- An individual is suspected to have sexually abused a child in the household, and the parent's actions indicate that the perpetrator is likely to have continued access to the child.

Note: If the social worker and supervisor's clinical assessment is that the perpetrator's access to children is no longer a current child protection concern, the policy override does not need to be selected. This can include parent's actions that are protective in nature.

2. Non-accidental injury to a child younger than 3 years of age
Any child in the household younger than the age of 3 has a physical injury resulting from actions or inactions of a parent.

3. Severe non-accidental injury to a child of any age
Any child in the household has a serious physical injury resulting from a parent's action or inaction. Severe injury includes brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that requires medical treatment and seriously impairs the health or well-being of the child.

4. Parent action or inaction resulted in death of a child due to abuse or neglect (past or current)
Any child in the household has died as a result of actions or inactions by the parent.

DISCRETIONARY OVERRIDE

A discretionary override is used by the ongoing worker whenever the worker believes that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment in which the worker could only *increase* the risk level, the risk reassessment permits the worker to *increase* or *decrease* the risk level by one step.

The reason a worker may decrease the risk level is that after a minimum of four months, the worker has acquired significant knowledge of the family. If a discretionary override applies, select yes, indicate the reason, and select the override risk level.

B. VISITATION PLAN EVALUATION

Visitation Frequency—Compliance With Plan for Child

(Social worker can use their professional judgment to determine if visits that are significantly shortened by the parent's late arrival/early departure will be considered missed.)

Regular: Parent regularly attends visits or calls in advance to reschedule (90–100% compliance).

Routine: Parent may miss visits occasionally and rarely requests to reschedule visits (65–89% compliance).

Sporadic: Parent misses or reschedules many scheduled visits (24–64% compliance).

Rare or Never: Parent does not visit or visits 24% or fewer of the allowed visits (0–24% compliance).

Quality of Face-to-Face Visit

Quality of visit is based on social worker's direct observation whenever possible, supplemented by observation of child, reports of foster parents, etc.

Quality of Face-to-Face Visit	
Quality	**Parent**
Strong or Adequate	• Consistently demonstrates acts of protection and supportive behaviours toward the child that are consistent with plan objectives. • Often reinforces appropriate roles and boundaries for child (e.g. preserves parent-child relationship; takes on adult roles and responsibilities). • Demonstrates an ability to recognize child's behaviours and cues; generally responds appropriately to behaviours and cues. • Identifies the child's physical and emotional needs; responds adequately to these needs. • Demonstrates effective limit setting and discipline strategies. • Demonstrates a focus on the child during visits; shows empathy to child.

Quality of Face-to-Face Visit	
Quality	**Parent**
	• Demonstrates interest in school, other child activities, medical appointments. • Visitation may have progressed to include extended visits, but extended visits are not required to score as adequate/strong.
Limited or Destructive	• May not demonstrate acts of protection and supportive behaviours towards the child that are consistent with plan objectives. • May struggle or have severely limited ability to reinforce appropriate roles and boundaries for child (e.g. preserve parent-child relationship; take on adult roles and responsibilities), and requires prompting to do so. • Demonstrates some ability to recognize child's cues and behaviours, but needs guidance in establishing an appropriate response to these cues and behaviours or is unable to respond appropriately. • May demonstrate some ability to identify child's physical and/or emotional needs, but may need assistance in consistently responding to the child in an appropriate manner. • Recognizes a need to set limits with child, but enforces limits or behaviour management in an inconsistent or detrimental manner. OR may not recognize a need to set limits. • May have ignored redirection by supervising worker. • May not be focused on child during parenting time and/or conducts self inappropriately during visit (e.g. arriving for parenting time while substance-impaired; reinforcing parentification of child; knowingly making false promises to child; or cursing at/violently arguing with worker in presence of child).

C. SAFETY THREATS

Review of Safety Threats

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

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

List the safety threat(s) selected at removal and describe whether the initial safety threats were resolved, or if not resolved, what the current circumstances are that would pose immediate threat of harm if the child were to be reunified. Consider current conditions in the home, current parent characteristics, child characteristics and interactions between parents and child during visitation.

1a. If yes, is there a safety intervention that can and will be incorporated into the case plan to mitigate these safety threats?

Answer no if the safety threats present at the initial safety assessment that led to removal have been resolved and go to question 2.

Answer yes if there are safety interventions available and appropriate to mitigate any identified safety threats. Use the definitions section to review both safety threats and safety interventions. Identify the safety threats and the interventions as applies to each identified threat, incorporating the safety interventions and plan into the Plan for the Child.

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

Indicate if any safety threat(s) have been identified in a safety assessment since the child's removal and initial placement into care (do not include safety threats identified that led to removal).

Review the list of safety threats provided in the definitions to examine whether any new safety threats emerged during the review period. If any new safety threats are identified that would pose immediate threat of serious harm to a child if reunified, describe the conditions and circumstances.

2a. If yes, is there a safety intervention(s) that can and will be incorporated into the Plan for the Child to mitigate these safety threats?

Use the definitions section to review both safety threats and safety interventions.

Answer "No" if there are no interventions available that will allow the children to return home at this time while other services continue.

Answer "Yes" if there are available safety interventions that will allow the children to be returned home with a safety plan that are incorporated into the Plan for the Child.

SAFETY DECISION

1. **SAFE:** No safety threats were identified at this time. Based on currently available information, no children are likely to be in immediate danger of serious harm if reunified with the parent.

2. **SAFE WITH A PLAN:** One or more safety threats are identified, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be safe with plan upon return home. SAFETY PLAN REQUIRED.

3. **UNSAFE:** One or more safety threats are identified, and continued placement is the only protecting intervention possible for one or more children. Without continued placement, one or more children will likely be in danger of immediate or serious harm.

D. PLACEMENT/PERMANENCY PLAN GUIDELINES TREE

Overrides

The placement/permanency plan guidelines tree recommends maintaining placement and reunification services, but conditions exist to recommend termination of reunification services. The recommendation, based on risk, visitation, and safety, is to continue the permanency plan goal of return home while maintaining the child in placement. However, conditions exist to proceed immediately to ending reunification services and changing the permanency goal to the child. Conditions for this override include the following.

- The parent has refused to participate in reunification services during the review period.
- The parent has an extensive history of child abuse and/or neglect, this episode represents the same behaviour and the parent is unlikely to change behaviour through services.
- The parent will be incarcerated for the next several years and is unable to participate in reunification services.
- The child refuses return home and is of an age to assist in determining a permanency goal.

The placement/permanency plan guidelines tree recommends changing goal from reunification, BUT there is probability of reunification within the next four months.
The child has been in placement for 12 cumulative months, and the parents have not reduced risk, not maintained acceptable visitation, and/or the household is unsafe. Examples of probability of reunification include the following.

- The child is in a placement to meet treatment needs and the parents are participating in all appropriate services but are currently unable to meet all the child needs.
- Risk has been reduced to low or moderate and parents had acceptable visitation but have been unable to resolve safety threats. However, there is a plan that will resolve the threats.
- One parent has made substantial progress in all areas while the other has not. There is a plan in place to resolve issues.

The placement/permanency plan guidelines tree recommends changing goal from reunification, BUT other extenuating factors or circumstances require continuation of reunification services for the next four months.
Examples include, but are not limited to the following.

- The child has severe emotional or behavioural problems or a serious medical condition, and reunification remains an appropriate goal.

- A temporary custody order has recently been granted, which requires continued reunification efforts for the next four months.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES
POLICY AND PROCEDURES

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

Unlike the initial risk assessment that contains separate indices for risk of neglect and risk of abuse, the risk reassessment is comprised of a single index. Research has demonstrated that for the reassessment, a single index best categorizes risk for future maltreatment.

WHICH CASES

All ongoing protective intervention cases in which all children remain in the home, or cases in which all children have been returned home and ongoing protective intervention services will be provided. If any children are placed out of the home, a risk reassessment is not required until all children have either returned home or a continuous custody order has been granted.

WHO

The social worker responsible for the case.

WHEN

Every four months after the completion of the initial FCAP and prior to the completion of an FCAP and Case Summary.

Prior to any case closure, if the most recent risk reassessment has been completed more than 30 days ago.

In cases where a parent has made a plan for the child to reside with another parent while they work on identified child protection concerns/case plan goals (and there is no present safety threat that indicates the child would not be safe to remain in the home), a risk reassessment will be completed during the case review period. Prior to the child returning home, an updated safety assessment can also be completed to ensure there are no current safety threats.

DECISION

The risk reassessment identifies the level of risk of future maltreatment. The risk level guides the decision to keep a case open or close a case. If the recommended action differs from the action taken, provide an explanation in the case summary.

Risk-Based Ongoing Protective Intervention Case Open/Close Guide	
Risk Level	**Recommendation**
Low	Close, if there are no unresolved safety threats
Moderate	Close, if there are no unresolved safety threats
High	Ongoing protective intervention case remains open
Very High	Ongoing protective intervention case remains open

For cases that remain open following reassessment, the NEW risk level guides minimum contact standards that will be in effect until the next reassessment is completed. Use the contact guidelines.

APPROPRIATE COMPLETION

A. Risk Reassessment

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

Items R1–R4

Items R1 and R2 refer to the time period PRIOR to the investigation that led to the opening of the current case. Scores for these items should be identical to corresponding items on the initial risk assessment unless additional information has become available.

It should be noted that there may be rare circumstances where the response to R1 on the risk reassessment will not be the same as the responses to N1 and N2, and R2 will not have the same responses as N3 and A3 on the risk assessment.

This rare circumstance may result when an ongoing protection case is open and has never had a prior case opening. For example, a case opened prior to SDM implementation and has remained open in ongoing protection since that time.

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

Item R4 may change if a child's condition has changed, or if a child with a described condition is no longer part of the household (children in out-of-home placement with a plan to return home are considered part of the household, and the family should be reassessed using the reunification assessment).

Items R5–R9

These items are scored based ONLY on observations since the most recent assessment or reassessment. Using the definitions, determine the appropriate response for each item and enter the corresponding score.

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

Overrides

After determining the scored risk level, the worker determines whether any of the override reasons exist for the review period. If a policy override was selected in a previous review period but has since been addressed and/or the social worker and supervisor's clinical assessment is that sufficient progress has been made, during the current case review period, to adequately mitigate risk to the child, the policy override does not need to be selected.

Policy overrides reflect incident seriousness and/or child vulnerability concerns and have been determined by the agency to warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. A *discretionary* override is used by the ongoing worker whenever the worker believes that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment, in which the worker could only *increase* the risk level, the risk reassessment permits the worker to *increase* or *decrease* the risk level by one step.

The reason a worker may decrease the risk level is that after a minimum of four months, the worker has acquired significant knowledge of the family. If a discretionary override applies, select yes, indicate the reason, and select the override risk level. Selection of any overrides require supervisory approval.

After completing the override section, indicate the final risk level.

Preliminary Recommendation Decision

The preliminary recommendation is based on the final risk level. If the final risk level is high or very high, the preliminary recommendation will be to continue ongoing protective intervention. If the final risk level is low or moderate, the preliminary recommendation will be to close ongoing protective intervention. If the preliminary recommendation for the case is to close the case, a safety reassessment (Part B) is required.

B. Safety Reassessment

B1. Review of Safety Threats

For question 1 of the safety reassessment section, review all prior safety assessments to determine if safety threats have been identified in this case. If no safety threats have been identified, go to the safety decision and indicate that the safety decision is safe. If there have

been safety threats, go to question 2 and indicate whether any of the safety threats are still present. If none are present, check no and provide a description of how each was resolved. If any are still present, check yes and indicate the current safety threat in the household and go to question 3.

For question 3, indicate whether there are safety interventions that can and will be incorporated into the FCAP to mitigate the safety threats. If none are available, check no and indicate the safety decision is unsafe. If safety interventions are available, check yes and indicate the safety decision is safe with services. Briefly describe the interventions in the space provided.

B2. Safety Decision

The safety decision is based on whether current safety threats exist and whether interventions are available and appropriate to mitigate those threats. The safety decision is either safe, safe with plan, or unsafe based on the following:

- *Safe*. No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.

- *Safe with plan*. One or more safety threats are identified in 1 or 2 above. Safety interventions have been initiated in a safety plan or in the FCAP and the child will either remain in the home, or will temporarily stay with a relative or significant other with consent of the parent, as long as the safety interventions mitigate the safety threat(s). It is recommended that ongoing protective intervention services continue.

- *Unsafe*. One or more safety threats are identified, and the signing of a Protective Care Agreement or removal is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate, serious harm

C. Final Action

The recommended case action is based on the final risk level of the household and the safety decision. Low and moderate risk, safe households are recommended for closure. High and very high risk and/or safe with plan/unsafe cases are recommended for continued protective intervention.

Recommended case action is based on the following.

Final Risk Level	Safety Decision From Part B2		
	Safe	Safe With Plan	Unsafe
Low/Moderate	Close case	Continue protective intervention	Continue protective intervention
High/Very High	Continue protective intervention	Continue protective intervention	Continue protective intervention

For the final action, select whether the case action is:

- Continue ongoing protective intervention services;
- Family declined continued ongoing protection services from child protection;
- Close ongoing protective intervention services;
- Low or moderate risk, safe; or
- Other.

If the SDM recommendation and final action taken do not match, document why.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES

r: 02/24

☐ Risk reassessment is not required at this time as the child is currently in an out-of-home placement.

Household Name: _____ **File #:** _____

Worker: _____ **Region:** _____

Primary Parent: _____ **Secondary Parent:** _____

Date of Assessment: _____

A. RISK REASSESSMENT **Score**

R1. Number of screened-in child protection referrals (CPR) prior to the investigation resulting in the current case opening
- ○ a. None 0
- ○ b. One 1
- ○ c. Two or more ..... 2 _____

R2. Household received ongoing protective intervention services prior to the investigation resulting in the current case opening
- ○ a. No 0
- ○ b. Yes ..... 1 _____

R3. Primary parent has a history of abuse or neglect as a child
- ○ a. No 0
- ○ b. Yes ..... 1 _____

R4. Child characteristics (*select applicable items*)
- ○ a. No child has any of the characteristics below 0
- ○ b. Yes (*select all that apply*) ..... 1 _____
  - ☐ One or more children in household is developmentally disabled
  - ☐ One or more children in household has a learning disability
  - ☐ One or more children in household is physically disabled
  - ☐ One or more children in household are medically fragile or diagnosed with failure to thrive

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

R5. New screened-in CPR for abuse or neglect since the initial risk assessment or the last reassessment
- ○ a. No 0
- ○ b. Yes ..... 1 _____

R6. Parent alcohol or drug use since the last assessment/reassessment (*select one*)
- ○ a. No history of alcohol or drug abuse problem 0
- ○ b. No current alcohol or drug abuse problem; no intervention needed 0
- ○ c. Yes, alcohol or drug abuse problem; problem is being addressed 0
- ○ d. Yes, alcohol or drug abuse problem; problem is <u>not</u> being addressed ..... 1 _____

Score

R7. Adult relationships since the last assessment/reassessment

○ a. No problems with adult relationships 0
○ b. Problems with adult relationships (*select all that apply*) ..... 1 _____
☐ Harmful/tumultuous relationships
☐ Domestic violence

R8. Primary parent mental health since the last assessment/reassessment (*select one*)

○ a. No history of mental health problem 0
○ b. No current mental health problem; no intervention needed 0
○ c. Yes, mental health problem; problem is being addressed 0
○ d. Yes, mental health problem; problem is <u>not</u> being addressed ..... 1 _____

R9. Primary parent, since the last assessment/reassessment, has provided physical care that is consistent with child needs

○ a. Yes 0
○ b. No ..... 1 _____

R10. Parent's progress with FCAP objectives since the last assessment/reassessment
(*score based on the parent demonstrating the least progress*)

○ No secondary parent

P	S	
○	○	a. Demonstrates new skills consistent with FCAP objectives OR is actively engaged in services and activities to gain new skills consistent with FCAP objectives 0
○	○	b. Does not demonstrate new skills consistent with FCAP objectives AND/OR participation is minimal and insufficient to contribute to achieving FCAP objectives ..... 1 _____

TOTAL SCORE _____

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

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

POLICY OVERRIDES.
Select **yes** if condition is applicable in the current review period. If **any** condition is applicable, override final risk level to very high.

○ Yes	○ No	1. Child is likely to have access with an individual who, historically or presently, has allegedly sexually abused a child.
○ Yes	○ No	2. Non-accidental injury to a child younger than 3 years of age.
○ Yes	○ No	3. Severe non-accidental injury to a child of any age.

○ Yes ○ No 4. Parent action or inaction resulted in death of a child due to abuse or neglect (past or current).

DISCRETIONARY OVERRIDE

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

○ Yes ○ No 5. If **yes**, override risk level (*select one*): ☐ Low ☐ Moderate ☐ High ☐ Very High

Discretionary override reason: _____

Supervisor's Review/Approval of Discretionary Override: _____ Date: _____

FINAL RISK LEVEL *(select final level assigned)*:

○ Low
○ Moderate
○ High
○ Very High

PRELIMINARY RECOMMENDED DECISION

○ Continue ongoing protective intervention services (risk is high or very high)

○ Close ongoing protective intervention services (risk is low or moderate—safety reassessment is required. Proceed to Part B.)

B. SAFETY REASSESSMENT

B1. REVIEW OF SAFETY THREATS

1. Have any safety threats been identified on any safety assessment (during the current review period) that presented an immediate danger of serious harm?
   ○ No (*if no, go to safety decision and select SAFE*)
   ○ Yes (*List prior safety threats and go to #2*)

2. If yes, are any safety threats identified still present?
   ○ No (*describe how the identified safety threat[s] was resolved, go to safety decision and select SAFE*):

   ○ Yes (*describe safety threat[s] present*)

3. If yes, is there a protective intervention(s) that can and will be incorporated into the FCAP to mitigate these safety concerns?
   - ○ No; safety interventions are not available/appropriate, and removal of one or more children from the home is required to ensure safety (if no, go to safety decision and select UNSAFE).
   - ○ Yes, one or more safety interventions are available to mitigate safety (describe and go to safety decision and select Safe with Plan).

B2. SAFETY DECISION

○ 1. **SAFE.** No safety threats were identified at this time. Based on currently available information, no children are likely to be in immediate danger of serious harm.

○ 2. **SAFE WITH PLAN.** One or more safety threats are identified in 1 or 2 above. Safety interventions have been initiated in a safety plan or in the FCAP, and the child will either remain in the home or temporarily stay with a relative or significant other with consent of the parent, as long as the safety interventions mitigate the safety threat(s). It is recommended that ongoing protective interventions services continue.

○ 3. **UNSAFE.** One or more safety threats are identified, and the signing of a protective care agreement or removal is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate, serious harm.

C. FINAL ACTION

Recommended case action is based on the following.

Final Risk Level	Safety Decisions From Part B		
	Safe	**Safe With Plan**	**Unsafe**
Low/Moderate	Close case	Continue services	Continue services
High/Very High	Continue services	Continue services	Continue services

Enter the action that will be taken.

○ Continue ongoing protective intervention services
○ Family declined continued ongoing protection services from child protection
○ Close ongoing protective intervention services
  - ○ Low or moderate risk, safe
  - ○ Other

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

Social Worker Name: _____ **Date Form Completed:** _____

Supervisor Name: _____ **Date of Supervisory Approval:** _____

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
SDM® FAMILY RISK REASSESSMENT FOR IN-HOME CASES
DEFINITIONS

A. RISK REASSESSMENT

R1. Number of screened-in child protection referrals (CPR) prior to the investigation resulting in the current case opening

Score the item based on the count of all investigations, verified or not, that were assigned for a protection investigation for any type of abuse or neglect prior to the investigation resulting in the current case opening. Where possible, history from other jurisdictions should be selected. Exclude investigations of out-of-home perpetrators (e.g. daycare) unless one or more parents failed to protect. This item should be the same as the total number of abuse and neglect investigations identified on the initial risk assessment, items N2 and A2.

R2. Household received ongoing protective intervention services prior to the investigation resulting in the current case opening

Where possible, history from other jurisdictions should be checked.

Any member of the current household, prior to this investigation resulting in the current case opening, has received ongoing child protection services AND that member was an alleged perpetrator. This item should be answered the same as items N3 and A3 on the most recent initial risk assessment.

*It should be noted that there may be rare circumstances where the response to R1 on the risk reassessment will not be the same as the responses to N1 and N2, and R2 will not have the same responses as N3 and A3 on the risk assessment.
This rare circumstance may result when an ongoing protection case is open and has never had a prior case opening. For example, a case opened prior to SDM implementation and has remained open in ongoing protection since that time.

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

Based on credible statements by the primary parent/parent or others, or any child protection history known to the agency, the primary parent/parent was abused or neglected as a child (child protection includes neglect and physical, sexual or emotional abuse). This item should be the same as item A8 on the initial risk assessment but may change if new information is available or if there has been a change in who is primary parent.

Note: Base your rating of this item on *current* definitions of abuse/neglect regardless of what it was labelled at the time.

R4. Child characteristics

Score this item based on credible statements by parent that a child has been diagnosed, statements from a physician or mental health professional, or review of records. Select each characteristic that is present and score 1 if any characteristic is present. This item should be the same as item N9 on the initial risk assessment but may change may change if a child's condition has changed or if new information has become available, or if a child with a described condition is no longer part of the household (children in out-of-home placement with a plan to return home are considered part of the household, and the family should be reassessed using the reunification reassessment).

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

b. Score 1 if any child has any of the characteristics below:

- Developmental disability: A condition diagnosed by a physician or mental health professional due to mental and/or physical impairments. Examples include intellectual disability, autism spectrum disorders, and cerebral palsy.

- Learning disability: Child has a specialized education plan to address a learning problem, such as dyslexia. Do not include a specialized education plan designed solely to address mental health or behavioural problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for a specialized education plan but does not yet have one, or who is in preschool.

- Physical disability: A severe acute or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include paralysis, amputation, and blindness.

- Medically fragile* or failure to thrive: Any child in the household has a diagnosis of medically fragile or failure to thrive as evidenced by parent's statement of such a diagnosis, medical records and/or doctor's report.

  **Medically fragile*: Any child has a medical condition that requires technological intervention and the condition, if untreated, is likely to result in death or serious harm. For example, child requires a trach/vent or central line feeding.

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

R5. New screened-in CPR for abuse or neglect since the initial risk assessment or last reassessment

Score 1 if at least one protection investigation has been initiated **since the initial risk assessment or last reassessment**. This includes open or completed investigations,

regardless of verification decision, that have been initiated since the initial assessment or last reassessment.

R6. Parent alcohol or drug abuse since the last assessment/reassessment

Indicate whether or not the primary and/or secondary parent has a current alcohol/drug abuse problem that interferes with the parent's or the family's functioning and they are not addressing the problem. If both parents have a substance abuse problem, rate the more negative behaviour of the two parents. Not addressing the problem is evidenced by:

- Substance use that affects or affected the parent's employment, criminal involvement, or marital or family relationships; or that affects or affected their ability to provide protection, supervision, and care for the child;
- An arrest since the last assessment/reassessment for driving under the influence or refusing breathalyzer testing;
- Self-report of a problem;
- Multiple positive drug tests;
- Health/medical problems resulting from substance use;
- The child's diagnosis with Fetal Alcohol Syndrome or Exposure (FAS or FAE) or the child had positive toxicology screen at birth and the primary or secondary parent was the birth parent.

Score the following:

a. Score 0 if there is no history of an alcohol or drug abuse problem.

b. Score 0 if there is no current alcohol or drug abuse problem that requires intervention.

c. Score 0 if there is an alcohol or drug abuse problem, and the problem is being addressed.

d. Score 1 if there is an alcohol or drug abuse problem, and the problem is <u>not</u> being addressed.

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

R7. Adult relationships since the last assessment/reassessment

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

a. Score 0 if not applicable or there are no problems observed.

b. Score 1 if yes, there are harmful/tumultuous adult relationships or domestic violence.

- Adult relationships that are harmful to domestic functioning or to the care the child receives. This may include but is not limited to: lack of communication about child needs and safety, disagreements between parents that negatively impact care and protection but does not include physical violence, control issues, threats and intimidation.
- The household has had, since the most recent assessment, physical assault(s) or periods of intimidation/threats/harassment between parents or between a parent and another adult.

