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PREVENTION AND IN-HOME SERVICES TO FAMILIES

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2.1 Intended audience for Section 2

The intent of Section 2, Prevention and In-Home Services to Families, is as follows:

- To provide program managers, *Family Services Supervisors*, and *Family Services Specialists* involved in In-Home services with best practice strategies for engaging families during an initial outreach contact, empowering families in decision-making, and maintaining family engagement and partnership.

Section 2 includes the following information:

- Guidelines for standardized assessments to create and inform individualized service plans.
- Definitions of case types for prevention to facilitate consistent data collection.
- Principles of practice for strength-based, trauma-informed family engagement practice and supervision in prevention, using the protective factors as a framework.
- Guidelines for trauma-informed case management.
- Supporting case decision-making through consistent use of available tools.

2.2 Definition of prevention services to families

Prevention services are an integral part of the continuum of all child welfare services. These services include, but are not limited to, providing information and services intended to: strengthen families and improve child well-being; minimize harm to children; maximize the abilities of families to protect and care for their own children; and prevent abuse, neglect, and the need for out-of-home care across the continuum of services within local departments of social services (LDSS).

There are three (3) levels of prevention services as families move across the continuum:

- **Primary prevention**: Activities with a universal focus that seeks to raise the awareness of the general public, service providers, and decision makers about the scope and problems associated with child maltreatment. For more information on primary prevention, see Section 1.16, Primary prevention: Public education and awareness activities for all families.

- **Secondary prevention**: Activities with a focus on populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance use disorder, young parental age, parental mental health concerns, and parental or child disabilities. Programs may target services for communities that have a high incidence of any or all of these risk factors. For more information on secondary prevention, see Section 1.17, Secondary prevention: Prevention services with at-risk families.

- **Tertiary prevention**: Activities with a focus on families where maltreatment has occurred and seeks to reduce the negative consequences of the maltreatment and to prevent its recurrence.

2.3 Tertiary prevention: In-Home services and foster care prevention

The primary goal of In-Home services is to support families to safely maintain children in their own homes or with relative/fictive kin caregivers in their own communities, by addressing identified safety and risk concerns and reducing the reoccurrence of child maltreatment. This is achieved through engagement of the family, support systems, and other service providers.

2.3.1 Principles of In-Home services

In-Home services provide interventions and services to families that are based on the following principles:

- Address child safety and risk factors.

- Preserve families by maintaining children safely in their own homes or with relative/fictive kin caregivers in their own communities.

- Prevent further abuse or neglect by strengthening the family's capacity to protect and nurture their children.

- Interventions and services are provided in a manner to reduce or eliminate re-traumatization to children and families.

- Deliver interventions and services within the context of the family's own community culture and the child's current living arrangement.
- Engage children, youth, and families in the planning process while producing better outcomes of safety, permanence, and well-being.

2.3.2 In-Home services population

In-Home services may serve the following population:

- Families self-referred due to significant crisis.
- Families who may have had a substantiation of abuse or neglect.
- Children or youth who, in the absence of preventive services, would be at imminent risk of out-of-home care or placement into foster care.
- Court involved children or youth that have not been removed from the home.
- A child who is receiving family reunification support after foster care placement.
- A pregnant or parenting youth in foster care.
- A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.

2.4 Opening a case

2.4.1 Application for services

The Code of Virginia and federal law require that child welfare information be maintained in the statewide child welfare information system. When safety factors or risk factors have been identified, the opening of an In-Home services case should occur without delay. The case must be opened electronically in the child welfare information system and opened through the case connect function within the family assessment or investigation, when applicable. The case must have a primary worker assigned within **three (3) business days** of case opening.

The Code of Virginia § 2.2-3700 requires that official records held by public agencies are to be open to inspection. Any individual may exercise his or her rights under the Virginia Freedom of Information Act (FOIA) and the Government Data Collection and Dissemination Practices Act to see public and personal information in the custody of any public agency. FOIA provides procedures for requesting records and responding to those requests. It also provides exceptions to providing certain information to individuals who make requests pursuant to the Code of Virginia.

When services are identified that will address identified safety and risk concerns and will reduce the reoccurrence of child maltreatment, a Service Application or a Family Service Agreement can be utilized to document the family's willingness to participate in services and allows for notification of their legal rights. For more information on the use of the Family Service Agreement, refer to the following instructions on FUSION.

See Section 2.10.10.1 for additional guidance if a family refuses services.

2.4.2 Information and referral only

In some cases, a family's needs can be addressed with information and referral only. Information and referral may include but are not limited to:

- No case will be opened.
- No ongoing assessment is needed.
- No referral was made.
- Family referred for services either outside the LDSS or internally to a program that does not require a case to be opened (e.g., parent education or home visiting services that are facilitated by the LDSS).

If a family refuses services even when there appears to be a need, the *Family Services Specialist* should consider follow-up via phone or written communication with additional information about how LDSS services can assist the family.

2.4.3 Frequency of worker visits

The first worker visit or attempted visit should occur **within five (5) business days** of opening a case. A *Family Services Specialist* must have a face-to-face visit with the child(ren) and family **at least one (1) time per month**. Face-to-face visits with an active member of the case must be made consistently so the *Family Services Specialist* and the family can assess ongoing safety, risk, level of functioning, and the status of the service plan objectives. Visits with the family should be well-planned, focused, and meaningful. The *Family Services Specialist* should also communicate with service providers on a consistent basis to assess the progress of the family and determine how they can be helpful in reinforcing the changes the family is making through the services provided.

2.4.4 Opening case narrative

An opening case narrative should be documented in the In-Home services case within the child welfare information system. This summary should include a brief explanation

about how the family became known to the LDSS and any needs or concerns relating to safety, risk, court involvement, and current status of the family's situation.

2.4.5 Case type

Below are definitions of case types for Family Support, In-Home, and Dual In-Home and Foster Care. For each case type, there is a reference to the case type to use in the child welfare information system and a clear definition of the criteria to use to determine the case type. As the family's situation changes or more intensive services are needed the case type may change.

2.4.5.1 Family Support

*These cases appear in the child welfare information system as Family Support (Early Prev/Family Preserv).

Services to support and preserve the family under the following conditions:

- The family has been identified to benefit from voluntary services and is not in need of In-Home services or a formal service plan.
- LDSS has determined that services provided are intended to help families alleviate crises and promote family well-being.
- This case type may include services ordered by the court related to a petition for relief of care and custody or court ordered custody, visitation, or mediation.
- Family has agreed to services.

2.4.5.2 In-Home (CPS: Ongoing Services)

*These cases appear in OASIS as In-Home (CPS: Ongoing Services)

Services to a family under the following conditions:

- A case that is associated with a concern of child maltreatment and as a result of a family assessment, investigation, or a high or very high risk assessment.
- An adoption or guardianship arrangement that is at risk of a disruption or dissolution that would result in a foster care placement.
- Absent effective preventive services, the child may be at imminent risk of out-of-home care or placement into foster care.

