California Department of Social Services
Validation of the SDM® Reunification Reassessment

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

I. INTRODUCTION

In early 1999, the State of California began a phased implementation of a new case management system for child welfare services (CWS). The California child welfare Structured Decision Making® (SDM) system was developed in 1998 by seven pilot counties with the assistance of Children's Research Center (CRC) and the California Department of Social Services (CDSS). Workgroups comprised of staff from pilot counties and CRC developed several objective assessments to improve child welfare case management, including the following:

- A hotline screening protocol, to help determine if an intake referral meets the criteria for an in-person investigative response;
- A response priority assessment, to help intake workers decide how quickly to respond to an allegation of abuse and/or neglect;
- A safety assessment, to identify service interventions to protect children during a protective service investigation;
- An actuarial risk assessment, which estimates the family's risk of future maltreatment at the close of an investigation;
- A family strengths and needs assessment, to help workers identify case plan goals and appropriate interventions when a case is opened for in-home or foster care services;
- A child strength and needs assessment, for identifying service interventions to improve the well-being of children.
- An in-home case risk reassessment, to evaluate progress toward case plan goals, update case plans, and estimate the likelihood of subsequent child maltreatment; and
- A foster care reunification reassessment, to monitor family progress towards reunification and inform the worker's decision to reunify a child.

The primary objectives of the SDM® system are to help child welfare agencies improve child well-being and safety and to expedite permanency. Workers complete SDM assessments at

critical points in the child welfare case management process, e.g., safety planning, case opening, case plan goal identification, and child reunification. The assessments are fully integrated into CDSS case management policy guidelines for intake screening, child protective services (CPS) investigation, and ongoing family services. Since SDM implementation in 1999, the California family risk assessment and risk reassessment have been validated twice, and the construct validity of the response priority and safety assessment has also been assessed. Since the SDM assessments workers use in foster care took longer to implement, and placement case outcomes require additional time to observe, it was not possible to assess them until recently. By 2005, 17 California counties had implemented the family strengths and needs assessment (FSNA) for case planning and the California reunification reassessment (CRR) for evaluating caregiver progress toward reunification.

In 2009 CDSS contracted with CRC to conduct a validation study of the CRR and the FSNA. Since the objectives of the SDM system are to improve child safety and expedite permanency, preferably by reunifying the child and family, this study attempts to (1) examine the relationship between foster care case assessment findings and two outcomes which reflect permanency and safety—child reunification and foster care reentry; (2) evaluate the utility of both assessments as constructs for improving reunification or reentry outcomes; and (3) propose changes in assessment procedure or content that may improve their performance.[1]

[1] The views expressed in this report are those of the authors and do not necessarily represent the views of the California Department of Social Services.

II. DEVELOPMENT AND IMPLEMENTATION OF THE SDM® FAMILY STRENGTHS AND NEEDS ASSESSMENT AND REUNIFICATION REASSESSMENT

The FSNA and CRR procedures adopted in the California pilot counties were initially developed and implemented in Michigan. A workgroup of Michigan caseworkers, supervisors, and CRC staff designed an FSNA to help workers evaluate families with children in foster care when reunification is the case plan goal. Group members reviewed relevant research and drew upon field experience to identify areas of family functioning workers should assess shortly after placement to develop a case plan for reunification. A separate reunification reassessment was developed to evaluate case plan progress, visitation compliance, and child safety at three-month intervals after the initial placement. Both assessments were supported by policy guidelines for case plan construction and permanency decisions. In 1997, these case management procedures were implemented in several pilot counties. A 2001 evaluation compared outcomes for cases served in Michigan pilot counties to those served in non-implementing counties. Pilot counties reunified children more quickly without increasing foster care reentry (Johnson & Wagner, 2005).

The California FSNA and CRR were developed by a workgroup of staff from California SDM counties and CRC staff. The California versions of these assessments share some similarities with Michigan's, and are supported by different case-planning and permanency guidelines. These assessments were developed after a review of relevant research available at that time. A careful evaluation of caregiver functioning, preferably one that involves the caregivers, has long been recognized as a critical first step in the foster care case-planning process (Seaburg, 1986; Rooney, 1988). The role that caregiver problems such as substance abuse, mental health, household relationships, domestic violence, social support, poverty, and housing play in reducing the prospects for successful reunification is also clear (Rzepnicki,

Schuerman, & Johnson, 1997; Jones, 1998; and Terling, 1999). In addition, many researchers have recommended that specific case plan goals for parent-child visitation (Fanshel, 1982) and participation in service interventions (Stein & Gambril, 1977; McMurtry & Lie, 1992) be clearly communicated.

The FSNA was developed for workers to use to evaluate families shortly after a child enters foster care. Caregiver functioning is assessed in areas that may impact child reunification, such as substance abuse, mental health, and social support. Each assessment domain can be scored as a problem that may require service intervention or a family strength that may assist the child's return. The FSNA was designed as the first step of a systematic approach to case planning. Workers complete the assessment and review the findings to develop case plan goals and service interventions for priority need areas to expedite the return-home goal. A separate child strength and needs assessment (CSNA) was also developed to identify case plan goals and service interventions for improving child well-being.

The CRR is used to evaluate progress toward the reunification goal *after* the FSNA is scored and the initial case plan has been implemented for six months. Workers use the CRR to evaluate caregiver progress toward case plan goals, quantity and quality of parent/child visitation, and child safety. The assessment findings and associated policy guidelines help workers decide if a child can safely be returned home.

This study examines the practical utility of the FSNA as a device for helping workers set case plan goals for reunification. Since it was developed in a workgroup of experienced practitioners, face validity has been established. The question addressed in this study is predictive validity, i.e., does the FSNA identify caregiver needs or strengths that impact subsequent reunification? This potential relationship is tested by evaluating whether worker-scored FSNA items have the expected relationship to reunification. Evidence that the

FSNA can differentiate family strengths or needs that forecast reunification would confirm its utility as a device that can help workers assess caregivers and develop case plans.

The CRR is evaluated in a similar manner, but it is tested against a different case outcome. Since the CRR helps the worker decide that a child can be safely returned home, its predictive validity is established by examining the relationship between the CRR assessment findings observed prior to reunification and reentry into foster care. The question is whether the CRR can help identify children with high or low rates of foster care reentry prior to the reunification decision.

III. RESEARCH SAMPLES

The California Child Welfare System Case Management System (CWS/CMS) and the webSDM data system were accessed to construct FSNA and CRR validation samples.[2] Data were extracted from the 17 California counties that implemented the FSNA and CRR assessments prior to the end of the first quarter of 2005. An initial sample extract identified the first placement episode for all children age 15 or younger removed from their homes between January 1 and December 31, 2005.[3] From this sample, permanency planning goals were examined to select children with a return-home goal. This resulted in a base sample of 21,105 children.[4]

Two separate subsamples were then drawn to conduct the FSNA and CRR analyses. The FSNA sample includes children entering foster care for whom workers conducted a caregiver(s) FSNA within 30 days prior to or 90 days after the initial placement. Reunification was observed during a standardized 15-month period following the initial placement. The CRR sample selected children from the base sample who (1) were reunified within 15 months of entry into placement and (2) had an CRR completed in a 90-day period preceding reunification.[5] Foster care reentry in the CRR sample was observed during the 12 months following reunification.

The 15-month post-removal reunification and the 12-month post-reunification foster care reentry outcomes reflect Child and Family Services Review (CFSR) performance standards.[6] The

[2] The webSDM database records SDM assessment findings scored by workers.

[3] The 2005 removals were selected to allow adequate time to observe reunification and subsequent reentry.

[4] If the first case plan goal after the removal episode was "Adoption," "Adoption with Sibling," "Legal Guardianship," "Long-term Foster Care with Non-relative," or "Long-term Foster Care with Relative," the placement was dropped from the analysis (these are children for whom the initial assumption was that they would not be reunified). It was assumed that the remaining cases were removed with a goal of reunification.

There were 22,386 children with at least one placement episode that began in 2005. Of those, 1,281 were 16 or older at the time of the initial removal and were not included in the sample.

[5] Children whose placement episodes were terminated for the reasons "Reunified with Parent/Guardian (Court)" and "Reunified with Parent/Guardian (Non-court)" were considered reunified.

[6] Adoption and Safe Families Act of 1997; Public Law 105–89.

FSNA and CRR assessments observed in this study were completed during the sample placement episode, and additional data were secured from the safety assessment and California family risk assessment workers completed for the investigation that led to the sample child removal.

These are convenience samples. The FSNA and CRR must be completed by workers to enter the validation samples, and completion rates vary by county and by time in placement. As a result, both research samples differ from the total population of children entering placement or who were reunified. Sampling issues are discussed in more detail in the body of the report.

IV. SDM® FSNA FINDINGS

A. FSNA Study Objectives

As noted above, this study examines the relationship between the FSNA findings and subsequent reunification of the child with the caregiver(s). The effort to examine this relationship has important practical implications for child welfare practice. Several child welfare researchers have noted that systematic, early identification of family characteristics that make reunification difficult or easy to achieve is a precondition for effective service intervention planning (Littell & Schuerman, 2002). The primary purpose of the FSNA at the practice level is to help workers set case plan goals with families and identify appropriate service interventions. In aggregate form, FSNA findings provide agencies with client information that can be used to manage service delivery operations. Families whose children enter foster care present a broad range of needs and strengths that may impact their reunification or permanency outcome. If workers can identify family characteristics associated with successful or problematic reunification outcomes shortly after placement, the agency is in a better position to deliver services that may improve permanency and child safety.

The internal workgroup that designed the FSNA and the CRR attempted to construct a simple case assessment and planning procedure to improve case management decisions within the time constraints present in field practice. Since this study examines the assessment's predictive validity and practical utility, it is, in some respects, a test of this design process. Research in other settings suggests that experienced staff can identify case characteristics that have some ability to forecast subsequent case outcomes (Meehl, 1954). For instance, workers in a family service agency developed an assessment and scored clients at intake. Researchers subsequently found that client assessment scores had a significant correlation to successful case closure (Blenkner, 1954). A second study (Blenkner, Bloom, & Nielson, 1971) obtained similar

results in an adult protective services agency. These studies were conducted in small, private agencies where three to six experienced workers assessed each client. Since this study examines assessments of thousands of families completed by hundreds of workers in 17 public child welfare agencies, it tests a similar approach in a large, diverse population of families and workers.

B. Design and Implementation of the FSNA

The FSNA was designed as a standardized assessment and case-planning framework that workers use to (1) assess caregivers in each family entering foster care with a reunification goal and identify priority need areas that the case plan should address; (2) refer them for specialized behavioral assessments (e.g., substance abuse or mental health evaluation) if necessary; and (3) develop a case plan that addresses these priority needs and identify service interventions for expediting child reunification. Workers enter assessment findings into an accessible database (online application) to provide a concise evaluation of family functioning for review by other workers, first-line supervisors, and program planning staff (Hawkins, 1979).

Individual California FSNA items identify caregiver needs (i.e., barriers to reunification) that may require service interventions to make reunification possible, as well as caregiver strengths that may support the reunification goal. A four-level scale identifies strengths and needs in eight domains: substance abuse/use, parenting skills, cultural identity, household relationships, social support systems, mental health, resource management, and physical health. Behavioral definitions are described in agency policy and procedure manuals and incorporated into worker training.[7]

[7] See Appendix A.

C. The FSNA Study Sample

The FSNA study sample was drawn from a total population of 21,105 children age 15 or younger who entered a placement episode with a return-home goal between January 1 and December 31, 2005, in the 17 sample counties. Given the research objective, the validation sample includes only cases with a completed FSNA. In addition, the FSNA had to be completed around the time the placement episode began, i.e., within 30 days prior to or 90 after of placement. There were 11,930 children, or 56.5% of the sample, for whom workers completed an FSNA within that timeframe.

The sample described above is child-based and some of the children in the sample belong to the same household. Although child-based items on the needs assessment reflect the strengths and needs of each individual child, the family items are the same for each child in that household. Since this study examines family items, including all of the children in the larger sample would introduce duplicate family item scores, an issue that may bias findings (see Webster, Shlonsky, Shaw, & Brookhart, 2005). To remedy this problem, one child was randomly selected from each household to avoid multiple observations of siblings with identical family item scores. Since the 11,930 sample children with a timely FSNA resided in 7,041 households, the final sample reflects 7,041 children.[8]

The ethnicity, age, placement type, time in care prior to reunification, and other characteristics of the children in the validation sample are shown in Table 1. Hispanic children are the largest ethnic group (46.2%), followed by Caucasian (28.4%) and African American (21.5%). Approximately 17.8% were in placement for 3 months or less prior to reunification or another type of closure. At the other end of the range, 49.9% were in placement 16 months or longer. The majority (more than 60%) of sample children were 5 years old or younger at

[8] There were 11,930 children removed to substitute care in 2005 with an FSNA completed within 90 days of removal. Those children belonged to 7,041 distinct households. One child from each household was randomly selected to represent each household/family. Since multiple children may be returned to the same household, this sampling approach provides a more reliable estimate of the FSNA relationship to reunification (see Webster et al., 2005).

placement entry; approximately 32% were under age 1; and about one third were age 6 or older. The initial placement was typically with non-relatives (75.4%) rather than relatives (22.6%). More than half the sample children (56.0%) had a sibling in placement, and 54.9% lived in families with two parents/caregivers prior to placement. In the 15-month period following placement entry, 44.4% of the sample children were reunified.

Table 1

SDM® FSNA
Household Sample Description

Child/Case Characteristics		N	%
Total Sample		**7,041**	**100.0%**
Child Ethnicity	Hispanic	3,256	46.2%
	Caucasian	2,001	28.4%
	African American	1,513	21.5%
	Asian	174	2.5%
	Native American	71	1.0%
	Other	26	0.4%
Time in Care[9]	0–3 months	1,255	17.8%
	4–6 months	588	8.4%
	7–9 months	709	10.1%
	10–12 months	376	5.3%
	13–15 months	597	8.5%
	16+ months	3,516	49.9%
Age at Entry (in Years)	Under 1	2,219	31.5%
	1–2	1,315	18.7%
	3–5	1,034	14.7%
	6–10	1,153	16.4%
	11–15	1,320	18.7%
Initial Placement Type	Non-relative	5,308	75.4%
	Relative	1,593	22.6%
	Unknown	140	2.0%
Placement Status of Siblings	No other siblings in care	3,101	44.0%
	Has other siblings in care	3,940	56.0%
Number of Parents/Caregivers	One	3,179	45.1%
	Two	3,862	54.9%
Return Home Within 15 Months of Removal	No	3,915	55.6%
	Yes	3,126	44.4%

The characteristics of this FSNA validation sample are significantly different than the total sample of children entering placement. In the total sample, 30.2% of the children were in

[9] Time in care reflects the placement length of all children in the sample. Placements for some children were terminated for a reason other than return home. Therefore, the number of children in placement 15 months or fewer is larger than the number of children who returned home within 15 months.

placement for three months or less (see Appendix B, Table B2). In the validation sample, only 17.8% of the children exited placement that soon. Consequently, the FSNA validation sample significantly underrepresents children in placement for a relatively short period of time. One reason for this disparity may be that workers had less time to complete an FSNA and develop family case plans for cases that exited care early. There are also significant differences in placement type, siblings in care, and reunification outcomes. For instance, 51.9% of children in the total sample were reunified within 15 months versus only 44.4% in the validation household sample. Finally, there is wide variation in the extent to which the 17 counties completed the FSNA for families entering placement. These sampling issues are explored further in Appendix B (see Tables B1 and B2), which compares sample and non-sample children.[10] It is not possible to determine the impact of sample disparity on the findings presented here, so inferences that can be drawn from them must be qualified.

D. FSNA Findings

The FSNA items were scored by workers shortly after the child was placed (within 90 days) but prior to reunification.[11] The predictive validity of the FSNA is evaluated by observing reunification during a 15-month standardized period following foster care entry.[12] As noted above, 3,126 (44.4%) of the children in the 7,041 families in the validation sample were returned home within 15 months.

Table 2 describes each FSNA item, the sample distribution of item scores, and their relationship to reunification at 15 months. Each item is organized into a four-level ordinal scale associated with the definitions that appear in "a," "b," "c," and "d." Workers choose "a" to

[10] The table comparisons are based on sample children because reliable information on household composition was unavailable when the FSNA was not completed.

[11] The FSNAs included in the analysis represent the initial FSNA completed within the placement episode for cases that had more than one completed.