R8. Primary parent mental health since the last assessment/reassessment

Indicate if there are credible and/or verifiable statements by the primary parent or others indicating that the primary parent:

- Has been diagnosed, or is currently being treated by a professional qualified to do so, for a mental illness/disorder other than substance-related disorders.

- Has/had multiple referrals for mental health/psychological evaluations, treatment or hospitalizations.

If primary parent has never been diagnosed but appears to have (or have had) a mental health problem, consider obtaining an assessment prior to scoring. Do not count reports motivated solely by efforts to undermine the credibility of the primary parent or other ulterior motives.

Addressing the problem is indicated by whether the parent is participating in interventions and following through with recommendations including, but not limited to, outpatient therapy, use of prescribed psychotropic medication, or inpatient treatment.

a. Score 0 if the primary parent does not have a current or past mental health problem.

b. Score 0 if there is a history of mental health problems but there is no mental health problem that requires intervention.

c. Score 0 if there is a mental health problem, and the problem is being addressed.

d. Score 1 if there is a mental health problem, and the problem is <u>not</u> being addressed.

R9. Primary parent, since the last assessment/reassessment, has provided physical care that is consistent with child needs

Physical care of the child includes feeding, clothing, shelter, hygiene and medical care of the child. Consider the child's age/developmental status.

ANSWER NO IF:

- If there has been a new Screened in CPR for neglect that relates to physical care during this review period AND was verified.

  OR
- Regardless of whether there is a new neglect verification, the child has been harmed or their well-being has been threatened because of unmet physical needs. Needs may be considered unmet regardless of whether the cause is neglectful or due to situations outside of the parent's control. For example:

  » Child has a significant medical/dental/vision condition that requires care and care is not being provided.

  » Child persistently does not *have,* or parent does not ensure*,* clothing that is appropriate for weather conditions, OR clothing is persistently unwashed.

  » Living environment lacks adequate utilities, has potentially dangerous conditions (e.g. unlocked poisons, dangerous objects in reach of small child), is unsanitary or is infested AND these conditions persist regardless of any attempt parents/carers have made to rectify problems. If living environment concerns are to the degree that it is *unsafe*, also score N10.

  » Child frequently goes hungry, thirsty, has lost weight or failed to gain weight.

  » The child is not being bathed regularly, as evidenced by their physical appearance and/or resulting in a strong odour

R10. Parent's progress with FCAP objectives since the last assessment/reassessment (*score based on the parent demonstrating the least progress*)

Identify whether a parent is actively engaged in achieving the objectives specified in the FCAP and is demonstrating the skills/behaviours (e.g. ability to manage substance use/abuse when caring for children; resolving conflict constructively and respectfully; using approved age-appropriate, non-physical discipline; developing a mutually supportive relationship with partner) that will enable the parent to create and maintain safety for the child(ren).

"Objectives" specifically refers to the service objectives in the FCAP identifying changes in parent behaviour necessary to create and maintain safety.

If there is only one parent, select "No Secondary Parent" and rate the primary parent. If there are two parents, rate progress for each. If progress differs between parents, score based on the parent demonstrating the least amount of participation/progress.

a. Demonstrates new skills consistent with FCAP objectives OR is actively engaged in services and activities to gain new skills consistent with FCAP objectives desired outcomes. The parent is demonstrating behavioural change consistent with the objectives in the FCAP (e.g. does not abuse alcohol, controls anger/negative behaviour, does not use physical punishment, refrains from domestic violence, provides emotional support for the child, etc.). This may include participation in activities identified on the FCAP toward achievement of new skills; and parents who successfully achieve desired behaviour change through activities not specifically identified on the plan but also enable parent to ensure child safety.

   Engagement in services and activities means that the parent's participation suggests acquisition and application of new skills, and not just compliance with attendance. Compliance with services and activities without demonstration of acquisition of new skills consistent with case plan objectives is not sufficient for scoring this category.

b. Does not demonstrate new skills consistent with FCAP objectives AND/OR participation is minimal /insufficient to contribute to achieving FCAP objectives. This may include minimal or complete refusal to participate in services or activities, or participation which has failed to result in behaviour change. Parents who are demonstrating some progress toward FCAP objectives but insufficient progress overall to address safety and risk factors should be scored here.

POLICY OVERRIDES

After completing the risk assessment, the worker determines whether any of the policy override reasons exist. Policy overrides reflect incident seriousness and/or child vulnerability concerns and have been determined by the agency to warrant a risk level designation of very high regardless of the risk level indicated by the assessment tool. Policy overrides require supervisory approval.

If a policy override was selected in a previous review period but has since been addressed and/or the social worker and supervisor's clinical assessment is that sufficient progress has been made, during the current case review period, to adequately mitigate risk to the child, the policy override does not need to be selected.

1. Child is likely to have access with an individual who, historically or presently, has allegedly sexually abused a child
Select this policy override in the following circumstances.

- Sexual abuse case AND the alleged perpetrator is likely to have access to the child they are alleged to have abused.

- An individual who is suspected to have sexually abused any child(ren) in the past will likely have access to children in the household. This is a concern as no information is available to suggest that circumstances have changed for the alleged perpetrator, increasing risk of sexual harm to other children.

- An individual is suspected to have sexually abused a child in the household, and the parent's actions indicate that the perpetrator is likely to have continued access to the child.

Note: If the social worker and supervisor's clinical assessment is that the perpetrator's access to children is no longer a current child protection concern, the policy override does not need to be selected. This can include parent's actions that are protective in nature.

2. Non-accidental injury to a child younger than 3 years of age
Any child in the household younger than the age of 3 has a physical injury resulting from actions or inactions of a parent.

3. Severe non-accidental injury to a child of any age
Any child in the household has a serious physical injury resulting from a parent's action or inaction. Severe injury includes brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that requires medical treatment and seriously impairs the health or well-being of the child.

4. Parent action or inaction resulted in death of a child due to abuse or neglect (past or current)
Any child in the household has died as a result of actions or inactions by the parent.

DISCRETIONARY OVERRIDE
A discretionary override is used by the ongoing worker whenever the worker believes that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment in which the worker could only *increase* the risk level, the risk reassessment permits the worker to increase or *decrease* the risk level by one step.

The reason a worker may decrease the risk level is that after a minimum of four months, the worker has acquired significant knowledge of the family. If a discretionary override applies, select yes, indicate the reason, and select the override risk level.

B. SAFETY REASSESSMENT

B1. Review of Safety Threats

1. **Have any safety threats been identified on any safety assessment (during the current review period) that presented an immediate danger of serious harm?**
   List any safety threat(s) that have been identified in the department's work with the family.

2. **If yes, are any safety threats identified still present?**
   Answer no if any safety threats present at other times have been resolved and describe how they were resolved.

   If yes, list any safety threat(s) currently active. Consider current conditions in the home, current parent characteristics, child characteristics, and interactions between parents.

3. **If yes, is there a protective intervention(s) that can and will be incorporated into the FCAP to mitigate these safety concerns?**
   Use the definitions section to review both safety threats and safety interventions.

   Answer no if no interventions are available that will allow the children to stay at home at this time.

   Answer yes if there are available safety interventions that will allow the children to stay at home with a safety plan that can be incorporated into the FCAP. Describe what actions are being taken.

SDM® SAFETY ASSESSMENT DEFINITIONS FOR REVIEW

1. **Parent caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by:**

   - Serious injury or abuse to the child other than accidental. Parent caused serious injury or abused the child as indicated by brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, and/or severe cuts; *and* the child requires medical treatment.

   - Parent fears they will maltreat the child. Parent expressed this fear directly to the social worker.

- Threat to cause serious harm or retaliate against the child. Parent threatened action that would result in serious harm, parent plans to retaliate against child for child protection investigation, or child expresses a credible fear that they will be maltreated by the parent and suffer serious harm.

- Excessive discipline or physical force. Parent used physical methods to discipline a child that resulted in or could easily result in serious injury, OR parent injured or nearly injured a child by using physical force. This could include using physical force with an object, such as a belt, to discipline the child.

- Propensity to violence. Parent has demonstrated a propensity to violence, through either a specific action or a pattern of actions, AND this creates imminent threat of harm to children.

  Indicators of propensity to violence include the parent:

  » Demonstrating a pattern of using violence or implied violence in response to situations; and/or

  » Being alleged to have killed or intentionally seriously injured another person through a violent assault.

- Drug-exposed infant. Evidence shows that the mother used alcohol, other drugs, or solvents during pregnancy, AND this has created imminent danger to the newborn child.

  » Indicators of drug use during pregnancy include drugs found in the mother's or child's system, mother's self-report, diagnosis of high-risk pregnancy due to drug use, efforts on mother's part to avoid toxicology testing, withdrawal symptoms in mother or child, and pre-term labor due to drug use.

  » Indicators of imminent danger include the level of toxicity and/or type of drug present, diagnosis of the infant as medically fragile as a result of drug exposure, and suffering of adverse effects by the infant due to introduction of drugs during pregnancy.

2. Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.

Suspicion of sexual abuse may be based on the following indicators.

- Child discloses sexual abuse verbally or child's behaviour indicates possibility of sexual abuse (e.g. age-inappropriate or sexualized behaviour toward self or others).

- Medical findings consistent with child sexual abuse.

- Sexual abuse allegation has been made against parent in the household, AND they have been or are being investigated for, charged with, or convicted of a sex offence (including a Registered Sex offender); has had other sexual contact with the child; or have been previously verified by the department or other child protection agencies. Investigations for a sexual offence include those by the department or other child protection agencies.

- Parent or others in the household have forced or encouraged the child to engage in sexual performances or activities (including forcing child to observe sexual performances or activities).

AND circumstances suggest that the child's safety may be of immediate concern, based on the following indicators.

- An alleged or convicted sexual abuse perpetrator, or an individual suspected of perpetrating, has access to a child.

- Parent blames child for the sexual abuse or the results of the investigation.

- Parent does not believe that the sexual abuse occurred.

3. Parent does not protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, emotional abuse, or neglect.

- Parent does not protect the child from serious harm or threatened harm as a result of physical abuse, sexual abuse, emotional abuse, or neglect by other family members, other household members, or others having access to the child. The parent does not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage. This includes a parent not taking protective action following a disclosure of harm from the child.

- An individual with known violent criminal behaviour/history resides in the home, and current circumstances (e.g. no change in individual's behavioural pattern over time) suggest that the child's safety may be of immediate concern.

- Parent takes the child to dangerous locations where drugs are manufactured, regularly administered, and/or sold (e.g. amphetamine labs, drug houses, or locations used for prostitution or pornography), and this is likely to recur.

  If domestic violence (DV) exists in the home, the DV threat for violence between adults, as outlined in 7, may be more appropriate to select as a threat.

4. Parent does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.

- Nutritional needs of the child are not met, AND this results in danger to the child's health and/or safety including malnutrition.
- Child's clothing is inappropriate for the weather to the extent that the child is in danger of hypothermia or frostbite.
- Parent does not seek treatment for the child's immediate, chronic, and/or dangerous medical condition(s) or does not follow prescribed treatment for such conditions.
- Child appears malnourished.
- Child has exceptional needs, such as being medically fragile, which the parent does not or cannot meet.
- Child is suicidal and/or seriously self-harming, and the parent will not/cannot take protective action.
- Child exhibits signs of serious emotional symptoms, lack of behavioural control, or serious physical symptoms as a result of maltreatment.
- Parent does not attend to the child to the extent that need for care goes unnoticed or unmet (e.g. parent is present but the child can wander outdoors alone, play with dangerous objects, play on an unprotected window ledge, or be exposed to other serious hazards).
- Parent leaves the child alone in circumstances that create opportunities for serious harm (time period and opportunity for harm is dependent on age and developmental stage, e.g. young child left unattended in vehicle on a hot day).
- Parent is currently unavailable to care for the child and no arrangements have been made (incarceration, hospitalization, abandonment, unknown location).

5. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

Based on the child's age and developmental status, the child's physical living conditions are hazardous and immediately threatening, including but not limited to:

- Leaking gas from stove or heating unit;
- Substances or objects accessible to young child that may endanger their health and/or safety (e.g. drug paraphernalia, scissors/knives, cleaning supplies);

- Lack of water or utilities and no alternate or safe provisions;
- Open/broken/missing windows accessible to young children;
- Exposed electrical wires;
- Excessive mould, garbage, or rotted or spoiled food that threatens child's health;
- Serious illness or significant injury due to living conditions that have not been remediated (e.g. lead poisoning, rat bites);
- Evidence of human or animal waste uncontained throughout living quarters;
- Unlocked and accessible guns and other weapons; and
- Drug production or sales from the home.

6. **Parent's current substance abuse seriously impairs their ability to supervise, protect, or care for the child.**
Parent has abused legal or illegal substances or alcoholic beverages to the extent that the parent is currently unable, or will likely be unable, to supervise, protect, or care for the child, which is likely to harm the child. Examples include but are not limited to:

- Co-sleeping with an infant or young child whilst under the influence of drugs, alcohol, or solvents;
- Driving under the influence of alcohol and/or other drugs with a child in the car; and
- Being unable to provide immediate care and/or supervision to a child in the event of an emergency or other essential need while under the influence of substances or alcohol.

7. **Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.**
There is evidence of domestic violence in the home, AND child's safety is of immediate concern. Examples include the following.

- Child was previously injured in domestic violence incident and violence is occurring in the home now.
- Child exhibits severe anxiety (e.g. nightmares, insomnia) related to situations associated with domestic violence.

- Child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of domestic violence in the home.

- Child's behaviour increases risk of injury (e.g. child attempted to intervene during violent dispute or participated in the violent dispute in an effort to protect a parent or stop the violence).

- Individuals in the home use guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.

- Evidence of serious, frequent, or escalating property damage resulting from domestic violence is apparent.

- Other indicators exist of highly dangerous domestic violence situations such as a perpetrator threatening or attempting to kill an adult, perpetrator harming household pets, and/or recent separation that is resisted by a violent partner.

8. **Parent's emotional, developmental, or cognitive functioning or physical condition/disability seriously impairs their current ability to supervise, protect, or care for the child.**
Evidence exists that the parent is mentally ill, developmentally delayed, cognitively impaired, or has a physical condition/disability, AND as a result, one or more of the following situations are observed.

- Parent's refusal to seek evaluation/treatment and/or to follow prescribed medications seriously impedes their ability to supervise, protect, or care for the child.

- Parent's inability to control emotions seriously impedes their ability to supervise, protect, or care for the child.

- Parent acts out or exhibits a distorted perception that seriously impedes their ability to supervise, protect, or care for the child.

- Parent's depression seriously impedes their ability to supervise, protect, or care for the child.

- Parent's current physical health/illness seriously impedes their ability to supervise, protect, or care for the child.

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

- Due to cognitive delay, the parent lacks basic knowledge and understanding related to parenting. Examples include not:

  » Knowing that infants need regular feedings;
  » Accessing and obtaining basic/emergency medical care;
  » Understanding proper diet; or
  » Providing adequate supervision.

9. **Parent describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.**
Examples of parent actions include:

- Describing the child in a demeaning or degrading manner (e.g. as evil, stupid, ugly);

- Cursing and/or repeatedly putting the child down;

- Scapegoating a particular child in the family;

- Blaming the child for a particular incident or family problems; and

- Including the child in a custody dispute and expecting their to act as an intermediary or choose sides between parents, etc.

10. **Parent's explanation for child's injury is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.**
Factors to consider include the child's age, location of injury, developmental needs of the child, and chronicity or severity of injuries. The child's safety may be of immediate concern when:

- The injury requires medical attention, AND medical assessment indicates the injury is likely to be the result of abuse; OR

- A suspicious injury that did not require medical treatment was located on an infant; or, for older children, on the torso, face, head, and/or covered multiple parts of the body; appeared to be caused by an object; or is in different stages of healing;

  AND

- One of the following is true:

  » Parent denies abuse or attributes injury to accidental causes; OR

» Parent's explanation, or lack of explanation, for the observed injury is inconsistent with the type of injury; OR

» Parent's description of the injury or cause of the injury minimizes the extent of harm to the child.

11. Parent refuses access to the child or hinders the investigation, or there is reason to believe that the family is about to flee.

This may be indicated by any of the following situations.

- Family currently refuses access to the child or cannot/will not provide the child's location.
- Family has removed the child from a hospital against medical advice to avoid investigation.
- Family has previously fled in response to a child protection investigation.
- Family has a history of keeping the child at home, away from peers, school, and other outsiders for extended periods of time for the purpose of avoiding investigation.
- Information exists that suggests the parent is intentionally coaching or coercing the child, or allowing others to coach or coerce the child, in an effort to hinder the investigation.

12. Current circumstances, combined with information that the parent has or may have previously maltreated a child in their care, suggest that the child's safety may be of immediate concern.

Current immediate threats to child safety and related previous maltreatment that was severe and/or represents an unresolved pattern must exist in order for this safety threat to be selected.

Previous maltreatment includes any of the following situations.

- Death of a child as a result of maltreatment.
- Serious injury or abuse to a child other than accidental. The parent caused serious injury defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child *and required medical treatment*.
- Unsuccessful reunification in connection with a prior child protection case opening.

- Prior removal/placement of a child by the department or other responsible child welfare agency or concerned party for the safety of the child.

- Prior child protection verification of maltreatment.

- Prior threat of serious harm to a child that involved the parent maltreating the child in a way that could have caused severe injury, retaliation or threatened retaliation against a child for previous incidents, or domestic violence that resulted in serious harm or threatened harm to a child.

- Child protection-recommended services were unsuccessful regarding changes in behaviour.

13. **Other (specify).** This option is for circumstances or conditions that pose an immediate threat of serious harm to a child and are not already described in safety threats 1–12.

SAFETY INTERVENTIONS

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety threats rather than long-term changes. If protective capacities exist, consider whether an in-home safety intervention can be put into place, leaving the child in the home. Please refer to child protection policies whenever applying any of the safety interventions for safety planning.

IN-HOME INTERVENTIONS

1. **Intervention or direct services by social worker.**
   Investigating worker or other child protection staff takes or plans actions, accepted by the parents, that specifically address one or more safety threats. Examples include:

   - Providing information about non-violent disciplinary methods, child development needs, or parenting practices;

   - Providing emergency material aid such as money, food, and infant formula;

   - Planning return visits to the home to check on progress;

   - Providing information on obtaining peace bonds and/or emergency protection orders; and

   - Providing information on child abuse and neglect and discussing the legal implications of abusive and neglectful behaviour.

Intervention DOES NOT INCLUDE the investigation itself or services provided to respond to family needs that do not directly affect safety.

2. **Use of family, neighbours, community elders, traditional healers, or other individuals in the community as safety resources.**
This can include applying the family's own strengths as resources to mitigate safety concerns and/or using extended family members, community elders, neighbours, or other individuals to mitigate safety concerns. Examples include:

   - Family's agreement to use non-violent means of discipline;
   - Engaging community resources (e.g. elders and/or traditional healers) to assist with safety planning such as agreeing to serve as a safety net or meet with the parent in crisis;
   - Engaging a grandparent to assist with child care or contact supervision;
   - Agreement by a neighbour to serve as a safety net for an older child; and
   - Commitment by a 12-step sponsor to meet with the parent daily and call the worker if the parent has used or missed a meeting.

3. **Use of community agencies or services as safety resources.**
Involving community-based organizations, faith-related organizations, or other agencies in activities to address safety concerns (e.g. using a local food bank). DOES NOT INCLUDE long-term therapy or treatment or placement on a waiting list for services.

4. **Parent appropriately protects the victim from the alleged perpetrator.**
A non-offending parent has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator. Examples include:

   - Agreement that the child will not be alone with the alleged perpetrator; and
   - Agreement that the parent will prevent the alleged perpetrator from physically disciplining the child.

5. **Alleged perpetrator leaves the home, either voluntarily or in response to legal action.**
Temporary or permanent removal of the alleged perpetrator. Examples include:

   - Arrest of alleged perpetrator;
   - Non-perpetrating parent requires alleged perpetrator to leave; or
   - Perpetrator agrees to leave.

6. **Non-offending parent moves to a safe environment with the child.** Parent who is not suspected of harming the child has taken, or plans to take, the child to an alternate location where there will be no access to the suspected perpetrator. Examples include:

   - Domestic violence shelter or transition house;
   - Home of a friend or relative; or
   - Hotel.

7. **Legal action planned or initiated—child remains in the home.** A legal action has commenced, or will be commenced, that will effectively mitigate identified safety factors. This includes family-initiated actions (e.g. restraining orders, mental health commitments, changes in custody/visitation/guardianship) and caseworker-initiated actions (e.g. application for a protective intervention order, emergency intervention order, and child remains in the home). *May only be used in conjunction with other safety interventions.*

8. **Parent makes arrangements for the child to stay with a relative or significant other.** The parent agrees to have the child temporarily stay with a relative or other suitable person while safety threats are being addressed. This should only include short-term voluntary agreements made between the parent and the relative or significant other. Examples include but are not limited to:

   - Child staying with a relative or significant other while environmental hazards are addressed;

   - Child staying with a relative or significant other while the offending parent moves to another location; or

   - Child staying with a relative or significant other to deescalate parent-child conflict.

9. **Other.** The family or worker identified a unique intervention for an identified safety concern that does not fit within items 1–7.

PLACEMENT INTERVENTIONS

10. **A child is in need of protective intervention, and a protective care agreement (PCA) is used/signed as an alternative to removal.** A PCA may be considered when:

    - Supportive services and informal care by family or significant others are unavailable or inadequate to ensure the child's safety;

- The social worker and the parent agree that out-of-home care is necessary to ensure child's safety;

- Parent agrees to plan that includes maintaining regular contact and involvement with the child;

- A plan is developed with the parent to reduce the safety threats that cause the child to be in need of protective intervention; or

- Reunification is expected to occur within the six months allowed in the PCA.

11. **Child removed because interventions 1–10 do not adequately ensure the child's safety.** One or more children are placed in the care of the manager of child protection pursuant to Section 20 of CYFA Act.

NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF CHILDREN, SENIORS AND SOCIAL DEVELOPMENT
CASE SUMMARY
POLICY AND PROCEDURES

The purpose of the Case Summary is to:

1) Summarize and analyze the department's involvement at each review period

2) Identify the decision regarding the progress made by the family, the child's need for protective intervention and current protection concerns if the child continues to be in need of protective intervention.

Which Cases
All cases receiving ongoing protective intervention services.

Who
The social worker responsible for the case.

When
Initial Case Summary: four months from completion of the initial FCAP form

Review Case Summaries: four months from the completion of the last Case Summary

An updated Case Summary must be completed in order to close a case if a case closes in the middle of a review period.

Appropriate Completion

Please refer to *Standard #7: Case Management in Ongoing Protective Intervention Services* in the Structured Decision Making® Practice Standards Manual for standards and practice considerations.

Header Information

Enter the case open start date, case number and ISM number.
Parent
Enter the name of the primary parent, address, date of birth and select role from a drop down menu. Enter the same for the secondary parent, if applicable.

Other Parent
If there is another parent who is not part of the household (e.g. biological parent is not part of the household), please enter the date of birth, address and select the role from a drop down menu.

Child/Children:
Enter the name of the child(ren), date of birth, and select from a drop down menu to indicate with whom the children are living.

Additional Household Members Not Identified Above
Indicate the name and date of birth of other household members other than the primary parent, secondary parent and children. Select role from the drop down menu. There is space in this section to further describe the household member's relationship to the child and family.

SECTION 1: Referrals Received Since Last Case Summary
The information in this section will need to be completed for each referral that was received since the last case summary. If this is the first case summary, identify any referrals that were received since the file transferred from assessment to ongoing protective intervention services. Document the referral date and use the drop down menu to select the protection concern. Then indicate whether or not this concern was verified. Indicate the most recent risk rating.

If referrals were not received during this review period, this section is not required.

SECTION 2: Risk Rating for Last Completed Case Summary

Identify the risk rating from the last Case Summary. If this is the first Case Summary, indicate the risk rating that was identified on the Protection Investigation Summary.