- The child or youth may meet eligibility for a reasonable candidate or candidate for foster care. LDSS must complete the Candidacy Determination Documentation Form in the child welfare information system. Additional information regarding candidacy determinations can be found in Section 2.6.6.5 or the online course available in the Virginia Learning Center (VLC).

- Family has agreed to services or services are court ordered.

2.4.5.3 Dual In-Home & Foster Care (Dual: CPS & Foster Care)

Services to a family under the following conditions:

- When a child is in the custody of the LDSS and is in foster care **and** there are other children remaining in the home who are not in the custody of the LDSS.

- Family has agreed to services or services are court ordered.

2.4.6 Transfer case within LDSS

When another *Family Services Specialist* in the LDSS is assigned the case, the LDSS must ensure a quick and smooth transition of the case to continue safety monitoring, commence the Child and Adolescent Needs and Strengths (CANS) assessment, and begin service planning with the family. If the case is transferred to another *Family Services Specialist*, the first contact or attempted contact must occur **within five (5) business days** of assignment. The first contact must be a face-to-face worker visit with the parents, custodians or legal guardians, relative/fictive kin caregivers, the child, the initial *Family Services Specialist*, and the newly assigned *Family Services Specialist*. This seamless transition helps to ensure a thorough assessment of strengths and needs of the child and family and that the service plan will be completed **within 30 calendar days** of opening the case.

If a case is being transferred to another worker in the LDSS, a case transfer staffing should be held. The meeting should address:

- The safety and risk factors identified.

- The existing safety plan with the family.

- Any pending legal matters and who is responsible for any upcoming court hearings.

- When a joint initial visit with the family will occur.

- The family's view of the concerns and needs that require In-Home services.
- Recommendations from the Family Partnership Meeting (FPM), if held.
- The "stage of change" of the family. (See "Motivational Strategies and Stages Handout").

The *Family Services Specialist* should receive the entire electronic and hard copy record for the family. The need for the entire record should not delay the transfer of enough information to begin essential services to prevent abuse or neglect.

2.5 Child safety scenarios in an In-Home services case

In-Home services aim to support families to safely maintain children or youth in their own home or with relative/fictive kin caregivers by eliminating identified safety and threat concerns and reducing risk of future child maltreatment. This is achieved through engagement of the family, their support system, and other service providers. During the delivery of In-Home services, LDSS must provide, arrange for, and coordinate interventions and services for children and families in the following safety scenarios:

- **Child or youth residing with parent(s) or relative/fictive kin caregiver(s).**
- **Child or youth temporarily residing with relative/fictive kin caregiver(s) and will return to the parent(s) or caregiver/guardian(s) within six (6) months.**
- **Child or youth permanently residing with relative/fictive kin caregivers(s).**

In-Home services involve the provision of accessible, equitable, individualized services to reduce the reoccurrence of child maltreatment or out of home placement. In-Home services in all the identified safety scenarios include, but are not limited to:

- Routine and uniform assessment **every 90 days**, to include:
  - Safety assessment.
  - Risk Assessment and Risk Reassessment.
  - Child and Adolescent Needs and Strengths (CANS).
  - Candidacy Determination.
  - For more information on initial contact and assessment to include safety and risk, see Section 2.6. For more information on the comprehensive assessment of the family's needs and strengths, see Section 2.7.

- Well-planned, focused, and meaningful face-to-face worker visits with the child and family **at least one (1) time per month.**

- Teaming to engage children, youth, and the family as partners in shared decision-making, to include:

    - Family Partnership Meetings (FPM) which must be held at critical decision points and prior to the development of the service plan.

    - Child and Family Team Meetings (CFTM) which must be held **every 90 days** and should be held **every 30 days** to help inform the service plan.

- Monitoring, expanding, and updating the service plan **every 90 days**. For more information on service planning and review, see Section 2.8 and Section 2.11 respectively.

- Referral and monitoring of services and connection to available formal supports (e.g., TANF, Relative Maintenance Support, early infant and child services, child care, mental health resources, education resources, after school programs, parent support groups, child development information, etc.). For more information on service delivery, see Section 2.10.

- Documentation of In-Home services activities in the child welfare information system.

- Case staffing between the assigned *Family Services Specialist* and *Family Services Supervisor* that provides coaching and support.

2.5.1 Child or youth residing with parent(s) or relative/fictive kin caregiver(s)

In-Home services to children and families in this safety scenario includes, but are not limited to:

- Safety assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.

    - The initial safety decision and safety plan are documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed. In the absence of an initial safety assessment, the initial safety decision and safety plan must be documented in a new Safety Assessment Tool in an In-Home services case in the child welfare information system **within three (3) business days**.

- The safety assessment must cover all children and youth in the home. The focus of the assessment is on conditions that exist at the time of the assessment.

- For more information on assessing safety, see Section 2.6.5.2.

- Risk assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** in the Risk Reassessment if the case is to remain open, until the case is closed.

  - In the absence of an initial risk assessment, the risk assessment must be conducted **within 30 calendar days** of opening an In-Home services case.

  - This risk assessment is completed on the household that includes all persons who have significant in-home contact with the child or youth, including those who have a familial or intimate relationship with any person in the home. The primary caregiver is the adult living in the household where the allegation occurs who assumes the most responsibility for the child or youth's care. When two adult caregivers are present and the *Family Services Specialist* is in doubt as to which one assumes the most responsibility for the child or youth's care, the adult with legal responsibility for the child or youth should be identified as the primary caregiver.

    When both parents are in the household, equally sharing caretaking responsibilities, and both have been identified as perpetrators or alleged perpetrators, the parent demonstrating the more severe behavior is identified as the primary caregiver.

    The secondary caregiver is defined as an adult living in the household who has routine responsibility for the child or youth's care, but less responsibility than the primary caregiver. A partner may be a secondary caregiver even though they may have minimal responsibility for care of the child or youth.

  - For more information on assessing risk, see Section 2.6.6.

- Risk Reassessment must be completed **every 90 days** until the case is closed. It must be completed before renewing or ending a service plan in the child welfare information system.

  - The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently to allow an In-Home services case to be closed, or whether the risk level remains high, and services should continue. This

is accomplished through evaluating whether behaviors and actions of the family have changed as a result of the service plan.

- *Family Services Specialists* should explain to the family the structure and process for conducting the reassessment and should link the reassessment process to the developed service plan.

- For more information on risk reassessment, see Section 2.11.1.

- Child and Adolescent Needs and Strengths (CANS) must be completed for any child(ren) and caregiver(s) in an In-Home services case who is identified in the service plan and receiving a direct or funded intervention or service, to include an evidence-based prevention service(s). At least one identified child and caregiver must be assessed with the DSS-Enhanced CANS in an In-Home services case. The CANS must be documented in the CANVaS online application **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.