[12] Predictive validity requires that the outcome criteria by observed *after* the assessment is completed. See Anastasi, A. (1986). Evolving concepts of test validation. *Annual Review of Psychology*, *37*, 1–16.

indicate a family strength and "b" to indicate adequate functioning. The "c" and "d" scores indicate needs. For example, worker scores on the substance abuse/use item (SN1) indicate that 2,296 (32.6% of the sample) families had an alcohol or drug abuse issue, and 2,080 (29.5%) had a serious, chronic alcohol or drug abuse dependency problem.[13] No substance abuse issues were identified for 1,366 (19.4%) families, and the remaining 1,299 (18.4%) received a strength rating because they were assessed as teaching and demonstrating a healthy understanding of alcohol and drugs to their children.

In effect, workers assess caregiver substance abuse/use by applying an ordinal scale that indicates strength at one end of the continuum and a serious problem at the other. The FSNA findings indicate that the most prevalent needs of sample caregivers were substance abuse needs (SN1), household relationship or domestic violence issues (SN2), parenting skill deficits (SN4), and mental health issues (SN5). On the other hand, workers found that many families were functioning well or adequately in several areas including substance use, social support (SN3) and resource management (SN6).

After completing the FSNA, the worker collaborates with the family to determine which domains are priority needs for the family and which areas may serve as priority strengths. During case plan development, the worker uses the identified priority needs and strengths of the family to determine case plan goals and service interventions.

Table 2 also shows the percentage of children reunified by the FSNA item score. The substance abuse assessment score, for instance, demonstrates a very strong relationship to reunification. In the total sample, 44.4% of the children returned home. In families workers scored as demonstrating a healthy understanding of substance abuse (i.e., a strength finding), 55.4% of the children were returned home. When the proactive strength was absent but no alcohol or drug abuse issues were identified, the reunification rate was somewhat lower,

[13] If two caregivers are present, workers score them separately and findings reflect the highest level of need observed.

i.e., 49.6%. Much lower reunification rates are observed among substance-abusing families. The sample child was reunified in 43.4% of the cases with a substance abuse issue and in only 35.2% of families with a chronic abuse problem. Since numerically higher item scores are assigned to problems, the negative correlation coefficient of -.145 (significant at the .000 level) indicates lower reunification among families who abuse drugs or alcohol.[14] Based on this finding, the worker assessment of substance abuse shortly after placement is a very strong predictor of future reunification.

Other FSNA item scores demonstrate a similar relationship to reunification. On the social support item (SN3), for example, workers identified 847 families as having "strong support" and subsequent child reunification was 53.5%. At the problem end of the support continuum, reunification was only 26.4% among families assessed as having "no support."

For every item but parenting skills (SN4), the strength score is associated with the highest reunification rate and lower rates are observed as the score moves toward the problem end of the scale. For parenting skills, however, the 53.2% reunification rate for the strength score (i.e., strong skills) is lower than the 56.0% reunification rate associated with the neutral or adequate parenting score. Despite this minor discrepancy, all eight FSNA item scores (SN1 through SN8) have a statistically significant negative correlation with child reunification, as expected.

The FSNA items with the strongest relationship to reunification are resource management (SN6), substance abuse (SN1), social support (SN3), and mental health (SN5). When it was scored by workers shortly after placement, the FSNA did identify family problems or needs that posed barriers to reunification, which confirms its predictive validity. Further testing of the FSNA indicates that it can independently differentiate strengths and needs (not shown).[15]

[14] The numeric scores used for statistical testing coded a caregiver strength, "a," as a negative integer (-1) and adequate or normal functioning, "b," as 0. Caregiver problems ("c" and "d") were assigned positive integers (1 and 2, respectively).

[15] This is tested by partitioning the "a" level, or strength, score and conducting bivariate tests. Needs are examined by partitioning "c" and "d" scores. All tests were significant in the expected direction. Multivariate analyses that evaluate "a" scores and combined "c" and "d" scores relative to the neutral "b" score were also conducted.

Table 2

Relationship Between SDM® FSNA Item Scores and Return Home Within 15 Months of Removal in Sample California Counties

Item	Sample Distribution		Child Returned Home Within 15 Months of Removal			
	N	%	N	%	Corr.	P Value
Total Sample	**7,041**	**100.0%**	**3,126**	**44.4%**		
SN1. Substance Abuse/Use					-.145	.000
a. Teaches and demonstrates a healthy understanding of alcohol and drugs	1,299	18.4%	719	55.4%		
b. Alcohol or prescribed drug use/no use	1,366	19.4%	678	49.6%		
c. Alcohol or drug abuse	2,296	32.6%	996	43.4%		
d. Chronic alcohol or drug abuse	2,080	29.5%	733	35.2%		
SN2. Household Relationships/Domestic Violence					-.072	.000
a. Supportive	839	11.9%	434	51.7%		
b. Minor or occasional discord	2,109	30.0%	992	47.0%		
c. Frequent discord or some domestic violence	3,238	46.0%	1,357	41.9%		
d. Chronic discord or severe domestic violence	855	12.1%	343	40.1%		
SN3. Social Support System					-.147	.000
a. Strong support system	847	12.0%	453	53.5%		
b. Adequate support system	2,925	41.5%	1,475	50.4%		
c. Limited support system	2,939	41.7%	1,111	37.8%		
d. No support system	330	4.7%	87	26.4%		
SN4. Parenting Skills					-.125	.000
a. Strong skills	154	2.2%	82	53.2%		
b. Adequately parents and protects child	1,372	19.5%	769	56.0%		
c. Inadequately parents and protects child	4,490	63.8%	1,917	42.7%		
d. Destructive/abusive parenting	1,025	14.6%	358	34.9%		
SN5. Mental Health/Coping Skills					-.132	.000
a. Strong coping skills	181	2.6%	103	56.9%		
b. Adequate coping skills	3,003	42.7%	1,512	50.3%		
c. Mild to moderate symptoms	2,998	42.6%	1,241	41.4%		
d. Chronic/severe symptoms	859	12.2%	270	31.4%		
SN6. Resource Management/Basic Needs					-.200	.000
a. Resources are sufficient to meet basic needs and are adequately managed	893	12.7%	513	57.4%		
b. Resources may be limited but are adequately managed	3,040	43.2%	1,553	51.1%		
c. Resources are insufficient or not well-managed	2,477	35.2%	917	37.0%		
d. No resources, or resources are severely limited and/or mismanaged	631	9.0%	143	22.7%		

Table 2

Relationship Between SDM® FSNA Item Scores and Return Home Within 15 Months of Removal in Sample California Counties

Item	Sample Distribution		Child Returned Home Within 15 Months of Removal			
	N	%	N	%	Corr.	P Value
Total Sample	**7,041**	**100.0%**	**3,126**	**44.4%**		
SN7. Cultural Identity					-.123	.000
a. Cultural component is supportive and no conflict present	722	10.3%	405	56.1%		
b. No cultural component that supports or causes conflict	4,861	69.0%	2,216	45.6%		
c. Cultural component that causes some conflict	1,246	17.7%	450	36.1%		
d. Cultural component that causes significant conflict	212	3.0%	55	25.9%		
SN8. Physical Health					-.109	.000
a. Preventive health care is practiced	974	13.8%	548	56.3%		
b. Health issues do not affect family functioning	4,993	70.9%	2,193	43.9%		
c. Health concerns/disabilities affect family functioning	874	12.4%	322	36.8%		
d. Serious health concerns/disabilities result in inability to care for child	200	2.8%	63	31.5%		

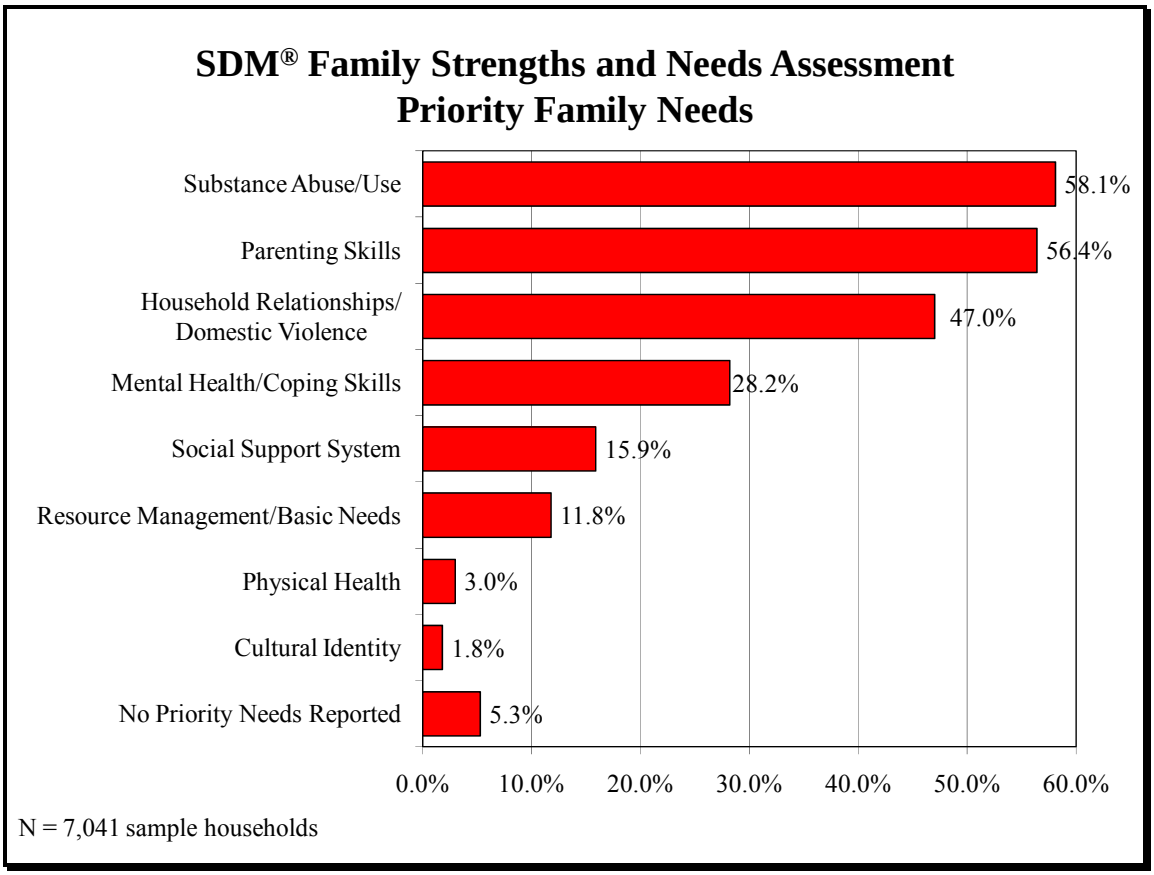
E. Implications for Case Planning

In practice, workers are to score the eight-item FSNA as a first step in the systematic case-planning process, which is expected to involve families when possible. Completed item scores are then reviewed and workers prioritize up to three needs that must be addressed to facilitate reunification. The initial case plan goals are established accordingly, e.g., to reduce substance abuse or improve parenting skills,[16] and service interventions are identified to help clients realize these goals. Family strengths are prioritized in a similar fashion and incorporated into the case plan. The priority family needs and strengths workers identified appear in Figures 1 and 2.

Substance abuse, indicated for 58.1% of the families in the sample, was the most frequently selected priority need (Figure 1). Parenting skill deficits were nearly as prevalent (56.4% of families). Household relationship/domestic violence issues were identified in 47.0% of families, and mental health/coping skills in 28.2%. Social support and resource management appeared as priority needs in 15.9% and 11.8% of families.

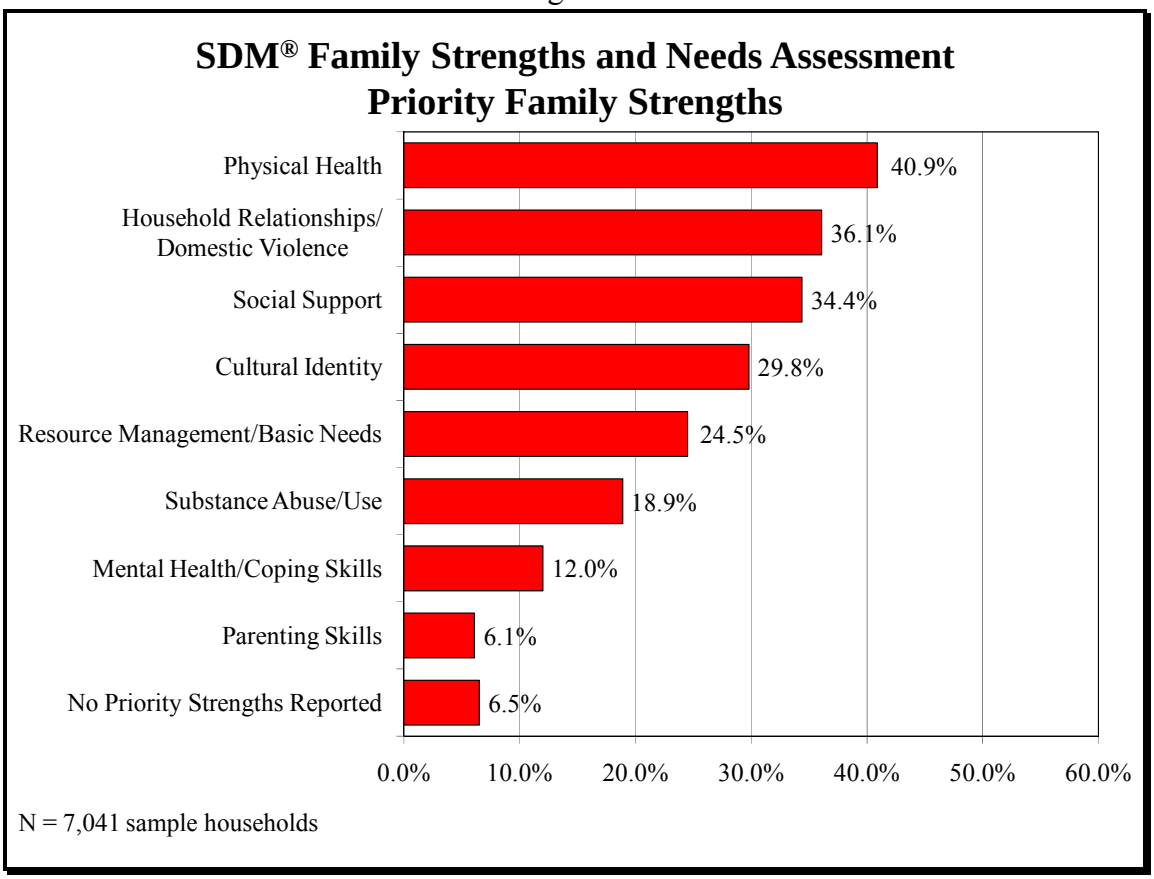
[16] While three priority needs are identified in the initial case plan, the FSNA is rescored and the case plan is reevaluated at six-month intervals. Other needs or strengths may be identified in an updated plan at that point.

Figure 1



Workers also identified family strengths (Figure 2). Physical health, positive household relationships/lack of domestic violence, and social support were positive attributes noted in more than one third of families. Cultural identity and resource management were viewed as strengths that would support reunification in 24% to 30% of families. The absence of substance abuse issues and the presence of coping skills were noted as strengths for 18.9% and 12.0% of the families workers assessed, respectively.

Figure 2



While workers score a standardized FSNA before prioritizing case plan goals, they exercise clinical judgment in conjunction with the family in choosing caregiver issues that must be addressed to reunify the child. As the findings reviewed above indicate, families in this sample show wide variance in strengths and needs on individual FSNA items. For instance,

about 62% of these families had a substance abuse issue, and the reduction of abusive alcohol or drug use is one obvious case plan goal. On the other hand, 38% of the families were not substance abusers, and their case plans may address other issues, such as mental health or social support.

While the FSNA evaluates only eight areas of functioning, possible combinations of caregiver strengths and needs are many and case planning is a highly individualized process. The FSNA simply provides a structure to help workers assess caregiver functioning. It does not engage clients in selecting individual case plan goals and identifying appropriate service interventions. An assessment that demonstrates predictive validity is advantageous because worker case plan choices are informed by evaluating caregiver characteristics that have a strong relationship to the desired case plan outcome—reunification. Successful reunification requires both accurate identification of caregiver problems *and* effective delivery of service interventions to address them. The extent to which identified problems were effectively addressed for families in this sample is not known, but it is possible to examine in more detail how FSNA findings impact reunification.