SECTION 3: Outcome of Risk Reassessment and/or Reunification Assessment
To complete this section, a risk reassessment or reunification assessment must be completed for this review period. Document the risk rating from the applicable assessment. If a reunification assessment was completed, identify the outcome of the assessment.

SECTION 4: List of Family's Strengths and Needs
Identify the top three family strengths and needs by selecting from the drop down menus. Identify the top three child strengths and needs (for each child) by selecting from the drop down menus. Do not complete this section if the case is closing.

SECTION 5: Decision Regarding Child's Need for Protective Intervention and Current Protection Concerns
If it is determined that a child is still in need of protective intervention, select this option and describe the concerns that need to continue to be addressed. If the case is closing, select the appropriate option. Please see Standard #8: *Case Closure – Ending Ongoing Protective Intervention Services* in the Structured Decision Making® Practice Standards Manual for further information.

SECTION 6: Case Summary
Please refer to *Standard #7: Case Management in Ongoing Protective Intervention Services* in the Structured Decision Making® Practice Standards Manual for further information on what to include in this section.

The social worker shall sign this form and the clinical program supervisor will approve it.

Newfoundland Labrador
Children, Seniors and Social Development

Case Summary

Case Open Start Date: _____ File #:_____ ISM ID:_____

Parents

Primary Parent	Role	Date of Birth	Address

Secondary Parent	Role	Date of Birth	Address

Other Parent(s) Not in Household (i.e. biological parents who are not part of household)

Name	Date of Birth	Address

Child/Children

Child's Name	Date of Birth	With Whom Living

Additional Household Members not Identified Above

Name	Role	Date of Birth

Section One - Referrals Received Since Last Case Summary

Referral Number	Referral Name	Protection Concern	Verified	Risk Level
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Section Two - Risk Rating for Last Completed Case Summary

Risk Rating for Previous Case Summary (if applicable)

- ◯ **Low Risk**
- ◯ **Moderate Risk**
- ◯ **High Risk**
- ◯ **Very High Risk**

Section Three - Outcome of Risk Assessment and/or Reunification Assessment

Risk Reassessment rating:

- ◯ **Low Risk**
- ◯ **Moderate Risk**
- ◯ **High Risk**
- ◯ **Very High Risk**

Risk Rating from Reunification Assessment:

- ◯ **Low Risk**
- ◯ **Moderate Risk**
- ◯ **High Risk**
- ◯ **Very High Risk**

Reunification Assessment Outcome:

- ◯ **Return Home**
- ◯ **Maintain Placement and Reunification Services**
- ◯ **Change Goal from Reunification**

Section Four - List of Family's Strengths and Needs (if applicable)

Top 3 Parent Strengths:

Primary Parent Name: _____

1.
2.
3.

Secondary Parent Name: _____

1.
2.
3.

Top 3 Parent Needs:

Primary Parent Name: _____

1.
2.
3.

Secondary Parent Name: _____

1.
2.
3.

Top 3 Child Strengths:

Child Name: _____

1.
2.
3.

Top 3 Child Needs:

Child Name: _____

1.
2.
3.

Section Five - Decision Regarding Child's Need for Protective Intervention and Current Protection Concerns

Protective Intervention Decision:

◯ **Child(ren) continues to be in need of Protective Intervention - continue with Ongoing Protective Intervention Services.**

If child is still in need of protective intervention, what are the protection concerns that continue to be addressed?

_____

_____

_____

◯ **Child(ren) not in need of protective intervention - end Ongoing Protective Intervention Services and close case.**

◯ **Child is no longer in need of protective intervention because the court has determined a child is not in need of protective intervention and CSSD has determined that no further intervention is required - close case.**

◯ **Case closure due to exceptional circumstances:**

- ◯ **Family moved out of province -** select this code if the family has left province without our knowledge or prior planning regarding the move.
- ◯ **Youngest child turned 16 -** select this code if the child in need of protective intervention has now turned 16 years of age.
- ◯ **Child is not returning home -** select this code if the child in need of protection is in the continuous custody of a manager and there are no other children in the home in need of protection.
- ◯ **Child deceased -** select this code if the child in need of protective intervention has died during our involvement with the family and there are no other children in need of protective intervention residing in the home.

Section Six - Case Analysis

Social Worker: Date completed:

Supervisor: Supervisor approval date:

Supervisor comments, if required:

Appendix A

Original FSNA

Newfoundland Labrador
Children, Seniors and Social Development

SDM Family Strengths and Needs Assessment For Parents and Children

☐ FSNA is not required because file is closing

Household Name:	File #:	Date of Assessment (YYYY-MM-DD):

Worker:	Region:	Initial or Reassessment #:

The following items should be considered for each family/household member. Worker should base the score on his/her assessment for each item, taking into account the family's perspective, child's perspective where appropriate, worker observations, collateral contacts, and available records. Refer to accompanying definitions to determine the most appropriate response. Enter the score for each item.

A. PARENT - Rate each parent

Primary Parent:

SN1 - Substance Use (Substances: alcohol, solvents, illegal drugs, inhalants, prescription/over-the-counter drugs):

SN2 - Household Relationships/Domestic Violence:

SN3 - Social Support System:

SN4 - Parenting Practices:

SN5 - Mental Health/Coping Skills:

SN6 - Cognition:

SN7 - Resource Management/Basic Needs:

SN8 - Cultural Identity:

SN9 - Physical Health:

SN10 - Prior Trauma:

SN11- Other identified Parent Strength/Need (not covered SN1-SN10):

Comments

Secondary Parent:

☐ No Secondary Parent

SN1 - Substance Use (Substances: alcohol, solvents, illegal drugs, inhalants, prescription/over-the-counter drugs):

SN2 - Household Relationships/Domestic Violence:

SN3 - Social Support System:

SN4 - Parenting Practices:

SN5 - Mental Health/Coping Skills:

SN6 - Cognition:

SN7 - Resource Management/Basic Needs:

SN8 - Cultural Identity:

SN9 - Physical Health:

SN10 - Prior Trauma:

SN11- Other identified Parent Strength/Need (not covered SN1-SN10):

Comments:

B. CHILD - Rate each child according to the current level of functioning

Child Name:

Child DOB (YYYY-MM-DD):

CSN1 - Emotional/Behavioural Health:

CSN2 - Physical Health/Disability:

Does child have a specialized educational plan? ◯ Yes ◯ No Describe:

CSN3 - Education:

CSN4 - Family Relationships:

CSN5 - Child Development:

CSN6 - Alcohol/Drugs:

CSN7 - Trauma:

CSN8 - Peer/Adult Social Relationships:

CSN9 - Criminal Behaviour (Delinquent behaviour includes any action that, if committed by an adult, would constitute a crime)

CSN10 - Other Identified Child Strength/Need (not covered in CSN1-CSN9):

Comment:

Child Name:

Child DOB (YYYY-MM-DD):

CSN1 - Emotional/Behavioural Health:

CSN2 - Physical Health/Disability:

Does child have a specialized educational plan? ◯ Yes ◯ No Describe

CSN3 - Education:

CSN4 - Family Relationships:

CSN5 - Child Development:

CSN6 - Alcohol/Drugs:

CSN7 - Trauma:

CSN8 - Peer/Adult Social Relationships:

CSN9 - Criminal Behaviour (Delinquent behaviour includes any action that, if committed by an adult, would constitute a crime)

CSN10 - Other Identified Child Strength/Need (not covered in CSN1-CSN9):

Comment:

Child Name:

Child DOB (YYYY-MM-DD):

CSN1 - Emotional/Behavioural Health:

CSN2 - Physical Health/Disability:

Does child have a specialized educational plan? ◯ Yes ◯ No Describe

CSN3 - Education:

CSN4 - Family Relationships:

CSN5 - Child Development:

CSN6 - Alcohol/Drugs:

CSN7 - Trauma:

CSN8 - Peer/Adult Social Relationships:

CSN9 - Criminal Behaviour (Delinquent behaviour includes any action that, if committed by an adult, would constitute a crime)

CSN10 - Other Identified Child Strength/Need (not covered in CSN1-CSN9):

Comment:

C. PRIORITY NEEDS AND STRENGTHS

Enter item number and description of up to three most serious needs (d and c) and greatest strengths (a and b) from Section A (items SN1-SN9) for each parent (P=Primary), S=Secondary, B=Both).

	Parent Priority Areas of Need	P	S	B			Parent Priority Areas of Strength	P	S	B
1.		◯	◯	◯		1.		◯	◯	◯
2.		◯	◯	◯		2.		◯	◯	◯
3.		◯	◯	◯		3.		◯	◯	◯

Rationale for selecting parent priority needs:

Rationale for selecting children's needs:

Note: All identified child needs must be addressed in the case plan.

Social Worker Name:

Date Form Completed (YYYY-MM-DD)

Supervisor Name:

Date of Supervisor Approval (YYYY-MM-DD)

Appendix B

Practice Standards

Department of Families and Affordability

Structured Decision Making Model

Practice Standards

March 2018

(Revised July 3, 2025)

Newfoundland Labrador

STRUCTURED DECISION MAKING MODEL

Table of Contents

ACKNOWLEDGEMENTS

The customization of the Structured Decision Making (SDM) Model (2016) would not have been possible without the following:

- The leadership and direction of Provincial Director, Michelle Shallow and the SDM Project Team working in partnership with Evident Change (formerly the Children's Research Center (CRC) and the SDM Work Group to customize and implement the most research informed decision making model available in child welfare for this province. Members included Joanne Cotter (Project Manager, Provincial Office), Meghan Hillier-Calder (Policy and Program Development Specialist, Provincial Office), and Erin Daley (Policy and Program Development Specialist, Provincial Office);

- Members of the SDM Work Group who volunteered their time and expertise to work with Evident Change and the SDM Project Team to inform a manual that is reflective of the needs of frontline child protection practice and effective service delivery. Members of the SDM work group included: Joanne Rose (Provincial Office), Mary Lou Lambert (Metro region), Lisa Goulding (Metro region), Shirley Pye (Metro region), Wally Fry (Central East region), Vanessa Edison (Central East region), Angela Bennett (Western region), Ashley Mullins (Western region), Nicole Larsh (Western region), Lenora Barry (Labrador region), and Kristin Eddy (Labrador region);

- Evident Change who diligently worked in partnership with the former Department of Child, Youth and Family Services (CYFS) representatives from Provincial Office and all four regions to customize and implement the SDM model for Newfoundland and Labrador;

- Provincial and Regional departmental staff who provided feedback throughout the customization process;

- Departmental Executive of the former CYFS for their leadership and assistance; and,

- Other jurisdictions, in particular British Columbia, Saskatchewan, and New Brunswick for sharing their experiences, policies, standards, and best practices to assist in the development of this manual.

INTRODUCTION

Structured Decision Making (SDM) is a comprehensive assessment and case management framework for child protection services that uses a series of assessment tools to assist social workers make critical decisions from whether to investigate a report of child maltreatment to deciding when to close a child protection case. SDM is currently the most research informed model available to child protection agencies.

Evident Change (formerly the Children's Research Center) (CRC) works in partnership with child-serving agencies to improve direct practice and organizational operations through models that integrate evidence- based assessments, family- centered engagement strategies, and implementation science.

The purpose of the SDM model is to promote ongoing safety and well-being while improving outcomes for children and families involved with the Protective Intervention Program. The decision model is a framework for practice and is consistent with the purpose and guiding principles of the Children, Youth and Families Act (CYFA).

Guiding Principles of the SDM model include:

1. Maintaining a strong focus on child safety, well-being, and permanence;
2. Strengthening assessment and enhancing the consistency and objectivity of decisions through a structured decision making process;
3. Integrating the use of clinical tools with professional practice;
4. Ensuring children and families are engaged in service planning, particularly in the development of formal plans such as the Safety Plan and Family Centered Action Plan (FCAP);
5. Building on a family's existing strengths and capacities to care for their children;
6. Linking interventions with reducing the future risk of maltreatment;
7. Utilizing both formal (community supports or the community as a whole) and informal (family, friends) supports in service planning and provision; and
8. Increasing the emphasis on engaging children and families in service.

SDM is an evidence and research-based model that identifies the key points in the life of a child protection case and uses structured assessments to improve the consistency and validity of each decision. SDM encourages the engagement of the child, family and their support system in decision making and service planning. Client engagement is not viewed as an end, rather as a means of effectively assessing and securing the safety of the child.

Responsibility for case decisions is shared by the social worker and the relevant supervisor. These standards reflect this joint responsibility. There are many references to the requirement for supervisory consultation prior to case decisions being made, as opposed to supervisory approval subsequent to those decisions. Distinctions are drawn throughout the manual between decisions requiring consultation and those requiring supervisory approval.

Child Protection Standards in Newfoundland and Labrador

The following standards guide the social workers and clinical program supervisors in their practice, including critical decisions, at each phase of service delivery; starting from intake, through assessment, onto ongoing protection, and finally termination/completion of child protection services. The final standard focuses on the process of supervision between a social worker and a clinical program supervisor that occurs throughout all phases of service.

The standards are organized to describe the activities that are required during distinct phases of child protection service, but do not prescribe how the Department of Families and Affordability (FAMA), herein referred to as the Department, will organize or structure its staff to provide the service.

The format for the nine key decisions include:

1. **Standards** – outlines the specific tasks or activities that are performed by the social worker. The standard will provide the minimum baseline for measuring the level of performance within the Department's accountability framework for child protection. Standards state what families and the public can expect.

2. **Intent of Standard** – outlines the rationale for each standard.

3. **Outcomes of Standard** – articulates the desired outcomes for children and families specifically related to each standard.

4. **Procedures** – precise, step by step actions that must be done to complete a task or activity. These are the rules of action outlining who does what task and the required times.

5. **Practice Considerations** – in contrast to the standards and procedures, practice considerations are only guidelines for practice and are not used as a measure of performance. They provide further information about a certain task, activity or function to consider when making a decision,

6. **References/Documents** – tools contain specific information to support professional practice and guide specific decisions at different points in the life of a case.

Foster Home and Residential Investigations

Allegations of child abuse/neglect in foster homes will follow Policy 4.13: Foster Home Investigations as outlined in the Protection and In Care Policy and Procedure Manual.

Allegations of child abuse/neglect in residential settings will follow Policy 4.17: Staffed Residential Placement Resources: Investigations as outlined in the Protection and In-Care Policy and Procedures Manual.

GLOSSARY OF TERMS

Approval	A supervisor's agreement of a case decision including a signature on a written Structured Decision Making document or case related form.
Day	Every day (except Saturdays, Sundays, and government holidays) unless the time period specified is six (6) days or more in which case "days" means calendar days.
Child	A person actually or apparently under the age of 16 years (Subsection 2(1)(d) of the CYFA).
Child Maltreatment	The omission or commission of an action by a parent that results in injury or harm to a child, or the injury or harm of a child by another person and the parent does not protect the child. Child maltreatment includes physical, sexual, emotional abuse, or neglect of a child.
Child Protection Referral	Information of alleged maltreatment of a child that is received and screened using the Screening and Response Time Assessment (SRTA).
Collateral Source or Contact	A person, professional or agency that is connected to the child or family that may have information about the alleged maltreatment and/or about the child and family in general. The information can assist in clarifying and confirming information about significant events or issues which have been provided by parents and children.
Consultation	A meeting either verbally or in person to discuss or collaborate on case specific issues.
Family Centered Action Plan	A written agreement developed collaboratively with parents to guide interventions to change conditions or behaviors that create risk to a child.
Family Strengths and Needs Assessment	The family strengths and needs assessment (FSNA) is used to evaluate the presenting strengths and needs of each family. This assessment tool is used to systematically identify critical family needs, and it helps plan effective service interventions.
Household	All persons who live in the home and interact with the child. An individual who does not live in the home, but who has an intimate relationship with a parent in the home and interacts with the child, can be considered a member of that household. When a child's parents do not live together, the child may be a member of two households.

Ongoing Protective Intervention Services	Services and interventions provided by the Department to children (and their families) determined to be in need of protective intervention due to a risk of future maltreatment.
Override	A decision to change the recommendation on a particular SDM tool based on policy direction or professional judgment.
Parent	Refers to (subsection 2(1)(x) of the CYFA): • The custodial mother or father of a child, • A custodial step-parent, • A non-custodial parent who regularly exercises/attempts to exercise rights of access, • A person to whom custody of a child has been granted by a written agreement or by a court order, or • A person who is responsible for the child's care and with whom the child resides, except a foster parent.
Permanency	Refers to a child/youth having legal and relational permanence. Legal permanence is defined as a child/youth remaining with or reunifying with family; being adopted or transferring custody. Relational permanence is ensuring that each child/youth has an enduring family or family-like relationship that is safe and stable; provides for the physical, emotional, social, cultural, and spiritual wellbeing of the child/youth; and is meant to last a lifetime.
Permanency Planning	The systematic process of carrying out goal directed activities designed to help a child live in a permanent family meant to last a lifetime.
Plan for the Child	The plan for the child(ren) (in accordance with Section 29 of the CYFA) that is filed with the court after a social worker has filed an Application for Protective Intervention Hearing requesting a supervision or custody order. The Plan for the Child outlines prior involvement with the child(ren) and family – the child protection concerns, and the recommended services and interventions to address these concerns. In cases where the child(ren) has been removed and is in care, the Plan for the Child outlines the efforts planned to maintain the child(ren)'s contact with the parent, family, or other person significant to the child(ren) and a description of the arrangements made or being made to recognize the importance of the child(ren)'s identify and cultural connections.
Primary Parent	Please refer to General Definitions, page 2, of the SDM Policy and Procedures Manual.
Protective Factors	Conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities.

Protection Investigation	The process of responding to a complaint of alleged child maltreatment to assess the immediate safety of the child and risk of future maltreatment to the child, and to determine the child's need for protective intervention. It involves interviewing and observing the child in need of protective intervention and interviewing their siblings, parents, and collateral sources; gathering information through the agency's records and through checks with the police, school, school, medical records, and any other means necessary. Depending on the allegation, the investigation may require joint interviews with the police.
Protective Investigation Plan:	The plan for conducting the protection investigation. It minimally identifies the social worker assigned to the investigation; identifies who will conduct the interviews; when and where the interviews will be conducted; what collaterals may be relevant and required to complete the investigation; and whether police involvement will be required.
Reasonable Grounds	There is some reasonable and reliable information upon which a social worker determines that a child may be in need of protective intervention.
Referral Source:	Any individual who reports concerns of alleged abuse or maltreatment of a child to the Department under Section 11 of the CYFA. The referral source may be a self-identified person or a person who wishes to remain anonymous.
Removal	A legal procedure whereby a child/youth, believed to be in need of protective intervention, has been removed from his/her parent's care and placed in the interim care of a manager until a judge makes an order at the Presentation Hearing.
Risk Assessment	The process of assessing future maltreatment of a child. The risk assessment is based on research cases with verified abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent verified abuse and neglect. The assessment tool does not predict recurrence but simply assesses whether a family is more or less likely to have another incident without intervention by the agency.
Safety Assessment	Safety assessment assesses the child's immediate danger and helps determine what interventions should be initiated or maintained to protect the child.
Safety Plan	A plan developed collaboratively with a family to address specific safety threats identified until a more comprehensive risk assessment and case plan can be completed.
Screening and Response Time Assessment	A tool to assist a social worker's professional assessment of information when screening and assigning a response priority to child protection referrals.

Secondary Parent	Please refer to General Definitions, page 2, of the SDM Policy and Procedures Manual.
Third Party	An individual other than a parent who allegedly maltreats a child. A third party is usually but not always an adult and may also include children in the household and/or in the community.
Third Party Maltreatment of a Criminal Nature	Maltreatment of a child/youth by someone other than the child/youth's parent (e.g. neighbor, family member, community member, teacher, coach). Third-party maltreatment of a criminal nature includes: a) physical abuse or risk of physical abuse; b) sexual abuse or risk of sexual abuse; and/or c) exploitation (e.g. sex trafficking) or risk of exploitation.

DEFINITION OF CHILD IN NEED OF PROTECTIVE INTERVENTION

Section 10 of the **Children, Youth and Families Act** states that a child is in need of protection when the child:

1.

(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent;

(b) is being, or is at risk of being, sexually abused or exploited by the child's parent;

(c) is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent;

(d) is being, or is at risk of being, physically harmed by a person and the child's parent does not protect the child;

(e) is being, or is at risk of being, sexually abused or exploited by a person and the child's parent does not protect the child

(f) is being, or is at risk of being, emotionally harmed by a person and the child's parent does not protect the child;

(g) is in the custody of a parent who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner;

(h) is abandoned;

(i) has no living parent and no adequate provision has been made for the child's care;

(j) has no parent available to care for the child and the parent has not made adequate provision for the child's care;

(k) has no parent able or willing to care for the child;

(l) is living in a situation where there is violence or is living in a situation where there is a risk of violence;

(m) is living with a parent whose actions show a propensity to violence or who has allegedly killed or seriously injured another person;

(n) has a parent who exercises access whose actions show a propensity to violence or who has allegedly killed or seriously injured another person;

(o) has been left without adequate supervision appropriate to the child's developmental level; or

(p) is actually or apparently under 12 years of age and has

- allegedly killed or seriously injured another person or has caused serious damage to another person's property, or
- on more than one occasion caused injury to another person or other living thing or threatened, either with or without weapons, to cause injury to another person or other living thing, either with the parent's encouragement or because the parent does not respond adequately to the situation.

2. For the purposes of paragraphs (1)(c) and (f), the indicators of emotional harm exhibited or demonstrated by a child may include:

   (a) Depression,

   (b) Significant anxiety,

   (c) Significant withdrawal,

   (d) Self-destructive behavior, or

   (e) Aggressive behavior, or

   (f) Delayed development.

3. For the purposes of paragraphs (1)(c), parental conduct or living situations that may lead to emotional harm or risk of emotional harm to the child may include:

   (a) Rejection,

   (b) Social deprivation,

   (c) Deprivation of affection,

   (d) Deprivation of cognitive stimulation,

   (e) Subjecting the child to inappropriate criticism, threats, humiliation, accusations or expectations,

   (f) Living in a situation where the mental or emotional health of a parent is negatively affecting the child,

   (g) Living in a situation where a parent is an abuser of alcohol or drugs, or

   (h) Living in a situation where there is violence.

4. Maltreatment types as identified in the Screening and Response Time Assessment correspond with Section 10 of the CYFA. Below is a comparison chart of SDM maltreatment types and allegations as listed in the CYFA.

Children Youth and Families Act and Maltreatment Category Crosswalk Chart

This crosswalk chart serves as a guide for social workers and supervisors when initiating court applications so that the Screening and Response Time maltreatment categories can be linked to the ground for a child to be in need of protection in the **Children Youth and Families Act.**

Physical Abuse	
Maltreatment Categories	**Sections of Children Youth and Families Act (CYFA)**
Suspicious death of a child due to abuse, and another child in care parent	10(1)(a) Is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
Non-accidental physical injury	10(1)(a) Is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
Unexplained or suspicious physical injury	10(1)(a) Is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
Parent giving the child toxic chemicals, alcohol or drugs	10(1)(a) Is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
Parent has acted in a way or threatened to act in a way that is likely to cause injury	10(1)(a) Is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
Propensity to violence	10(1)(a) Is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent. 10(1)(c) Is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent. 10(1)(m) Is living with a parent whose actions show a propensity to violence or who has allegedly killed or seriously injured another person. 10(1)(n) Has a parent who exercises access

	whose actions show a propensity to violence or who has allegedly killed or seriously injured another person
Emotional Abuse	
Maltreatment Categories	**Sections of Children Youth and Families Act (CYFA)**
Parental action has or is likely to emotionally harm the child	10(1)(c) Is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent.
Exposure to violence in the home or between parents	10(1)(c) Is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent. 10(1)(l) Is living in a situation where there is violence .
Sexual Abuse	
Maltreatment Categories	**Sections of Children Youth and Families Act (CYFA)**
Parent engaging or in attempting to engage in a sexual act or sexual contact with child	10(1)(b) is being, or is at risk of being, sexually abused or exploited by the child's parent.
Sexual exploitation of a child by a parent	10(1)(b) is being, or is at risk of being, sexually abused or exploited by the child's parent.
Exposure to sexually explicit conduct or sexually explicit materials	10(1)(b) is being, or is at risk of being, sexually abused or exploited by the child's parent.
Physical, behavioral, or suspicious indicators consistent with sexual abuse	10(1)(b) is being or is at risk of being, sexually abused or exploited by the child's parent.
Threat of sexual abuse	10(1)(b) is being, or is at risk of being, sexually abused or exploited by the child's parent.