  - The CANS identifies and prioritizes the strengths and needs of the child and family and assists in the planning and provision of services. In addition to service planning, the CANS can be used to measure progress over time at both the child and family levels.

  - For more information on CANS, see Section 2.7.1.

- Service Plan must be developed **within 30 calendar days** of opening the case. It must be re-evaluated **every 90 days thereafter** or sooner if safety, risk, or family circumstances change. The service plan must be documented in the child welfare information system. For more information on service planning and review, see Section 2.8 and Section 2.11 respectively.

- Candidacy Determination must be documented in the child welfare information system **within the first 30 days of case opening** and **every 90 days thereafter** in conjunction with developing and renewing the service plan. LDSS must use the Candidacy Determination Documentation Form in the child welfare information system to document the child or youth's candidacy determination.

  - For more information on Candidacy Determination, see Section 2.6.6.5.

- Decision-making and case management

  - Within six (6) months, the *Family Services Specialist* must assess progress toward reaching goals and objectives as outlined in the service

plan. If the case is to remain open for 12 months or longer, that justification must be documented in the child welfare information system.

- *Family Services Specialists* must give proper consideration to both static and dynamic factors on the risk reassessment when determining whether the case should remain open or close.

- *Family Services Specialists* should use formal and informal family engagement strategies during monthly worker visits to gather information about change over time, which should be documented in the child welfare information system.

  Family Partnership Meetings (FPM) must be held at critical decision points and prior to the development of the service plan.

  Child and Family Team Meetings (CFTM) must be held **every 90 days** and should be held **every 30 days** to help inform the service plan.

  This collective information can then form the basis for risk reassessment. The use of formal engagement strategies, such as FPMs to conduct the formal reassessment, develop an updated service plan, or engage in planning for case closure, is highly recommended.

- For more information regarding case closure, see Section 2.12.

2.5.2 Child or youth temporarily residing with relative/fictive kin caregiver(s) and will return to the parent(s) or caregiver/guardian(s) within six (6) months

In-Home services to children and families in this safety scenario includes, but are not limited to:

- Safety assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.

  - The initial safety decision and safety plan are documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed. In the absence of an initial safety assessment, the following circumstances must be documented in a new Safety Assessment Tool in an In-Home services case in the child welfare information system **within three (3) business days**.

- The safety assessment must cover all children in the home of the relative/fictive kin caregiver and all others present. The focus of the assessment is on conditions that exist at the time of the assessment.

- For more information on assessing safety, see Section 2.6.5.2.

- Risk assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** in the Risk Reassessment if the case is to remain open, until the case is closed.

  - In the absence of an initial risk assessment, the risk assessment must be conducted **within 30 calendar days** of opening an In-Home services case.

  - This risk assessment is completed on the previous primary caregiver, with whom the child or youth will most likely return with services. If two adult caregivers were present and the *Family Services Specialist* is in doubt as to which one assumes the most responsibility for the child or youth's care, the adult with legal responsibility for the child or youth should be identified as the primary caregiver.

    If both parents were in the household, equally sharing caretaking responsibilities, and both were identified as perpetrators or alleged perpetrators, the parent demonstrating the more severe behavior is identified as the primary caregiver.

    The secondary caregiver is defined as an adult living in the household who had routine responsibility for the child or youth's care, but less responsibility than the primary caregiver. A partner may be a secondary caregiver even though they may have minimal responsibility for care of the child or youth.

  - The risk assessment is not completed on the relative/fictive kin caregiver(s).

  - For more information on assessing risk, see Section 2.6.6.

- Risk Reassessment must be completed **every 90 days** until the case is closed. It must be completed before renewing or ending a service plan in the child welfare information system.

  - The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently for the child or youth to return home safely with services. This is accomplished through evaluating whether behaviors and actions of the family have changed as a result of the service plan.

- *Family Services Specialists* should explain to the family the structure and process for conducting the reassessment and should link the reassessment process to the developed service plan.

- The risk assessment is not completed on the relative/fictive kin caregiver(s).

- For more information on risk reassessment, see Section 2.11.1.

- Child and Adolescent Needs and Strengths (CANS) must be completed for any child(ren) and caregiver(s) in an In-Home services case who is identified in the service plan and receiving a direct or funded intervention or service, to include an evidence-based prevention service(s). At least one identified child and caregiver must be assessed with the DSS-Enhanced CANS in an In-Home services case. The CANS must be documented in the CANVaS online application **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.

  - The CANS identifies and prioritizes the strengths and needs of the child and family and assists in the planning and provision of services. In addition to service planning, the CANS can be used to measure progress over time at both the child and family levels.

  - For more information on CANS, see Section 2.7.1.

- Service Plan must be developed **within 30 calendar days** of opening the case. It must be re-evaluated **every 90 days thereafter** or sooner if safety, risk, or family circumstances change. The service plan must be documented in the child welfare information system. For more information on service planning and review, see Section 2.8 and Section 2.11 respectively.

- Candidacy Determination must be documented in the child welfare information system **within the first 30 days of case opening** and **every 90 days thereafter** in conjunction with developing and renewing the service plan. LDSS must use the Candidacy Determination Documentation Form in the child welfare information system to document the child or youth's candidacy determination.

  - For more information on Candidacy Determination, see Section 2.6.6.5.

- Decision-making and case management

  - A Family Partnership Meeting (FPM) must be conducted when it is assessed that the child is not safe to reside with the primary caregiver. The purpose of the meeting is for the family and the agency to facilitate

planning to identify a relative or kin caregiver with whom the child can temporarily reside. The FPM should identify the services and supports needed to sufficiently mitigate further safety and risk concerns for the child or youth to return home safely. The FPM should also address visitation needs for the child or youth with the previous primary caregiver. The FPM must be documented in the child welfare information system. For guidance on conducting the FPM, refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.

- Within six (6) months of case opening, the *Family Services Specialist* must assess progress toward reaching goals and objectives as outlined in the service plan. If the case is to remain open for 12 months or longer, that justification must be documented in the child welfare information system.

- *Family Services Specialists* must give proper consideration to both static and dynamic factors on the risk reassessment when determining whether the child can return home safely with services.

- *Family Services Specialists* should use formal and informal family engagement strategies during monthly worker visits to gather information about change over time, which should be documented in the child welfare information system.

  Family Partnership Meetings (FPM) must be held at critical decision points and prior to the development of the service plan.

  Child and Family Team Meetings (CFTM) must be held **every 90 days** and should be held **every 30 days** to help inform the service plan.

  This collective information can then form the basis for risk reassessment. The use of formal engagement strategies, such as FPMs to conduct the formal reassessment, develop an updated service plan, or engage in planning for case closure, is highly recommended.