F. Examining the Relative Strength of FSNA Findings in Predicting Reunification

Since each of the FSNA items has a strong bivariate relationship to reunification, multivariate analyses were conducted to identify areas of family functioning that present the greatest barriers to reunification and highlight where additional or more intensive service interventions may be required to improve case outcomes. Some families have a mental health issue but no substance abuse problems, while others have both. A question relevant to service delivery planning is the relative impact of all eight FSNA item scores on reunification when evaluated simultaneously. The logistic regression findings in Table 3 provide an estimate of each

item's relative impact. The first column identifies the FSNA item and the second column shows the coefficient (B) estimated for it. Statistical significance test findings appear in column five (Sig.) and the odds ratio[17] (Exp[B]) in column six.[18] A fairly straightforward interpretation of the FSNA item findings can be made by examining both statistical significance and the sign and size of the coefficient (B). Items with statistically significant ($p \leq .05$) results are marked with an asterisk in column one. When an FSNA item is statistically significant, the numerical size and sign of its coefficient indicate relative impact on reunification. For instance, the -0.130 coefficient for substance abuse indicates that higher FSNA scores (e.g., needs) significantly reduce the likelihood of reunification. Similar interpretation can be applied to other items.

Table 3

Logistic Regression of SDM® FSNA Items on Return Home Within 15 Months of Removal

FSNA Item	B	S.E.	Wald	Sig.	Exp(B)	95.0% Confidence Interval Exp(B)	
						Lower	Upper
Substance Abuse/Use*	-0.130	0.027	22.488	0.000	0.878	0.832	0.926
Household Relationships/ Domestic Violence	0.012	0.034	0.127	0.722	1.012	0.946	1.083
Social Support System*	-0.166	0.041	16.504	0.000	0.847	0.782	0.918
Parenting Skills*	-0.137	0.046	9.006	0.003	0.872	0.797	0.954
Mental Health/Coping Skills*	-0.139	0.040	12.071	0.001	0.870	0.805	0.941
Resource Management/Basic Needs*	-0.283	0.039	53.512	0.000	0.753	0.698	0.813
Cultural Identity	-0.048	0.049	0.989	0.320	0.953	0.866	1.048
Physical Health	-0.066	0.046	2.080	0.149	0.936	0.856	1.024

*Coefficient statistically significant at $p \leq .05$.

[17] An odds ratio of one indicates that the item score has no impact on the odds of reunification. An odds ratio that is greater than one indicates higher reunification odds. Ratios lower than one indicate reduced odds (lower likelihood) of reunification.

[18] Logistic regression models the logarithm of the odds of success for variables or outcomes with two choices (for example, yes or no). The equation is $\log(p/1\text{-}p) = \beta_0 + \beta_1 x$, where p is the proportion of success and x is the explanatory variable. The beta coefficient (β) is the value that is multiplied by the variable value. The odds ratio is the exponent of the beta coefficient, and its confidence interval is the exponent of β plus or minus the standard error. The 95% confidence interval indicates the range of values between which the actual odds ratio is likely to be. In other words, we can be 95% confident that the true odds ratio falls between the estimated ratios given. Significance tests are based on the Wald statistic.

Five FSNA items proved significant in this multivariate analysis: substance abuse (SN1), social support (SN3), parenting skills (SN4), mental health (SN5), and resource management (SN6). Children whose caregivers experienced these five problems proved less likely to reunify. In addition, the items' impact on reunification is additive in that caregiver(s) experiencing problems in several areas as opposed to one or two are less likely to reunify. Resource management, which includes housing difficulties and poverty, has the largest coefficient (-0.283) and appears to have the greatest impact on reunification.

Three FSNA items (household relationships, cultural identity, and physical health) did not prove significant in this validation sample. They were, however, significant in bivariate findings and may impact reunification in some families.

Several studies of child reunification conducted in California and other jurisdictions (see Harris & Courtney, 2002; Wells & Guo, 1999; or Webster et al., 2005) have identified child characteristics that impact reunification. These include age, ethnicity, placement type, number of siblings in placement, family composition, and previous placement history. Because other studies have demonstrated that these case characteristics impact child reunification, a more rigorous test of the predictive validity of the FSNA can be conducted by controlling for their influence. The basic question is whether FSNA item scores retain their predictive validity when these alternative predictors of reunification are considered.

Logistic regression findings (see Appendix C) indicate that the same five FSNA items found significant in the abbreviated regression model shown above—substance abuse (SN1), social support (SN3), parenting skills (SN4), mental health (SN5), and resource management (SN6)—remained significant when child age and ethnicity, initial placement type, family composition (siblings in care, two-parent household), prior placement and CPS investigation history, and substantiation type (abuse versus neglect) were included in the regression model.

While all these control variables had a significant relationship to the reunification outcome, FSNA findings continued to make a significant contribution to the prediction of reunification. In effect, worker-scored FSNA items pass this more rigorous test of utility.

While the findings are very positive, inferences drawn from findings must be qualified in the following way. Children in this validation sample differ in many respects from the total population of children entering foster care, e.g., they remained in foster care longer and were less likely to be reunified. It is not possible to estimate the impact of sampling on the study findings or to judge how well they may transfer to the total population.

V. SDM® REUNIFICATION REASSESSMENT FINDINGS

A. Reunification Reassessment Study Objectives

The CRR is a companion assessment to the FSNA designed by another California SDM workgroup in 1998. When children enter foster care with a reunification goal, workers use the FSNA to identify caregiver needs and strengths, set case plan goals, and engage appropriate service interventions shortly after placement. The next decision point is whether to return the child home or change the permanency plan goal. The CRR helps workers evaluate caregiver case plan progress after the initial case plan goals are established and service delivery has begun. It assists in estimating probable child safety and stability after reunification. Will the child subsequently be maltreated and returned to foster care? Will reunification prove successful in the longer term? These are critical questions, and foster care reentry is generally viewed as the best available measure of successful reunification (Frame, Berrick, & Brodowski, 2000). Consequently, the predictive validity of the CRR is evaluated by examining the relationship of worker-scored assessment findings to foster care reentry. Reentry was observed during a 12-month period after reunification, consistent with the CFSR performance standard.[19]

B. Reunification Reassessment Design and Implementation

The recommendation for initial CRR completion in California is six months after case opening, preceding the first permanency review, or any other time a worker considers returning a child home. It is repeated every six months as long as the child remains in care with a return-home goal, i.e., until a permanency goal is achieved. The CRR informs the decision to (a) reunify the child, (b) continue reunification services, or (c) change the permanency goal from reunification to adoption or another permanency option. Agency permanency planning policies

[19] Return to care (foster care reentry) serves as a proxy for the federal CFSR measure regarding permanency. Although a return to care shows that a return home was unsuccessful, it does not mean that the reason for return to care was subsequent maltreatment.

are incorporated into the assessment's decision guidelines. The following review uses abbreviated definitions to describe assessment procedures.[20] The CRR has three components: (a) reunification risk reassessment; (b) visitation evaluation; and (c) the reunification safety assessment. Each one is described in Figure 3.

The reunification risk reassessment is comprised of three scored items and two override procedures. The first item reflects the family's actuarial risk classification on the most recent CPS referral (R1); the second (R2) scores new maltreatment substantiations in the current period (i.e., the period preceding the review), if any; and the third (R3) evaluates caregiver progress relative to current case plan goals (i.e., based on the FSNA). If caregiver goals are to successfully complete substance abuse treatment and parenting skills training, progress is evaluated relative to these expectations. These three item scores are totaled to assign a preliminary reunification risk level of low, moderate, high, or very high. At this point, workers may exercise an override established by agency policy. Four policy override reasons (sexual abuse with ongoing perpetrator access, new non-accidental injury to an infant, new serious injury to a child, or new child death) are assessed. If any policy override reason is present during the review period, the reunification risk level is overridden to very high. If this policy override is not required, the worker can make a one-level discretionary adjustment to the final risk level based on clinical judgment and subject to supervisor approval. The final reunification risk level of low, moderate, high or, very high is derived after both policy and worker overrides are made.[21]

Once the final reunification risk level is determined, workers evaluate caregiver and child visitation. Caregiver visitation frequency and quality are each assessed using a four-level ordinal scale similar in design to an FSNA item. Caregiver visitation frequency can be scored by workers as "totally," "routinely," "sporadically," or "rarely or never" based on the percentage of

[20] Complete definitions for the CRR are described in agency policy and procedure manuals and were incorporated into worker training prior to implementation.

[21] In the sample used for this study, workers exercised 8 policy overrides and 334 discretionary overrides.

available visits the caregiver actually made. Visitation quality is evaluated separately as "strong," "adequate," "limited," or "destructive."[22] Once visitation frequency and quality are scored, they are jointly evaluated to determine if visitation was acceptable. Acceptable visitation requires total or routine visitation frequency and strong or adequate visitation quality; otherwise, it is unacceptable. Workers can override the visitation finding under certain conditions.[23]

Workers are not required to complete a home safety assessment unless the final reunification risk level is low or moderate *and* visitation compliance is acceptable (e.g., frequency is "totally" or "routine" *and* quality is "strong" or "adequate"). The safety assessment, typically completed during a recent home visit, evaluates 13 potential safety threats as well as caregiver protective capacities. If no safety threats are found, the household is "safe." If threats are identified but can be mitigated by supporting services, it is assessed as "conditionally safe." When an identified safety threat cannot be controlled, the home is "unsafe." The safety finding must be "safe" or "conditionally safe" to return the child. The safety decision specifically requires confirmation that the safety threat that led to the removal has been resolved or can now be controlled.

The decision-making guidelines established for the CRR advise a return home when reunification risk is low or moderate, visitation is acceptable, and the household is safe or conditionally safe, i.e., when all three CRR components have been evaluated positively (see bold text highlights in Figure 3). While there is a clear standard for proceeding with reunification, workers exercise a great deal of judgment when scoring the assessment and can exercise discretionary overrides at several points. Also, in practice, reunification recommendations are

[22] Summary definitions are shown here, but detailed scoring definitions and case examples are described in the CRR scoring policy guidelines (see Appendix A).

[23] Very few overrides were exercised for sample cases shown. Only 3 were overridden to acceptable and 35 to unacceptable. A policy override was applied to some supervised visitations.

occasionally not followed, i.e., cases are sometimes reunified despite not meeting reunification standards for all three components.

Figure 3
CALIFORNIA SDM® REUNIFICATION REASSESSMENT SUMMARY

REUNIFICATION RISK REASSESSMENT

		Score
R1.	**Risk level on most recent referral (not reunification risk level or risk reassessment)**	
	a. Low 0	
	b. Moderate 3	
	c. High 4	
	d. Very high 5	_____
R2.	**Has there been a new substantiation since the initial risk assessment or last reunification reassessment?**	
	a. No 0	
	b. Yes 2	_____
R3.	**Progress toward case plan goals**	
	a. Successfully met all case plan objectives and routinely demonstrates desired behavior ..... -2	
	b. Actively participating in programs; routinely pursuing objectives detailed in case plan; frequently demonstrates desired behavior ..... -1	
	c. Partial participation in pursuing objectives in case plan; occasionally demonstrates desired behavior 0	
	d. Refuses involvement in programs or has exhibited a minimal level of participation with case plan; rarely or never demonstrates desired behavior 4	_____
	Total Score	_____

REUNIFICATION RISK LEVEL

Risk Level (based on total score)

☐ Low (-2 to 1) ☐ Moderate (2 to 3) ☐ High (4 to 5) ☐ Very High (6 and above)

OVERRIDES (during current period)

Policy Overrides: Indicate if any of the following are true in the current review period. Incident may be current or historic. Treatment status is current. *Presence of one or more policy override conditions increases risk to very high.*

☐ 1. Sexual abuse; perpetrator has access to child and has not successfully completed treatment.
☐ 2. Non-accidental physical injury to an infant, and caregiver has not successfully completed treatment.
☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment; caregiver has not successfully completed treatment.
☐ 4. Death of a sibling as a result of abuse or neglect in the household; caregiver has not successfully completed treatment.

Discretionary Override: *Reunification risk level may be adjusted up or down one level.*

☐ 5. Reason: _____

FINAL REUNIFICATION RISK LEVEL (*mark one*):

☐ **Low** ☐ **Moderate** ☐ High ☐ Very High

VISITATION PLAN EVALUATION (*See definitions below.*)

Visitation Frequency—Compliance With Case Plan	Quality of Face-to-face Visit
Totally	**Strong**
Routinely	**Adequate**
Sporadically	Limited
Rarely or Never	Destructive

Visitation Override: ☐ Policy: Visitation is supervised for safety. ☐ Discretionary (reason): _____

SAFETY DECISION (*complete safety section only if risk is low/moderate and visitation is acceptable*)

Identify the safety decision by marking the appropriate line below. This decision should be based on the assessment of all safety threats, safety interventions, and any other information known about the case. Mark one line only.

☐ 1. **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.

☐ 2. One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be **conditionally safe** upon return home. SAFETY PLAN REQUIRED.

☐ 3. One or more safety threats are present, 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.

PLACEMENT/PERMANENCY PLAN GUIDELINES AND RECOMMENDATION SUMMARY

Complete permanency plan guideline decision trees and definitions are located in Appendix A of this report. This section leads to one of the following permanency plan recommendations:

☐ Return Home ☐ Continue Reunification Services ☐ Terminate Reunification Services

C. The CRR Study Sample

The predictive validity of the CRR was evaluated by selecting a base sample of children age 15 or younger who entered a foster care episode in 2005 and were reunified within 15 months.[24] In this total population of 10,943 children, only 3,286 (30.0%) had a reunification assessment completed during their placement episode. Since guidelines require CRR completion at fixed intervals and prior to a reunification decision, multiple assessments are possible and their findings may change over time. Assessments completed close to the child's reunification date were selected to represent worker evaluations of case progress in the period preceding reunification. Among the 3,286 children with an CRR, 2,600 children had one completed within a 90-day period preceding their reunification.[25] The ethnicity, age, time in care prior to reunification, and placement type for 2,600 sample children are shown in Table 4. The majority were Hispanic (58.0%), 24.5% were Caucasian, and 14.9% were African American. Approximately half were 5 years old or younger at entry into foster care. Approximately 28% were reunified within 6 months of foster care entry, 51% in months 7 to 12, and the remaining 21.0% had been in foster care for 13 to 15 months. Twenty-three percent of the sample children were initially placed with relatives. During the 12-month period following their reunification, 13.3% of the 2,600 sample children reentered foster care.

[24] A child-based sample was employed in the CRR study because visitation and home safety assessment findings are child-based, i.e., they may vary among children in the same family.

[25] In the population of 10,943 children, only 3,286 had a CRR. In this 3,286-case subsample, 677 were completed more than 90 days prior to the child returning home and 9 cases were missing assessment findings. This resulted in 2,600 cases in which a CRR was completed within 90 days of return home.

Table 4 SDM® Reunification Reassessment Sample Description			
Child/Case Characteristics		**N**	**%**
Total Sample		**2,600**	**100.0%**
Child Ethnicity	Hispanic	1,508	58.0%
	Caucasian	638	24.5%
	African American	388	14.9%
	Asian	37	1.4%
	Native American	26	1.0%
	Other	3	0.1%
Age at Entry (in Years)	Under 1	385	14.8%
	1–2	455	17.5%
	3–5	543	20.9%
	6–10	701	27.0%
	11–15	516	19.8%
Time in Care	0–3 months	268	10.3%
	4–6 months	454	17.5%
	7–9 months	1,007	38.7%
	10–12 months	326	12.5%
	13–15 months	545	21.0%
Placement Type	Non-relative	1,997	76.8%
	Relative	602	23.2%
	Unknown	1	0.0%
Subsequent Foster Care Reentry Within 12 Months	No	2,255	86.7%
	Yes	345	13.3%

Since the validation sample is composed of children who received a CRR assessment, it has significantly different characteristics than the total sample of 10,943 reunified children. One major difference is the time children were in foster care prior to reunification. In the total sample of 10,943 children, 53.2% were reunified within three months versus only 10.3% of the children in the validation sample. As a result, the validation sample significantly overrepresents cases reunified after several months in care. Workers were much less likely to complete a CRR for

children reunified shortly after placement. The validation sample is similar to the total sample in terms of prior CPS investigations or out-of-home placements and subsequent foster care reentry. There are significant differences in child ethnicity, age, placement type, and siblings in placement (see Appendix B, Tables B1 and B2). The fact that the validation sample differs significantly from the population of reunified children limits its utility for assessing the relationship between CRR findings and subsequent reentry.

D. CRR Findings

Table 5 shows the relationship between the CRR component findings and post-reunification foster care reentry. For instance, workers assessed reunification risk as low or moderate for 2,216 (85.2%) of the sample children, and 384 (14.8%) were assessed as high or very high risk. The percentage of children reentering foster care within 12 months is significantly lower among cases evaluated as low and moderate risk (12.5%) compared to high or very high risk cases (17.7%). This component of the CRR did identify children who were less likely to reenter care.

Caregiver visitation is acceptable when frequency is total or routine and visitation quality is strong or adequate. The reentry rate was 12.9% among the 2,447 children with acceptable caregiver visitation, but rose to 19.6% when visitation was unacceptable.

Safety is the final component of the CRR assessment. The 2,126 sample children returned to homes considered safe or conditionally safe had a reentry rate of 12.0%, versus 19.0% of the 474 children assessed as unsafe.