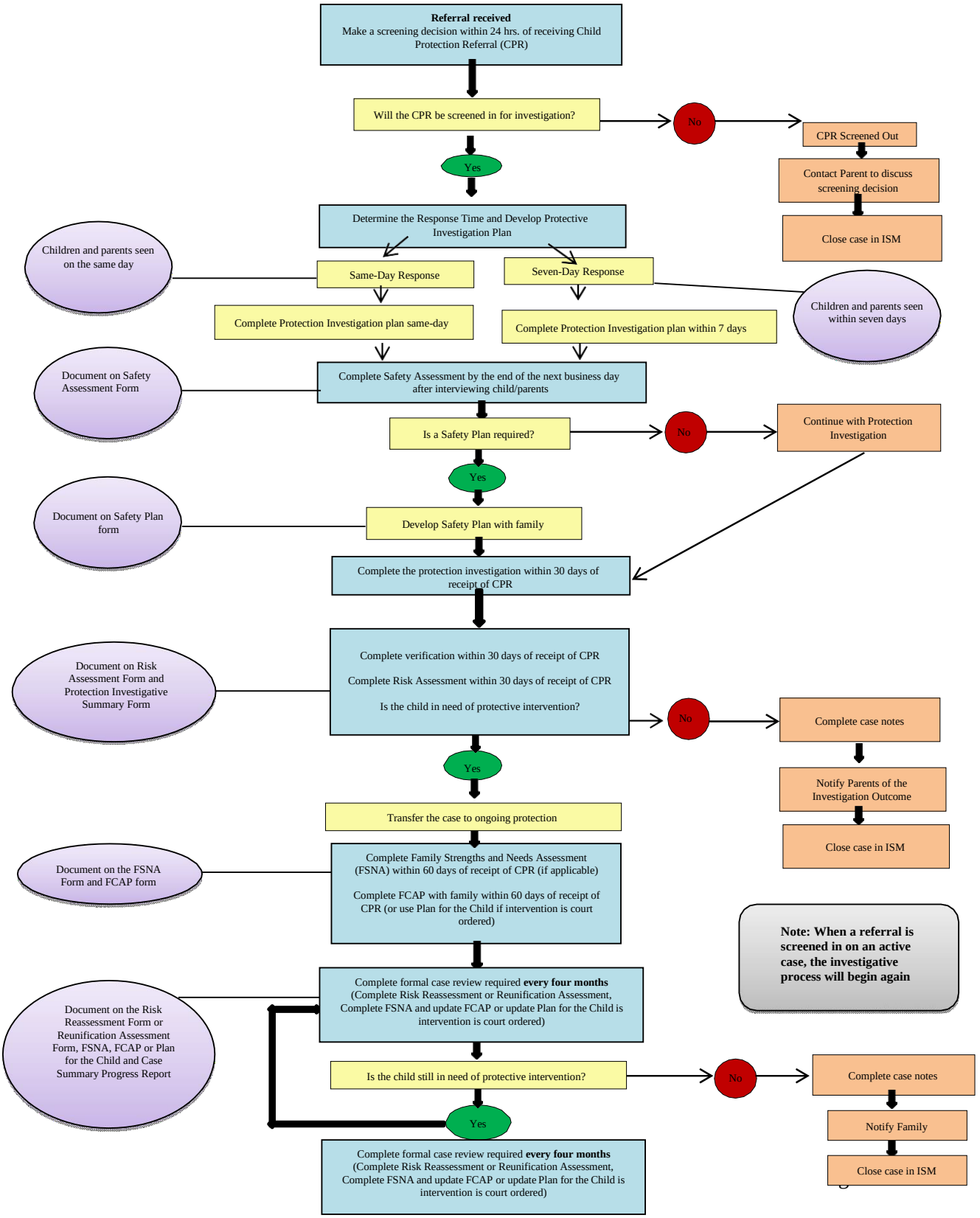
Neglect	
Maltreatment Categories	**Sections of Children Youth and Families Act (CYFA)**
Suspicious death of a child due to neglect, and another child is in the care of a parent	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent. 10(1)(c) is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent.
Abandonment or unwilling/unable/unavailable parent	10(1)(h) is abandoned. 10(1)(i) has no living parent and no adequate provision has been made for the child's care. 10(1)(j) has no parent available to care for the child and parent has not made adequate provision for the child's care. 10(1)(k) has no parent able or willing to care for the child.
Inadequate supervision	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent. 10(1)(c) is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent. 10(1)(o) has been left without adequate supervision appropriate to the child's developmental level.

Neglect Continued	
Maltreatment Categories	**Sections of Children Youth and Families Act (CYFA)**
Failure to protect against physical, emotional and sexual abuse	10(1)(d) is being, or is at risk of being, physically harmed by a person and the child's parent does not protect the child. 10(1)(e) is being, or is at risk of being, sexually abused or exploited by a person and the child's parent does not protect the child. 10(1)(f) is being, or is at risk of being, emotionally harmed by a person and the child's parent does not protect the child. 10(1)(l) is living in a situation where there is violence or is living in a situation where there is a risk of violence.
Failure to thrive	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent . 10(1)(c) is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent. 10(1)(g) is in the custody of a parent who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner .

Neglect Continued	
Maltreatment Categories	**Sections of Children Youth and Families Act (CYFA)**
Inadequate medical, dental, and/or mental health care	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent. 10(1)(c) is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from actions, failure to act or pattern of neglect on the part of the child's parent. 10(1)(g) is in the custody of a parent who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner.
Inadequate clothing or hygiene	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent. 10(1)(c) is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent.
Inadequate food/nutrition	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
Exposure to unsafe home and immediate environment	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
Child under 12 year committing serious offence	10(1)(p)(i)Allegedly killed or seriously injured another person or has caused serious damage to another person's property.

Neglect Continued	
Maltreatment Categories	**Sections of Children Youth and Families Act (CYFA)**
Inadequate response to child, under 12 years, committing a pattern of serious offences	10(1)(p)(ii) on more than one occasion caused injury to another person or other living thing or threatened, either with or without weapons, to cause injury to another person or other living thing, either with the parent's encouragement or because the parent does not respond adequately to the situation.
Exposure to illegal drug activity	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent. 10(1)(c) is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent.
Involving child in criminal activity	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent. 10(1)(c) is being, or is at risk of being, emotionally harmed by the parent's conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act or pattern of neglect on the part of the child's parent.
Newborn exposure or risk of exposure to drugs or alcohol	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
Other High Risk Birth	10(1)(a) is being, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.

Case Management Flow Chart



STANDARD # 1	SCREENING THE INFORMATION - ENGAGING THE REFERRAL SOURCE
STANDARD	All information of alleged child maltreatment received by the department is considered a Child Protection Referral (CPR). A social worker shall engage the referral source to obtain as much information as possible about the alleged child maltreatment to make a screening decision. Other individuals may also be contacted for information to inform the screening decision if it is believed they can provide more information. A social worker shall use the Screening and Response Time Assessment (SRTA) tool to assess the information received and, in consultation with a supervisor, to determine the screening decision within 24 hours of receipt of the CPR. The final screening decision will fall into one of two categories: 1. Screen In for Protection Investigation; OR 2. Screen Out – No Protection Investigation Required. A social worker shall refer all alleged physical and sexual abuse concerns, whether the information is screened or out in accordance with SDM, to the applicable policing agency immediately. Further information on police involvement in child maltreatment cases can be found in Policy 1.5: **Police Involvement** in the Protection and In Care Policy and Procedure Manual. If information is related to **third-party maltreatment of a criminal nature**, a social worker shall document the information on the **Third-Party Maltreatment Information for Police** form and immediately report to the police. Further information on third-party maltreatment of a criminal nature can be found in **Policy 7.4** in the Protection and In Care Policy and Procedure Manual. If a CPR is screened out, a social worker, in consultation with a supervisor, shall contact the parent alleged to have maltreated the child to advise them of the screening decision and, where appropriate, discuss resources in the community that may assist the parent and their family. If a CPR is screened out and the children are on another active Protective Intervention Program (e.g. screened out referral received on mom and children have an active PIP with their dad), the social worker who screened out the referral shall notify the children's active PIP social worker of the screened out referral. All information obtained shall be documented on the CPR form as soon as possible and no later than 24 hours of receipt of the information.

	A supervisor shall review and approve the CPR form within 24 hours of receipt of referral.
INTENT OF STANDARD	The purpose of gathering information about the alleged maltreatment and the child and family is to: 1. Establish the credibility of the referral concerns; 2. Determine if the information meets the threshold for a CPR or a General Request for Information/Inquiry; 3. To inform screening decision; and 4. Obtain information that will be beneficial for the investigation and future collaboration with the family.
OUTCOMES	1. Completing the SRTA will provide a thorough and comprehensive collection of relevant information including an accurate description of the reported incident or condition. 2. The screening process begins with the assessment of: • Immediate safety threats to a child(ren). Refer to Standard #4 for more information about assessing child safety. • Child and family functioning (current and historical). • The need for child protective intervention and/or services. 3. Ensure the referral source understands their on-going duty to report, and 4. Families receive a timely and appropriate response to referrals regarding the safety and well-being of their children.
PROCEDURES	**Screening Criteria** When screening information, a social worker shall consider whether: 1. The subject of the information is a child as defined in the Children, Youth and Families Act (CYFA); 2. The information meets a definition of child maltreatment as outlined in the SRTA; 3. The information provided is credible and motivated by genuine concern for the child and family, and 4. The child and family are located within the region's jurisdiction. If the child and family do not reside within the region's jurisdiction, a social worker shall obtain information from the referral source and refer the matter to the appropriate regional intake social worker for screening and follow up. If a referral source is reporting concerns regarding a youth as defined in section 2(1)(ff) of the CYFA, a social worker shall provide information about the Youth Services Program to the referral source including that: 1. It is a voluntary program; 2. Youth should be encouraged to self-refer for service; and

PROCEDURES CONTINUED	3. A referral may only be made on behalf of a youth if they agree to it. Where information is received regarding concerns for a youth and the referral source indicates that mental capacity may be an issue, a social worker shall record the information and initiate contact with the youth to complete an assessment in accordance with the Policy 5.2: Assessing Service Eligibility and Determining a Youth's Need for Protective Intervention in the Protection and In Care Policy and Procedure Manual. Information from individuals contacting the department in error or calling to obtain information about community resources does not constitute a CPR and does not need to be documented on the CPR form. For more information, refer to page 25, Assessing and Documenting the Information, General Request for Information/Inquiry. **Engaging the Referral Source** Written referrals are also received (e.g. email, police report) outlining concern of maltreatment of a child. If written information is received, a social worker shall review and determine if the referral source needs to be contacted for any of the information outlined above that may be missing from the written referral. Sometimes referrals are received from individuals wanting to remain anonymous. In those situations, a social worker shall encourage the referral source to disclose their identity and provide contact information in case the social worker needs to obtain further information at a later date. There are times when the information known by a referral source (or other individuals contacted) is limited and may cover only some of the areas outlined above. A screening decision will still need to be made based on the information known at the time of the referral. **A social worker shall document all questions asked of the referral source on the CPR form even if the referral source was unable to provide the information requested.** A social worker shall also ask the referral source whether they want their identity to be kept confidential and record their response on the CPR form. This is an important question to ask as some referral sources (e.g. professionals working with the family, family members) are open to the release of their name as a referral source. In these situations, the identity of the referral source does not need to be kept confidential. Further information regarding the documentation of referral sources in a client file can be obtained from the department's Documentation Guide, Appendix D, Policy 7.2: File Documentation.

PROCEDURES CONTINUED	**Obtaining Detailed Information from the Referral Source**

1. When obtaining information of alleged maltreatment, the social worker engages the referral source to:

2. Obtain the name, present location and contact information for every child whom the caller believes may need protection;

3. Obtain the name, present location and contact information for the child's parent/caregiver and other family members such as siblings;

4. Obtain the name, and contact information of the person alleged to have caused the need for protection, if not a family member, including their relationship to the child;

5. Obtain a full and detailed report of the incident(s) or circumstance that cause the caller to be concerned that the child may need protection;

6. Obtain information about the alleged perpetrator's ability to access the victim today and in the future;

7. Obtain information about the child and family's strengths and sources of support (kin, significant others, or community professionals who have been or currently are supports for the family) including their contact information;

8. Obtain information about factors present that may affect the personal safety of a social worker going to the client's home (family known to have a dangerous pet, individual possess firearms, individual with a history of harming others, selling drugs from the home, etc.);

9. Obtain other information required to complete the CPR form, on all family members and other individuals living in the home such as primary language, ethnicity or cultural beliefs;

10. Obtain information about the referral source's relationship to the child and family;

11. Assess the referral source's motivation and the credibility of information provided;

12. Provide information about the referral source's ongoing duty to report;

13. Request contact information for the referral source in case the social worker needs to contact them at a later date for clarifying information; and

PROCEDURES CONTINUED	14. Explain the CYFA requirement for confidentiality of referral source names, if requested, and the limits to confidentiality. Where possible, useful information to obtain from the referral source includes the following: 1. The situation/circumstances which prompted the referral source to call; 2. Sources of information (did they observe an incident or obtain second hand information); 3. Exploration of opinions made by referral source to determine on what the opinion is based; 4. Any actions taken by the referral source or others to intervene in family; 5. Length and severity of alleged maltreatment; 6. Whether previous incidents of maltreatment have occurred ; 7. If the family is aware of the referral; 8. Ethnic or cultural considerations; 9. Individual and family strengths including time when the family may cope well, when parents may interact positively with their children and so forth; 10. Others who may have information about the incident, the child and family and their sources of support; 11. Quality of parental relationship; and 12. Quality of parent - child relationship. **Obtaining Additional Information/Records Check** A social worker may contact other individuals for information to make the screening decision, especially in cases where the information lacks detail and the screening decision cannot be easily made. Examples include contacting a neighbor or a community professional involved with the family. When information is received about alleged maltreatment of a child by a third party and it is unclear whether the parent has acted or will act to protect the child, the social worker **shall** contact the parent to assess their protectiveness in order to make a screening decision. A social worker shall complete a check of the Integrated Service Management (ISM) system, which includes a child welfare history search, and other provincial records (e.g. card indexes) to determine if there is a previous record of contact between the department and the child, family or alleged perpetrator that may be relevant to determining if an investigation is required.

PROCEDURES CONTINUED	Where a departmental record exists, relevant information shall be included on the CPR. A brief review of previous involvement should occur, noting the date of the referral, the verification decision and whether the child required protective intervention. **Assessing and Documenting the Information** Although a social worker has 24 hours to make and document the screening decision on the CPR form, they shall complete an initial assessment of the information immediately to determine if a same day response is required. The urgency of a same day response (e.g. immediately or by the end of the working day) depends on the situation and information currently known to the department about the child and family. In exceptional circumstances and in consultation with a supervisor, a social worker may need to obtain additional information to make a screening decision (e.g. location of child and family cannot be determined). In this situation, the screening decision timeframe may be extended up to a maximum of 72 hours of receipt of the referral to obtain the information necessary to make the screening decision. Notwithstanding the screening time, the maximum time to action the referral is still seven days. For example, if the time it took to screen the information was 72 hours (3 days), the referral must be actioned within the following four days. **Assessing a Parent's Protectiveness – Third Party Maltreatment Referrals** Assessing a parent's protectiveness in third party maltreatment cases is directly linked with our legislative requirement to investigate situations of child maltreatment when it involves acts of parental omission or commission. To determine a parent's protectiveness, the social worker needs to assess if a parent is aware of the alleged maltreatment of their child and what their response has been or will be in the future to protect their child. The department cannot assess a parent's protectiveness if they are not made aware of the current maltreatment concerns. When information is received alleging third party maltreatment, the parent must be contacted to advise of the information and for the social worker to assess the parent's protectiveness (i.e. omission) in relation to the information reported. Once the social worker has assessed whether the parent played a role in the maltreatment or not, a screening decision is made on the third party maltreatment information. An assessment of a parent's protectiveness is unique to the child, their family and the presenting situation. Factors that could be explored with the referral source and parents include:

PROCEDURES CONTINUED	1. The parent's response to the alleged maltreatment or verification of maltreatment (i.e. Do they believe that maltreatment occurred? Are they emotionally supporting the child or are they supporting the alleged perpetrator?); 2. The parent's emotional and cognitive ability to understand the situation (e.g. Are there known mental health or parenting capacity issues that would interfere with a parent's ability to protect the child from future harm?); 3. Whether the parent is cooperating with the police investigation and is open to the department's recommendations, where provided (e.g. sought medical attention and counseling support for the child); 4. Whether the parent is willing to follow the department's direction regarding the alleged perpetrator's future contact with the child or has decided themselves to prohibit contact; and 5. The social worker should also review historical case information to determine whether the parent acted in a protective manner in the past, if required. All information related to **third-party maltreatment of a criminal nature** shall be reported to the police. The social worker shall document the information on the **Third-Party Maltreatment Information for Police** form and immediately report to the police. Further information on third-party maltreatment **of** a criminal nature can be found in **Policy 7.4** in the Protection and In Care Policy and Procedure Manual. **New Referrals on an Ongoing Protection Case** When information is received on a family in receipt of ongoing protective intervention services, a social worker shall assess the information in accordance with the SRTA tool and, in consultation with a supervisor, determine if the referral will be screened in for a protection investigation. Information received shall be documented on a CPR to document the screening decision and the clinical rationale for the decision made. **Contacting a Parent About a Screened Out Referral** The preferred method of contacting the parent alleged to have maltreated the child to discuss a screened out referral is by telephone. If the parent cannot be reached by telephone to discuss a screened out referral, a social worker shall send a **registered letter** (and document the date the letter was sent in a case note) to the parent's last known address and request that they contact the department to discuss information received about the family. Specific details about the screened out referral is **not** outlined in the letter. The parent is then responsible for contacting the social worker to obtain further information. Staff will not attend a parent's home to discuss a screened out referral. It is not a requirement to notify the other parent of the screened out

PROCEDURES CONTINUED	referral. Notification can occur with that parent if determined necessary by the social worker and supervisor. **Assessing and Documenting the Information** As indicated in the procedures section, calls to the department made in error or to obtain information about community resources for a particular family is considered a **General Request for Information/Inquiry** and do not need to be documented on the CPR form. The **General Request for Information/Inquiry** enables the social worker to document information pertaining to families that do not have an open intake, assessment, or ongoing protection case and do not meet the departmental mandate. If, during these calls, the social worker obtains information that should be assessed in accordance with the SRTA, the call should be documented on the CPR form.
PRACTICE CONSIDERATIONS	**Planning our Intervention and Permanency Planning for Children** Planning our intervention with a family begins with engaging the referral source in the screening process. A social worker obtains as much information as possible about family members, the alleged perpetrator and the nature of the referral, including information about the child and family's involvement with community professionals, the family's support network, the family's strengths and so forth. It is essential to: 1. Gather and assess detailed information as it will inform subsequent decisions made with the family; 2. Assist with permanency planning for children, and 3. Set the stage for all interventions provided by the department. **Motivation of Referral Source and Credibility of Information** Most reports of child maltreatment are based on genuine and credible concerns about children. Sometimes the reporter's motivation may be based on concern for the child but the information provided is vague. These situations usually contain insufficient evidence to justify an investigation, or reflect information reported based on differences in values or beliefs about parenting but do not constitute maltreatment concerns. The credibility of a report is often correlated with the motivation of the reporter. However, it is possible that credible reports of maltreatment are received even where there is a concern regarding the referral source's motivation. A social worker may need to discuss with the referral source any concerns they may have about contacting the department. These can range from

	fear that the family will retaliate to fear of having to testify in court. The following questions may help assess the motivation of the referral source and credibility of the information provided: 1. Source of referral information (was it by direct observations, second hand information, or were there other witnesses?) 2. What are the reasons (if any) for wanting to remain anonymous? 3. If there was a delay in reporting, what is the reason for reporting now? 4. Has the reporter made previous child protection referrals? If so, where they credible? 5. Is the reporter focused on the best interest of the child? 6. Are there any other possible motivations behind the report, such as a conflicting relationship with the parents, conflict arising from custody and access of children? 7. Does the reporter present as sober, coherent, and genuinely concerned for the child? **Informing the Referral Source About the Department and Role** To assist the referral source in understanding the department's mandate and role in the community, the social worker may discuss with the referral source: 1. Their role as a community member in protecting children; 2. Their ongoing duty to report concerns of child maltreatment; and 3. Options open to the department to respond to all referrals which include; screening in for an investigation and follow up, or screening out the referral and contacting the family to discuss concerns/refer them to community resources, if appropriate.
REFERENCES/ DOCUMENTS	1. The **Screening and Response Time Assessment** tool is used to make the screening decision; 2. The **Child Protection Referral** tool is used to document Child Protection Referrals. Please refer to the CPR form in the Structured Decision Making (SDM) Policy and Procedures Manual for further information regarding its completion; 3. Department of Families and Affordability Children and Youth in Care and Custody Standards and Procedures Manual for Staffed Residential Placement Resources 4. Child Protection and In Care Policy and Procedure Manual, Policy 1.5: **Police Involvement** and Policy 5.2: **Assessing Service Eligibility and Determining a Youth's Need for Protective Intervention** 5. Child Protection and In Care Policy and Procedure Manual, Policy 7.4 Reporting Third-Party Child/Youth Maltreatment Information to Police 6. **Third-Party Child/Youth Maltreatment Information of a Criminal Nature for Police"** form 7. Documentation Guide, Appendix D, Policy 7.2: **File Documentation**. 8. **Children, Youth and Families Act**

STANDARD #2	ASSESSING A SCREENED IN REFERRAL – DETERMINING THE RESPONSE TIME AND DEVELOPING THE PROTECTION INVESTIGATION PLAN
STANDARD	**Determining Response Priority** A social worker shall immediately assess a screened in CPR to determine a response time. The response time is determined by the level of urgency or assessed level of present or imminent threat to the safety of a child. A social worker shall, in consultation with a supervisor, determine the response priority using the SRTA and their professional assessment of the referral information. A social worker shall document the response time decision, and the supporting reasons, on the CPR form within 24 hours of receipt of the CPR. The supervisor shall review and approve the CPR within 24 hours of receipt of the CPR. The response time will fall into one of the two categories: 1. Same day; OR 2. Within seven days. If the child is not seen within the response time assigned, the social worker shall make all efforts to interview the child as soon as possible and document why the child could not be seen within response time assigned. If additional information is received about the family after a response time is assigned, the social worker, in consultation with their supervisor, shall review the response priority to determine if it should change and the reasons supporting the change must be documented in the electronic case file. **Developing the Protection Investigation Plan** When it has been determined that the referral will be investigated, the protection investigation plan is developed by the social worker who will conduct the investigation, following a thorough review of all current and historical information known about the child and family. A social worker shall consult with a supervisor to develop the protection investigation plan and obtain supervisory approval before starting the investigation. If possible, the protection investigation plan shall be documented on the CPR. If not, the protection investigation plan shall be documented in the electronic case file. The protection investigation plan shall be documented prior to the commencement of an investigation, if possible.