- A FPM must be held prior to the child or youth returning to the parent(s) or caregiver/guardian(s) of origin and prior to the decision of case closure. The FPM may result in the decision for the child or youth to remain permanently with the relative/fictive kin caregiver. For more information on this safety scenario, see Section 2.5.3.

- For more information regarding case closure, see Section 2.12.

2.5.3 Child or youth permanently residing with relative/fictive kin caregivers(s)

In-Home services to children and families in this safety scenario includes, but are not limited to:

- Safety assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.
    - The initial safety decision and safety plan are documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed. In the absence of an initial safety assessment, the following circumstances must be documented in a new Safety Assessment Tool in an In-Home services case in the child welfare information system **within three (3) business days**.
    - The safety assessment must cover all children in the home of the relative/fictive kin caregiver and all others present. The focus of the assessment is on conditions that exist at the time of the assessment.
    - For more information on assessing safety, see Section 2.6.5.2.
- Risk assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** in the Risk Reassessment if the case is to remain open, until the case is closed.
    - In the absence of an initial risk assessment, the risk assessment must be conducted **within 30 calendar days** of opening an In-Home services case.
    - This risk assessment is completed on the previous primary caregiver living in the household where the allegation occurred. If two adult caregivers were present and the *Family Services Specialist* is in doubt as to which one assumes the most responsibility for the child or youth's care, the adult with legal responsibility for the child or youth should be identified as the primary caregiver.

      If both parents were in the household, equally sharing caretaking responsibilities, and both were identified as perpetrators or alleged perpetrators, the parent demonstrating the more severe behavior is identified as the primary caregiver.

      The secondary caregiver is defined as an adult living in the household who had routine responsibility for the child or youth's care, but less

responsibility than the primary caregiver. A partner may be a secondary caregiver even though they may have minimal responsibility for care of the child or youth.

- The risk assessment is not completed on the relative/fictive kin caregiver(s).
- For more information on assessing risk, see Section 2.6.6.

- Risk Reassessment must be completed **every 90 days** until the case is closed. It must be completed before renewing or ending a service plan in the child welfare information system.
  - The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently to allow an In-Home services case to be closed, or whether the risk level remains high, and services should continue. This is accomplished through evaluating whether behaviors and actions of the caregiver/guardian(s) has changed as a result of the service plan and to assess visitation needs. For more information on risk reassessment considerations and decisions that guide case closure, see Section 2.11.1.1 and Section 2.11.1.2 respectively.
  - *Family Services Specialists* should explain to the family the structure and process for conducting the reassessment and should link the reassessment process to the developed service plan.
  - The risk assessment is not completed on the relative/fictive kin caregiver(s).
  - For more information on risk reassessment, see Section 2.11.1.
- Child and Adolescent Needs and Strengths (CANS) must be completed for any child(ren) and caregiver(s) in an In-Home services case who is identified in the service plan and receiving a direct or funded intervention or service, to include an evidence-based prevention service(s). At least one identified child and caregiver must be assessed with the DSS-Enhanced CANS in an In-Home services case. The CANS must be documented in the CANVaS online application **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.
  - The CANS identifies and prioritizes the strengths and needs of the child and family and assists in the planning and provision of services. In addition to service planning, the CANS can be used to measure progress over time at both the child and family levels.

- For more information on CANS, see Section 2.7.1.

- Service Plan must be developed **within 30 calendar days** of opening the case. It must be re-evaluated **every 90 days thereafter** or sooner if safety, risk, or family circumstances change. The service plan must be documented in the child welfare information system. For more information on service planning and review, see Section 2.8 and Section 2.11 respectively.

- Candidacy Determination must be documented in the child welfare information system **within the first 30 days of case opening** and **every 90 days thereafter** in conjunction with developing and renewing the service plan. LDSS must use the Candidacy Determination Documentation Form in the child welfare information system to document the child or youth's candidacy determination.

  - For more information on Candidacy Determination, see Section 2.6.6.5.

  - A FPM must be held prior to the child or youth returning to the parent(s) or caregiver/guardian(s) of origin and prior to the decision of case closure. The FPM may result in the decision for the child or youth to remain permanently with the relative/fictive kin caregiver. For more information on this safety scenario, see Section 2.5.3.

- Decision-making and case management

  - A Family Partnership Meeting (FPM) must be conducted when it is assessed that the child is not safe to reside with the primary caregiver. The purpose of the meeting is for the family and the agency to facilitate planning to identify a relative or kin caregiver with whom the child can temporarily reside. The FPM should identify the services and supports needed to sufficiently mitigate further safety and risk concerns for the child or youth to return home safely. The FPM should also address visitation needs for the child or youth with the previous primary caregiver. The FPM must be documented in the child welfare information system. For guidance on conducting the FPM, refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.

  - Within six (6) months, the *Family Services Specialist* must assess progress toward reaching goals, objectives, and visitation needs as outlined in the service plan. If the case is to remain open for 12 months or longer, that justification must be documented in the child welfare information system.

- *Family Services Specialists* must give proper consideration to both static and dynamic factors on the risk reassessment.

- *Family Services Specialists* should use formal and informal family engagement strategies during monthly worker visits to gather information about change over time, which should be documented in the child welfare information system.

  Family Partnership Meetings (FPM) must be held at critical decision points to include prior to custody hearings and prior to the development of the service plan.

  Child and Family Team Meetings (CFTM) must be held **every 90 days** and should be held **every 30 days** to help inform the service plan.

  This collective information can then form the basis for risk reassessment. The use of formal engagement strategies, such as FPMs to conduct the formal reassessment, develop an updated service plan, or engage in planning for case closure, is highly recommended.

- For more information regarding case closure, see Section 2.12.

2.6 Initial contact and assessment in an In-Home services case

This section of guidance presents the framework for assessment, planning, service delivery, and evaluation that can increase positive outcomes for families.

2.6.1 Frequency of worker visits

The frequency of worker visits with the child and family should be determined from the safety, risk, and needs that have been assessed. The minimum contact requirement is a face-to-face worker visit between the *Family Services Specialist* and the child and family **at least one (1) time per month** and should occur in the home.

2.6.2 Additional contacts defined

- Collateral contacts: These are contacts with people who have information about the family and/or are providing interventions for the child/family. These include police, attorneys, teachers, neighbors, relatives, and treatment providers, among others. Collaterals do not include the principals in the case such as the child and parents.

- Designated contacts: The *Family Services Specialist/Supervisor* or service team may delegate and document additional face-to-face contacts to providers with a contractual relationship to the LDSS and/or other agency staff such as

family services specialist aides or other service providers outlined in the service plan. The *Family Services Specialist* must always maintain **at least one (1)** face-to-face worker visit with the parent/guardian and child per month.

2.6.3 Parental permission to speak to a child

The *Family Services Specialist* must gain consent from the parents or legal guardian to speak to a child outside their presence unless a court order specifies consent is not required. This should be discussed with the family while developing the service plan and documented in the child welfare information system.