Findings demonstrate that scores on the risk, visitation, and safety components of the CRR appear to have the expected relationship to reentry. Children were much less likely to reenter foster care when workers evaluated caregivers positively.

The CRR guidelines require a safety assessment when both the reunification risk level and visitation meet standards for reunification. When both risk and visitation met standards for a child, the reentry rate was 12.5%. When only one or neither component met standards, reentry rates were significantly higher (15.6% and 21.5% respectively).

While meeting standards on each component of the CRR demonstrates the expected relationship to reentry, the decision guidelines only recommend reunification when all three components meet standards, i.e., reunification risk is low or moderate, visitation is acceptable, and child is safe or conditionally safe. A large percentage of sample children (2,066 cases, or 79.5%) met this CRR guideline prior to reunification, but 534 did not. As Table 5 indicates, subsequent foster care reentry was found to be significantly lower when this decision guideline was followed. Foster care reentry was only 11.9% when all three CRR standards were met. It was approximately 18% when two or fewer standards were met. These findings indicate that the CRR and the decision guidelines it employs can help workers improve reunification decisions and when used appropriately, they should help workers reduce foster care reentry.

Table 5

Relationship Between SDM® Reunification Reassessment Component Scores and Foster Care Reentry Within 12 Months for Children Reunified Within 15 Months of Removal in Sample California Counties

CRR Components	Sample Distribution		Foster Care Reentry Within 12 Months			
	N	%	N	%	Corr.	P Value
Total Sample (excluding CRR safety)	**2,600**	**100.0%**	**345**	**13.3%**		
Risk Level					-.054	.005
Risk low or moderate (standard met)	2,216	85.2%	277	12.5%		
Risk high or very high (standard not met)	384	14.8%	68	17.7%		
Visitation Acceptability (after overrides)					-.047	.017
Visitation acceptable	2,447	94.1%	315	12.9%		
Visitation unacceptable	153	5.9%	30	19.6%		
Risk and Visitation					-.060	.002
Both standards met (risk low or moderate and visitation acceptable)	2,184	84.0%	273	12.5%		
Risk or visitation standard met	295	11.3%	46	15.6%		
Neither standard met	121	4.7%	26	21.5%		
Safety					-.080	.000
Safe or safe with services (standard met)	2,126	81.8%	255	12.0%		
Unsafe or no safety completed (standard not met)	474	18.2%	90	19.0%		
Risk, Visitation, and Safety					-.073	.000
All three standards met	2,066	79.5%	246	11.9%		
Two of three standards met	174	6.7%	32	18.4%		
None or one standard met	360	13.8%	67	18.6%		

These findings are qualified by disparities between the validation sample and the total population of reunified children. Worker CRR completion was relatively low; only 30% of reunified children in the sample counties were assessed and the rate varied by county. In addition, children in care for several months before reunification were much more likely to have an CRR completed. These sampling issues make it difficult to recommend significant modification of the current assessment, as does the fact that all three assessment components had a strong relationship to reentry in the validation sample. A detailed analysis of individual CRR

items including progress toward case plan goals, visitation frequency, and visitation quality are presented and discussed in Appendix D (see Tables D1 and D2).[26]

E. Examining the Relative Strength of CRR Guideline Findings in Predicting Reentry

The findings above indicate that when all three components of the CRR met the standard for reunification, foster care reentry was significantly lower. Several previous studies have examined child reentry after reunification (Terling, 1999; Wells & Guo, 1999; and Jones, 1998). Two recent studies of children in California (Frame et al., 2000; Shaw, 2006) identified several child characteristics which had a strong statistical relationship to foster care reentry. These characteristics included child age, ethnicity, months in placement prior to reunification, placement type (relative versus non-relative care), sibling(s) in placement, abuse versus neglect history, the number of family caregivers, and the child's previous placement history. Since the CRR was developed to assess the reunification prospects of all children entering foster care, it should demonstrate predictive utility when these other case characteristics are considered. Consequently, the predictive validity of the CRR score was tested in a logistic regression model that included other case characteristics known to impact reentry.[27] The CRR score remained significant in this test (see Appendix D, Table D3), which suggests that the assessment does help workers estimate the likelihood of a successful reunification.

[26] These findings indicate that the relationship between case plan progress (R3) and reentry is relatively weak. This item could perhaps be improved by altering the way workers observe it. There may also be some benefit in altering the risk level from the initial referral (R1) by substituting the neglect risk classification for the final risk level.

[27] When the standard was met in each of three areas—risk, visitation, and safety—CRC assigned a score of 1; when the standard was not met, a score of 0 was assigned. Each child in the sample received a total score between 0 and 3 that represented the number of standards met on his/her reunification reassessment.

VI. SUMMARY

By early 2005, 17 California counties implemented two SDM assessments developed by a workgroup of staff from California SDM counties and CRC for use in foster care. The FSNA was designed to help workers develop case plans for cases with a reunification goal. The CRR was developed to help workers make decisions about reunification. Workers in these counties have used these assessments to evaluate several thousand families. Since the objectives of the SDM system are to improve child safety and expedite permanency, preferably by reunifying the child and family, this study attempts to (1) examine the relationship between foster care case assessment findings and two case outcomes which reflect permanency and safety—child reunification and foster care reentry; (2) evaluate the utility of both assessments as constructs for improving reunification and reentry outcomes; and (3) propose changes in assessment procedure or content to improve performance.

Two separate validation samples were employed in this study: one to evaluate the FSNA, which is used to assess the child's caregivers, and a second sample to evaluate the CRR, which helps workers assess caregiver case plan progress. The FSNA validation study examined the practical utility of the assessment in helping workers establish case plan goals for child reunification. This was accomplished by examining its predictive validity, i.e., does the FSNA identify caregiver problems or strengths that impact subsequent reunification? In a sample of more than 7,000 cases, each of eight worker-scored FSNA items (used to evaluate substance abuse, household relationships, mental health, etc.) demonstrated a strong, statistically significant relationship to child reunification. Evidence suggests that the FSNA scores observed shortly after placement identify family strengths or functional problems that forecast reunification success or failure that occurs several months after placement. The FSNA's utility as a device to help workers assess clients and develop case plans that can promote the reunification

goal was further confirmed in multivariate tests that controlled for the child's child welfare history, family structure and demographic characteristics.

Since the CRR helps workers decide if a child can be safely returned home to live with caregivers, it was evaluated in a similar manner but against a different case outcome. Predictive validity was tested by examining the relationship between CRR assessment findings observed just prior to reunification and reentry into foster care 12 months afterward. The question posed was, can the CRR help workers identify children who can be successfully reunified before that decision is made? Workers evaluate three separate CRR components: reunification risk, caregiver visitation acceptability, and home safety. In a sample of 2,600 reunified children, all three assessment components demonstrated a significant relationship to reentry in the expected direction; a positive worker evaluation was associated with a much lower reentry rate. The CRR decision guidelines recommend reunification only when all three components receive a positive worker evaluation (i.e., when standards for all three are met). Sample child cases where all three components met standards had a much lower reentry rate than cases where standards were not met for all three components (i.e., cases in which the CRR result did not recommend reunification). Additional multivariate tests that controlled for the child's child welfare history, family structure, and demographic characteristics confirmed the CRR's predictive validity against the reentry case outcome.

While the findings confirm the predictive validity of both assessments, the validation samples in which the tests were conducted are not representative of all foster care cases served in the 17 sample counties. There are two reasons for this: (1) Workers did not complete the FSNA and CRR assessments for all cases, and actual completion rates vary widely across the 17 counties; and (2) the assessments are much more likely to be completed for cases that remain in foster care for a longer period of time. These two factors have the potential to bias the findings

of this study in a manner that cannot be accurately estimated. While this is an important qualification, both assessments demonstrated strong predictive validity in the convenience samples in which they could be evaluated.

VII. RECOMMENDATIONS

The FSNA and CRR appear to be serving their intended purpose when workers rely upon them to help assess families. Since worker-scored assessment findings did demonstrate a strong relationship to case outcomes associated with child permanency and safety, there is evidence to support the conclusion that the CRR and FSNA can improve the case management decisions of workers who use them appropriately. Based on the findings in this report, CRC recommends the following:

- Counties should encourage workers to complete the FSNA and CRR for all cases they serve within timeframes established by policy guidelines. The current completion rate for these assessments is very low in some counties, particularly for the CRR.

- Supervisor/manager monitoring of completion via SafeMeasures® could be an important mechanism for increasing completion.

- Clarify current policy regarding assessment requirements for returning a child home shortly after placement entry. For example, require completion of a home safety assessment prior to returning a child within 60 days after removal, and a reunification reassessment if a return home is considered more than 60 but less than 180 days following removal.

- Increase worker understanding of both the FSNA and CRR by developing an advanced training that emphasizes worker case planning. The use of the FSNA should be integrated into a core curriculum that demonstrates how FSNA findings can be referenced by workers to establish measurable case plan goals with clients. The use of the CRR as a mechanism for monitoring evaluating case plan progress would also be integrated into this training. Both family maintenance and family reunification case planning could be addressed.

- Since there is some evidence from this study that workers have difficulty estimating client case plan progress (see Appendix D), the core team may wish to revise current definitions for estimating this important construct when developing the new core curriculum.

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Appendix A

SDM® FSNA and Definitions

SDM® CRR and Definitions

CALIFORNIA
FAMILY STRENGTHS AND NEEDS ASSESSMENT
(for Caregivers and Children)

r: 10-07

Case Name: _____ **Case Number:** _____

Referral Date: ___/___/___ **Date of Assessment:** ___/___/___ **Initial** or **Reassess #:** ☐1 ☐2 ☐3 ☐4 ☐5 ___

County: _____ **Worker:** _____

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

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

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

Primary Caregiver: _____ **Secondary Caregiver:** _____

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. CAREGIVER—Rate each caregiver.

		Caregiver Score	
		Primary	**Secondary**
SN1.	**Substance Abuse/Use** (Substances: alcohol, illegal drugs, inhalants, prescription/over-the-counter drugs)		
	a. Teaches and demonstrates a healthy understanding of alcohol and drugs ..... +3		
	b. Alcohol or prescribed drug use/no use 0		
	c. Alcohol or drug abuse ..... -3		
	d. Chronic alcohol or drug abuse ..... -5	_____	_____
SN2.	**Household Relationships/Domestic Violence**		
	a. Supportive ..... +3		
	b. Minor or occasional discord 0		
	c. Frequent discord or some domestic violence ..... -3		
	d. Chronic discord or severe domestic violence ..... -5	_____	_____
SN3.	**Social Support System**		
	a. Strong support system ..... +2		
	b. Adequate support system 0		
	c. Limited support system ..... -2		
	d. No support system ..... -4	_____	_____
SN4.	**Parenting Skills**		
	a. Strong skills ..... +2		
	b. Adequately parents and protects child 0		
	c. Inadequately parents and protects child ..... -2		
	d. Destructive/abusive parenting ..... -4	_____	_____
SN5.	**Mental Health/Coping Skills**		
	a. Strong coping skills ..... +2		
	b. Adequate coping skills 0		
	c. Mild to moderate symptoms ..... -2		
	d. Chronic/severe symptoms ..... -4	_____	_____

Caregiver Score

		Primary	Secondary
SN6.	**Resource Management/Basic Needs**		
a.	Resources are sufficient to meet basic needs and are adequately managed ..... +1		
b.	Resources may be limited but are adequately managed 0		
c.	Resources are insufficient or not well-managed ..... -1		
d.	No resources, or resources are severely limited and/or mismanaged ..... -3	_____	_____
SN7.	**Cultural Identity**		
a.	Cultural component is supportive and no conflict present ..... +1		
b.	No cultural component that supports or causes conflict 0		
c.	Cultural component that causes some conflict ..... -1		
d.	Cultural component that causes significant conflict ..... -3	_____	_____
SN8.	**Physical Health**		
a.	Preventive health care is practiced ..... +1		
b.	Health issues do not affect family functioning 0		
c.	Health concerns/disabilities affect family functioning ..... -1		
d.	Serious health concerns/disabilities result in inability to care for the child ..... -2	_____	_____
SN9.	**Identified Caregiver Strength/Need (not covered in SN1-SN8)**		
a	Significant strength ..... +1		
b.	Not applicable 0		
c.	Minor need ..... -1		
d.	Significant need ..... -2	_____	_____

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	Child 5 Score	Child 6 Score
CSN1.	**Emotional/Behavioral**						
a.	Strong emotional adjustment ..... +3						
b.	Adequate emotional adjustment 0						
c.	Limited emotional adjustment ..... -3						
d.	Severely limited emotional adjustment ..... -5	____	____	____	____	____	____
CSN2.	**Physical Health/Disability**						
a.	Good health ..... +3						
b.	Adequate health 0						
c.	Minor health/disability needs ..... -3						
d.	Serious health/disability needs ..... -5	____	____	____	____	____	____
CSN3.	**Education**						

Does child have a specialized educational plan? ☐ No ☐ Yes, describe: _____

a.	Outstanding academic achievement ..... +3						
b.	Satisfactory academic achievement or child not of school age 0						
c.	Academic difficulty ..... -3						
d.	Severe academic difficulty ..... -5	____	____	____	____	____	____
CSN4.	**Family Relationships**						
a.	Nurturing/supportive relationships ..... +2						
b.	Adequate relationships 0						
c.	Strained relationships ..... -2						
d.	Harmful relationships ..... -4	____	____	____	____	____	____

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

CSN5. Child Development

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

CSN6. Substance Abuse

a. Chooses drug-free lifestyle ..... +2
b. No use/experimentation 0
c. Alcohol or other drug use ..... -2
d. Chronic alcohol or other drug use ..... -4

CSN7. Cultural Identity

a. Cultural component is supportive and no conflict present ..... +1
b. No cultural component that supports or causes conflict 0
c. Cultural component that causes some conflict ..... -1
d. Cultural component that causes significant conflict ..... -3

CSN8. Peer/Adult Social Relationships

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

CSN9. Delinquent Behavior

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

a. Preventive activities ..... +1
b. No delinquent behavior 0
c Occasional delinquent behavior ..... -1
d. Significant delinquent behavior ..... -2

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

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

COMMENT: _____

C. PRIORITY NEEDS AND STRENGTHS

Enter item number and description of up to three most serious needs (lowest scores) and greatest strengths (highest scores) from Section A (items SN1-SN9) for each caregiver (P=Primary; S=Secondary, B=Both).

Caregiver Priority Areas of Need	**P**	**S**	**B**	**Caregiver Priority Areas of Strength**	**P**	**S**	**B**
1. _____ _____				1. _____ _____			
2. _____ _____				2. _____ _____			
3. _____ _____				3. _____ _____			

Note: All identified child needs must be addressed in the case plan.

CALIFORNIA
FAMILY STRENGTHS AND NEEDS ASSESSMENT
(for Caregivers and Children)
DEFINITIONS

CAREGIVER

SN1. Substance Abuse/Use

(Substances: alcohol, illegal drugs, inhalants, prescription/over-the-counter drugs)

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

b. Alcohol or prescribed drug use/no use. The caregiver may have a history of substance abuse or may currently use alcohol or prescribed drugs; however, it does not negatively affect parenting skills and functioning. Include abstinence.

c. Alcohol or drug abuse. The caregiver continues to use despite negative consequences in some areas such as family, social, health, legal, or financial. The caregiver needs help to achieve and/or maintain abstinence from alcohol or drugs.

d. Chronic alcohol or drug abuse. The caregiver's use of alcohol or drugs results in behaviors that impede ability to meet his/her own and/or his/her child's basic needs. He/she experiences some degree of impairment in most areas including family, social, health, legal, and financial. He/she needs intensive structure and support to achieve abstinence from alcohol or drugs.

SN2. Household Relationships/Domestic Violence

a. Supportive. 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 caregiver may have a history of domestic violence but demonstrates an effective or adequate coping ability regarding any past abuse.

b. Minor or occasional discord. 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 discord or some domestic violence. 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. May be evidenced by the following:

- Custody and visitation issues are characterized by frequent conflicts.
- The caregiver's pattern of adult relationships creates significant stress for the child.

- Adult relationships are characterized by occasional physical outbursts that may result in minor injuries; and/or controlling behavior that results in isolation or restriction of activities. Both the offender and the victim seek help in reducing threats of violence.

d. Chronic discord or severe domestic violence. Internal or external stressors are present and the household experiences minimal positive interactions. May be evidenced by the following:

- Custody and visitation issues are characterized by harassment and/or severe conflict, such as multiple reports to law enforcement and/or CPS.

- The caregiver'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 behaviors toward other household members. Violent or controlling behavior has or may result in injury.

- Neither caregiver or only one caregiver is willing to seek help in reducing threats of violence, OR previous treatment efforts have not been successful in reducing domestic violence incidents.