	If a social worker referred the maltreatment concerns to their local policing agency, then the social worker will consult with the police agency (RNC/RCMP) to develop the protection investigation plan. Further information on police involvement in child maltreatment cases can be found in Policy 1.5: Police Involvement in the Protection and In Care Policy and Procedure Manual.
INTENT OF STANDARD	The purpose of determining a response time and developing a protection investigation plan is to assist in: 1. Making well-informed response time decisions to determine response time based on the level of urgency and the imminent threat to a child's safety; and 2. Developing a purposeful investigation plan so the social worker has clear expectations on how to proceed with the investigation.
PROCEDURES	The SRTA is the primary decision-making tool to determining the most appropriate response time for a referral. A social worker shall consider historical and all other available information to inform a response time decision. **Determining the Response Time** A social worker shall use the Response Time Decision section of the SRTA and the accompanying definitions when making the response time decision. In accordance with the maltreatment definitions outlined in the SRTA, a response time will be assigned to the referral. A same day response requires contact with the child and family on the same day the information is received. A within seven day response requires contact with the child and family within seven calendar days of receipt of referral. **Developing the Protection Investigation Plan** The protective investigation plan must be purposeful and focused on the child's need for safety and protection and will outline the steps to be taken to obtain information about the child and family to complete the investigation. A social worker shall identify and document all the relevant activities required to complete the protection investigation including: 1. Reviewing all documentation on file, if the family had previous involvement with the department, prior to assessing safety. 2. Deciding when and where to see the child; 3. Determining when the parents are notified of the referral (i.e. before interviewing the children or after); 4. Considering cultural influences on the investigative process; 5. Determining relevant collateral contacts

	In situations where a same day response is required, the social worker shall consult with their supervisor on the development of the protection investigation plan and document the agreed upon protection investigation plan in advance of actioning the referral, if possible. When a within seven day response time has been determined, the social worker shall consult with a supervisor within 24 hours of receiving the CPR to develop the protection investigation plan and then document the approved plan on the CPR or in a case note on the electronic case file.
PRACTICE CONSIDERATIONS	**Determining Appropriate Response Time** When considering the appropriate response to an allegation that a child may be in need of protection, the social worker considers all known information about the situation, including both factors that may be considered threatening for the child and those that may be considered protective. The social worker's professional judgment and the SRTA assist in determining the severity of the incident or condition that has led the caller to believe that the child may be in need of protection. The consideration of that incident within the context of broader information known about the child and family's functioning results in a more accurate, customized decision about the most appropriate response, based on the needs of the child and family. **Same Day Response and Child Cannot be Located** If the social worker is unable to locate the client during regular business hours in response to referrals with a same day response time, a plan must be developed to action the referral, in consultation with a supervisor. If a CPR has been determined to have a same day response time and the child cannot be located, the social worker should consider whether the police should be alerted and requested to contact the department if they come in contact with the family. The social worker should consider any significant relationships and available resources to the child including their ability to access them and determine if they can lessen the threat of harm to the child. **Initiating a Child Protection Investigation** The decision regarding how quickly to initiate an investigation is based on: 1. Vulnerability of the child (e.g. age, health, mobility, visibility); 2. The immediate need for support for the child; 3. Current injury of harm to the child that may require medical examination; 4. Presence of safety threats to the child;

PRACTICE CONSIDERATIONS CONTINUED	5. Possible additional risk to the child resulting from disclosure; 6. Potential safety of other children in the same household; 7. The need to gather forensic evidence; and 8. Availability of the individuals. **Consideration of Safety Issues** In considering the protection investigation plan, the social worker should be aware of safety issues for the client and themselves. The social worker must consider potential threats to safety that may need to be addressed prior to commencing the protection investigation. Further information on social worker safety is covered in Standard #3.
REFERENCES/ DOCUMENTS	The Screening and Response Time Assessment tool is used to inform both the screening decision and the response time decision. Information related to the SRTA is located in Standard #1. The Child Protection Referral tool is used to document Child Protection Referrals. Please refer to the CPR form in the SDM Policy and Procedures Manual for further information regarding its completion; Protection and In Care Policy and Procedure Manual, Policy 1.3: Determining the Need for Protective Intervention and Policy 1.5: Police Involvement.

STANDARD #3	CONDUCTING A CHILD PROTECTION INVESTIGATION
STANDARD	A social worker shall complete a child protection investigation within 30 days of receipt of a CPR. A social worker shall use the protection investigation plan to guide the investigation. If more information becomes available regarding the safety and protection of a child, the social worker shall review (and revise when necessary) the protection investigation plan. A social worker shall refer all alleged physical and sexual maltreatment, whether the information is screened in or out in accordance with SDM, to the applicable policing agency immediately. Further information on police involvement in child maltreatment cases can be found in **Policy 1.5: Police Involvement** in the Protection and In Care Policy and Procedure Manual. All information related to **third-party maltreatment of a criminal nature** shall be reported to the police. The social worker shall document the information on the **Third-Party Child/Youth Maltreatment Information of a Criminal Nature for Police** form and immediately report to the police. Further information on third-party maltreatment **of** a criminal nature can be found in **Policy 7.4** in the Protection and In Care Policy and Procedure Manual. The social worker shall assess and consider whether a traditional or customized approach will be needed for the initial point of investigation. The social worker shall continue to assess, throughout the investigation, whether the approach initially chosen continues to be the most appropriate one. All child protection investigations shall include the following investigative steps; 1. A review of all documentation on electronic and/or paper file if the family had previous involvement with the department; 2. Face-to-face contact with the child alleged to be the victim and an interview using methods consistent with the child's developmental stage and ability to communicate; 3. Interviews or direct observation of sibling and /or other children residing and/or being cared for in the home; 4. Direct observation of the child's living situation. If information is obtained that the child's living conditions are hazardous and/or neglectful, the entire home is observed and in particular, the child's sleeping area; 5. Interview of the child's non-maltreating parent; 6. Interview of the parent who is alleged to have maltreated the child, with or without the police, dependent on the referral information and

STANDARD CONTINUED	as per policing agency's protocol; 7. Direct observation of parent child interactions; 8. Interviews of other potential witnesses identified, if appropriate (this may be done jointly with the police, depending on the referral concerns); 9. Interviews of all other adults in the household; 10. Obtaining relevant information from collaterals involved with the child and family (e.g. school, counselor, police, physician, neighbor, family member); 11. Consideration of the child's medical information in the clinical assessment of safety and risk (i.e. consulting with your supervisor and medical professionals to determine if a medical examination may be required); When it is determined that a medical examination is required due to a disclosure of abuse and/or neglect, the social worker shall arrange for the medical examination to be completed as soon as possible following the disclosure, in accordance with the availability of a qualified health practitioner. 12. Complete child protection record checks on all members of the household. This information is required to complete the risk assessment and gain the most accurate risk rating. For ongoing protection files, this step does not need to be repeated for every referral received, however, checks must be completed for new members of the household or when new information is received that may necessitate a check; 13. Complete Provincial Court criminal record checks on all adult members of the household; 14. Request and subsequently review information from an out of province child protection agency about a family's involvement with that particular agency, if applicable; and 15. A review of the current Risk Assessment, Family Strengths and Needs Assessment (FSNA), and Family Centered Action Plan (FCAP) if the CPR is on an ongoing protection case.
INTENT OF STANDARD	The purpose of conducting a child protection investigation is to: 1. Thoroughly gather and assess information about the alleged incident or maltreatment 2. Assess the immediate safety of the child 3. Assess the risk of future maltreatment to a child 4. Determine if any new child protection concerns are verified 5. Determine if child is in need of protection 6. Determine if case will be transferred to ongoing protection services or closed 7. Engage the child and family in a manner that will facilitate understanding of their child and family's needs and strengths beyond those related to the referral incident 8. Develop a relationship with the family that will facilitate their participation in child protection services.

OUTCOMES	1. The investigation results in credible evidence and information having been gathered **OR** all reasonable efforts have been made to collect evidence and continuing the investigation would yield no new information; and 2. The investigation has not been more prolonged or intrusive than was required to achieve the above outcomes. 3. All children and families receiving child protection services in Newfoundland and Labrador are screened for risk of future child abuse and neglect.
PROCEDURES	1. Further information about interviewing family members such as type of questions and information to obtain from a child is included in Appendix A: Interview and Observation Questions. 2. When the social worker interviews a child at school, daycare, or another community resource, the Interview of Child form shall be provided to the school or community resource confirming the authority of the social worker to interview the child; this form shall also be provided to the parent(s), if requested. 3. When a child/family cannot be located and a child is considered to be in immediate danger, a social worker shall make every effort to locate them, including: a) Involving the police if the child is highly vulnerable; and b) Sending alerts to other regions and placing on provincial and, where required, inter-provincial information systems. Refer to Appendix B of the Policy and Procedure Manual: Provincial/Territorial Protocol on Child and Families Moving Between Provinces and Territories. 4. Engaging both Parents Parents play a critical role in the growth and development of their children. It is important that a thorough review of the family's history as well as any potential sources of support and protection for the child be explored. For these reasons, it is important that both parents are contacted and engaged during the investigation. **Completing Interviews** All family members should be interviewed privately and individually so that: 1. They can speak without concern about what another family may think; 2. The investigating social worker can compare information gathered in one interview with information gathered in other interviews and can therefore assess the credibility of information gathered; 3. The investigating social worker can utilize information gathered from one interview to assist in planning subsequent interviews; and 4. Family members can also be interviewed more than once, if necessary.

PRACTICE CONSIDERATIONS	When conducting a protection investigation, consideration should be given to the ethno cultural orientation or Indigenous heritage of the child and family and the need for an interpreter. The interpreter should not be connected to the family of the alleged victim or of the alleged offender; if this is not possible, the social worker shall consult with their supervisor to determine next steps. In the case of a child or family with hearing impairment, it is important to use a qualified interpreter. **Interview of Child Victim** The purpose of interviewing the identified child victim is: 1. To gather information regarding the alleged maltreatment, circumstances leading up to the maltreatment and any risk of future maltreatment; 2. To assess the child's immediate safety; 3. To assess the immediate safety of other children living or being cared for in the home; 4. To assess the strengths, risks and needs regarding the child and their parent; and 5. To identify extended family, relatives, members of the community who might play a role in keeping the child safe and supporting the family. **Interview of Other Children** The purpose of interviewing and observing siblings/other children living in the household is: 1. To determine if siblings/other children living in the household have experienced maltreatment; 2. To assess the level of vulnerability of siblings/other children living in the household; 3. To gather information confirming the nature and extent of any maltreatment of the identified child; and 4. To gather further information about the family that may assist in assessing risk to the identified child and any siblings. **Interview of Non-Maltreating Adults** The purpose of interviewing all of the non-maltreating adults in the household is: 1. To determine what adults know about the alleged maltreatment; 2. To gather information related to the risk of maltreatment and the safety of the child;

PRACTICE CONSIDERATIONS CONTINUED	3. To gather information regarding family strengths or protective factors; and 4. To determine the adult's capacity to protect the child if indicated. **Interview of Alleged Maltreating Parent** The purpose of interviewing the alleged maltreating parent is: 1. To evaluate the alleged maltreating parent's reaction to the alleged maltreatment; 2. To evaluate the alleged maltreating parent's reaction to the child and their condition; and 3. To gather further information about this person and the family in relation to the risk to the safety of the child. **The Sequence of Interviews** The social worker and supervisor decide together, when developing the protection investigation plan, with whom to initiate the investigation. It is important to work collaboratively with the family whenever possible and is preferable to obtain the parents' agreement to interview the child if the safety of the child and the protection investigation is not compromised as a result. The primary focus is always the safety and protection of the child. **Scheduled vs. Unannounced Visits** It must be determined, prior to the commencement of the protection investigation, whether it is in the child's best interest for the social worker to initiate an unannounced visit to interview the parent, or to contact the parent to schedule an interview. The decision regarding announced/unannounced interviews will be based on a consideration of the following: 1. The severity of the reported child protection concern; 2. The social worker's ability to protect the child and to gather information in sufficient detail; 3. The likelihood that the family will flee from the current address or jurisdiction; and 4. Impact on the protection investigation and being able to interview child without any undue influence by the parent. Scheduled visits may be preferred where it is assessed that there are no immediate threats to the child's safety. Scheduled visits may be experienced by the family as being more respectful and may maximize the potential to engage the parent in a discussion regarding the alleged concerns and possible solutions.

PRACTICE CONSIDERATIONS CONTINUED	Unannounced visits may be necessary when: 1. The social worker needs to determine whether or not the perpetrator is in the household; 2. There is fear that a family may flee; 3. It is not possible to contact the family to arrange an appointment; 4. It is necessary to interview the child immediately; and 5. It is necessary to assess the child's living conditions without the family having the opportunity to modify any of its usual conditions. **Determining the Location of Interviews** Initial face-to-face contact with the child's parent can occur inside or outside the child's household depending on the circumstances. The choice of interview location will be based on a consideration of the following: 1. The social worker's ability to protect the child; 2. The social worker's ability to gather information in sufficient detail; 3. The availability of interviewing space for private interviews of children; 4. The availability of interviewing space that is conducive to the child's comfort and need for safety; and 5. The need to assess the child's living conditions without the family having the opportunity to modify any of its usual conditions. **Locating an Absent Parent** Parents play a critical role in the growth and development of their children and for this reason, it is important that both parents are contacted and interviewed during an investigation. It is important that any potential sources of support and protection as well as any safety threats for the child be explored. If the social worker observes the lack of one parent in the household, they shall ask the parent who is present about the whereabouts of the other parent and that parent's relationship with the child, both past and present. For the purposes of permanency planning for the child, obtain the following information: 1. Name; 2. Nickname/aliases; 3. Address; 4. Date of birth; and 5. Telephone number.

PRACTICE CONSIDERATIONS CONTINUED	Ask the child, when age and developmentally appropriate, what they know about the absent parent; when did they last have contact and what was the nature and quality of that contact. Does the child want contact with the absent parent? What explanations have they been given as to why no contact exists? Ask extended family members about who might have contact with the absent parent and follow up with parents, siblings, grandparents, friends of the present and absent parent. Check departmental records. If there is reason to believe current or past involvement, follow up with other departments/agencies/programs (e.g. justice, probation, RNC/RCMP, addiction and mental health services, etc.). **Contacting Collaterals for Information** Collaterals are an important source of information. The quality of information obtained from collaterals is more important than the number of collaterals contacted. In some situations, a social worker may only contact one collateral, while in other situations, multiple collaterals may be contacted. The information requested should be relevant to assessing family functioning, strengths, risks and safety threats and are required to verify the particular alleged maltreatment type reported in the referral. Parents need to be involved in the plan to gather information from specific collaterals and, although their consent is not required, it should be requested for the purpose of collateral checks. At times, a social worker may determine that parental consent would jeopardize the investigation. Further information about obtaining collateral information is found in the Protection and In Care Policy and Procedures manual, Policy 6.2***:*** **Right to Information and Information Sharing.** **Social Worker's Personal Safety** When working with families, particularly during the investigation process, a social worker must be aware of personal safety issues and the approach they may use to minimize risk to them. The social worker needs to be concerned about the protection of the child and their own safety.

PRACTICE CONSIDERATIONS CONTINUED	A family's response to the investigating social worker may range from behaving cooperatively to making hostile threats. The social worker may get an idea of what to expect from information obtained: 1. During the screening process; 2. From a review of departmental records indicating previous criminal or violent behavior by family members; 3. From past contacts with family member(s) who were hostile or dangerous; and 4. From a criminal records check. When a social worker is concerned about their personal safety they should: 1. Consult with their supervisor about requesting police assistance or a co-worker to accompany them when conducting initial visits; 2. Advise their supervisor or coworkers about the location of meetings with family members in the community; 3. Arrange interviews to take place at a departmental office to mitigate concerns of personal safety; and/or 4. Take a cell phone to visits to make calls or to accept calls from a departmental staff who may be calling to monitor the workers' safety. If a social worker has been threatened by a client, they shall consult with their supervisor about the matter for support and to determine if the matter should be reported to the police for investigation.
REFERENCES/ DOCUMENTS	Protection and In Care Policy and Procedure Manual – Policy no, 1.7: **Interview of Child** and Policy 6.2: **Right to Information and Information Sharing** Protection and In Care Policy and Procedure Manual – Appendix B: **Provincial/Territorial Protocol on Children, Youth and Families Moving Between Provinces and Territories** **Interview of Child** form, Form # 51-08-07-41-02-2011-06-30. SDM Practice Standards - Appendix A**: Interview and Observation Questions**

STANDARD #4	ASSESSING CHILD SAFETY AND SAFETY PLANNING - COLLABORATING WITH THE FAMILY
STANDARD	**Safety Assessment** A social worker shall complete a safety assessment on all children who may be in need of protection identified on the CPR screened in for a protection investigation. The purpose of the safety assessment is to: 1. Assess whether any child is likely to be in immediate danger of serious harm/maltreatment that requires intervention, and 2. Determine what interventions should be initiated or maintained to protect the child. Following consultation with a supervisor, a social worker shall complete a safety assessment by: 1. Conducting a face-to-face interview with the child; 2. Observing a child who developmentally is not able to be interviewed; 3. Interviewing the child's parents; 4. Assessing the child's home environment; and 5. Contacting relevant collaterals if it is required to determine the child's safety. If one or more children are not present in the household during the investigation (e.g. attending summer camp) but the household is determined to be safe, the child shall be interviewed upon their return to ensure their safety but the completion of another Safety Assessment is not required. A social worker shall also assess the child's home environment and contact relevant collaterals if it is required to determine the child's safety. **If, during the course of the investigation, safety threats were identified leading to a safety plan, then a review of the safety threat(s) must be completed prior to closing the case and documented on the review portion of the safety plan and in the electronic case file.** If safety threats remain unresolved, the case shall be transferred to receive ongoing protection services. **A social worker shall complete a review of the safety assessment decision at any time throughout the investigation when new information becomes available that may affect the safety decision (e.g. change in family circumstance such as birth of a**

STANDARD CONTINUED	**new baby/discharge of baby from the hospital, new partner enters or leaves the household).** A social worker shall complete the **Safety Assessment** form by the end of the next business day following the safety assessment. A supervisor shall review and approve the **Safety Assessment** form within 10 days of the social worker submitting the form for approval. **Safety Planning** A social worker shall develop a safety plan immediately when one or more safety threats are present and in-home safety interventions have been initiated. The child will either remain in the household or temporarily stay with a relative or significant other with consent of the parent, as long as the safety intervention mitigates the safety threat(s). A social worker shall complete the safety plan in collaboration with the family and they must be in agreement with the plan. Whenever possible and consistent with the child's safety, the social worker actively involves the family, extended family members, community members, and/or other individuals as required, in identifying safety threats, developing and implementing a safety plan and monitoring and assessing its progress. A safety plan is a short term planning tool and will remain in effect until: 1. The safety threat is resolved and the child is no longer in immediate danger (within 30 days); 2. A determination is made that the child is no longer in need of protective intervention; or 3. A determination is made that a child is in need of protective intervention and the FSNA is completed and the FCAP is developed (not to exceed 60 days) where any outstanding safety threats will have to be addressed. A social worker shall, in consultation with a supervisor, review the safety plan in accordance with the review date set by the social worker and the family, or earlier if a new referral is received, or if any additional information becomes known that would affect the safety of the child. A safety plan shall contain an end date to reflect the conclusion of the safety plan interventions.
INTENT OF STANDARD	The purpose of assessing child safety and safety planning is to:

INTENT OF STANDARD CONTINUED	1. Promote an effective safety assessment for a child and secure their immediate safety throughout the investigation; 2. Encourage social workers to engage collaboratively with families to assess and determine the protective factors that will help mitigate immediate safety threats for a child; 3. Outline, for social workers, the tasks that are to be completed to reduce safety threats to the child; and 4. Encourage social workers to consider factors that make children more or less vulnerable to maltreatment.
OUTCOMES	1. Children are safe from immediate threats of harm or maltreatment. 2. Children maintain ties to their parents/primary caregivers, extended family, community, culture, and religious affiliation through their members' greater involvement in safety planning.
PROCEDURES	A safety assessment is both a process and a document. The process is conducted with the family in order to determine if any of the safety threats described in the document are present in the family. The child's safety is assessed before leaving the child in the home or returning the child to the home during an investigation. The **Safety Assessment form** is completed on the next working day after completion of the process with the family. The safety assessment process is completed for all investigations at the point of the first face-to-face contact within the response time, for all referrals on new or ongoing protection cases that are assigned for investigation. Changing circumstances such as loss of income, moves, illness of parent or child or a change in the family composition can be anticipated to induce stress within a family. These changing circumstances, in addition to changes in information that is known about the family, and/or changes in the ability of safety interventions to mitigate safety threats prompt completion of a new safety assessment. The safety assessment process is completed immediately. **Completing a Safety Assessment** When completing a safety assessment a social worker should consider two criteria: 1. Immediacy – is a dangerous situation already present for the child or likely to reoccur without intervention; and 2. Seriousness – dangerous situations that must be addressed to avoid the likelihood of harm to a child's life. All safety threats shall be explored and assessed when determining a safety decision. When a child is assessed as "safe with plan" or "unsafe" a social worker shall, in consultation with a supervisor, provide, facilitate or arrange interventions to mitigate the safety

PROCEDURES CONTINUED	threats jeopardizing the child's safety. A social worker shall document all interventions to assess safety of the child, which may include those initiated by the parent or the department, on the **Safety Plan** form. There are six steps to completing and documenting the safety assessment. Please refer to the SDM Policy and Procedures Manual, **SDM Safety Assessment** section for further detail on completing and documenting the safety assessment. If safety threats exist, they exist for all of the children in a family. The same safety decision shall be made for all children in a family. 1. **SAFE** - when circumstances which placed the children in immediate danger of serious harm have been resolved without an ongoing intervention, and no safety threat exists, the children are considered safe. 2. **SAFE WITH PLAN** – if a safety threat is present and immediate interventions are required, the safety decision shall be that all children are safe with a plan and a safety plan is required. A safety plan could involve either **in-home** interventions or placing with **kin**. 3. **UNSAFE** – if a safety threat is present and the only protecting intervention to ensure the child's safety is signing a Protective Care Agreement or removal, the safety decision shall be that all children are unsafe. The purpose of a safety plan is to address immediate safety threats identified during the safety assessment. The development of a safety plan is a significant intervention during the investigation phase. Developing the safety plan is a collaborative process with the parents. The social worker is also encouraged to plan, involve, collaborate and consider the views of: 1. The child, family and extended family; 2. The appropriate community or community members; 3. Other significant persons known to the child and family, and 4. Service providers who can play a role in keeping the child safe. Parents are always encouraged to share their views and ideas about safety planning. However, if the family and social worker are unable to come to an agreement to ensure child safety, the social worker must consult with their supervisor regarding next steps. The safety planning process begins when the social worker, in

PROCEDURES CONTINUED	consultation with a supervisor, identifies which safety threats are creating immediate danger for the children. The social worker determines how these safety threats are creating danger, then plans with the family to develop the steps that must be taken to reduce the threat to the children. The safety plan is documented on the **Safety Plan** form and a copy provided to the parents as well as any significant others who signed the **Safety Plan** form. The social worker must complete all sections of the **Safety Plan** form including the safety threats, strengths and protective factors, action required, person responsible, start date, review date, end date, and signatures. The actions required in the safety plan must be clearly stated with specific time lines. For more information on the completion of the **Safety Plan** form, please see the SDM Policy and Procedures Manual. Where at all possible, children should be maintained in their family household with support and services under a safety plan during an investigation. If the children cannot remain home under a safety plan, a social worker may consider an interim out of home living arrangement for the children or until the investigation is completed or safety threats no longer exist, whichever comes first. Prior to the conclusion of the investigation, a social worker shall, in consultation with a supervisor, complete a review of the **Safety Plan** form at least once during the protective investigation (within 30 days), which includes a review of all safety threats to determine if the threats still exist or if any new threat has become known. The actions taken to address the threats must be reviewed and changed, if required.
PRACTICE CONSIDERATIONS	It is important to highlight the difference between safety and risk. The safety assessment differs from the risk assessment in that it assesses the child's present danger and the interventions currently needed to protect the child. In contrast, a risk assessment assesses the likelihood of future maltreatment. A safety assessment is a critical point in the life of a case. A social worker has to decide, often with limited information, if a child is safe or needs immediate protection from serious harm. The safety assessment should not rely solely on reports by clients and similarly, the safety plan should not rely primarily on client's promises to change their behavior. Assessing safety for a child should involve gathering comprehensive and credible information about the situation that has become threatening to the child. The analysis of the information gathered should be guided by a cautious evaluation of the

PRACTICE CONSIDERATIONS CONTINUED	facts with child safety being paramount, while being respectful of the parent. The development and implementation of the safety plan is one of the most important interventions during the protection investigation. The social worker must be supportive and collaborative while being authoritative in planning to protect the child. Family and community strengths should be utilized to develop the safety plan. The following sources of information may be considered in making a safety decision: 1. Information gathered at intake; 2. Departmental case history; 3. Interview/observation of child; 4. Interview with parents; 5. Analysis of current situation in the household; and 6. Collateral information known at the time of the safety assessment. A safety assessment considers all safety threats that make children more or less vulnerable to the effects of maltreatment including the age of the child, child's temperament, child's behavior, and the type of severity of injury to the child. There are additional safety threats specific to parental influence including parental response to alleged maltreatment, parenting skills and level of functioning, access to the child, conditions of the home environment, and history of maltreatment. The following factors should be considered in assessing the adequacy of the safety plan: 1. Whether the family helped construct the safety plan; 2. Whether the family is willing and able to participate in the plan; 3. Whether a similar safety plan was developed before and if it worked; 4. Whether the intervention is likely to address the unsafe situations; 5. Whether the intervention is available in the community; 6. Whether the intervention can be implemented quickly enough to ensure the child's safety; 7. Whether the service or support is sufficiently close and easy for the family to use; and 8. Whether the safety intervention is immediately available, easily accessible and capable of immediate impact. Monitoring a safety plan requires: 1. Follow up visits by the social worker;

PRACTICE CONSIDERATIONS CONTINUED	2. Regular communication with others (collaterals, relatives, community members); and 3. Continued assessment of the child's safety status. **Safeguards for the Child During the Investigation** Throughout the investigation, the social worker considers all appropriate means to ensure the child's safety including: 1. Involvement of extended family, friends, or other members of the community who might play a role in keeping the child safe during the investigation; 2. Use of out-of-home care options; 3. Involvement of community agencies or members; and 4. The provision of services or emergency funds. While safety is the prevailing concern for the first face-to-face contact, the manner of engaging the family will depend upon social work clinical skills. Whenever possible, the social worker uses a strength-based approach to initiate the contact, while remaining observant for the presence or absence of safety threats. The first face-to-face contact may be limited to assessing safety if there are significant safety issues. At other times, the social worker will also begin to gather information regarding risk and/or strengths and needs items as well as additional clinical information.
REFERENCES/ DOCUMENTS	The **SDM Safety Assessment** tool is to be used to document the safety assessment. Further information about what to include in the **SDM Safety Assessment** tool can be found in the SDM Policy and Procedures Manual. The **Safety Plan** form is used to document the safety plan with the family. Further information about what to include in the **Safety Plan** form can be found in the SDM Policy and Procedures Manual.