2.6.4 Contact information

The *Family Services Specialist* must enter and update all case contacts, narratives, and data in the child welfare information system **within five (5) business days**.

2.6.4.1 Worker visit with the child or youth

The following information is collected, assessed, and documented in case contacts in the child welfare information system.

- Identified safety concerns addressed.
- Child or youth's feelings/observations about the factors that led to LDSS involvement and the impact of trauma.
- Concerns pertaining to the child or youth's needs, services, and case goals.
- Education.
- Family interactions with parents, relative/fictive kin caregivers, or siblings.
- Extracurricular activities, hobby participation, or cultural traditions.
- Medical, dental, or mental health needs.
- Observation of the child's physical, emotional, and mental appearance.

2.6.4.2 Worker visit with the parent/guardian/relative or kin caregiver

The following information is collected, assessed, and documented in case contacts in the child welfare information system.

- Identified safety and risk concerns address.

- Progress toward reaching goals and objectives as outlined in the service plan.
- Medical/dental/mental health concerns, appointments, treatment, and follow up care for the child and/or themselves.
- Child behaviors: worker and parent concerns, developmental concerns, and any behavioral management plan, if applicable.
- Education: school status/performance, behaviors, and educational services being provided.
- Tasks required to meet child's needs.
- Inquiry about non-custodial parents.
- Any new CPS reports since last contact.
- Law enforcement or court system involvement since last contact.
- Needs or services not being provided.
- Observation of the home, including the sleep environment for any child less than one (1) year of age. For additional information related to safe sleep environments, see VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 4.5.6.7.1, Safe sleep environment and practices.

2.6.4.3 Contact with collaterals or designated contacts

- Information regarding the safety of the child and reduction of risk of future maltreatment.
- Information regarding their contact with the family.
- Medical/dental/mental health concerns, appointments, treatment and follow up care for the child and/or the parents/guardians.
- Education: school status/performance, behaviors, and educational services being provided.
- Status of any criminal or civil court matters.

2.6.5 Consideration of safety at initial contact

2.6.5.1 Initial safety assessment in an In-Home services case

An initial safety assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed. The purpose of the initial safety assessment is to:

- Assess whether any children are currently in immediate danger of serious physical harm that may require a protection intervention.
- Determine what interventions should be maintained or initiated to provide appropriate protection.

Safety Assessments differ from Risk Assessments in that the purpose is to assess a child's present or immediate danger and the interventions currently needed to protect the child. In contrast, Risk Assessments evaluate the likelihood of future maltreatment.

A safety and risk field guide is available on FUSION. This field guide may be used by the *Family Services Specialist* in the field to help guide interviews as it provides the safety factors, protective capacities, and risk factors that should be identified in every assessment. This field guide must be used in conjunction with the definitions provided for the safety and risk assessment tools.

2.6.5.2 Assessing safety in an In-Home services case

Safety assessment is both a process and a document. The process of assessing child safety is ongoing throughout the life of an In-Home services case. The initial safety decision and safety plan are documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed.

In the absence of an initial safety assessment, the safety decision and safety plan must be documented in a new Safety Assessment Tool in an In-Home services case in the child welfare information system **within three (3) business days** of case opening. The following circumstances must be considered when documenting the assessment:

- A change in family circumstances such that one (1) or more safety factors previously present are no longer present.
- A change in information known about the family in that one (1) or more safety factors not present before are present now.

- A change in availability of safety interventions to mitigate safety factors and require changes to the safety plan.

When safety is reassessed, the safety plan should be reviewed and revised accordingly. A FPM should be considered if safety concerns escalate.

Family Services Specialists must be familiar with the safety assessment process and tool. See VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 4, Family Assessment and Investigation, for guidance on completing the Safety Assessment Tool. Additional information about the safety assessment can be found in Module 2 of CWSE 1510: Structured Decision Making in Virginia located in the Virginia Learning Center. The final safety decision is one (1) of the following:

- **SAFE**. There are no children likely to be in immediate danger of serious harm at this time. No safety plan is required.

- **CONDITIONALLY SAFE**. Protective safety interventions have been taken and have resolved the unsafe situation for the present time. A safety plan is required to document the interventions.

- **UNSAFE**. Approved removal and placement was the only possible intervention for the child. Without placement, the child will likely be in danger of immediate serious harm. A court order is required to document intervention.

If a child is assessed as unsafe and court action is required, it is important for the LDSS to obtain legal counsel prior to petitioning for the removal of a child. Removal of a child should only occur after consideration of alternatives to an out-of-home placement. The court will need to establish that reasonable efforts have been made to prevent the removal and there are no alternatives less drastic than removal that could reasonably protect the child's life or health. The LDSS will need to determine whether to file for an Emergency Removal Order (ERO) or a Preliminary Removal Order (PRO). Refer to VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 8, Judicial Proceedings, for guidance on ERO and PRO. The main difference between an ERO and PRO is the urgency. An ERO may be issued ex-parte and the preliminary removal hearing must be held **within five (5) business days**. The PRO differs from the ERO in that a hearing must take place before PRO can be issued.

If the safety decision is unsafe and the child is removed and placed into foster care and no other children remain in the home, the In-Home services case type must be changed to foster care in the child welfare information system.

If any child is placed into foster care and other siblings or children remain in the home, the In-Home services case type must be changed in the child welfare information system to reflect a dual case type (Dual In-Home & Foster Care).

2.6.5.3 Safety decision and FPM

The LDSS should schedule a FPM when the *Family Services Specialist* assesses the child's safety to be in jeopardy or at risk of removal or out of home placement. Safety concerns are paramount and necessary action to address safety concerns must not be delayed. The FPM should be scheduled **within 24 hours** after safety concerns have been identified and the agency is considering removal. The FPM must be documented in the child welfare information system. For guidance on conducting the FPM, refer to the Engagement. This meeting provides the opportunity for family and community participation in the decision-making process for the child. Engaging relatives and natural supports of the family will be crucial to facilitate planning to determine whether:

- The child can remain or return home safely with services.
- There will be voluntary placement of the child by the parent or caregiver with a relative/fictive kin caregiver with provision of services and a safety plan.
- The agency should file for custody and facilitate placement into foster care.

The *Family Services Specialist* and *Family Services Supervisor* should discuss the convening and timing of a FPM at this critical decision point. Additional guidance for holding a FPM when there is DV can be found in Section 1.9 of the VDSS Child and Family Services Manual, Chapter H. Domestic Violence, Section 1.9, Family Partnership Meetings (FPM) and DV.

2.6.6 Determining risk level at initial contact

The initial risk level is documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed. In the absence of an initial risk assessment, the risk assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.