SN3. Social Support System

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

b. Adequate support system. As needs arise, the family uses extended family, friends, cultural, religious, and community resources to provide support and/or services such as child care, transportation, supervision, role-modeling for caregiver(s) and child, parenting and emotional support, guidance, etc.

c. Limited support system. The family has limited support system, is isolated, or is reluctant to use available support.

d. No support system. The family has no support system and does not utilize extended family and community resources.

SN4. Parenting Skills

a. Strong skills. The caregiver displays good knowledge and understanding of age-appropriate parenting skills and integrates use on a daily basis. The caregiver expresses hope for and recognizes the child's abilities and strengths and encourages participation in family and community. The caregiver advocates for family and responds to changing needs.

b. Adequately parents and protects child. The caregiver displays adequate parenting patterns that are age-appropriate for the child in areas of expectations, discipline, communication, protection, and nurturing. The caregiver has basic knowledge and skills to parent.

c. Inadequately parents and protects child. Improvement of basic parenting skills is needed by the caregiver. The caregiver has some unrealistic expectations and gaps in parenting skills,

demonstrates poor knowledge of age-appropriate disciplinary methods, and/or lacks knowledge of child development that interferes with effective parenting.

d. Destructive/abusive parenting. The caregiver displays destructive/abusive parenting patterns that result in significant harm to the child.

SN5. Mental Health/Coping Skills

a. Strong coping skills. The caregiver demonstrates the ability to deal with adversity, crises, and long-term problems in a constructive manner. The caregiver demonstrates realistic and logical judgment. The caregiver displays resiliency and has a positive, hopeful attitude.

b. Adequate coping skills. The caregiver demonstrates emotional responses that are consistent with circumstances and displays no apparent inability to cope with adversity, crises, or long-term problems.

c. Mild to moderate symptoms. The caregiver displays periodic mental health symptoms including, but not limited to, depression, low self-esteem, or apathy. The caregiver has occasional difficulty dealing with situational stress, crises, or problems.

d. Chronic/severe symptoms. The caregiver displays chronic, severe mental health symptoms including, but not limited to, depression, apathy, or severe low self-esteem. These symptoms impair the caregiver's ability to perform in one or more areas of parental functioning, employment, education, or provision of food and shelter.

SN6. Resource Management/Basic Needs

a. Resources are sufficient to meet basic needs and are adequately managed. The caregiver has a history of consistently providing safe, healthy, and stable housing; nutritional food; and clothing. The caregiver successfully manages available resources to meet basic care needs related to health and safety.

b. Resources may be limited but are adequately managed. The caregiver provides adequate housing, food, and clothing. The caregiver adequately manages available resources to meet basic care needs related to health and safety.

c. Resources are insufficient or not well-managed. The caregiver provides housing, but it does not meet the basic needs of the child due to such things as inadequate plumbing, heating, wiring, or housekeeping. Food and/or clothing do not meet basic needs of the child. The family may be homeless; however, there is no evidence of harm or threat of harm to the child. The caregiver does not adequately manage available resources which results in difficulty providing for basic care needs related to health and safety.

d. No resources, or resources are severely limited and/or mismanaged. Conditions exist in the household that have caused illness or injury to family members such as inadequate plumbing, heating, wiring, housekeeping; there is no food, food is spoiled, or family members are malnourished. The child chronically presents with clothing that is unclean, not appropriate for weather conditions, or is in poor repair. The family is homeless, which results in harm or threat of harm to the child. The caregiver lacks resources, or severely mismanages available resources, which results in unmet basic care needs related to health and safety.

SN7. Cultural Identity

For this item, cultural identity may refer to an ethnic, religious, or social identity that reflects the unique characteristics of the caregiver. Cultural identity is not limited to identification with a minority culture and may refer to the prominent culture. Note that the reference to cultural conflict within the family includes inter-generational cultural conflict.

a. Cultural component is supportive and no conflict present. The caregiver identifies with a culture and its connected community, and that cultural identification is a resource. He/she experiences no conflict related to cultural identity.

b. No cultural component that supports or causes conflict.

- The caregiver identifies with a culture and its community; however, that cultural identity is not serving as a resource to them. He/she experiences no conflict related to cultural identity;
- OR the caregiver has no particular identification with a culture, and the absence of cultural identity is not resulting in conflict with family or community.

c. Cultural component that causes some conflict.

- The caregiver identifies with a culture and its connected community, and that cultural identity may or may not be a resource to them. He/she experiences *some* conflict related to cultural identity;
- OR the caregiver has no particular identification with a culture, and the absence of cultural identity is resulting in *some* conflict with family or community, and this is having an adverse impact on the child.

d. Cultural component that causes significant conflict.

- The caregiver identifies with a culture and its connected community, and that cultural identity may or may not be a resource to them. He/she experiences *significant* conflict related to cultural identity;
- OR the caregiver 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.

SN8. Physical Health

a. Preventive health care is practiced. The caregiver teaches and promotes good health.

b. Health issues do not affect family functioning. The caregiver has no current health concerns that affect family functioning. The caregiver accesses regular health resources for him/herself (e.g., medical/dental).

c. Health concerns/disabilities affect family functioning. The caregiver has health concerns or conditions that affect family functioning and/or family resources.

d. Serious health concerns/disabilities result in inability to care for the child. The caregiver has serious/chronic health problem(s) or condition(s) that affects his/her ability to care for and/or protect the child.

SN9. Identified Caregiver Strength/Need (not covered in SN1 – SN8)

a. Significant strength. A caregiver 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. Not applicable. The caregiver has no area of strength or need relevant for case planning that is not included in SN1-SN8.

c. Minor need. A caregiver 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. Significant need. A caregiver 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.

CHILDREN

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

CSN1. Emotional/Behavioral

a. Strong emotional adjustment. The child displays strong coping skills in dealing with crises and trauma, disappointment, and daily challenges. The child is able to develop and maintain trusting relationships. The child is also able to identify the need for, seeks, and accepts guidance.

b. Adequate emotional adjustment. The child displays developmentally appropriate emotional/coping responses that do not interfere with school, family, or community functioning. The child may demonstrate some depression, anxiety, or withdrawal symptoms that are situationally related. The child maintains situationally appropriate emotional control.

c. Limited emotional adjustment. The child has occasional difficulty in dealing with situational stress, crises, or problems, which impairs functioning. The child displays periodic mental health symptoms including, but not limited to: depression, running away, somatic complaints, hostile behavior, or apathy.

d. Severely limited emotional adjustment. The child's ability to perform in one or more areas of functioning is severely impaired due to chronic/severe mental health symptoms, such as fire-setting, suicidal behavior, or violent behavior toward people and/or animals.

CSN2. Physical Health/Disability

a. Good health. The child demonstrates good health and hygiene care, involving awareness of nutrition and exercise. The child has no known health care needs. The child receives routine preventive and medical/dental/vision care and immunization.

b. Adequate health. The child has no health care needs or has minor health problems or a disability that can be addressed with minimal intervention that typically requires no formal training (e.g., oral medications). Age-appropriate immunizations are current.

c. Minor health/disability needs. The child has health care or disability needs that require routine interventions that are typically provided by lay persons after minimal instruction (e.g., glucose testing and insulin, cast care).

d. Serious health/disability needs. The child has serious health problems or a disability that requires interventions that are typically provided by professionals or caregivers who 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, study team, etc.)

a. Outstanding academic achievement. The child is working above grade level and/or is exceeding the expectations of the specific educational plan.

b. Satisfactory academic achievement or child 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. 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. Severe academic difficulty. The child is working below grade level in more than half of 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

For children in voluntary or court-ordered placement, score the child's family, not his/her placement family.

a. Nurturing/supportive relationships. 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. Adequate relationships. The child experiences positive interactions with family members and feels safe and secure in the family, despite some unresolved family conflicts.

c. Strained relationships. Stress/discord 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. Harmful relationships. Chronic family stress, conflict, or violence severely impedes the child's sense of safety and security. The family is unable to resolve stress, conflict, or violence on their own and is not able or willing to obtain outside assistance.

CSN5. Child Development

For this item, base assessment on developmental milestones as described on pages 79-81.

a. Advanced development. The child's physical and cognitive skills are above his/her chronological age level.

b. Age-appropriate development. The child's physical and cognitive skills are consistent with his/her chronological age level.

c. Limited development. The child does not exhibit most physical and cognitive skills expected for his/her chronological age level.

d. Severely limited development. Most of the child's physical and cognitive skills are two or more age levels behind chronological age expectations.

CSN6. Substance Abuse

a. Chooses 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/experimentation. The child does not use alcohol or other drugs. 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. Alcohol or other drug use. The child's alcohol or other drug use results in disruptive behavior and discord in school/community/family/work relationships. Use may have broadened to include multiple drugs.

d. Chronic alcohol or other drug use. The child's chronic alcohol or other drug use results in severe disruption of functioning, such as loss of relationships, 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. Cultural Identity

For this item, cultural identity may refer to an ethnic, religious, or social identity that reflects the unique characteristics of the child. Cultural identity is not limited to identification with a minority culture and may refer to the prominent culture. Note that the reference to cultural conflict within the family includes inter-generational cultural conflict.

a. Cultural component is supportive and no conflict present. The child identifies with a culture and its connected community, and that cultural identification is a resource. He/she experiences no conflict related to cultural identity.

b. No cultural component that supports or causes conflict. The child identifies with a culture and its connected community; however, that cultural identity is not serving as a resource to him/her. He/she experiences no conflict related to cultural identity; OR the child has no particular identification with a culture, and the absence of cultural identity is not resulting in conflict with family or community.

c. Cultural component that causes some conflict. The child identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences *some* conflict related to cultural identity; OR the child has no particular identification with a culture, and the absence of cultural identity is resulting in *some* conflict with family or community.

d. Cultural component that causes significant conflict. The child identifies with a culture and its connected community, and that cultural identity may or may not be a resource to him/her. He/she experiences *significant* conflict related to cultural identity; OR the child has no particular identification with a culture, and the absence of cultural identity is resulting in *significant* conflict with family or community.

CSN8. Peer/Adult Social Relationships

a. 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. Adequate social relationships. The child demonstrates adequate social skills. The child maintains stable relationships with others; occasional conflicts are minor and easily resolved.

c. 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. 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. Delinquent Behavior

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

a. Preventive activities. The child is involved in community service and/or crime prevention programs and takes a stance against crime. The child has no arrest history, and there is no other indication of criminal behavior.

b. No delinquent behavior. The child has no arrest history, and there is no other indication of criminal behavior, or the child has successfully completed probation, and there has been no criminal behavior in the past two years.

c. Occasional delinquent behavior. The child is or has engaged in occasional, non-violent delinquent behavior and may have been arrested or placed on probation within the past two years.

d. Significant delinquent behavior. The child is or has been involved in any violent or repeated non-violent delinquent behavior that has or may have resulted in consequences such as arrests, incarcerations, or probation.

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

a. Significant 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. Not applicable. A child has no area of strength or need relevant for case planning that is not included in CSN1-CSN9.

c. Minor need. A 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. Significant need. A 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.

r: 11-05

CALIFORNIA
REUNIFICATION REASSESSMENT*

Case Name: _____ **Date Completed:** ____/____/____

Case #: _____ **Household Assessed:** _____

Is this the removal household? ☐ Yes ☐ No **Assessment # (mark):** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

A. REUNIFICATION RISK REASSESSMENT

Score

R1. Risk Level on Most Recent Referral (not reunification risk level or risk reassessment)
- a. Low 0
- b. Moderate 3
- c. High 4
- d. Very high ..... 5 _____

R2. Has There Been a New Substantiation since the Initial Risk Assessment or Last Reunification Reassessment?
- a. No 0
- b. Yes ..... 2 _____

R3. Progress toward Case Plan Goals
- a. Successfully met all case plan objectives and routinely demonstrates desired behavior ..... -2
- b. Actively participating in programs; routinely pursuing objectives detailed in case plan; frequently demonstrates desired behavior ..... -1
- c. Partial participation in pursuing objectives in case plan; occasionally demonstrates desired behavior 0
- d. Refuses involvement in programs or has exhibited a minimal level of participation with case plan; rarely or never demonstrates desired behavior ..... 4 _____

Total Score _____

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 and above	☐ Very High

OVERRIDES (during current period)

Policy Overrides: Indicate if any of the following are true in the current review period. Incident may be current or historic. Treatment status is current.
- ☐ 1. Sexual abuse; perpetrator has access to child and has not successfully completed treatment.
- ☐ 2. Non-accidental physical injury to an infant, and caregiver has not successfully completed treatment.
- ☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment; caregiver has not successfully completed treatment.
- ☐ 4. Death of a sibling as a result of abuse or neglect in the household; caregiver has not successfully completed treatment.

Discretionary Override: (Reunification risk level may be adjusted up or down one level.)
- ☐ 5. Reason: _____

FINAL REUNIFICATION RISK LEVEL (mark one):

☐ Low ☐ Moderate ☐ High ☐ Very High

Supervisor's Review/Approval of Discretionary Override:

_____ Date: ____/____/____

* To be completed for each household to which a child may be returned (e.g., father's home, mother's home).

B. VISITATION PLAN EVALUATION (See definitions below.)

Visitation Frequency Compliance with Visitation Plan	Quality of Face-to-Face Visit			
	Strong	**Adequate**	**Limited**	**Destructive**
Totally				
Routinely				
Sporadically				
Rarely or Never				

Shaded cells indicate acceptable visitation.

Overrides:

☐ Policy: Visitation is supervised for safety.
☐ Discretionary (reason): _____

Definitions

Visitation Frequency—Compliance with Case Plan
(Visits that are appreciably shortened by late arrival/early departure are considered missed.)

Totally: Caregiver regularly attends visits or calls in advance to reschedule (90-100% compliance).
Routinely: Caregiver may miss visits occasionally and rarely requests to reschedule visits (65-89% compliance).
Sporadically: Caregiver misses or reschedules many scheduled visits (26-64% compliance).
Rarely or Never: Caregiver does not visit or visits 25% or fewer of the allowed visits (0-25% 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.)

Strong — Consistently:

X demonstrates parental role.
X demonstrates knowledge of child's development.
X responds appropriately to child's verbal/non-verbal signals.
X puts child's needs ahead of his/her own.
X shows empathy toward child.

Adequate — Occasionally:

X demonstrates parental role.
X demonstrates knowledge of child's development.
X responds appropriately to child's verbal/non-verbal signals.
X puts child's needs ahead of his/her own.
X shows empathy toward child.

Limited — Rarely:

X demonstrates parental role.
X demonstrates knowledge of child's development.
X responds appropriately to child's verbal/non-verbal signals.
X puts child's needs ahead of his/her own.
X shows empathy toward child.

Destructive — Never:

X demonstrates parental role.
X demonstrates knowledge of child's development.
X responds appropriately to child's verbal/non-verbal signals.
X puts child's needs ahead of his/her own.
X shows empathy toward child.

C. IF RISK LEVEL IS LOW OR MODERATE AND CAREGIVER HAS ATTAINED AN ACCEPTABLE LEVEL OF COMPLIANCE WITH VISITATION PLAN, COMPLETE A REUNIFICATION SAFETY ASSESSMENT. OTHERWISE GO TO SECTION D, PLACEMENT/PERMANENCY PLAN GUIDELINES.

r: 10-07

CALIFORNIA
REUNIFICATION SAFETY ASSESSMENT

Factors Influencing Child Vulnerability (conditions resulting in child's inability to protect self; mark all that apply to any child):

☐ Age 0-5 years
☐ Significant diagnosed medical or mental disorder
☐ School age, but not attending school
☐ Diminished mental capacity (e.g., developmental delay, non-verbal)
☐ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)

SECTION 1A: SAFETY THREATS

Yes	No		
☐	☐	1.	Since the initial safety assessment, caregiver has caused serious physical harm or made a plausible threat to cause physical harm to a child as indicated by: ☐ Serious injury or abuse to the child other than accidental. ☐ Caregiver fears he/she will maltreat the child. ☐ Threat to cause harm or retaliate against the child. ☐ Excessive discipline or physical force. ☐ Drug-exposed infant.
☐	☐	2.	The severity of previous maltreatment or the caregiver's response to previous incidents AND current circumstances suggest that the child's safety may be an immediate concern.
☐	☐	3.	Child sexual abuse was substantiated or is still suspected, and current circumstances suggest that child safety is an immediate concern.
☐	☐	4.	Since the initial safety assessment, caregiver has failed to protect the child from serious harm or threatened harm by others, OR current circumstances suggest that the caregiver would likely be unable to protect the removed child from serious harm by others if the child were returned home.
☐	☐	5.	Caregiver's explanation for the injury to the child was, and remains, questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be an immediate concern.
☐	☐	6.	The family is refusing access to another child, there is reason to believe that the family is about to flee, or the whereabouts of another child cannot be ascertained.
☐	☐	7.	Since the initial safety assessment, the caregiver has failed to meet the child's immediate needs for food, clothing, shelter, and/or medical and/or mental health care, OR current circumstances suggest that the caregiver would likely be unable to meet those needs for the removed child if the child were returned home.
☐	☐	8.	Physical living conditions in the household are hazardous and immediately threatening, based on the child's age and developmental status.
☐	☐	9.	Caregiver's substance use is currently and seriously affecting ability to supervise, protect, or care for the child.
☐	☐	10.	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
☐	☐	11.	Caregiver 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.
☐	☐	12.	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child if the child were returned home.
☐	☐	13.	Other (specify): _____

SECTION 1B: PROTECTIVE CAPACITIES
Mark all that apply.