STANDARD #5	CONCLUDING THE CHILD PROTECTION INVESTIGATION
STANDARD	A social worker shall complete a child protection investigation within 30 days of receipt of the CPR, including all required SDM investigation assessment tools and case transfer documentation for cases that require transfer to ongoing protection services. The SDM Risk Assessment shall be completed for all child protection investigations. A child protection investigation is concluded when all information is gathered to determine whether: 1. The original or new child protection concerns are verified or not verified; 2. A child is in need of protection; and 3. All reasonable efforts have been made to collect evidence and continuing the investigation would yield no new information. The conclusion of the protection investigation is made in consultation with a supervisor; within the context of a full case review and analysis of all relevant information shall be documented on the Protection Investigation Summary (PIS). In some cases, the original alleged maltreatment cannot be verified but information is obtained during the investigation that may lead to verification of other protection issues. Additional alleged maltreatment disclosed during the initial interviews with the child and parents shall be added within 24 hours of conducting the interviews. A new maltreatment type can be added at any time for a CPR that is awaiting approval or screened in. Cases are transferred where a determination has been made that a child is in need of protective intervention (if the case is in assessment) or continue to receive ongoing protection services (if the case is in ongoing protection). Cases with a high or very high overall risk rating require, and should receive, ongoing child protection services if a child has been found to be in need of protective intervention. Cases rated low and moderate are recommended for closure and may be linked to formal and informal resources in the community, unless there are outstanding safety threats. Cases are closed where a determination has been made that a child is not in need of protective intervention. Closure documentation is completed and submitted for approval within 30 days from the date of referral.

STANDARD CONTINUED	At the completion of the child protection investigation, the electronic case file documentation shall contain: 1. Documentation of all steps taken, consultations with supervisors, and information obtained throughout the investigation in case notes; 2. Documentation of the safety assessment and safety plan on the safety assessment and safety plan forms; 3. Documentation of the risk assessment on the risk assessment form; 4. PIS which contains the referral verification decision and whether a child is in need of protective intervention; and 5. Supervisor's signature (and date) indicating approval of the documentation including the investigative process. The documentation completed at the conclusion of all investigations is approved by the supervisor within 10 days of receipt of the completed case documentation, at which time the case can be either closed or transferred to ongoing protection services. In exceptional circumstances, there may be times when outstanding clinical assessments may not be able to be completed prior to closing the case. For example, a CPR has been screened in for investigation and the social worker cannot locate the family despite having attempted and exhausted all options reasonably available (records checks, provincial database). As the family cannot been located, the Safety Assessment, Risk Assessment, and Protection Investigation Summary are not able to be completed. In these cases, clear documentation is required to explain the reasoning behind the incomplete assessments. A family shall be notified of the outcome of a protection investigation as soon as possible and within 30 days of the decision being made. Throughout a protection investigation, the social worker shall observe all children if they are present in the home during every home visit. Where a child is home during the social worker's visit and is unable to be observed during the visit (e.g. the child refuses to see the social worker and goes to their room or leaves the home), the social worker shall document the reasons why the child was not able to be observed in the electronic case file, and consult with a supervisor to determine the most appropriate plan for observing the child.
INTENT OF STANDARD	The purpose of outlining the steps of a child protection investigation is to ensure investigations are: 1. Thorough; 2. Comprehensive; 3. Timely; and

INTENT OF STANDARD CONTINUED	4. Involve a structured, guided and collaborative process of case decision-making. It is intended that the case record and documentation pertaining to child protection investigations are clinically focused and include a summary and analysis of the information gathered in required case work decisions.
OUTCOMES	Protection investigations are concluded and families are notified of the outcome of the protection investigation in a timely manner so that: 1. Ongoing child protection services can commence as soon as possible or continue for investigations on cases already involved in ongoing protection services; 2. The department is not involved with a child and family any longer than is necessary; and 3. Case documentation is timely, thorough, and accurate.
PROCEDURES	The focus of all child protection investigations is on protecting the child(ren) who was the subject of the referral, and any other child in the home who may be affected by the alleged maltreating person. **Concluding a Child Protection Investigation** 1. A child protection investigation is completed for all referrals screened in for investigation, including new referrals on active cases. 2. A child protection investigation is informed by the Protection Investigation Plan developed in consultation with a supervisor and includes the following steps: a) A face to face interview (or observation if an interview is not developmentally appropriate) of the child allegedly needing protection consistent with the child's age, developmental stage and ability to communicate (this may be done jointly with the police depending on the referral concerns) b) Interviews (or observations if an interview is not developmentally appropriate) of other children residing in the home consistent with their age, developmental stage and ability to communicate; c) Interview of the parents, including the non-maltreating parent and alleged perpetrator of the alleged maltreatment (this may be done jointly with the police depending on the referral concerns); d) Direct observation of the child's living situation, including the child's sleeping area if there are concerns presented or observed about neglectful or hazardous conditions in the home; e) Observations of parent/child interaction;

PROCEDURES CONTINUED	f) Interview of all other adults in the household (this may be done jointly with the police depending on the referral concerns); g) A criminal records check, where required as part of the protection investigation plan; h) Obtaining relevant information from collaterals involved with the child and family (e.g. school, counselor, police, neighbor, family member); i) A review of all documentation on file if the family had previous involvement with the department; j) Request and subsequently review information from an out of province placement protection agency about a family's involvement with that particular agency; and k) A review of the current RA, FSNA, and FCAP if the CPR is on an active case. Further information about interviewing/observing a child can be found in the Protection and In Care Policy and Procedures Manual, Policy 1.7: **Interview of a child** and SDM Practice Standards Manual, Appendix A: **Interview and Observation Questions.** 3. The frequency, location, nature and intent of the observations and interviews with the child are dependent on a number of clinical factors including but not limited to: a) Previous injury to a child b) Child protection history c) Current safety threats 4. A protection investigation is concluded when all information is gathered to determine: a) Whether the original and/or additional child protection concerns are verified or not verified; and b) Whether the child needs ongoing protective intervention. **Completing Risk Assessments with Families** The SDM Risk Assessment (RA) tool is an assessment of future risk of maltreatment, which is completed for all protection investigations. The RA is both a process and a document. The process is conducted with the family in order to consider which risk factors contained in the document are present within the family. The completion of the RA tool is completed prior to both the verification decision and conclusion of the investigation. The RA tool **does not predict** recurrence of maltreatment but simply assesses whether a family is more or less likely to have another incident without intervention by the department.

PROCEDURES CONTINUED	The RA is meant to inform, not replace, the use of professional judgment when assessing risk of future abuse and/or neglect to a child. The RA is a clinical tool used to guide case decisions. The RA is completed with the intent of engaging families in a purposeful conversation regarding their unique circumstances. The RA should be used as a vehicle for engaging families by: 1. Enabling their meaningful involvement in defining the problems; 2. Defining what needs to change; and 3. Working toward a concrete goal of child safety. The social worker explains clearly to families what is meant by risk assessment, the reason for doing one and how the family's participation will assist in making important decision that a risk assessment informs. The social worker is clear about the protection concerns and what is not working, but encourages the family to "tell their story" in their own words, while continually encouraging, challenging and probing until all of the risk factors have been explored. When completed collaboratively with families, the RA will result in clear problem definition. Coupled with the safety assessment, the Family Strengths and Needs Assessment (FSNA) and the Family Centered Action Plan (FCAP), the social worker and family will have an understanding of what safety will look like for their child, utilizing their existing strengths, and additional services or supports. Other service providers may have information that could enhance the RA. **Verifying Protection Concerns** To make a verification decision, a social worker carefully considers all of the information gathered and the credibility of such information. In addition to the information provided through a review of case history and interviews/observations of the parent, children, other family members, witnesses and community partners, a social worker may also need to review medical or forensic evidence (e.g. blood work or report of an injury to a child) and the opinion of professionals involved with a family, such as a medical doctor or psychologist. The decision is whether the alleged protection concerns have been verified and whether a child is in need of protective intervention and is made in consultation with a supervisor. The social worker and supervisor shall review and analyze all relevant information gathered throughout the investigation when determining the decision.

PROCEDURES CONTINUED	When making a verification decision, a social worker is not verifying whether an incident occurred per se, rather the social worker is verifying the maltreatment allegation(s). Information provided during an investigation may be complex, and at times contradictory, alleged maltreatment may be verified even when a parent or child denies that an alleged incident occurred or when physical evidence is inconclusive or nonexistent. Where a child and/or parent deny that the alleged incident occurred, the worker uses their professional knowledge and skills to make a decision, on the balance of probabilities, about whether an incident occurred **and** resulted in harm or risk of harm to the child. In applying the "balance of probabilities" test, a social worker shall consider whether: 1. The evidence gathered and reviewed is credible. Credible evidence means that the available facts are trustworthy, believable and dependable; and 2. The evidence gathered and reviewed is persuasive. Persuasive information means that after carefully reviewing and weighing evidence it supports the conclusion that maltreatment has occurred or has not occurred. **Determining if the Child is in Need of Protection** A child is generally in need of protective intervention when they have suffered or are likely to suffer some form of maltreatment as a result of an act of omission or commission by their parent. Risk of maltreatment exists on a continuum, from low to very high risk. The determination that a child is in need of protective intervention has to be more precise than a judgment that there is some risk of maltreatment that exists or is present in every family. Both the safety assessment and risk assessment are helpful in structuring and informing this decision. Because the safety assessment is more narrowly focused than the risk assessment, identifying imminent threats with potentially severe results, a determination during or at the conclusion of an investigation that safety threats remain present may result in a determination that a child is in need of protective intervention.

PROCEDURES CONTINUED	Although a risk assessment is a relevant and valuable clinical tool, it is not sufficient in and of itself to support a determination that a child is in need of protective intervention. The determination is based on a broader assessment of the family's circumstances and the family members' capacities and behavior. An overall risk rating of high or very high will generally (but not always) result in a determination that a child is in need of protective intervention. Similarly, while a referral eligibility screening tool such as the SRTA assists in deciding about the severity of the incident or condition that has been verified, it should not be used on its own to drive the decision about whether a child is in need of protection, as severity is not the sole factor that requires consideration. The social worker assesses the outcomes of all SDM assessments, the behaviors, conditions, strengths, and needs that are present and explores their current impact on the child, and how likely they are to result in abuse or neglect in the future. This determination is not as precise or concrete as the verification of a child protection concern and requires a greater use of analysis and judgment. The use of any one tool to make this decision is inappropriate and insufficient. **Case Decision for New or Reopened Cases** The decision about whether the child is in need of protective intervention or not as well as the risk rating will determine whether ongoing child protection services will be provided or the case will be closed. Cases with a determination that a child is in need of protective intervention are eligible for ongoing child protection services. All other cases are closed. When a case is being closed, the social worker considers if services or resources in the community will prevent or reduce risk of future maltreatment to the child. If so, the child and family are provided with information about, or referred to appropriate resources. There are three possible outcomes of an investigation of maltreatment on new/reopened cases: 1. **Alleged maltreatment type is not verified and the child is not in need of protective intervention**. In this situation the original alleged maltreatment (and additional alleged maltreatment types, if identified) is not verified and the child is not in need of protection. The family is notified of the investigation outcome and the case is closed.

PROCEDURES CONTINUED	2. **Alleged maltreatment type is verified but the child is not in need of protective intervention**. In this situation the alleged maltreatment type – initial and/or additional maltreatment types has been verified but the concerns have been addressed, the parent(s) has responded appropriately to the situation/information provided by the social worker or there is no concern regarding the parent's ability to protect the child. The family is notified of the investigation outcome and the case is closed. 3. **Alleged maltreatment type is verified and the child is in need of protective intervention.** In this situation the alleged maltreatment – initial and/or additional alleged maltreatment types has been verified. Concerns remain about the parent(s) response to the alleged maltreatment, or with their ability to protect the child and as a result the child is in need of protective intervention. The family is notified of the investigation outcome and need for ongoing protective intervention. **Outcomes of an Investigation for Ongoing Cases** The decision about whether the child is in need of protective intervention or not will determine whether there are new protection concerns as a result of the investigation that need to be addressed in an FCAP. There are two possible outcomes of an investigation of maltreatment on an ongoing case: 1. There are **new** protection concerns verified as a result of this investigation that need to be addressed in a FCAP. 2. There are **no new** protection concerns verified as a result of this investigation that need to be addressed in FCAP. **Closing following a Protection Investigation – Notification and Referral to Community Resources** Parents (both maltreating and non-maltreating parents) shall be advised of the investigation outcome as soon as possible and within 30 days of the decision being made. Notification shall be communicated personally (face-to-face or via telephone) and in writing through the completion of the **Notification of Conclusion of a Protection Investigation** form. The decision to close a case shall be documented on the PIS form. The following closure codes are options on the PIS: 1. **Child is not in need of Protective Intervention - close case –** select this code if the investigation has determined that the child is not in need of protective intervention

PROCEDURES CONTINUED	2. **Child is no longer in need of protective intervention because the court has determined a child is not in need of protective intervention and the department has determined that no further intervention is required – close case**– select this code if legal means have been pursued to ensure a child's safety and well-being and have not been successful (see "When a Court has Determined a Child is Not in Need of Protective Intervention" in Standard #8 for more information) 3. **Investigation Discontinued** a) Family moved out of province - Select this code if the family has left the province without our knowledge or prior planning regarding the move and prior to the conclusion of the investigation b) Family cannot be located - Select this code if the family cannot be located despite the social worker having exhausted all options to locate the family (records checks/checking with collaterals such as the school and police for information about a family's location, visiting potential locations to see if the family resides there); c) Youngest child turned 16 years of age. d) Child deceased - Select this code if the child in need of protective intervention has died prior to the conclusion of the investigation and there are no other children in need of protective intervention residing in the household. e) Referral information does not match family – select this code if the investigation cannot be completed because the referral information does not match the demographic information of the family referred. When a decision is made to close an assessment case following an investigation, a social worker also considers if services in the community may help the family deal with psychosocial issues identified and if so, provides the family with information about or facilitates a referral to appropriate community resources. Prior to the completion of the PIS, all required safety assessment tools and risk assessment tools shall be completed. If the safety assessment process or risk assessment process has not been completed prior to an investigation needing to be discontinued, the respective forms will not be required in order to close the case.
PRACTICE CONSIDERATIONS	Not all child protection investigations require the same level of information gathering. The amount of information required for the verification and determination decision is dependent on the nature of the referral concerns and the safety and risk identified for a child.

PRACTICE CONSIDERATIONS CONTINUED	Resources should be targeted to more serious and complex cases to ensure thorough information gathering. Information gathered should be relevant and only as intrusive as required to assess the child's safety, to make a verification decision, determine a child's need for protection, and determine the risk rating for the child. **Feedback for Completing the PIS** 1. Indicate whether information in the PIS form pertains to one or multiple referrals; 2. Indicate outcome of safety and risk assessments; 3. Summarize the investigation: a) State date referral(s) was received and actioned; b) Description of actions taken (interviews, observations, collaterals) c) Explain whether all protection concerns were addressed during the investigation; d) Explain if additional protection concerns arose during the investigation and if they have all been addressed; e) Describe the outcome of the investigation – safety assessment, risk assessment, verification decision; f) Critically consider all information obtained during the investigation to determine if the child is in need of protective intervention; and g) Summarize decision as to whether or not the child is in need of protective intervention. 4. Indicate whether the case will close or transfer. The PIS form is used to: 1. Document the verification decision; 2. Document the **Safety Assessment** and **Risk Assessment** outcomes; 3. Document an analysis of the investigation that forms the basis for a decision about whether a child needs protective intervention; and 4. Document the protective intervention decision.
REFERENCES/ DOCUMENTS	The **SDM Risk Assessment** tool is used to inform the overall risk rating for the family. Further information about what to include in the risk assessment can be found in the SDM Policy and Procedures Manual. **Notification of Conclusion of a Protection Investigation** form (Form #:51-08-07-42- 318-2015-07) **Protection Investigation Summary** form (Form #: 51-08-07-42-18-856-201507) Protection and In Care Policy and Procedure Manual – Policy 1.7: **Observing and Interviewing Children.**

STANDARD #6	TRANSITIONING A CASE TO ONGOING PROTECTION SERVICES - PLANNING WITH FAMILIES
STANDARD	When a decision is made to transfer a case to ongoing protection services, the transition shall occur in a timely manner. The supervisor must review and approve all required documentation to ensure the case is ready for transfer. The case transfer is effective on the date the assessment social worker's supervisor approves all required case transfer documentation. Any existing safety plan shall continue without interruption during the transfer from assessment to ongoing protection. The social worker is responsible for managing any safety plan and addressing emergency family needs, unless the family has moved to another jurisdiction, until the case is officially transferred. A Family Strengths and Needs Assessment (FSNA) shall be completed on every case that has been transferred to ongoing protection services. The FSNA is completed within 60 days of receipt of the referral and prior to the development of the Family Centered Action Plan (FCAP). A social worker shall develop a Family Centered Action Plan (FCAP) collaboratively with the family when a child has been determined to be in need of protective intervention and document the plan on the FCAP form. A social worker shall complete the FCAP within 60 days of receipt of referral. The ongoing social worker shall notify all other service providers of their identity and contact information once assuming case responsibility. All documentation completed by the social worker to transfer a case is approved by the supervisor within 10 days of receipt of the completed case documentation, at which time the case can be transferred to ongoing protection services.
INTENT OF STANDARD	The purpose of this standard is: 1. To ensure case transfers to ongoing protection services are conducted smoothly, with as little disruption or delay in services to the child and family as possible, and with no interruption to the safety plan. 2. To emphasize the importance of case planning in ongoing protection services, as it is the foundation for all subsequent casework decisions and activities (interventions).

OUTCOMES	Ongoing involvement is necessary to ensure: 1. The child is safe from immediate safety threats; 2. The family understands the child protection concerns; 3. Services for the children of families continue without delay during the case transition process; 4. The family understands the outcome of their FSNA; 5. The family, its relatives, extended family and community supports have participated in developing the FCAP; 6. The family understands what they, their social worker and all others participating in the FCAP will do to resolve the child protection concerns; and 7. The family understands how progress will be measured.
PROCEDURES	**Case Transfer** Cases may transfer from one social worker, team, zone, or region. Despite this, the transfer shall still occur in a timely manner. **Review of Safety Threats in Planning with Families** Because family systems are continually changing, the ongoing safety of the child is examined and reviewed as part of the case transfer process and to inform the FCAP development. By jointly reviewing the safety plan, the social worker and the family can discuss the plan's relevance and effectiveness. The process facilitates client engagement and allows the ongoing protection social worker to assess: 1. The family's level of insight regarding the child protection concerns; 2. The family's ability to identify strengths and supports within their family; and 3. The family's willingness and ability to follow through with a safety plan or FCAP. The social worker and family examine/review the existing safety plan to ensure its continued effectiveness, considering: 1. The level of participation and cooperation of the parties; 2. The effectiveness, suitability and dependability of service providers; 3. Whether the safety threats are being managed; 4. To what extent the safety threats continue to be present; and 5. Whether protective capacities have been enhanced and are able to assure safety. **The FSNA Process** 1. The FSNA is designed to assist the social worker to identify the presence of parent and child strengths and resources as well as to identify the underlying needs of family members that are

PROCEDURES CONTINUED	associated with safety threats or longer-term risk of maltreatment. It helps social workers to systematically collect information and supports the development of a FCAP or a Plan for the Child that can target the areas of need. 1. The social worker completes the FSNA by: • Explaining to the family the purpose and process of the assessment; • Actively encouraging and engaging the family's participation in the process; • Obtaining signed consents and gathering information from all relevant sources; • Ensuring that the information gathered includes all aspects of the family's circumstances including: • Individual and family strengths; • Individual and family needs; • Resources available to the family; and • Any additional risk factors. The social worker engages the family in a dialogue, using the process of completing the FSNA to help the family identify its strengths, problems and goals regarding change. The information gathered while completing the assessment process is analyzed and interpreted by the social worker and reviewed with a supervisor. **Completing the FCAP** The case planning process provides a vehicle for sharing issues and looking for solutions. Together, the social worker and the family identify intervention strategies and services that would assist in the reduction and/or elimination of risk, and would increase the safety and well-being of the child. The FCAP also provides a way to measure the family's progress for both the family and social worker. The social worker develops an FCAP by: 1. Having the family participate in the case planning process; 2. Assisting the family in identifying those individuals and/or community partners whom they see as being a support to them and whom they would view as important participants in case plan discussion; 3. Engaging relevant service providers to discuss the goals and objectives; 4. Carefully considering any and all solution-focused options put forth by family members and service providers; 5. Ensuring that family uniqueness is honored and valued by customizing a FCAP that matches the family's individual strengths and needs;

PROCEDURES CONTINUED	6. Developing realistic, clear and measurable goals that are understood and agreed to by the child and family (refer to SMART objectives when developing FCAP goals and objectives); and 7. Documenting goals, objectives and activities on the FCAP form.
PRACTICE CONSIDERATIONS	The FSNA process is an interactive one that includes all members of the family, extended family (when appropriate), and any community supports or service providers who have been involved with the family in the past and present. **Content of the FSNA** The social worker gathers all information that can assist in formulating an accurate and comprehensive assessment of the family's strengths as well as any issues or risk factors that may affect child safety. This assessment services as a baseline to help the family identify and make the important changes necessary to safely care for their children. The assessment will also support the development of effective intervention strategies, and measurement of the family's progress. The assessment will include information provided by: 1. Departmental files; 2. The family and extended family; 3. Other persons in the family household; 4. Neighbors and/or community members involved with the family; 5. Other persons or agencies providing services to the family; 6. The social worker's direct observation of the child and the family. **Developing the FCAP** The FCAP is the link between the FSNA and direct practice intervention in ongoing protection services. It is an action plan that guides the family, social worker, other service providers and all casework activities toward well-defined goals and outcomes against which progress can be measured over time. The FCAP is a process and a document. The result of the case planning process is an FCAP document that is a record of clear and measurable goals, objectives and activities that must be achieved by participants, with time frames for completion. The purpose of ongoing protection services is to assist the family in making changes to behavior(s) or condition(s) that have caused risk to a child, rather than to change the unique character of a family system. Prior to the social worker and family developing specific interventions, there must be a complete and thorough examination and understanding of the family functioning that includes the family's strengths and needs.