The *Family Services Specialist* must gather information in order to complete the Family Risk Assessment which includes assessing the following risk factors:

- **Caregiver related**

- History of childhood maltreatment.
- History of mental health concerns.
- History of substance use disorder.
- History of criminal activity (adult or juvenile).
- DV incidents in past year.
- History of prior CPS, In-home, or foster care services.
- Developmental or physical disability.
- Medically fragile or failure to thrive.
- Substance exposed newborn.
- Delinquency.
- Mental health or behavioral problem.
- Prior injury as result of abuse or neglect.

- **Caregiver and child relationship**
  - Blames child.
  - Justifies maltreatment.
  - Provides insufficient emotional or psychological support.
  - Uses excessive or inappropriate discipline.
  - Domineering.
  - Provides physical care inconsistent with child needs.

- **Other**
  - Housing is unsafe.
  - Family is homeless.

The *Family Services Specialist* must determine the likelihood of any occurrence or recurrence of abuse or neglect by completing a Family Risk Assessment. The Family Risk Assessment does not predict recurrence but assesses whether a family is more

or less likely to have an incident of abuse or neglect without intervention by the agency. The Family Risk Assessment is completed based on conditions that exist at the time the incident is reported and assessed as well as prior history of the family. Risk is calculated in the Family Risk Assessment tool completed in the child welfare information system. For accurate completion, it is critical to refer to the definitions. The Family Risk Assessment tool with definitions is located under CPS forms on the VDSS public website. Selections made on the Family Risk Assessment tool must be based on supporting narrative in the child welfare information system.

Assessed risk will be:

- **Low**. The assessment of risk related factors indicates that there is a low likelihood of future abuse or neglect and no further intervention is needed or
- **Moderate**. The assessment of risk related factors indicates that there is a moderate likelihood of future abuse or neglect and minimal intervention may be needed or
- **High**. The assessment of risk related factors indicates there is a high likelihood of future abuse or neglect without intervention or
- **Very High**. The assessment of risk-related factors indicates there is a very high likelihood of future abuse or neglect without intervention.

Overrides, either by policy or discretionary, may increase risk one level and require *Family Services Supervisor* approval. The initial In-Home services risk level may never be decreased.

2.6.6.1 Risk level guides in an In-Home servcice case

When risk is clearly defined and objectively quantified, resources are targeted to families at higher risk because of the greater potential to reduce subsequent maltreatment. The risk level helps inform the decision whether or not to open a case as follows:

Low Risk	Close case
Moderate risk	Remain open OR close case
High Risk	Open and Maintain to In-Home Services
Very High Risk	Open and Maintain to In-Home Services

The *Family Services Specialist* and *Family Services Supervisor* should assess the decision to open and maintain a case for services and document in the child welfare information system the decision not to open a case. For more guidance on service planning in a case, refer to Section 2.8: Service planning of this manual.

2.6.6.2 Risk level determines need to convene FPM

A FPM should be scheduled by the LDSS when the worker assesses a child to be at “high” or “very high” risk of abuse or neglect or the child is at risk for out-of-home placement in those families who will be or are receiving services. This meeting is scheduled to develop the plan and services to prevent the out-of-home placement and identifies the circumstances under which a removal might be considered. The meeting should convene **within 30 days** of initiating services and prior to the development of the service plan. The FPM must be documented in the child welfare information system. For guidance on conducting the FPM, refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.

2.6.6.3 Domestic violence (DV) and substance use disorder as risk factors

Two (2) family concerns that can have a major impact on safety and risk are DV and drug or alcohol misuse by the child’s caregivers.

There are several evidence-based tools that can be used to screen for DV depending on who is being interviewed. The "HITS" (Hurt, Insult, Threaten, Scream) screening tool may be used to screen for DV with family members, professionals, service providers, and mandated reporters. The Women's Experience with Battering Tool (WEB) is designed to be used with potential victims of DV. These screening tools and additional guidance regarding screening for DV can be found in the VDSS Child and Family Services Manual, Chapter H. Domestic Violence, Section 1.4, Screening for DV. This chapter presents an overview of DV and the related statutory requirements impacting LDSS and local DV programs. Information specific to Prevention, CPS, and Foster Care is provided. Additional information about DV can be found on the VDSS public website.

LDSS may also request an evaluation for substance or drug misuse. The CAGE-AID tool is a screening tool that provides questions that can be worked into the interviews with the primary caregivers, and a “yes” to any question may indicate a need for an AOD (alcohol or other drug) evaluation.

2.6.6.4 Screen all children for human trafficking

Federal law, specifically Title 1 of the Preventing Sex Trafficking and Strengthening Families Act (HR 4980), requires child welfare agencies to identify, document, and determine appropriate services for children and youth at risk of human trafficking. While research indicates that youth in foster care are one of the most vulnerable populations, all children who experience abuse or neglect are at risk.

2.6.6.4.1 Signs of human trafficking

Signs that a child is a victim of human trafficking may include but are not limited to:

- History of emotional, sexual, or other physical abuse.
- Signs of current physical abuse or sexually transmitted diseases.
- History of running away or current status as a runaway.
- Inexplicable appearance of expensive gifts, clothing, cell phones, tattoos, or other costly items.
- Presence of an older boyfriend or girlfriend.
- Alcohol or drug misuse.
- Withdrawal or lack of interest in previous activities.
- Gang involvement.

2.6.6.4.2 When human trafficking is identified

If the LDSS identifies or receives information that a child has been a victim of human trafficking, they must notify local law enforcement **within two (2) hours** of identifying or receiving such information and document such notification in the child welfare information system.

The LDSS may contact the National Human Trafficking Resource Center (NHTRC) at 1-888-373-7888 if they suspect human trafficking of a minor. NHRTC operates a hotline to help identify and coordinate with local organizations that protect and serve victims of trafficking.

Refer to the VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 4, Investigations and Family Assessments,

Appendix I: Sex Trafficking of Children Indicators and Resources for additional information regarding screening and safety considerations for victims of human trafficking, which includes sex trafficking.

Additional information regarding human trafficking can be found in the online course, CWSE4000: Identifying Sex Trafficking in Child Welfare. This course is also available on the VDSS public website.

2.6.6.5 Candidacy determination in an In-Home services case

A critical assessment that must be completed in all In-Home services cases is determining candidacy. In order to determine candidacy, the *Family Services Specialist* must evaluate whether or not a child is at imminent risk of out-of-home placement. Imminent risk means a child and family's circumstances demand that a defined service plan is put into place **within 30 days**. The service plan must identify interventions, services, or supports, and absent these interventions, services, or supports, foster care placement is the planned arrangement for the child.

Possible determinations include:

- **Reasonable candidate:** The *Family Services Specialist* must determine if the child is a reasonable candidate when they assess that the child is at risk of foster care placement if services are not provided.

- **Candidate for foster care:** The *Family Services Specialist* must determine if the child is a candidate for foster care when they assess that the child can remain safely in the child's home or in a kinship arrangement as long as an evidenced-based and trauma-informed prevention service(s) (e.g., mental health, substance use disorder, or in-home parent skill-based program services) is provided. The service(s) necessary to prevent the entry of the child into foster care must be identified in Virginia's approved federal Prevention Plan available on FUSION.