Child

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

Caregiver

☐ 2. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions.

☐ 3. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger.

☐ 4. Caregiver has the ability to access resources to provide necessary safety interventions.

☐ 5. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.

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

☐ 7. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.

☐ 8. There is evidence of a healthy relationship between caregiver and child.

☐ 9. Caregiver is aware of and committed to meeting the needs of the child.

☐ 10. Caregiver has history of effective problem solving.

Other

☐ 11. _____

SECTION 1C: SAFETY THREAT RESOLUTION
Review the safety assessment that led to removal. For any safety threat present at removal that is no longer present, document how safety threats were resolved.

SECTION 2: SAFETY INTERVENTIONS

If no safety threats are present, skip to Section 3. For each identified safety threat, review available protective capacities. With these protective capacities in place, can the following interventions control the threat to safety? Consider whether the threat to safety appears related to caregiver's knowledge, skill, or motivational issues.

Consider whether safety interventions 1-8 will allow the child to return home. If protective capacities 2, 3, and/or 7 are not marked, carefully consider whether *any s*afety interventions 1-8 are appropriate to protect the child if the child were to be reunified at this time. Mark the item number for all safety interventions that will be implemented. If there are no available safety interventions that would allow the child to return home, indicate by marking item 9 or 10.

Mark all that apply:

☐ 1. Intervention or direct services by worker.

☐ 2. Use of family, neighbors, or other individuals in the community as safety resources.

☐ 3. Use of community agencies or services as safety resources.

☐ 4. Have the caregiver appropriately protect the victim from the alleged perpetrator.

☐ 5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.

☐ 6. Have the non-offending caregiver move to a safe environment with the child.

☐ 7. Legal action planned or initiated—child remains in the home.

☐ 8. Other (specify): _____

☐ 9. Voluntary placement continues.

☐ 10. Protective custody continues because interventions 1-9 do not adequately ensure child's safety.

SECTION 3: SAFETY DECISION

Identify the safety decision by marking the appropriate line below. This decision should be based on the assessment of all safety threats, safety interventions, and any other information known about the case. Mark one line only.

☐ 1. 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.

☐ 2. One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home. SAFETY PLAN REQUIRED.

☐ 3. One or more safety threats are present, 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.

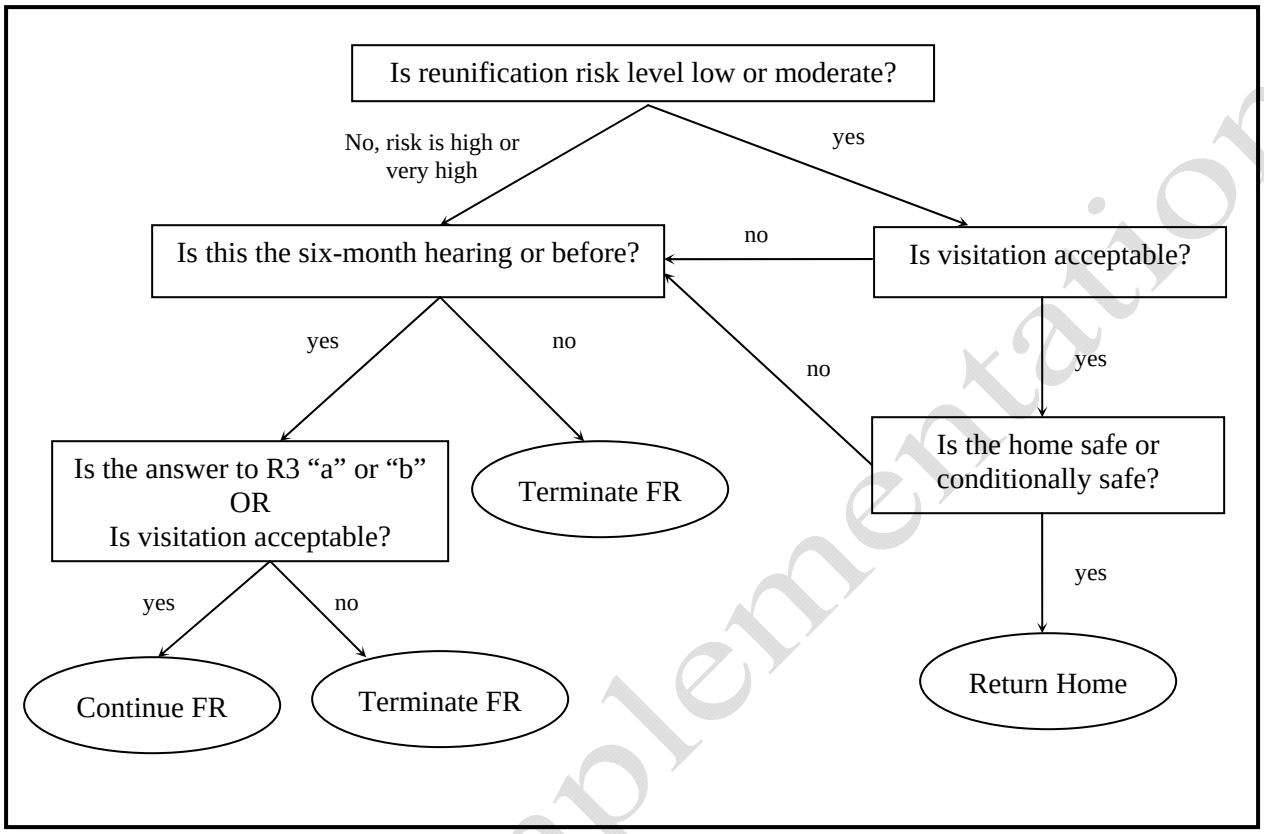
☐ All children remain in placement.
☐ The following children will be recommended for return home: *(enter name)*

_____ _____ _____ _____ _____ _____

D. PLACEMENT/PERMANENCY PLAN GUIDELINES

Complete for each child receiving family reunification services and enter results in Section E. Consult with supervisor and appropriate statutes and regulations.

Children under age three years at time of removal



OVERRIDES (select one)

☐ No override applicable (policy or discretionary).

Policy:

☐ Child has been in placement 15 of the last 22 months (change to "Terminate FR").

☐ The tree leads to "Terminate FR" and it is the six-month hearing or before, BUT there is a probability of reunification within six months (change to "Continue FR").

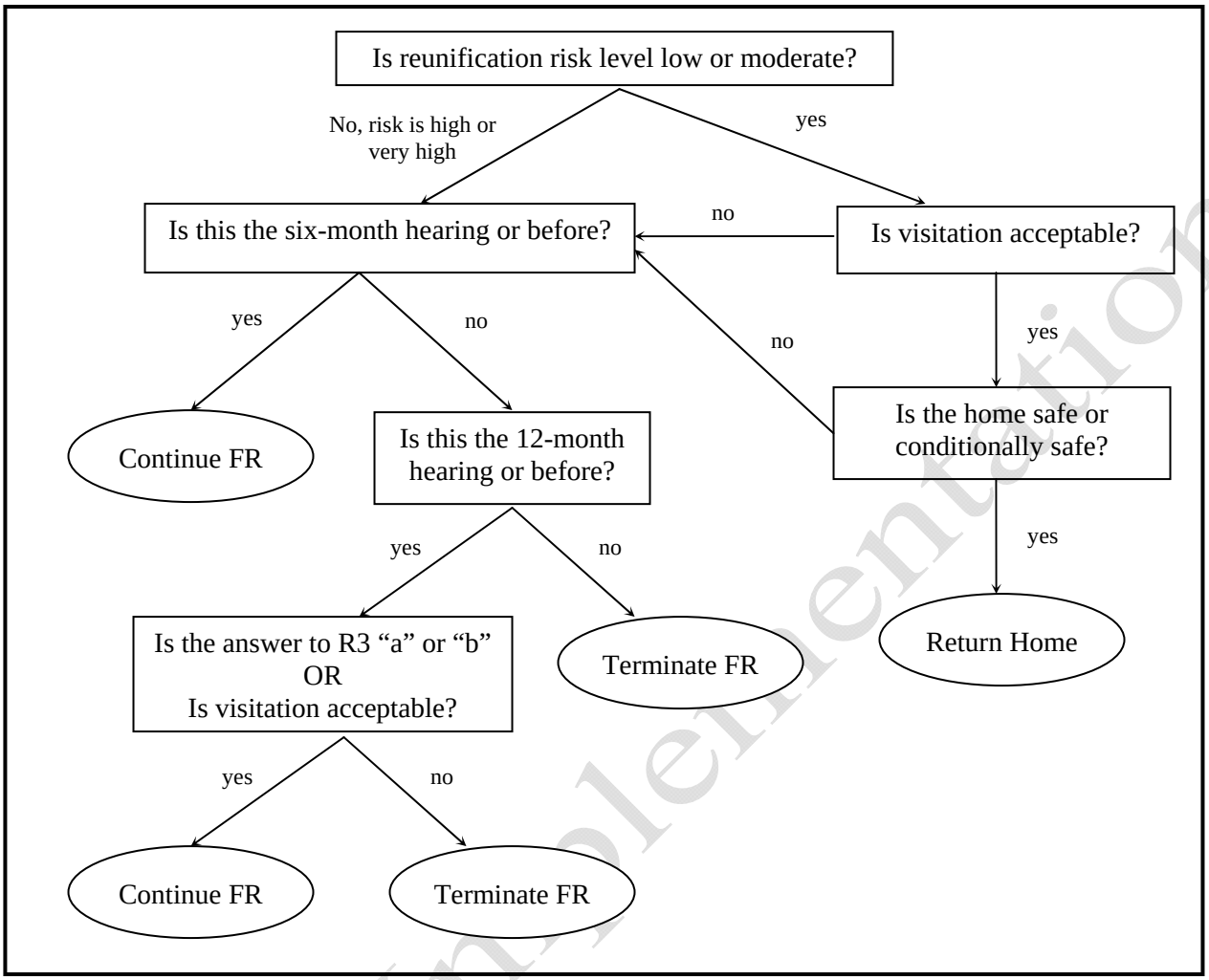
☐ The tree leads to "Continue FR," but conditions exist to recommend termination of FR (change to "Terminate FR"). Specify: _____

Discretionary:

☐ Specify: _____

Change Recommendation to: ☐ Return Home ☐ Continue FR ☐ Terminate FR

Children age three years and older at time of removal



OVERRIDES (select one)

☐ No override applicable (policy or discretionary).

Policy:

☐ Child has been in placement 15 of the last 22 months (change to "Terminate FR").

☐ The tree leads to "Terminate FR" and it is the 12-month hearing or before, BUT there is a probability of reunification within six months (change to "Continue FR").

☐ The tree leads to "Continue FR," but conditions exist to recommend termination of FR (change to "Terminate FR"). Specify: _____

Discretionary:

☐ Specify: _____

Change Recommendation to: ☐ Return Home ☐ Continue FR ☐ Terminate FR

E. RECOMMENDATION SUMMARY

If recommendation is the same for all children, enter "all" under child # and complete row 1 only.

Child #	Recommendation		
	Return Home	**Continue Family Reunification Services**	**Terminate Family Reunification Services; Implement Permanent Alternative**
1.			
2.			
3.			
4.			

F. SIBLING GROUP

If at least one child under the age of three at the time of removal has a recommendation of "Terminate Family Reunification Services" and at least one other child has any other recommendation, will all children be considered a sibling group when making the final permanency plan recommendation?

☐ No

☐ Yes. The recommendation for all children will be "Terminate Family Reunification Services."

* If the decision is to return all children home, complete a safety assessment to document the plan for any children for whom safety threats were identified.

CALIFORNIA
REUNIFICATION SAFETY ASSESSMENT
DEFINITIONS

SECTION 1A: SAFETY THREATS

1. Since the initial safety assessment, caregiver has caused serious physical harm or made a plausible threat to cause physical harm to a child as indicated by:

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

- Caregiver fears he/she will maltreat the child and/or requests that placement continue.

- Threat to cause harm or retaliate against the child. Threat of action that would result in serious harm; or household member plans to retaliate against child for CPS investigation.

- Excessive discipline or physical force. The caregiver has tortured a child or used physical force in a way that bears no resemblance to reasonable discipline or punished the child beyond the duration of the child's endurance.

- Drug-exposed infant. There is evidence that the mother used alcohol or other drugs during pregnancy AND this has created imminent danger to the infant.

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

  » Indicators of imminent danger include: the level of toxicity and/or type of drug present; the infant is diagnosed as medically fragile as a result of drug exposure; the infant suffers adverse effects from introduction of drugs during pregnancy.

2. The severity of previous maltreatment or the caregiver's response to previous incidents AND current circumstances suggest that the child's safety may be an immediate concern.

There must be both current immediate threats to child safety AND related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.

Previous maltreatment includes any of the following:

- Prior death of a child as a result of maltreatment.
- Prior serious injury or abuse to the child other than accidental—caregiver caused serious injury, defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child *and requires medical treatment.*
- Failed reunification—the caregiver had parental rights terminated as a result of a prior CPS investigation.
- Prior removal of a child—removal/placement of a child by CPS or other responsible agency or concerned party was necessary for the child's safety.
- Prior CPS substantiation—a prior CPS investigation was substantiated for maltreatment.
- Prior inconclusive CPS investigation—factors to be considered include seriousness, chronicity, and/or patterns of abuse/neglect allegations.
- Prior threat of serious harm to a child—previous maltreatment that could have caused severe injury; retaliation or threatened retaliation against a child for previous incidents; prior domestic violence that resulted in serious harm or threatened harm to a child.
- Prior service failure—failure to successfully complete court-ordered or voluntary services.

3. Child sexual abuse was substantiated or is still suspected, and current circumstances suggest that child safety is an immediate concern.

Suspicion of sexual abuse may be based on indicators such as the following:

- The caregiver or others in the household have committed rape, sodomy, or other sexual contact with the child.
- The caregiver 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).
- Access to the child by a possible or confirmed sexual abuse perpetrator exists.

4. Since the initial safety assessment, caregiver has failed to protect the child from serious harm or threatened harm by others, OR current circumstances suggest that the caregiver would likely be unable to protect the removed child from serious harm by others if the child were returned home.

- The caregiver fails to protect the child from serious harm or threatened harm by other family members, other household members, or others having regular access to the child. The caregiver would not provide supervision necessary to protect the child from potentially serious harm by others based on the child's age or developmental stage. Harm includes physical or sexual abuse or neglect.

- An individual with recent, chronic, or severe violent behavior resides in the home, or the caregiver allows access to the child.

5. Caregiver's explanation for the injury to the child was, and remains, questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be an immediate concern.

- A medical exam showed that the injury was the result of abuse; the caregiver gave no explanation, denied, or attributed to accident. Medical evaluation indicated that the injury was non-accidental; the caregiver denied or attributed injury to accidental causes.

- The caregiver's explanation for the observed injury was or remains inconsistent with the type of injury.

- The caregiver's description of the cause of the injury minimized the extent of harm to the child.

- The caregiver's and/or collateral contacts' explanation for the injury has significant discrepancies or contradictions. There are significant discrepancies between what the caregiver has said and what other contacts have said about the cause of the injury.

6. The family is refusing access to another child, there is reason to believe that the family is about to flee, or the whereabouts of another child cannot be ascertained.

- The family removed the child from a hospital against medical advice to avoid investigation.

- The family has previously fled in response to a child abuse/neglect investigation.

- The family has a history of keeping the child away from peers, school, or other outsiders for extended periods to avoid investigation.

- The family is otherwise attempting to block or avoid investigation/assessment.

7. Since the initial safety assessment, the caregiver has failed to meet the child's immediate needs for food, clothing, shelter, and/or medical and/or mental health care, OR current circumstances suggest that the caregiver would likely be unable to meet those needs for the removed child if the child were returned home.

- The caregiver has no housing or is currently residing in an emergency shelter. If the child were returned to the caregiver, the child's needs for minimally safe conditions (water, structurally safe environment, protection from severe weather elements) would not be met. If the child were returned to the caregiver, the child would have no or inappropriate space for sleeping, clothing, or food storage.