PRACTICE CONSIDERATIONS CONTINUED	The social worker seeks to be holistic in their approach, obtaining knowledge and understanding of the child and family. This is done by considering the family's uniqueness, including ethnicity, culture, religion, and relationship to the family's extended family and community. The social worker uses the information gathered, plus their direct observations of the family and the input from family members to create a thorough analysis of the information gathered. The social worker shares this analysis with the family prior to or at the time of the FCAP process, and encourages full discussion. A copy of the FCAP is provided to the family, and any other individual who has signed the FCAP, once all signatures have been received (e.g. parents, social worker, and supervisor). **Explaining the Concept of Case Planning to the Family/Support Network** The social worker: 1. Explains and reviews the purpose and process for development of the FCAP with the family; 2. Emphasizes that this is the family's opportunity to "have its voice heard"; and 3. Explains and reviews with the family and other service providers that this is an opportunity for the family to contribute directly towards the goals and expected outcomes that will be included in the FCAP. **The Case Planning Process** The process of completing the FCAP includes an honest, open and clear discussion between the social worker and the family that results in the identification of specific goals, objectives and activities for the family to achieve. The collaborative, respectful assessment of underlying individual and family needs that are associated with safety threats or longer-term risk of maltreatment is balanced with an assessment of strengths and protective capacities that mitigate against risk. The resulting FCAP guides all subsequent interventions that are designed to change the conditions or behaviors that cause risk to the child. A copy of the FCAP is provided to the family, and any other individual who has signed the FCAP, once all signatures have been received. The FCAP is managed and reviewed continuously throughout the process of ongoing protection services.

PRACTICE CONSIDERATIONS CONTINUED	**Collaborative Planning with Families** Collaborating with families to develop the FCAP significantly improves the chances of its successful implementation, it should be noted that the social worker will not endorse any plans that they do not feel would adequately address child safety and risk simply for the sake of achieving agreement with the family.
REFERENCES/ DOCUMENTS	Family Strengths and Needs Assessment. Further information about what to include in the Family Strengths and Needs Assessment form can be found in the SDM Policy and Procedures Manual. Family Centered Action Plan Form #: 51-08-07-42_14-858-201507. Further information about what to include in the Family Centered Action Plan form can be found in the SDM Policy and Procedures Manual. Practice Standards: SMART Objectives and Activities

S.M.A.R.T.

OBJECTIVES AND ACTIVITIES

Specific
Measurable
Achievable
Result-focused and relevant
Time-limited

An objective is defined as:

"a statement that describes a specific behavioral outcome that will achieve the desired permanency goal. It's the behavior that must be achieved and maintained in order for the child to be safe."

Objectives:

- Are about behavioral change;
- Are more specific in scope than goals;
- Describe, in measurable terms, the end state of exactly what change is desired; and
- Describe the outcome that represents the elimination of the identified need or problem.

Objectives must have the following characteristics; they must be specific, measurable, achievable, result-focused and time-limited (S.M.A.R.T.) and should be formulated to address the factors that place the child at risk. This will assure that planned services are directed toward eliminating the concerns that initially brought the family to the attention of the Department and that services are individualized to meet each need.

Part of the social worker's responsibility, through casework intervention, is to engage and empower the client to become invested in these objectives in order to succeed.

It is important to remember to focus only on those objectives that relate to the risk of recurrence of maltreatment. Many families have multiple areas in their lives where changes could be made to improve parenting. If these areas are not related to risk they should not be the focus of objectives unless families feel strongly about including them.

Objectives are Specific

An objective clearly describes a behavior that must occur, or that must stop occurring, before the case is successfully closed.

This can create confusion for social workers when distinguishing between descriptions of parental behaviors that represent “end states” (objectives) and descriptions of parental behaviors that represent activities (planned services).

Like objectives, activities are also always written in behavioral terms, because by definition, they are statements of a person’s actions.

The differentiating factor is whether the change in the parent’s behavior is the desired end in itself (an objective) or a step towards and a means of achieving the objective (an activity).

Example:

Objective: Mr. O’Brien will understand and use only approved discipline methods with his children. Within 30 days, Mr. O’Brien will be able to explain to his social worker how he would use discipline methods he is learning, and why this is better for his children.

Activity: Mr. O’Brien will **attend, participate in** and **complete** all seven sessions of the identified parenting program.

Note that the verb in the objective tells us what Mr. O’Brien will do with his sons, while the verbs in the activity tell us what he will do to move towards the objective.

Objectives are Measurable

The parties to the plan must be able to reach consensus regarding whether the stated objectives have been accomplished.

The objective must include some easily discernible criteria by which achievement can be measured.

Writing measurable objectives is one of the most difficult parts of the case planning process. Many of the expected outcomes in child protection do not lend themselves to easy, precise quantification.

Some criteria are easy to observe but more difficult to measure. For example, one cannot write a measureable objective related to home cleanliness by quantifying the amount of dirt that is allowable in a home. A practical solution is an objective that includes many observable behaviors that are associated with cleanliness.

Example:

“The floor will be cleared of dirt, debris, food and garbage.” The objective provides realistic and measureable criteria against what to measure home cleanliness.

Social workers may be accustomed to writing objectives that contain the work improve such as “improved child care” or “improved housing conditions”.

“Improve” implies the existence of a describable baseline and a describable increase from the baseline. It also sometimes implies underlying values that define some behaviors as more desirable than others.

If observers have different values, they may not agree on what can be considered an improvement. In neither case is there an adequate description of an end state that can be measured.

Objectives are Achievable

Objectives must be realistic so that clients are able to accomplish them.

Example:

“Over the next 6 months, Mr. O’Brien will demonstrate the ability to discipline his children during visits without using physical punishment” is achievable; “Mr. O’Brien will not discipline his child” is neither achievable nor desirable.

Objectives are Relevant and Result Focused

This characteristic of objectives appears deceptively self-evident.

It is not uncommon, however, for social workers to derive their objectives from a “laundry list” of potential conditions that might improve parenting or care of the child.

Example:

“Mr. O’Brien uses non-violent methods of disciplining his child, including time-out and restriction of privileges as reported by the child and as witnessed by the social worker” could be an appropriately written objective but not for all situations in which there has been child maltreatment.

Objectives must be selected in the context of the factors that put the child at risk.

If the assessed problem is that the father is an alcoholic and has blackouts during which time the child receives no care, the objective stated above is unrelated to the assessed problem.

A better (more relevant and result focused) objective would be, “Mr. O’Brien will remain sober at all times he is supervising his children and will ensure that his children are adequately supervised at all other times, as evidenced by social worker observation, service provider observation and no new referrals for neglect during the next 60 days.”

Objectives are Time-Limited

A time frame within which the objectives can reasonably be expected to be completed should be included in the objective statement.

The assignment of a timeframe provides an additional criterion by which achievement of the objective can be measured.

Time should not be thought of just in terms of “court time.”

Smaller blocks of time for specific activities to be completed work best with clients who may be overwhelmed with the prospect of completing the whole case plan.

However, in order not to have to revise the written plan unnecessarily, it is best to have larger blocks of time (consistent with court times, if applicable) stated for objectives.

Smaller blocks of time are more appropriate for activities that are known to be time-limited.

STANDARD #7	CASE MANAGEMENT IN ONGOING PROTECTION SERVICES
STANDARD	A social worker shall complete a formal review of all cases receiving ongoing protective intervention services four (4) months following the development of the initial FCAP and every four (4) months thereafter. A formal case review shall be completed in collaboration with a family and their support network, where possible. The social worker shall complete the case review process for cases where children are living at home, a Kinship Care, Protective Care Agreement (PCA), or foster care arrangement. A social worker shall consult with a supervisor in the completion of the Risk Reassessment or Reunification Assessment, FSNA, FCAP, and Case Summary form. A social worker shall document the analysis of the information collected for the purpose of the formal case review on the Case Summary form. When a social worker is completing a home visit, the social worker shall observe all children if they are present in the home during every home visit. Where a child is home during the social worker's visit and is unable to be observed during the visit (e.g. the child refuses to see the social worker and goes to his/her room or leaves the home), the social worker shall document, in the electronic case file, the reasons why the child was not able to be observed and consult with a supervisor to determine the most appropriate plan for observing the child. A social worker shall make, at minimum, face-to-face contact with families in receipt of ongoing protection services based on the identified risk level. Effective **October 1, 2018,** the contact standards are outlined as follows: a) **Low-Moderate Risk:** Every two months; b) **High:** Once per month c) **Very High:** Twice per Month **For Low, Moderate and High Risk cases:** Contact with parents, at minimum, must be in the family home. Contact with children may occur in the family home or a different setting (e.g. school, daycare) as determined by the social worker and

STANDARD CONTINUED	supervisor. **For Very High Risk Cases:** One contact must include both parents and all children. The second contact must include all children but it will be the social worker and supervisor's discretion as to whether both parents should be seen; at least one parent shall be seen. Contact with parents, at minimum, must be in the family home. Contact with children may occur in family home or a different setting (e.g. school, daycare) as determined by the social worker and supervisor. All information reporting concerns about a child is considered to be a potential referral. Where information of alleged maltreatment of a child is received on an ongoing protection case, the social worker shall screen the information in accordance with Standard #1 and Standard #2. Cases that are being transferred require the completion of all documentation that is required for a regular case review prior to transfer. Cases that are being closed must be done so in accordance with Standard #8.
INTENT OF STANDARD	The purpose of this standard is to: 1. Describe the role and responsibilities of the ongoing protection services social worker; 2. Ensure timely case planning and review as it sets the stage for all case decisions and activities and determines when a family may no longer need protective intervention services; and 3. Ensure social workers engage families and their support network in case planning and the formal review process.
OUTCOMES	1. The child and family receive services identified in the FCAP or the Plan for the Child; 2. The family makes progress toward achieving its goals/objectives; 3. Risk of child maltreatment is reduced; 4. Children, youth, and families maintain ties to each other, their culture, their religion and members of their extended family and/or community; and 5. The child who is in out-of-home care achieves permanency in a timely manner.
PROCEDURES	A formal case review shall include the following: 1. An ongoing evaluation of the family's progress toward meeting the desired outcomes of the FCAP or Plan for the Child;

PROCEDURES CONTINUED	2. A recent interview or observation of the child (within the last 30 days) with the child in need of protection intervention, their siblings, and parents; 3. Involve an analysis of information provided during a social worker's regular and ongoing meetings with the child, parent, and other family members since the last case review or transfer to ongoing protective intervention services including information provided by each family member; 4. The frequency, location, nature and intent of the observations and interviews with the child are dependent on a number of clinical factors including, but not limited to: a) Previous injury to the child b) Child protection history c) Current safety threats d) Risk of harm to the child e) Age of the child f) Vulnerability factors including child's visibility in the community, physical, emotional or development issues g) Date of last contact with the child h) Willingness of the child to engage; 5. Observations of the parent child interactions; 6. An analysis of information received by collaterals since the last case review or transfer to ongoing protective intervention services; 7. A reassessment of risk through the completion of the Risk Reassessment or Reunification Assessment; 8. A reassessment of the family's strengths and needs through the completion of the Family Strengths and Needs Assessment; 9. A review of the current FCAP form and the completion of a new FCAP based on current assessment of risk and outcomes and activities required until the next formal case review (if required); and 10. An Assessment of visitation and permanency plans through the completion of the Reunification Assessment if a child is in care or kinship arrangement. The formal case review for **in-home** cases (children are residing in the home) requires completion of the following: 1. Risk Reassessment; 2. Family Strengths and Needs Assessment; 3. Family Centered Action Plan; and 4. Case summary. The formal case review for **kinship** service cases (children residing in kinship service homes on agreement) requires completion of the

PROCEDURES CONTINUED	following: 1. Reunification Assessment; 2. Family Strengths and Needs Assessment (FSNA); 3. Family Centered Action Plan (FCAP); and 4. Case Summary. The formal case review for a case with a **Protective Care Agreement (PCA)** requires completion of the following: 1. Reunification Assessment; 2. Family Strengths and Needs Assessment (FSNA); 3. Family Centered Action Plan (FCAP); and 4. Case Summary. The formal case review for a case where children have been **removed** requires completion of the following: 1. Reunification Assessment; 2. Family Strengths and Needs Assessment; 3. Case Summary **Please note:** While the Reunification Assessment (RUA) is required to be completed for out of home placements (i.e. in care, kinship), there may be rare circumstances where a child is initially safety planned out of the home, where maltreatment has occurred, and a clinical determination has been made that the child cannot safely return to the home, for an extended period of time until the concerns have been adequately addressed. However, the child has not been removed or is not residing in a kinship arrangement. In these cases, an RUA should still be considered in determining appropriateness of reunification. A Risk Reassessment (RRA) is only required, by policy, when all children reside in the home. During ongoing protective intervention, the FCAP is implemented and managed. The social worker continually provides support and evaluates progress in achieving goals and objectives. The social worker may need to adjust the plan to better meet the unique needs of the child and family as they emerge over time or circumstances. For families where children have been removed or there is a supervision order in place, the Plan for the Child is implemented and managed. The social worker continually provides supports and evaluation progress. The role of the social worker is to: 1. Meet with the family regularly and directly provide service to the family to support the achievement of identified goals and objectives; 2. Respond to any planned or unplanned changes or

PROCEDURES CONTINUED	circumstances; 3. Initiate a court application when required; 4. Prepare the family for participation in services; 5. Arrange, coordinate and monitor supportive services; 6. Assess the appropriateness of services; 7. Assure that the focus on goals and objective is maintained; 8. Facilitate communication amongst service providers; 9. Evaluate progress toward achieving goals and objectives; and 10. Develop and implement an alternate permanency plan if a child's reunification with their parent is unlikely. The formal case review requires a reassessment of risk of future maltreatment **or** if at least one child is in care or in a kinship service home, a reunification assessment including: a) A reassessment of risk; b) An assessment of the quality and frequency of visitation; c) An assessment of the environment to which the child is being returned; d) An assessment of the family's strengths and needs; During or following the completion of all required assessments, the social worker collects information from all service providers regarding the family's progress toward achieving FCAP goals. The review/reassessment process culminates in a formal **case plan review** every four (4) months from the last review. The review may occur within the context of a case conference, which may involve all family members and their support persons who participated in the FCAP or Plan for the Child, including other service providers whenever possible. Notwithstanding the four month case review process, when a Reunification Assessment recommends a child return home, a FCAP needs to be reviewed and revised/updated, as needed, prior to or shortly after a child has returned home (unless the child is returned home under a Supervision Order, in which the Plan for the Child, filed with the court, replaces the FCAP). **Case Review or Termination Documentation** Formal case reviews take place every 4 months following the completion of the initial FSNA and FCAP: 1. The risk reassessment or the reunification assessment; 2. Family strengths and needs assessment; 3. A case summary containing the following:

PROCEDURES CONTINUED	a) Referrals received since last case summary and the verification decision; b) Summary of the family's strengths and needs; c) An analysis of outcomes of all assessments, significant case events, review of the FCAP and the family's progress or lack of progress in achieving goals, objectives and tasks contained in the FCAP; d) Case decision – continue on going protection services or close the case; e) Summary and analysis of current child protection concerns if child is still in need of protective intervention; and Supervisor's signature indicating approval of the services provided and decisions made [within ten (10) days of social worker sending completed documentation to the supervisor]. **Permanency Planning** At the time of the first formal review and all subsequent reviews following a child being placed in care, it is critical to consider what the likelihood is for the family to achieve reunification. If the issues, problems and needs are significant, the family has made little or no progress in achieving its goals/objectives and reunification is unlikely, an alternate permanency plan is developed with the family. A Reunification Assessment guides this decision. It is important to involve all interested extended family members, significant others, relatives or other family support persons who may ultimately become the child's permanent caregiver. The social worker should conduct a thorough, continuous search for persons who may commit to participation in a permanency plan for the child. Wherever possible, the child should be placed with a family who is willing to work cooperatively with the child's parent toward reunification but is also willing to become the child's permanent family if needed. **New Referral on an Ongoing Protection Case** All information reporting alleged child maltreatment is considered to be a potential referral. A report that a child may be in need of protective intervention is given an immediate initial assessment by the family's ongoing protection services social worker and a screening decision is made. Standard #2 applies in decision-making regarding the initiation of a child protection investigation when a new, previously unknown incident or condition is reported.

PROCEDURES CONTINUED	When a child protection investigation is conducted on an ongoing protection case, the social worker completes: 1. A safety assessment; 2. A risk assessment; 3. Protection investigation summary with verification decision; and 4. An FCAP if new safety or risk factors have emerged. All information obtained during the investigation is recorded in case notes. • The information obtained during the investigation and the verification decision are integrated in PIS form and considered as part of the assessment of the child and family's strengths and needs and the overall analysis of the case **at the time of the next regularly scheduled (four month) case review**.
PRACTICE CONSIDERATIONS	The evaluation of a family's progress is an ongoing process that occurs during every home visit with a family. All interviews, home visits and interactions with family members are planned and purposeful to ensure a focus on meeting the outcomes of an FCAP or Plan for the Child. Planning does not mean that all home visits are always scheduled, rather that the intervention with a family, even crisis intervention, involves some level of preplanning about what may be required to deescalate a situation to ensure a child's immediate safety and the ongoing assessment of risk. In evaluating a family's progress, whenever possible schedule home visits with the child/youth and family mutually agreeable times. This reflects a respectful and collaborative approach to working with a family. It is important to be transparent with families and advise them that unannounced visits may occur at times. Unannounced home visits may be necessary when: 1. The social worker needs to determine whether or not the alleged perpetrator is in the home; 2. It is not possible to contact the family to arrange an appointment; and 3. It is necessary to assess the child's living conditions without the family having the opportunity to modify any of its usual conditions. A formal case review should be discussed with a family in a case conference format including the parents, informal or formal supports, a social worker and supervisor.

PRACTICE CONSIDERATIONS CONTINUED	Achieving permanency for every child is integral to their future health and well-being so it is important to continually assess whether a child can reunite with their family or if an alternate permanency plan is required. **Direct vs. Indirect Service Provision** The social worker provides direct service each time they interact with the family. In addition, the social worker provides indirect service by helping the family to access the services that were identified in the FCAP. The social worker needs to have a good knowledge of the family's community and the services or resources available. **Managing and Reviewing the FCAP** Managing the FCAP involves continuous, purposeful and focused discussion with the family members. The family's ability and willingness to follow the FCAP and meet the objectives laid out in the plan may vary from time to time. It is important for the social worker and family to have honest and open dialogue when this occurs. It may be that the FCAP requires adjustment to better "fit" the relevance and/or needs of the child and family circumstance at a particular time. The social worker shall review the FCAP or Plan For the Child with the family on a regular basis to assess the family's progress. Together the social worker and the family will: 1. Identify the objectives that have been achieved; 2. Determine which (if any) of those achieved objectives continue to be relevant, and should therefore be retained in the plan; 3. Identify the objectives that remain incomplete; 4. Determine which of the outstanding objectives remain relevant and require completion; 5. Determine which of the outstanding objectives require modification; 6. Determine which of the outstanding objectives (if any) can be discontinued because they are no longer relevant; 7. Identify any new objectives that should be added to the FCAP; 8. Write down the revised set of objectives, and obtain the agreement of the family; 9. Determine the specific formal and/or informal supports or services that are required to assist the family in achieving the revised list of mutually determined goals; 10. Determine whether or not those supports/services can be accessed by/for the family;

PRACTICE CONSIDERATIONS CONTINUED	11. Review with the family the effectiveness of other service providers and their impact related to any change both positive and negative regarding the family; and 12. Identify existing, additional, or new supports or services that will continue to be, or will become, part of the FCAP. The social worker keeps the family and all other participants involved in the FCAP informed of any changes to the plan. Doing so will ensure that all the participants in the FCAP clearly understand the common goals and objectives of the plan, and what is expected of each participant. If the plan is to be discussed with service providers, it is important to obtain consent from the family to do so. **Case Conferences** Case conferences serve a critical function in child protection work. Case conferences enable the extended family, community and professionals to come together directly with the child, and family to openly discuss concerns, identify strengths and seek realistic solutions. These discussions result in a case plan that contains specific and deliberate expectations allowing progress to be measured. Case conferences should be used for situations requiring significant decisions in the life of a case such as: 1. The development of the initial FCAP and for case reviews; 2. Prior to the child coming into care on a planned basis or following a child coming into care on an unplanned basis; 3. Prior to a child returning home from care; 4. Any time a critical/significant decision is to be made about the child; 5. Prior to court if there is a lack of agreement; 6. To address lack of progress on an issue; and 7. Prior to case closure. It is anticipated that regular case planning and conferences will be facilitated by the social worker, who invites the child, family, service providers and the family's chosen circle of support. The level of complexity of a case will determine what type of strategy will be most helpful based on the social worker's clinical analysis. Regular case conferences are a mechanism for all service providers involved and families to share information and to build the case plan.

REFERENCES/ DOCUMENTS	Family Centered Action Plan, Form # 51-08-07-42_14-858-201507. Further information about what to include in the Family Centered Action Plan can be found in the SDM Policy and Procedures Manual. Family Strengths and Needs Assessment, Form # 51-08-07-42-312- 201507. Further information about what to include in the Family Strengths and Needs Assessment can be found in the SDM Policy and Procedures Manual. Plan for the Child, Form # 51_08_07_47_19_2011 06. Further information about completing the Plan for the Child form can be found in the Protection and In Care Policy and Procedures Manual. Contact Standards in the SDM Policy and Procedures Manual. Case Summary, Form # 51-08-07-42-316-201507. Further information about what to include in the Case Summary can be found in the SDM Policy and Procedures Manual.