The specific eligibility requirements for candidacy is a service plan that clearly documents all of the following criteria:

- That absent effective preventive services, foster care placement is the planned arrangement for the child.

- That the service plan was developed jointly with the child, and the parents or guardians.

- A description of the services offered or provided to prevent the removal of the child from the home.

- The In-Home services case is actively being managed to maintain the child in the home, or in a kinship arrangement, in order to prevent placement into foster care.

An alternative eligibility requirement includes:

- Evidence of court proceedings in relation to the removal of the child from his/her home, in the form of a petition, a court order, or transcript of the court proceedings and a copy is maintained in the child's service record.

The *Family Services Specialist* must document in the child welfare information system, in conjunction with developing and renewing the service plan, the child's candidacy determination **within the first 30 days of case opening and every 90 days thereafter**. LDSS must use the Candidacy Determination Documentation Form in the child welfare information system to document the child's candidacy determination. Additional information regarding candidacy determination can be found in the online Candidacy Determination course found in the VLC.

It is important to note that candidacy eligibility and documentation are related to the fiscal reimbursement for case management provided by the LDSS or the provision of evidenced-based and trauma-informed prevention services and does not replace the requirement to determine the need for preventive services. If the child is eligible, the LDSS may claim title IV-E reimbursement for administrative activities performed on behalf of the child regardless of whether the child is actually placed in foster care.

2.6.6.6 Family Partnership Meeting (FPM)

Family engagement is a relationship-focused approach that provides structure for decision-making that empowers both the family and the community in the decision-making process.

A FPM may be held any time to solicit family input regarding safety, services, and permanency planning; however, for every family involved with the LDSS these are the decision points at which a FPM must be held:

- Once a CPS investigation or family assessment has been completed and the family is identified as "high" or "very high" risk and the child is at risk of out-of-home care or placement.

- Prior to removing a child, whether emergency or planned.

- Prior to any change of placement for a child already in foster care, including a disruption in an adoptive placement.

- Prior to the development of a foster care plan for the foster care review and permanency planning hearings. The purpose is to discuss permanency options and concurrent planning, as well as the foster care goal.

- When a meeting is requested by the parent (birth, foster, adoptive or legal guardian), child, or *Family Services Specialist* to address one of the four decision points above.

The *Family Services Specialist* and *Family Services Supervisor* should discuss the convening and timing of a FPM at these critical decision points. The meeting should convene **within 30 calendar days** of opening an In-Home services case and prior to the development of the service plan.

See Section 2.10.5: Using teaming in child welfare practice for additional guidance that supports teaming as part of family engagement and best practice.

All FPMs must be documented in the child welfare information system. For more guidance regarding FPMs, please refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement. Additional guidance for holding a FPM when DV is present can be found in the VDSS Child and Family Services Manual, Chapter H. Domestic Violence, Section 1.9, Family Partnership Meetings (FPM) and DV.

2.6.6.7 Child and Family Team Meeting (CFTM)

Another practice strategy to ensure family engagement, voice, choice, and teaming are Child and Family Team Meetings (CFTM). A CFTM includes the child, parents, extended family, and all service providers. A CFTM provides a mechanism by which regular review of services and progress is shared among all the individuals involved in the case and where the family's needs and preferences are routinely informing decision-making.

There is no fixed formula for CFTM size or composition.

- **Formation** - CFTM members should include all available family members, *Family Services Specialist* and *Family Services Supervisor*, any contracted service providers, health care providers, educational partners, and child and parent advocates. When applicable, team members should also include mental health professionals, spiritual leaders, caregivers, Guardian ad Litems, CASA volunteers and others, as identified. Collaboration among team members from different agencies is essential. Team composition should be competent and have the right balance of personal interest in the family, knowledge of the family, technical skills,

cultural awareness, authority to act, flexibility to respond to specific needs, and time necessary to fulfill the commitment to the family.

- **Functioning** - Most importantly the teaming process must develop and maintain unity of effort among all team members. CFTM members should develop a unified vision of what would have to happen for the case to close. The team must assess, plan, implement and prepare for safe case closure.

- **Frequency** - The frequency of a CFTM will vary depending on the individual circumstances of each case. The CFTM should help inform the service plan and should be held prior to any service plan review.

In the matrix provided in the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement, the FPM and CFTM are compared and contrasted. The opportunities for family engagement, incorporation of voice and choice and teaming are clear in both, but differences are also highlighted.

2.6.6.8 Services for children of Native American, *Alaskan Native* or Aleut heritage

Children of Native American or *Alaskan Native* or Aleut heritage of a federally recognized tribe are subject to the Indian Child Welfare Act (ICWA). Virginia currently has seven (7) federally recognized tribes. In January 2016, The United States Department of Interior granted federal recognition to the Virginia Pamunkey Indian Tribe. In January 2018, the following tribes were granted federal recognition: Chickahominy, Eastern Chickahominy, Monacan, Nansemond, Rappahannock, and Upper Mattaponi.

A child is covered by ICWA when the child meets the federal definition of an *American Indian Child*. Specifically, the child is an unmarried person under 18 years of age and is either:

- A member of a federally recognized Indian tribe.

- Eligible for membership in a federally recognized tribe and is the biological child of a member of a federally recognized Indian tribe (25 U.S.C. § 1903).

Under federal law, individual tribes have the right to determine eligibility and/or membership. However, in order for ICWA to apply, the child must meet one of the criteria above.

If there is any reason to believe a child is an *American Indian Child* and is at risk of entering foster care, the LDSS must treat that child as an *American Indian Child*, unless and until it is determined that the child is not a member or is not eligible for membership in an Indian tribe. Once it has been determined the child is either a member or eligible for membership in a federally recognized tribe, the LDSS must make active efforts to reunite the *American Indian Child* with their family or tribal community if already in foster care. Active efforts must begin from the time the possibility arises that a child may be removed from their parent, legal guardian or Indian custodian and placed outside of their custody.

Active efforts are more than reasonable efforts. Active efforts apply to providing remedial and rehabilitative services to the family prior to the removal of an *American Indian Child* from his or her parent or Indian custodian, and/or an intensive effort to reunify an *American Indian Child* with his/her parent or American Indian custodian.

Examples of active efforts include, but are not limited to:

- Engaging the *American Indian Child*, their parents, guardians, and extended family members.
- Taking necessary steps to keep siblings together.
- Identifying appropriate services and helping parents overcome barriers.
- Identifying, notifying, and inviting representatives of the *American Indian Child's* tribe to participate in shared decision-making meetings.
- Involving and using available resources of the extended family, the child's Indian tribe, Indian social service agencies and individual caregivers.