- The caregiver's home does not have the capacity to keep (refrigeration or heating) food or drink for the child. The child would be starved or deprived of food or drink for long periods of time due to either the caregiver's refusal or inability to provide food or the proper means to keep food, or the conditions of the home prevent the child from having food or drink.

- The caregiver does not have the means to acquire resources to provide the child with clothing that would protect him/her from severe weather elements.

- The caregiver did not seek treatment for the child's immediate medical condition(s) while the child was with him/her for visitation.

- The caregiver did not follow prescribed treatments or administer prescribed medications for the child during visitation.

- The child has exceptional needs that the caregiver did not meet while in his/her care for visitation. Needs include being medically fragile, or needing mental health evaluation or treatment.

- The child is suicidal, and the caregiver did not take protective action to protect the child from self-induced harm during visitation.

- The child showed effects of maltreatment (e.g., emotional symptoms, lack of behavior control, or physical symptoms) during the time the child was with the caregiver for visitation.

8. Physical living conditions in the household are hazardous and immediately threatening based on the child's age and developmental status.

- Leaking gas from stove or heating unit.

- Substances or objects accessible to the child that would endanger his/her health and/or safety.

- Lack of water or utilities (heat, plumbing, electricity) and no alternate or safe provisions are made.

- Open/broken/missing windows.
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food that threatens health.
- Serious illness or significant injury has occurred due to living conditions, and these conditions still exist (e.g., lead poisoning, rat bites).
- Evidence of human or animal waste throughout living quarters.
- Guns and other weapons are not locked.
- Methamphetamine production in the home.

9. Caregiver's substance use is currently and seriously affecting ability to supervise, protect, or care for the child.

There is a current, ongoing pattern of substance abuse that significantly impairs the caregiver's functioning and would negatively affect the child's care and safety if he/she were returned home.

10. 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 this creates a safety concern for the child. Examples may include:

- The child was previously injured in domestic violence incident.
- The child exhibits severe anxiety (e.g., nightmares, insomnia) related to situations associated with domestic violence.
- The child cries, cowers, cringes, trembles, or otherwise exhibits fear as a result of domestic violence in the home.
- The child would be at potential risk of physical injury.
- The child's behavior would increase risk of injury (e.g., attempting to intervene during violent dispute, participating in the violent dispute).
- Use of guns, knives, or other instruments in a violent, threatening, and/or intimidating manner.
- Evidence of property damage resulting from domestic violence.

11. Caregiver 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 caregiver actions include:

- The caregiver describes the child in a demeaning or degrading manner (e.g., as evil, stupid, ugly).
- The caregiver curses and/or repeatedly puts the child down.
- The caregiver scapegoats a particular child in the family.
- The caregiver blames the child for a particular incident or family problems.
- The caregiver places the child in the middle of a custody battle.

12. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child if the child were returned home.
Caregiver appears to be mentally ill, developmentally delayed, or cognitively impaired, AND as a result, one or more of the following are observed:

- The caregiver's refusal to follow prescribed medications impedes his/her ability to parent the child.
- The caregiver's inability to control emotions impedes his/her ability to parent the child.
- The caregiver acts out or exhibits a distorted perception that impedes his/her ability to parent the child.
- The caregiver's depression impedes his/her ability to parent the child.
- The caregiver 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, expected to be still for extended periods, be toilet trained, eat neatly, expected to care for younger siblings, or expected to stay alone).
- Due to cognitive delay, the caregiver lacks the basic knowledge related to parenting skills such as:
  - » not knowing that infants need regular feedings;
  - » failure to access and obtain basic/emergency medical care;
  - » proper diet; or
  - » adequate supervision.

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 his/her family environment in relation to any real or perceived threats to safety and is able to communicate at least two options for obtaining immediate assistance if needed (e.g., calling 911, running to neighbor, telling teacher).

- The child is emotionally capable of acting to protect his/her own safety despite allegiance to his/her caregiver or other barriers.

- The child has sufficient physical capability to defend him/herself and/or escape if necessary.

Caregiver

2. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions.

The caregiver has the ability to understand that the current situation poses a threat to the safety of the child. He/she is able to follow through with any actions required to protect the child. He/she is willing to put the emotional and physical needs of the child ahead of his/her own. He/she possesses the capacity to physically protect the child.

3. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger.

The caregiver is cognizant of the problems that have necessitated intervention to protect the child. The caregiver is willing and able to verbalize what is required to mitigate the threats that have contributed to the threat of harm to the child and accepts feedback and recommendations from the worker. The caregiver expresses willingness to participate in problem resolution to ensure that the child is safe.

4. Caregiver has the ability to access resources to provide necessary safety interventions.

The caregiver has the ability to access resources to contribute toward safety planning, or community resources are available to meet any identified needs in safety planning (e.g., able to obtain food, provide safe shelter, provide medical care/supplies).

5. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.

The caregiver 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.

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

The non-offending caregiver understands that continued exposure between the child and the offending caregiver poses a threat to the safety of the child, and the non-offending caregiver is willing and able to protect the child by ensuring that the child is in an environment in which the non-offending caregiver will not be present. If necessary, the non-offending caregiver is willing to ask the offending caregiver to leave the residence. As the situation requires, the non-offending caregiver will not allow the offending caregiver to have other forms of contact (telephone calls, electronic correspondence, mail, or correspondence through third-party individuals, etc.) with the child.

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

The caregiver accepts the involvement, recommendations, and services of the worker or other individuals working through referred community agencies. The caregiver cooperates with the continuing investigation/assessment, allows the worker and intervening agency to have contact with the child, and supports the child through all aspects of the investigation or ongoing interventions.

8. There is evidence of a healthy relationship between caregiver and child.

The caregiver displays appropriate behavior toward the child, demonstrating that a healthy relationship with the child has been formed. There are clear indications through both verbal and non-verbal communication that the caregiver is concerned about the emotional well-being and development of the child. The child interacts with the caregiver in a manner evidencing that an appropriate relationship exists and that the child feels nurtured and safe.

9. Caregiver is aware of and committed to meeting the needs of the child.

The caregiver is able to express the ways in which he/she has historically met the needs of the child for supervision, stability, basic necessities, mental/medical health care, and developmental/education. The caregiver is able to express his/her commitment to the continued well-being of the child.

10. Caregiver has history of effective problem solving.

The Caregiver has historically sought to solve problems and resolve conflict using a variety of methods and resources, including assistance offered by friends, neighbors, and community members. The caregiver has shown an ability to identify a problem, outline possible solutions, and select the best means to resolution in a timely manner.

SECTION 2: SAFETY INTERVENTIONS

Safety interventions are actions taken to specifically mitigate any identified safety threats. They should address immediate safety considerations rather than long-term changes. Follow county policies whenever applying any of the safety interventions.

1. Intervention or direct services by worker.
Actions taken or planned by the investigating worker or other CPS staff 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 food; planning return visits to the home to check on progress; providing information on obtaining restraining orders; and providing definition of child abuse laws and informing involved parties of consequences of violating these laws. DOES NOT INCLUDE services provided to respond to family needs that do not directly affect safety.

2. Use of family, neighbors, or other individuals in the community as safety resources.
Applying the family's own strengths as resources to mitigate safety concerns; using extended family members, neighbors, or other individuals to mitigate safety concerns. Examples include: family's agreement to use non-violent means of discipline; engaging a grandparent to assist with child care; agreement by a neighbor to serve as a safety net for an older child; commitment by a 12-step sponsor to meet with the caregiver daily and call the worker if the caregiver has used or missed a meeting; or the caregiver's decision to have the child spend a night or a few days with a friend or relative.

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

4. Have the caregiver appropriately protect the victim from the alleged perpetrator.
A non-offending caregiver has acknowledged the safety concerns and is able and willing to protect the child from the alleged perpetrator. Examples include: agreement that the child will not be alone with the alleged perpetrator or agreement that the caregiver will restrain the alleged perpetrator from physical discipline of child.

5. Have the alleged perpetrator leave 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 caregiver "kicking out" alleged perpetrator who has no legal right to residence; perpetrator agrees to leave.

6. Have the non-offending caregiver move to a safe environment with the child.
A caregiver not suspected of harming the child has taken or plans to take the child to an alternate location where there will be no access to the suspected perpetrator. Examples include: domestic violence shelter, home of a friend or relative, hotel.

7. Legal action planned or initiated—child remains in the home.
Legal action has already commenced, or will be commenced, that will effectively mitigate identified safety threats. This includes family-initiated actions (e.g., restraining orders, mental health commitments, change in custody/visitation/guardianship) and CPS-initiated actions (file petition and child remains in the home).

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

9. Voluntary placement continues.
A voluntary agreement is signed between the caregiver and the CPS agency. This voluntary agreement is consistent with W&I 11400 (o).

10. Protective custody continues because interventions 1-9 do not adequately ensure child's safety.
One or more children remain protectively placed pursuant to W&I 309.

SECTION 3: SAFETY DECISION

1. 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.

2. One or more safety threats are present, and protecting safety interventions have been planned or taken. Based on safety interventions, child would be conditionally safe upon return home. SAFETY PLAN REQUIRED.

3. One or more safety threats are present, 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.

Appendix B

FSNA Sample Comparison

CRR Sample Comparison

Table B1

FSNA Sample Description

Child/Case Characteristics		FSNA Sample (by Child)		Non-sample (by Child)		Total	
		N	%	N	%	N	%
Total Sample		**11,930**	**100.0%**	**9,175**	**100.0%**	**21,105**	**100.0%**
Child Ethnicity*	Caucasian	3,087	25.9%	2,692	29.3%	5,779	27.4%
	African American	2,427	20.3%	1,745	19.0%	4,172	19.8%
	Asian	282	2.4%	287	3.1%	569	2.7%
	Hispanic	5,959	49.9%	4,159	45.3%	10,118	47.9%
	Native American	116	1.0%	221	2.4%	337	1.6%
	Other	59	0.5%	71	0.8%	130	0.6%
Child Age at Entry* (in Years)	Under 1	2,277	19.1%	1,638	17.9%	3,915	18.6%
	1–2	1,847	15.5%	1,299	14.2%	3,146	14.9%
	3–5	2,133	17.9%	1,676	18.3%	3,809	18.0%
	6–10	2,970	24.9%	2,352	25.6%	5,322	25.2%
	11–15	2,703	22.7%	2,210	24.1%	4,913	23.3%
Placement Type*	Non-relative	8,923	74.8%	7,238	78.9%	16,161	76.6%
	Relative	2,784	23.3%	1,352	14.7%	4,136	19.6%
	Unknown	223	1.9%	585	6.4%	808	3.8%
Placement Status of Siblings*	No other siblings in care	3,258	27.3%	2,970	32.4%	6,228	29.5%
	Has other siblings in care	8,672	72.7%	6,205	67.6%	14,877	70.5%
Investigations Prior to Removal Incident?*	No prior investigations	4,529	38.0%	3,389	36.9%	7,918	37.5%
	One or more prior investigations	7,401	62.0%	5,786	63.1%	13,187	62.5%
Child Placed Prior to Sample Episode?*	No prior placements	10,169	85.2%	7,453	81.2%	17,622	83.5%
	One or more prior placements	1,761	14.8%	1,722	18.8%	3,483	16.5%
Number of Caregivers*	One	5,265	44.1%	4,012	43.7%	9,277	44.0%
	Two	6,665	55.9%	5,163	56.3%	11,828	56.0%
Frequency Worker Met Face-to-face Contact Standard*	0.0%	31	0.3%	211	2.3%	242	1.1%
	0.1–33.3%	38	0.3%	182	2.0%	220	1.0%
	33.4–66.7%	1,584	13.3%	1,111	12.1%	2,695	12.8%
	66.8–100.0%	10,277	86.1%	7,671	83.6%	17,948	85.0%
Time in Care*	0–3 months	2,097	17.6%	4,283	46.7%	6,380	30.2%
	4–6 months	988	8.3%	475	5.2%	1,463	6.9%
	7–9 months	1,268	10.6%	649	7.1%	1,917	9.1%
	10–12 months	683	5.7%	376	4.1%	1,059	5.0%
	13–15 months	1,050	8.8%	480	5.2%	1,530	7.2%
	16+ months	5,844	49.0%	2,912	31.7%	8,756	41.5%
Child Returned Home Within 15 Months*	No	6,468	54.2%	3,694	40.3%	10,162	48.1%
	Yes	5,462	45.8%	5,481	59.7%	10,943	51.9%

*Chi-square comparison of sample to non-sample cases significant at the .05 level.

Table B2

CRR Sample Description

Child/Case Characteristics		Reunification Sample		Non-sample		Total	
		N	%	N	%	N	%
Total Sample		**2,600**	**100.0%**	**8,343**	**100.0%**	**10,943**	**100.0%**
Child Ethnicity*	Caucasian	638	24.5%	2,525	30.3%	3,163	28.9%
	African American	388	14.9%	1,621	19.4%	2,009	18.4%
	Asian	37	1.4%	300	3.6%	337	3.1%
	Hispanic	1,508	58.0%	3,712	44.5%	5,220	47.7%
	Native American	26	1.0%	134	1.6%	160	1.5%
	Other	3	0.1%	51	0.6%	54	0.5%
Child Age at Entry* (in Years)	Under 1	385	14.8%	1,369	16.4%	1,754	16.0%
	1–2	455	17.5%	1,244	14.9%	1,699	15.5%
	3–5	543	20.9%	1,524	18.3%	2,067	18.9%
	6–10	701	27.0%	2,207	26.5%	2,908	26.6%
	11–15	516	19.8%	1,999	24.0%	2,515	23.0%
Placement Type*	Non-relative	1,997	76.8%	6,830	81.9%	8,827	80.7%
	Relative	602	23.2%	1,193	14.3%	1,795	16.4%
	Unknown	1	0.0%	320	3.8%	321	2.9%
Placement Status of Siblings*	No other siblings in care	531	20.4%	2,433	29.2%	2,964	27.1%
	Has other siblings in care	2,069	79.6%	5,910	70.8%	7,979	72.9%
Investigations Prior to Removal Incident?	No prior investigations	972	37.4%	3,267	39.2%	4,239	38.7%
	One or more prior investigations	1,628	62.6%	5,076	60.8%	6,704	61.3%
Child Placed Prior to Sample Episode?	No prior placements	2,237	86.0%	7,118	85.3%	9,355	85.5%
	One or more prior placements	363	14.0%	1,225	14.7%	1,588	14.5%
Number of Caregivers*	One	984	37.8%	3,516	42.1%	4,500	41.1%
	Two	1,616	62.2%	4,827	57.9%	6,443	58.9%
Time in Care*	0–3 months	268	10.3%	5,558	66.6%	5,826	53.2%
	4–6 months	454	17.5%	875	10.5%	1,329	12.1%
	7–9 months	1,007	38.7%	780	9.3%	1,787	16.3%
	10–12 months	326	12.5%	592	7.1%	918	8.4%
	13–15 months	545	21.0%	538	6.4%	1,083	9.9%
Subsequent Foster Care Reentry Within 12 Months	No	2,255	86.7%	7,155	85.8%	9,410	86.0%
	Yes	345	13.3%	1,188	14.2%	1,533	14.0%

*Chi-square comparison of sample to non-sample cases significant at the .05 level.

Appendix C

Multivariate Analyses of SDM® FSNA Items

Several studies of foster care children in California and other jurisdictions (see Harris & Courtney, 2002; Wells & Guo, 1999; or Webster et al., 2005) have identified child characteristics that impact reunification. These include age, ethnicity, placement type, number of siblings in placement, family composition (two parents versus single parent), and previous placement history. A more rigorous test of the predictive validity of the FSNA can be conducted by controlling for the influence of these characteristics to determine if FSNA item scores retain predictive validity.

Logistic regression findings below indicate that the five FSNA items found significant in a regression model with only FSNA items entered—substance abuse (SN1), social support (SN3), parenting skills (SN4), mental health (SN5), and resource management (SN6)—remained significant when child age and ethnicity, initial placement type, and other variables were included in the model. While all these variables had a significant relationship to the reunification outcome, FSNA findings continued to make a significant contribution to the prediction of reunification, and the assessment passes this more rigorous test of utility.

Logistic regression findings in Table C provide an estimate of each FSNA item's relative impact when regressed with other case characteristics. The first column identifies the FSNA item and the second column shows the coefficient (B) estimated for it. Statistical significance test findings appear in column five (Sig.) and the odds ratio[28] (Exp[B]) in column six.[29] A fairly straightforward interpretation of the FSNA item findings can be made by examining both statistical significance and the sign and size of the coefficient (B). Items with statistically significant ($p \leq .05$) results are marked with an asterisk in column one. For statistically

[28] An odds ratio of one indicates that the item score has no impact on the odds of reunification. An odds ratio that is greater than one indicates higher reunification odds. Ratios lower than one indicate reduced odds (lower likelihood) of reunification.