STANDARD #8	CASE CLOSURE – ENDING ONGOING PROTECTION SERVICES
STANDARD	An ongoing protective intervention case is ready for closure when: 1. Safety threats have been resolved and when identified risks have been reduced and can be managed safely with the strengths, and capacity of the family and their support network (family, community professionals); or 2. Exceptional circumstances occur that require case closure. The decision to terminate child protection involvement shall be made in collaboration with the family and in consultation with a supervisor. The social worker shall interview all children in the household within the 30 days of file closure. If it is not possible to interview a child due to their age and/or stage of development, the social worker is required to observe the child within 30 days of file closure. The social worker shall document and complete all required SDM documents and submit to the supervisor in accordance with Standard #7. Closure documentation is completed within three (3) weeks of notifying the family of the decision to close the case or at the time of the next regularly scheduled case review, whichever comes first. The supervisor shall approve the case closure documentation and close the Protective Intervention Program using the applicable case closure code within ten (10) days of the social worker completing the documentation. When advising the family of case closure, a social worker should engage the family in a discussion about available community services the family and prevent an escalation of any risk of subsequent maltreatment, if deemed necessary.
INTENT OF STANDARD	The purpose of this standard is: 1. To ensure the decision to terminate child protection services emerges from a case evaluation and is based on: a) Observable changes in behavior and family functioning indicative of resolved safety threats and lowered risk of future maltreatment; b) The family having demonstrated the ability to access and use resources to assist them in problem solving; and c) The achievement of goals and objectives. 2. To emphasize that service termination is a carefully planned process of transition in which the Department generally decreases the

INTENT OF STANDARD CONTINUED	intensity of its interventions, and the family gradually assumes full responsibility for the safety and well-being of its children.
OUTCOMES	1. Families have demonstrated their ability to ensure the safety and well-being of their children; 2. Families are aware of how to identify a need for services in the future and know whom to contact to access these services; 3. Families understand the importance of contacting community based services to meet their needs before child protection services become necessary; and 4. Families agree to seek services in the community prior to reoccurrences of child maltreatment.
PROCEDURES	**Case Closure Decision** 1. The decision to terminate ongoing child protection services is reviewed with and approved by a supervisor, within the context of a case review during a regularly scheduled supervisory session. 2. The case closure decision is: a) Discussed with the family; b) Informed by interviews with the children and parents and recent collateral information; and c) Based on a review of the family's progress since the last formal case review. 3. At a minimum, the following criteria must be met: a) All children in the household have been interviewed within 30 days of file closure. If it is not possible to interview a child due to their age and /or stage of development, they are required to be observed within 30 days of file closure. b) There is no evidence of current or safety threats; c) A review of the FCAP concludes that objectives identified in the FCAP have been achieved or that significant progress has been made and the family is able to sustain the change made; and d) A recent Risk Reassessment confirms that there are no safety threats present and the factors that were identified as contributing toward safety threats and risk factors in the earlier risk assessment/risk reassessment documents no longer exist, or have been reduced significantly enough that they no long pose direct safety threats and/or child well-being concerns. When discussing case closure with the family, a social worker engages the family in a discussion about community resources

PROCEDURES CONTINUED	that could be accessed to assist the family and prevent an escalation of any risk of subsequent maltreatment. Sometimes the Department will need to close a case even though the above criteria have not been met. Circumstances requiring case closure without the above criteria include: 1. The family is refusing to work with the Department to address risk factors and the court has determined that there is no legal basis to provide mandatory Ongoing Protective Intervention Services; 2. An alternate permanency plan (placed for adoption, custody transferred to another individual, a long-term Kinship Care Agreement without Custody has been signed with the parent(s), or the child is now in the Continuous Custody of a manager) has been achieved for the child and there are no other children in need of protective intervention in the home; 3. All children determined to be in need of protection have reached 16 years of age; 4. The child is deceased and there are no other children under 16 years of age living in the home; 5. The parent has died and there is no other parent currently on the file; 6. The family has moved out of province and another jurisdiction is now providing service; and 7. The family cannot be located despite the social worker having exhausted all options to locate the family (records checks/checking with collaterals such as the school and police for information about a family's location, visiting potential locations to see if the family resides there). If a family cannot be located, the social worker and supervisor shall discuss the need to send alerts to other regions and place on provincial and, where required, inter-provincial information systems. Refer to the Provincial/Territorial Protocol on Children and Families Moving Between Provinces and Territories. **When a Court has Determined a Child is Not in Need of Protective Intervention** When a client is declining to work with the Department to address safety/risk factors, a social worker shall consider legal options to ensure the child's safety and well-being such as filing an application for a supervision order or seeking a warrant to remove. When a court has determined a child is not in need of protective intervention, this means that court proceedings have been pursued to ensure a child's safety and well-being and have not been successful (e.g. an application for a supervision order has been filed and a judge has declared that a child is not in need of protection).

PROCEDURES CONTINUED	In these situations, a social worker shall ensure all legal options have been explored in consultation with a supervisor and legal counsel, and that the client is still refusing to work voluntarily with the Department **before closing the case.** **Case Closure Documentation** A social worker shall document and complete all outstanding clinical documents prior to closing a case, including circumstances where other closure code reasons are used. Case closure documentation covering the period from the date of the last case review to the date of service termination is required when closing a case. If the most recent FCAP was focused on working with the family towards case closure, and the termination of service to the family occurs within 3 months of the FCAP, it is not necessary to complete a new FSNA, unless that assessment does not accurately reflect the family's current functioning. Case closure documents include: 1. Safety Assessment (when a previous safety threat was identified and led to a safety plan) EXCEPT in Ongoing Protection cases where a Risk Reassessment (RRA) or Reunification Assessment (RUA) has to be completed as there is a Safety Reassessment built into the RRA/RUA forms; and 2. Risk Reassessment (if the most recent RRA was completed prior to 30 days ago) 3. Reunification Assessment (if the most recent RUA was completed prior to 30 days ago); 4. Case Summary. When an order for continuous custody is made, a social worker can close the case without having to complete the case review documents **(with the exception of the Case Summary form)** for the next scheduled case review period. The Case Summary form is required to be completed as this is where the social worker documents the decision to close the case. Closure documentation is completed within three (3) weeks of notifying the family of the decision to close the case or at the time of the next regularly scheduled case review, whichever comes first. In exceptional circumstances, there may be times when outstanding clinical assessments may not be able to be completed. For example, a CPR has been screened in for investigation on an ongoing protection

PROCEDURES CONTINUED	case. The social worker cannot locate the family despite having attempted and exhausted all options reasonably available (e.g. phone calls, home/school visits, provincial databases, collaterals) or the social worker has confirmed the family has moved out of province. As the family cannot been located/contacted, the Safety Assessment, Risk Assessment, and Protection Investigation Summary for that investigation are not able to be completed. In these cases, clear documentation is required to explain the reasoning behind the incomplete assessments. A supervisor shall approve the case closure documentation and close the Protective Intervention Program using the applicable case closure code within ten (10) days of the social worker completing the documentation. **Case Closure Codes** A supervisor shall electronically close the case by selecting the appropriate code from the list below. If the case is closing due to one of the six circumstances outlined in the Procedures section, an exception closure code may be used that corresponds with the circumstance requiring closure (e.g. the child is now in the continuous custody of a manager). The file shall contain up to date SDM documentation. A list of regular and other closure codes are as follows: **Regular Closure Reasons/Codes** 1. **Child no longer in need of protection (Ongoing Protective Intervention cases)** – select this code if the case was transferred to ongoing protective intervention services due to the child's need for protective intervention but is now ready for closure; 2. **Child is no longer in need of protective intervention because the court has determined a child is not in need of protective intervention and the Department has determined that no further intervention is required – close case**; 3. **Investigation Discontinued – Referral Information Does Not Match Family –** select this code if a case is closing due to a determination that the referral information did not match the family originally identified in the referral and no other protection concerns were observed; 4. **Parent is Involved in Another Active PIP File** – select this code if a parent is involved in another active PIP file and has been added to that file. The closing file must be cross referenced to the active PIP file.

PROCEDURES CONTINUED	**Other Case Closure Reasons/Codes** 1. **Family moved out of province** – select this code if the family has left the province without our knowledge or prior planning regarding the move; 2. **Family cannot be located** – select this code if the family cannot be located despite the social worker having exhausted all options to locate the family (records checks/checking with collaterals such as the school and police for information about a family's location, visiting potential locations to see if the family resides there). If a family cannot be located, the social worker and supervisor shall discuss the need to send alerts other regions and placed on provincial and, where required, inter-provincial information systems. Refer to the Provincial/Territorial Protocol on Children and Families Moving Between Provinces and Territories. 3. **Youngest child turned 16** – select this code if the child in need of protective intervention has now turned 16 years of age and there are no other children under the age of 16 in the home; 4. **Child is not returning home** - select this code if the child in need of protective intervention is in the continuous custody of a manager, is placed for adoption, is in the custody of another individual other than the parent from whom the child was removed(including a long-term Kinship Care Agreement with custody), or a long-term Kinship Care Agreement without Custody has been signed with the parent(s), and there are no other children in need of protective intervention in the home;" 5. **Child deceased** – select this code if the child in need of protective intervention has died during our involvement with the family and there are no other children in need of protective intervention; or 6. **Parent(s) deceased** – select this code if the parent(s) of the child in need of protective intervention has died during our involvement with the family and there is no other parent/caregiver involved in the file who has child protection concerns and is caring for the child. **Advising the Family of Case Closure** In addition to discussing the case closure decision in person with a family, a social worker shall also advise the family of case closure in writing. The reason for closure should be specified, such as the family has met the objectives outlined in the FCAP and the child is no longer in need of protective intervention or the case is closing as the youngest child is now 16 years of age and beyond the legislative age mandate for involvement.

PRACTICE CONSIDERATIONS	**Indicators of Family Readiness for Closure** When the social worker is considering whether or not to close the case, the following are some indications that the family may be ready to manage on its own: 1. The parent has been able to develop and now uses positive/acceptable strategies to address and manage child behaviors; 2. The family has been able to demonstrate that family members have learned and integrated appropriate coping and problem solving strategies; and 3. The parent has the skills to be, and sees the value in being proactive in seeking assistance in parenting issues. **Advantages of Involving the Family in Discussions of Case Closure** 1. The family may more clearly understand that their efforts toward achieving goals will result in their improved capacity to care for and provide a safe home for their child. 2. Because the family has an opportunity to contribute to the "how" and "when" case closure will occur, there may be a higher probability that the family will be able to sustain the improvements it has achieved. 3. Working together in the closure process may improve client confidence that the family will be able to respond to any future stress or crisis that will arise. This may result in a reduction in the need for the family to receive services from the Department in the future, or an increased likelihood that the family will contact the Department and self-refer earlier because they see the Department as being helpful. 4. The case closure process is an opportunity for the family and the child protection worker to reflect together on successes and achievements. **Advantages of Involving the Supervisor in Discussions of Case Closure** 1. Review of the case with the supervisor allows for an objective review of the social worker's recommendation, and ensures there are no aspects of concern that are being overlooked. 2. The supervisor may be able to help strategize to ensure the family has access to ongoing community supports. **Advantages of Involving Service Providers in Discussions of Case Closure** 1. There is an opportunity to discuss and clarify the future role and

PRACTICE CONSIDERATIONS CONTINUED	working relationships that community service providers will have with the family. 2. Where formal service providers are expecting to reduce their involvement with the family, there is an opportunity to identify any problems that might arise, and strategize accordingly before the service is withdrawn. 3. If service providers, when informed of the plan to close the case, express no child protection concerns, their reaction may be seen as validation of the social worker's decision. 4. If service providers, when informed of the plan to close the case, do express protection concerns, the social worker should review the information and any impact on the case closure with their supervisor and/or strategize as to how to mitigate these concerns.
REFERENCES/ DOCUMENTS	Case Summary, Form # 51-08-07-42-316-201507.

STANDARD #9	CLINICAL SUPERVISION AND CASE CONSULTATION
STANDARD	This standard articulates the minimum requirements with respect to supervisory consultations, review and approval of casework decisions. Any decision that affects the safety or permanency of a child shall be made in consultation with or reviewed and/or approved by a supervisor prior to implementation. Consultation with a zone manager may also occur, where necessary, on complex clinical cases. The supervisor shall approve and sign all related SDM documents. All cases are reviewed with a supervisor on an ongoing basis within the context of a regularly scheduled supervision session or as required. Cases with a higher degree of risk or complexity may be reviewed more often. The following decisions are reviewed with and/or approved by the supervisor: 1. Plan for worker safety (when required) is reviewed prior to beginning an investigation; 2. Every new or revised safety plan is assessed by the supervisor and approved prior to its implementation; 3. When no safety threats or concerns are present, the safety assessment is reviewed with the supervisor during the next business day; 4. The verification decision and the decision about whether a child is in need or protective intervention is reviewed within the context of a regularly scheduled consultation prior to the completion of an investigation. This process consists of a comprehensive case review including: a) Referral information; b) Steps taken during the investigation; c) All relevant information obtained during the investigation; d) Results of the safety assessment and safety plan, risk assessment, family strengths and needs assessment, FCAP, risk reassessment, and reunification assessment as applicable; e) Overrides on the assessment tools; and f) Placement of a child/youth in out-of-home care with extended family or community members or in an approved placement.

STANDARD CONTINUED	The supervisor shall review and approve documents, including regular case review and closure documents, completed by the social worker within 10 days of the social worker submitting the documents to their supervisor. The supervisor also provides ad hoc consultation or authorizes decisions when decisions are required to be made quickly to ensure the immediate safety of a child. All case specific content discussed with a supervisor (including reviews and approvals or decisions and the rationale for them) is documented in case notes by the social worker. Consultations must be reviewed by supervisors in accordance with the Departmental Documentation Guide, Appendix D, Policy 7.2: File Documentation. 1. The supervisor's signature on case documentation submitted by the social worker at the end of an investigation, a formal case review, case transfer, or case closure indicates approval of: a) The quality of the investigation or quality and effectiveness of ongoing protection services in relation to expectations of relevant standards, policies, procedures and protocols; b) The social worker's assessment of safety and risk and the appropriateness of associated decision and plans; c) Casework decision making (effectively, timely, appropriate); and d) The written documentation in accordance with the Departmental Documentation Guide, Appendix D, Policy 7.2: File Documentation.
INTENT OF STANDARD	The purpose of clinical consultation and supervision is to: 1. Provide a structured, guided and collaborative process of case decision making; 2. Provide a range of supervisory involvement in decision-making. Case review approval is matched with level of risk and complexity of the case, as well as, the level of knowledge and skill of the social worker; 3. Support casework decision being made within the context of an appropriate level of knowledge, skill and objectivity; and 4. Ensure an appropriate level of accountability for the quality of service provided and supporting documentation.

OUTCOMES	Clinical supervision should assist in: 1. Casework decisions being objective and supporting the safety and well-being of the child; 2. Children and families receiving a high quality of service, in accordance with relevant standards, policies, procedures, and protocols; 3. Exceptions to standards, policies, procedures, and protocols resulting in increased safety for the child and/or better meet the unique needs of the child and family; 4. Case documentation being timely, thorough and accurate; and 5. Documentation accurately reflecting information obtained about families, assessments and decisions (including rationale).
PROCEDURES	**Clinical Supervision** Case consultations occur during regularly scheduled supervision meetings between the social worker and supervisor. The social worker prepares for supervision by reviewing the case information and formulating a recommended course of action. The focus of discussion during supervision is on the rationale for decisions that are being recommended by the social worker. The social worker's ability to formulate a recommended course of action will vary depending on their level of knowledge, skill and experience. Supervisors will collaborate with social workers and play a more directive and educational role with staff on an as needed basis. Casework activities that are the focus of clinical supervision include: 1. The ability of the social worker to engage the family and the quality of the relationship; 2. The appropriate use of authority; 3. The accuracy of the SDM assessments and associated decisions and plans; 4. The process of development of the FCAP with the family and whether the family has been integrally involved; 5. The appropriateness of services and interventions in addressing the unique needs of the child and family; and 6. The review of progress and outcomes being achieved. **Ad Hoc Case Consultation** Unscheduled ad hoc consultations may be necessary when decisions need to be made on an urgent basis in order to secure the safety of a child. There are, however, disadvantages to

PROCEDURES CONTINUED	relying too heavily on this approach. There is generally little time to prepare for them and they can be hurried and unstructured. In addition, decisions may be made without sufficient time to consider alternatives carefully. **The Role of the Supervisor in Supervision** Child protection services is a very complex process involving the collection synthesis and analysis of vast amounts of information. Decisions which result from this process have a direct impact on children and families. Clinical supervision and supervisory consultation are fundamental in this process and impact the quality of service provision to children and families.
PRACTICE CONSIDERATIONS	**The Role of Supervisor in Supervision** The social worker is the case manager and has the most direct knowledge of the family. Thus, it is not intended that every caseload decision is made with a supervisor. Casework decisions are guided by the use of clinical tools such as the SDM assessment tools, which are specifically designed to inform and enhance decision-making throughout the casework process. Clinical tools do not make decisions; social workers make casework decisions based on information and observation gathered through their interactions with the family. The supervisor shall support and facilitate the assessment, investigation or on-going service through a regularly scheduled supervisory process of collaboration case review, analysis, and decision-making, as well as feedback, guidance, and direction. Social workers who have attained a level of skill can make routine decisions on cases without supervisory input. Supervision provides the opportunity for both the social worker and supervisor to rely on each other for information. The supervisor shall facilitate the social worker's ownership of the case and the associated decisions. This is achieved when the supervisor creates an expectation that the social worker applies their training, knowledge, experience and required skills to make recommendations for service or intervention. The supervisor shall further emphasize the difference between independent decision making and those decisions that require supervisory input as outlined in departmental standards and policies. In addition, the supervisor's role is one of accountability and

PRACTICE CONSIDERATIONS CONTINUED	quality assurance. The supervisor shall monitor the quality of the assessment and investigation and its components or the quality of ongoing service provision, as well as compliance with relevant standards, policies, procedures, and protocols. The frequency and type of consultation required (which may exceed the standard but not fall below it) is based on an assessment of the level of knowledge and skill of the social worker, as well as the complexity and level of risk of the case. As a general rule, higher risk cases are reviewed more frequently. The social worker may seek consultation with a supervisor at any time that a decision is either complex and/or has impact on a child's safety. **The Process of Clinical Supervision** All cases are reviewed with a supervisor on an ongoing basis within the context of a regularly scheduled supervision session or as required. Best practices to consider may include supervision at the following points: 1. At least once every month during an investigation; 2. Minimally once every six weeks for ongoing protection cases; and 3. Prior to case closure and completion of an investigation. Clinical supervision is focused on case-specific information that is relevant to making casework decisions and social worker-specific issues that are related to the provision of effective intervention. The ability of the social worker to engage the client and the quality of the rapport or helping relationship between the social worker and client are brought into focus during case-specific discussions, as is the issue of an appropriate use of authority inherent in the social worker's role. Child protection social workers deal with personally challenging, emotionally charged issues and circumstances. Their values and beliefs or unresolved personal issues can affect how they feel about, interact with, or respond to clients and most importantly can impact on their abilities to make decisions objectively. Supervisors assist social workers in assessing how their values, beliefs, and life experiences may be impacting on their interactions with clients and on their ability to engage clients effectively. The supervisor continually reviews, evaluates and coaches by providing feedback, guidance and direction.

APPENDIX A

INTERVIEW AND OBSERVATION QUESTIONS

Interviews

1. Interviewing the Child Alleged to be in Need of Protective Intervention

The purpose of seeing and interviewing the child first is to gather information to determine if the child has been maltreated and to obtain information to verify or refute the referral allegations. The social worker should use age appropriate interviewing techniques to gather accurate and pertinent information to minimize trauma to the child.

Examples of information that the social worker should attempt to obtain from the child are:

a) What happened (with respect to the alleged maltreatment), when and where it occurred and who was present;

b) The child's current physical and emotional condition;

c) The type, severity and duration of the maltreatment;

d) The impact of maltreatment on the child (e.g. extreme withdrawal, fear of parents);

e) The identity of others who have information about the child's condition and the family situation;

f) The child's personality characteristics;

g) Unusual or inappropriate behavior or feelings;

h) Other who reside in the home;

i) The child's relationship with and feeling toward the parents and siblings;

j) The child's perception of the relationships among others in the household;

k) The child's perception of how family problems are addressed;

l) The child's relationship with peers, extended family and/or other significant persons; and

m) The child's daily routine (e.g. school, day care, home life, outside activities).

2. Interviewing the Siblings

Following the interview with the child alleged to be in need of protective intervention, the next step should be to interview siblings. The purpose is to determine if the siblings have experienced maltreatment and to assess their level of vulnerability to maltreatment. In addition, the social worker will gather corroborating information about the nature and extend of any maltreatment of the identified child. Examples of information that the social worker should gather from siblings include:

a) The siblings personality characteristics, behaviors, and feelings;

b) Information about alleged maltreatment;

c) Maltreatment they have experienced and, if so - how, when, where, how often, and for how long;

d) Further information about the parent (e.g. feelings and behaviors frequently exhibited, problems, child rearing techniques, and parents' relationships outside the home);

e) Further information about the family's functioning, dynamics, demographics, and characteristics; and

f) Information that could not be obtained from the identified child or confirmation of information gathered during the initial interview.

3. Interviewing the Non-Maltreating Parent

When interviewing the non-maltreating parent, the primary purpose is to determine their capacity to protect the child, to find out what this individual knows about the alleged maltreatment, and to gather information related to the risk of maltreatment. Examples of information that the social worker should gather from the non-maltreating parent include:

a) Description of alleged maltreatment;

b) Feelings regarding the maltreatment;

c) Acceptance of the child's version of what might have happened and who the parent/caretaker deems is responsible;

d) Capacity to protect the child and his/her opinion about the vulnerability of the child(ren);

e) Feelings, expectations, and perspective about the identified child and siblings;

f) Description of the characteristics, feelings, and behaviors of the child(ren), approach to, and view of parenting, methods of discipline, and relationship to the children;

g) Relationship to the alleged maltreating caretaker, roles in the family and overall family functioning, and levels of communication and affection;

h) Approach to solving problems, ability to deal with stress, use of drugs/alcohol and view of him or herself;

i) History as a child (positive and negative memories);

j) Criminal activity, or history of physical or mental health problems;

k) Relationships with others, or involvement in community activities;

l) Demographics about the family, including financial status and other factors that may be stress producing; and

m) View of supports in his/her life, relationships with extended family.

4. Interviewing the Alleged offending Parent

When it appears that the alleged offending parent may have committed a criminal offence, the police must be notified immediately and prior to the interviewing of the individual. It is the responsibility of the police to interview the alleged offender and obtain a statement. Where it appears that a child's safety is threatened and the police are not available to respond, the social worker must take measures to ensure the protection of the child without jeopardizing the police investigation.

When interviewing the alleged offending parent, the intent is to evaluate their reaction to the allegations of maltreatment and to gather further information about them and the family in relation to the risk and safety of the child(ren). Examples of information that the social worker gather are:

a) How they describe what happened in relation to any alleged maltreatment;

b) Their response to the incident(s);

c) Their present emotional state, particularly in terms of the possibility of further harm to the child;

d) Their view of the child and the child's characteristics and condition;

e) Their relationship with the child(ren) and others in the family;

f) Their approach to parenting, expectations, and sensitivity to children;

g) Their description of the roles and functioning in the family, methods of communication and level of affection;

h) Their approach to solving problems, dealing with stress, use of drugs or alcohol, view of self and coping;

i) Their history as a child and an adult, including any health or mental health problems, criminal history;

j) Their relationships outside the home, supports, memberships, and affiliations;

k) Their description of demographics about the family, including financial status and other factors that may be stress producing;

l) Their access to the child; and

m) Their willingness to accept help.

Observations

Part of the process of gathering adequate information includes the social worker's responsibility to observe the identified child, siblings and parents within the family environment. Observation of the child(ren)'s behavior and the parent-child dynamics can provide valuable clues to the presence of maltreatment. The social worker must look for indicators of possible maltreatment and view those indicators in the context of the referral concerns, information provided by the child, parents and others about the family, family strengths and protective factors and current literature about a particular type of maltreatment.

1. Physical Indicators of Maltreatment:

The physical indicators such as the condition of the child(ren), including:

a) Any observable effects of maltreatment such as bruises, broken bones, cuts, welts, abrasions, and

b) The physical status of home, including cleanliness, hazards or dangerous living conditions.

2. Emotional and Behavioral Indicators of Maltreatment:

a) A child who shows marked behavioral or emotional changes in one or more areas of functioning where there is no clear precipitating factor;

b) A child who has unusual or sudden fear of adults or one particular individual;

c) A child who shows fear of removing clothing in gym classes or in a doctor's office, or refuses to use toilet facilities when attending day programs;

d) A child who doesn't want to go home, or strongly objects to going to day care or school;

e) A child who shows an overly detailed, age-inappropriate knowledge of sexual behavior, including sexualized drawings, “provocative" sexual behavior, or a preoccupation with sex in conversation;

f) A child who, in the absence of the parents, is inappropriately affectionate with strangers;

g) Severe depression or any serious self-destructive behavior, like drug abuse or attempted suicide;

h) Sleeping disturbances like nightmares, fear of going to bed, screaming, or fear states such as phobias or hysteria;

i) A child who attempts inappropriate sexual behavior with other children, particularly younger children and perhaps in an angry, aggressive or controlling way;

j) Unusual or sudden fear of particular areas of the house, for example bathrooms, any room with closed doors, a bedroom; and

k) A child whose personal hygiene is consistently substandard.

3. Parental Behaviors That may Indicate Maltreatment:

a) A parent who is vague or inconsistent about details of an injury he/she would be expected to know about. The parent may also blame a third party for the injury;

b) Parents who show no concern and resist contact with the child once the child is admitted for medical treatment;

c) A parent who refuses to consent to further diagnostic tests or treatment when it is clearly required for the safety and well-being of a child;

d) A parent whose behavior puts the child at risk or is insensitive to the child's needs. The degree of risk will vary depending on the age and developmental level of the child;

e) A parent who shows evidence of temper, impulsiveness, loss of control or fear of losing control in relation to the child, to the extent that the child's safety or well- being is endangered;

f) A parent or family who is isolated from the community or support systems;

g) A parent who suffers from a mental illness that may at times limit his/her ability to protect the child; and

h) A parent who is consistently critical or unsympathetic towards the child