[29] Logistic regression models the logarithm of the odds of success for variables or outcomes with two choices (for example, yes or no). The equation is $\log(p/1-p) = \beta_0 + \beta_1 x$, where p is the proportion of success and x is the explanatory variable. The beta coefficient (β) is the value that is multiplied by the variable value. The odds ratio is the exponent of the beta coefficient, and its confidence interval is the exponent of β plus or minus the standard error. The 95% confidence interval indicates the range of values between which the actual odds ratio is likely to be. In other words, we can be 95% confident that the true odds ratio falls between the estimated ratios given. Significance tests are based on the Wald statistic.

significant items, the numerical size and sign of its coefficient indicate relative impact on reunification.

The numeric scores used for coding FSNA items assigned a caregiver strength, "a," as a negative integer (-1) and adequate or normal functioning, "b," as 0. Caregiver problems ("c" and "d") were assigned positive integers (1 and 2, respectively). Other variables in the equation, including child ethnicity and child age, were assigned a 1 or 0, representing yes and no, to indicate whether the child was part of each subcategory. Although these variables were entered into the equation as dummy variables (1 or 0), all of the subcategories were mutually exclusive, meaning each child in the sample was entered as a "yes," or a 1, for only one subcategory. The Caucasian ethnicity variable and children under 1 were omitted from the equation and served as reference categories. Therefore, interpretation of the results for these categories shows the likelihood of reunification in each other group compared to the reference group. For instance, children in each of the other ethnic groups were less likely to reunify within 12 months than Caucasian children while children in each group over the age of 1 were more likely to reunify within 12 months than children under the age of 1.

Prior placements and prior investigations were entered into the equation as counts representing the number of prior placements and the number of prior investigations in which the child had been involved before the sample removal. Placement with relatives, abuse substantiation, and two-caregiver home were assigned a 1 or a 0 to represent yes, the child possessed this characteristic or no, the child did not possess this characteristic. However, these variables were not part of a larger category and did not have reference variables like child age and ethnicity did. Therefore, the impact of these characteristics on the return-home outcome of the children/households that had them can be interpreted in relation to those children/households that did not. For example, children with two parents were more likely to return home within 12 months than children without two parents.

Table C

Logistic Regression of SDM® FSNA Items and Other Child Characteristics on Return Home Within 15 Months of Removal

FSNA Item	B	S.E.	Wald	Sig.	Exp(B)	95.0% Confidence Interval Exp(B)	
						Lower	Upper
Substance Abuse/Use*	-0.130	0.027	22.488	0.000	0.878	0.832	0.926
Household Relationships/ Domestic Violence	0.012	0.034	0.127	0.722	1.012	0.946	1.083
Social Support System*	-0.166	0.041	16.504	0.000	0.847	0.782	0.918
Parenting Skills*	-0.137	0.046	9.006	0.003	0.872	0.797	0.954
Mental Health/Coping Skills*	-0.139	0.040	12.071	0.001	0.870	0.805	0.941
Resource Management/Basic Needs*	-0.283	0.039	53.512	0.000	0.753	0.698	0.813
Cultural Identity	-0.048	0.049	0.989	0.320	0.953	0.866	1.048
Physical Health	-0.066	0.046	2.080	0.149	0.936	0.856	1.024
Child Ethnicity							
Caucasian							
Other	-0.430	0.419	1.052	0.305	0.651	0.286	1.479
Native American	-0.140	0.254	0.304	0.581	0.869	0.529	1.430
Asian	-0.311	0.168	3.417	0.065	0.733	0.527	1.019
African American*	-0.540	0.074	52.589	0.000	0.583	0.504	0.674
Hispanic*	-0.248	0.062	15.934	0.000	0.781	0.691	0.882
Child Age at Entry (in Years)							
Under 1							
1–2*	0.444	0.075	35.330	0.000	1.559	1.347	1.805
3–5*	0.459	0.083	30.391	0.000	1.582	1.344	1.862
6–10*	0.346	0.085	16.658	0.000	1.413	1.197	1.669
11–15	0.114	0.088	1.687	0.194	1.121	0.943	1.332
Placement Type							
Relative*	-0.372	0.063	35.366	0.000	0.689	0.610	0.779
Number of Siblings in Placement*	0.058	0.020	8.329	0.004	1.060	1.019	1.103
Number of Prior Investigations*	-0.046	0.013	12.912	0.000	0.955	0.931	0.979
Prior Placement*	-0.219	0.085	6.645	0.010	0.803	0.680	0.949
Removal Referral Substantiation Type							
Abuse*	0.236	0.063	13.940	0.000	1.267	1.119	1.434
Two-caregiver Home*	0.239	0.051	21.783	0.000	1.270	1.149	1.405

*Coefficient statistically significant at $p \leq .05$.

Appendix D

SDM® CRR Item-by-item Analysis

Multivariate Analyses of SDM® CRR Item Results

CRR Item-by-item Analysis

As Table D1 indicates, individual items (R1, R2, and R3) in the reunification risk component of the CRR and the scored risk level and final risk level after overrides are related to reentry in the expected direction. A higher numerical score indicates a higher risk of reentry. However, the initial risk level (R1) and the progress toward case goals assessment (R3) made by the worker were not statistically significant in this validation sample. On the other hand, both the scored risk level and the override risk level are significantly related to reentry in the manner expected.

Weak findings for the initial risk level appear to be related to the sample. This item was significant in a much larger sample of 8,787 reunified cases, shown in Table D2.[30] This table also shows the relationship of neglect risk classification and prior placement history to reentry. Since both neglect risk and prior placement are highly significant, future efforts to revise the CRR should consider incorporating them into the assessment. Prior placement history could be scored with recent substantiation in R2. Since the R3 item, which measures case progress based on worker judgment, has a relatively weak relationship to reentry, a revised definition or additional training could improve it.

Workers also evaluate visitation frequency and quality separately. As Table D1 indicates, both items are related to reentry in the expected direction and both are significant (higher scores are assigned to problematic visitation). Visitation is acceptable if frequency is routine or total and visit quality is strong or adequate (see bold). This combined visitation evaluation is also significant in the expected direction before and after overrides.

Finally, the safety finding is significant. Children found to be safe or safe with interventions have much lower reentry rates than children whom workers scored as unsafe.

[30] The sample represented in Table D2 is larger than the reunification reassessment sample because completion of the reunification reassessment was not a requirement to be included in the sample of 8,787 cases.

Table D1

Relationship Between SDM® Reunification Reassessment Component Scores and Foster Care Reentry Within 12 Months of Return Home for Children Reunified Within 15 Months of Removal in Sample California Counties

Item	Sample Distribution		Cases in Which Child Returned Home Within 15 Months of Removal and Reentered Substitute Care During the Subsequent 12 Months			
	N	%	N	%	Corr.	P Value
Total Sample	**2,600**	**100.0%**	**345**	**13.3%**		
R1. Risk Level on More Recent Referral					.005	.792
Low	296	11.4%	39	13.2%		
Moderate	368	14.2%	40	10.9%		
High	1,390	53.5%	197	14.2%		
Very High	546	21.0%	69	12.6%		
R2. New Substantiation Since the Initial Risk Assessment or Last Reunification Reassessment					.080	.000*
No	2,524	97.1%	323	12.8%		
Yes	76	2.9%	22	28.9%		
R3. Progress Toward Case Plan Goals					.014	.466
Successfully met all case plan objectives and routinely demonstrates desired behavior	824	31.7%	95	11.5%		
Actively participating in programs; routinely pursuing objectives in case plan; frequently displays desired behavior	1,497	57.6%	212	14.2%		
Partial participation in pursuing objectives in case plan; occasionally demonstrates desired behavior	207	8.0%	29	14.0%		
Refuses involvement in programs or has exhibited a minimal level of participation with case plan; rarely or never demonstrates desired behavior	72	2.8%	9	12.5%		
Scored Risk Level (before overrides)					.041	.035*
Low	424	16.3%	48	11.3%		
Moderate	1,619	62.3%	214	13.2%		
High	465	17.9%	63	13.5%		
Very High	92	3.5%	20	21.7%		
Final Risk Level (after overrides)					.056	.005*
Low	547	21.0%	60	11.0%		
Moderate	1,669	64.2%	217	13.0%		
High	292	11.2%	52	17.8%		
Very High	92	3.5%	16	17.4%		

Table D1

Relationship Between SDM® Reunification Reassessment Component Scores and Foster Care Reentry Within 12 Months of Return Home for Children Reunified Within 15 Months of Removal in Sample California Counties

Item	Sample Distribution		Cases in Which Child Returned Home Within 15 Months of Removal and Reentered Substitute Care During the Subsequent 12 Months			
	N	%	N	%	Corr.	P Value
Total Sample	**2,600**	**100.0%**	**345**	**13.3%**		
Risk Level					-.054	.005*
Risk Low or Moderate	2,216	85.2%	277	12.5%		
Risk High or Very High	384	14.8%	68	17.7%		
Visitation Frequency					.090	.000*
Totally	1,845	71.0%	209	11.3%		
Routinely	634	24.4%	115	18.1%		
Sporadically	71	2.7%	5	7.0%		
Rarely/Never	50	1.9%	16	32.0%		
Visitation Quality					.057	.004*
Strong	1,539	59.2%	180	11.7%		
Adequate	958	36.8%	145	15.1%		
Limited	83	3.2%	18	21.7%		
Destructive	20	0.8%	2	10.0%		
Visitation Acceptability (before overrides)					-.024	.220
Visitation acceptable	2,449	94.2%	320	13.1%		
Visitation unacceptable	151	5.8%	25	16.6%		
Visitation Acceptability (after overrides)					-.047	.017*
Visitation acceptable	2,447	94.1%	315	12.9%		
Visitation unacceptable	153	5.9%	30	19.6%		
Risk and Visitation					-.060	.002*
Both components met standards (risk low or moderate and visitation acceptable)	2,184	84.0%	273	12.5%		
Risk or visitation met standard	295	11.3%	46	15.6%		
Neither component met standards	121	4.7%	26	21.5%		
Permanency Plan Recommendation					-.047	.015*
Return Home	1,900	73.1%	230	12.1%		
Continue Services	616	23.7%	104	16.9%		
Terminate Services	84	3.2%	11	13.1%		

Table D1

Relationship Between SDM® Reunification Reassessment Component Scores and Foster Care Reentry Within 12 Months of Return Home for Children Reunified Within 15 Months of Removal in Sample California Counties

Item	Sample Distribution		Cases in Which Child Returned Home Within 15 Months of Removal and Reentered Substitute Care During the Subsequent 12 Months			
	N	%	N	%	Corr.	P Value
Total Sample	**2,600**	**100.0%**	**345**	**13.3%**		
Safety Decision**					.076	.000*
Safe	900	34.6%	99	11.0%		
Safe with services	1,226	47.2%	156	12.7%		
Unsafe or no safety completed	474	18.2%	90	19.0%		
Risk, Visitation, and Safety**					-.073	.000*
All three components met standards	2,066	79.5%	246	11.9%		
Two of three components met standards	174	6.7%	32	18.4%		
None or one component met standards	360	13.8%	67	18.6%		

*Significant at $p < 0.05$.

**When a safety assessment was not completed because risk and/or visitation had not met standards, the safety finding was coded as unsafe.

Table D2

Relationship Between Initial SDM® Risk Levels and Prior Placement Episodes and Foster Care Reentry Within 12 Months of Return Home for Children Reunified Within 15 Months of Removal in Sample California Counties

Item	Sample Distribution		Cases in Which Child Returned Home Within 15 Months of Removal and Reentered Substitute Care During the Subsequent 12 Months			
	N	%	N	%	Corr.	P Value
Total Sample	**8,787**	**100.0%**	**1,178**	**13.4%**		
Final Risk Level (at the time of the removal referral)					.061	.000
Low	60	0.7%	6	10.0%		
Moderate	973	11.1%	89	9.1%		
High	3,737	42.5%	462	12.4%		
Very High	4,017	45.7%	621	15.5%		
Neglect Risk Level (at the time of the removal referral)					.102	.000
Low	382	4.3%	20	5.2%		
Moderate	1,501	17.1%	134	8.9%		
High	3,598	40.9%	453	12.6%		
Very High	3,306	37.6%	571	17.3%		
Placement Episode Prior to Sample Episode					.072	.000
No	7,666	87.2%	956	12.5%		
One or more	1,121	12.8%	222	19.8%		

Multivariate Analyses of CRR Results

Previous studies for foster care reentry after reunification (Terling, 1999; Wells & Guo, 1999; and Jones, 1998) as well as two recent studies of children in California (Frame et al, 2000; Shaw, 2006) have identified child characteristics with a strong, statistical relationship to foster care reentry. These include child age, ethnicity, number of months in placement prior to reunification, placement type (relative versus non-relative care), sibling(s) in placement, abuse versus neglect history, the number of family caregivers, and the child's previous placement history. Since the CRR was developed to assess the reunification prospects of all children entering foster care, it should demonstrate predictive utility when these other case characteristics are considered. Consequently, the predictive validity of the CRR compliance score was tested in a logistic regression model with other case characteristics known to impact reentry.

Compliance with each of three CRR components, including risk, visitation, and safety, was scored 1, while non-compliance was scored 0. The three component scores were added to create a compliance score ranging from 0 to 3 shown in the model below. Child ethnicity, child age, and initial placement with relatives were assigned a 1 or 0, representing yes and no, to indicate whether the child possessed each characteristic. Although these variables were entered into the equation as dummy variables (1 or 0), all of the variables in one category (e.g., ethnicity) were mutually exclusive, meaning each child in the sample was entered as a "yes," or a 1, for only one subcategory. Caucasian and children under 1 were omitted from the equation and served as reference categories. Therefore, interpretation of the results for these categories shows the likelihood of reunification in each other group compared to the reference group.

Initial placement with relatives, other siblings in care, prior placement, substantiation for abuse, substantiation for neglect, and two adults in home were assigned a 1 or a 0 to represent yes, the child possessed this characteristic or no, the child did not possess this characteristic. For

these variables, the impact of each on likelihood of reentry can be compared to those children who did not possess the characteristics. For example, the odds of a child with two parents reentering care were lower than those without two parents. Time in care was entered into the equation as a categorical variable and assigned values between 1 and 5; 0 to 3 months served as the reference category against which the other time in placement categories can be compared.

As the findings indicate, the CRR composite score is highly significant. The negative coefficient indicates that higher compliance scores are associated with much lower odds of reentry. Child ethnicity also had a significant impact on reentry; both African American and Hispanic children were more likely to reenter care than Caucasians. Other variables, such as child age or length of stay in care, were not significant in this sample. Prior placement for neglect approached significance.

Table D3

Logistic Regression of SDM® Reunification Risk, Visitation, and Safety in Compliance and Other Case Characteristics on Foster Care Reentry Within 12 Months of Return Home in Sample California Counties

Variable	B	S.E.	Wald	Sig.	Exp(B)	95.0% Confidence Interval Exp(B)	
						Lower	Upper
Reunification Risk, Visitation, and Safety Compliance Score*	-.563	.145	14.978	.000	.569	.428	.757
Child Ethnicity							
Asian	0.936	.490	3.642	.056	2.549	.975	6.666
African American*	.724	.217	11.113	.001	2.062	1.347	3.155
Hispanic*	.509	.180	7.998	.005	1.664	1.169	2.367
Child Age							
Up to 1 year							
1–2	-.357	.234	2.333	.127	.700	.443	1.106
3–5	-.336	.227	2.197	.138	.715	.458	1.114
6–10	-.294	.216	1.854	.173	.746	.489	1.138
11–15	.041	.219	0.034	.853	1.041	.677	1.601
Time in Care (months)							
0–3			5.822	.213			
4–6	-.050	.249	.041	.839	.951	.584	1.548
7–9	-.090	.217	.173	.677	.914	.597	1.399
10–12	.308	.247	1.548	.213	1.360	.838	2.208
13–15	-.190	.248	.588	.443	.827	.508	1.344
Initial Placement With Relatives	-.032	.154	.042	.837	.969	.716	1.311
Child Has Other Siblings in Care	.048	.167	.083	.773	1.049	.756	1.456
Placement Prior to Sample Placement	-.110	.206	.283	.595	.896	.599	1.342
Placement Investigation Substantiated for Abuse	-.098	.146	.451	.502	.907	.681	1.207
Placement Investigation Substantiated for Neglect	-.363	.213	2.915	.088	.696	.459	1.055
Two Adults in Home	.148	.138	1.158	.282	1.160	.885	1.519

*Coefficient statistically significant at $p \leq .05$.