An *American Indian Child* who is officially determined by the tribe to not be a member or eligible for membership in a federal tribe is not subject to the requirements of ICWA. In instances where ICWA does not apply, but the child is biologically an *American Indian Child*, part of a Virginia tribe that is not federally recognized or considered Indian by the Indian community, the LDSS should consider tribal culture and connections in the provision of services to the child.

Additional information is located in Child and Family Services Manual, Chapter C. Child Protective Services, Section 1, Appendix A: Indian Child Welfare Act (ICWA).

In the event an *American Indian Child* is in imminent danger and does not live on a reservation where the tribe exercises exclusive jurisdiction, CPS has the authority to exercise emergency removal of the child. Additional guidance

regarding the removal of an *American Indian Child* can be found in Child and Family Services Manual, Chapter C. Child Protective Services, Section 4, Family Assessment and Investigation. If a child is removed and placed into foster care, see the Child and Family Services Manual, Chapter E. Foster Care, Section 3, Entering Foster Care and Child and Family Services Manual, Chapter C. Child Protective Services, Section 8, Judicial Proceedings, Appendix D, Guidelines for State Courts and Agencies in American Indian Child Welfare Custody Proceedings.

2.6.7 Screening for trauma

Research demonstrates the relationships between trauma, child traumatic stress, and the risk of abuse or neglect. Trauma screening refers to a tool or process that is a brief, focused inquiry to determine whether an individual has experienced one or more traumatic events, has reactions to such events, has specific mental or behavioral health needs, or needs a referral for a comprehensive trauma-informed mental health assessment. At initial contact, if there is an indication that any of the traumatic events listed below are present in the family, a comprehensive trauma assessment is recommended via referral or agency approved tool (see Section 2.7.3):

- Sexual abuse or assault.
- Physical abuse or assault.
- Emotional abuse or psychological maltreatment.
- Chronic neglect.
- Serious accident or illness.
- Psychiatric hospitalization.
- Witness to DV.
- Victim or witness to community violence.
- Victim or witness to school violence.
- Natural or manmade disasters.
- Forced displacement or homelessness.
- War, terrorism, or political violence.
- Traumatic grief or separation.

- System induced trauma (e.g., removal, change in placements, etc.).

2.6.8 Reasonable diligence to locate family

The LDSS must use reasonable diligence to locate a missing child or family in an In-Home services case.

> 22 VAC 40-705-150 F. The local department must use reasonable diligence to locate any child for whom a founded disposition of abuse or neglect has been made and/or a child protective services case has been opened pursuant to § 63.2-1503 F of the Code of Virginia. The local department shall document its attempts to locate the child and family.

2.6.8.1 What constitutes reasonable diligence

The *Family Services Specialist* must document all reasonable and prompt attempts to locate the child and family. The worker should check the following, where applicable:

- Child welfare information system.
- Postal Service for last known or forwarding address.
- Neighbors, landlords, or known relatives/kin.
- School records.
- Department of Motor Vehicles.
- Department's Division of Support Enforcement.
- Department of Corrections or Probation and Parole.
- Law Enforcement.
- Telephone and utility companies.
- Employer.
- Person locator tools or SPIDeR searches.
- Internet searches including generic search engines such as Google, Yahoo, Bing, etc.
- Social networks such as Facebook, Instagram, or Twitter.

- Other appropriate contacts.

A Reasonable Diligence Checklist is located on FUSION.

2.6.8.2 Conducting periodic checks for missing child/family

If the *child who is a victim* or family is not found, the *Family Services Specialist* must conduct periodic checks. Periodic checks for the missing child/family must continue monthly for **at least 90 days**, until the LDSS is satisfied with the resolution of the case. The *Family Services Specialist* must document the timetable in a case contact in the child welfare information system as well as the results of the periodic checks. The *Family Services Specialist* must document the results of the monthly periodic checks in the child welfare information system.

2.6.8.3 If missing child is at-risk of being or is a victim of sex trafficking

Pursuant to 71(a)(35)(B) of P.L. 117-348, the LDSS, in conjunction with the child's legal guardian, must provide immediate verbal notification to the appropriate local law enforcement agency and the National Center for Missing and Exploited Children (NCMEC) ***within 24 hours*** *upon receiving information on any child that is missing. NCME only accepts reports from the legal guardian. The LDSS should follow up by sending subsequent written notification* ***with 48 hours*** *or as required by law enforcement protocol. The LDSS should ask law enforcement to enter information about the child into the Federal Bureau of Investigation (FBI) National Crime Information Center (NCIC) database which includes information on missing persons. The LDSS should maintain regular communication with law enforcement and the NCMEC to provide a safe recovery of a missing or abducted child, including the information outlined below.*

Once a report is filed with law enforcement, the LDSS must contact the NCMEC at 1-800-843-5678. Information to be shared with law enforcement and the NCMEC (as appropriate) includes:

- *Biographical information and recent photographs of missing or abducted child.*
- *A description of the child's physical features, such as height, weight, sex, ethnicity, race, hair color, and eye color.*
- *Names and addresses of friends, relatives, present and former foster parents and placement staff, and acquaintances.*
- *Suspected destinations.*
- *Prior disappearances and outcome.*

Endangerment information that should be highlighted in communications with law enforcement officials may include, but not limited to:

- *The child's pregnancy status.*
- *Prescription medications.*
- *Suicidal tendencies.*
- *Vulnerabilities to being sex trafficked.*
- *Other health or risk factors.*

2.7 Comprehensive assessment of the family's needs and strengths

Once the family and the LDSS have made the decision to open a case, the next step is to conduct a comprehensive assessment with the family. This phase provides the foundation for continued engagement with the family and service planning and delivery.

It is critical that the assessment process with the family is mutual. The *Family Services Specialist* should discuss the expectations of the family and *Family Services Specialist* during the assessment process, how the family can use the information to make an informed decision about whether or not they want or need services, what services are needed, and how services will be delivered and by whom.

Protective factors should be considered in all aspects of work with families along the child welfare continuum, including prevention. Strength-based, family focused assessments can help *Family Services Specialists* and families identify the protective factors that reduce risks or solve the problem that is presented. Practice models and tools should be structured around both mitigating risk factors and identifying and strengthening protective factors.

2.7.1 Child and Adolescent Needs and Strengths (CANS) assessment

The Child and Adolescent Needs and Strengths (CANS) assessment must be completed in all In-Home services cases and documented in the CANVaS online application. The CANS assessment must be completed by a certified CANS rater who has the primary or secondary case assignment.

2.7.1.1 CANS

CANS is a comprehensive, multi-domain, standardized assessment instrument which helps plan and manage In-Home at both an individual and system of care level. It helps guide service planning, track child and family outcomes, promote resource development, and support decision-making. Use of the CANS for

children served by LDSS permits analysis of state-wide trends in strengths and needs and can inform state and regional policy and community action, particularly in regard to service provision and evaluation of efforts to improve outcomes.

2.7.1.2 Who should be assessed with CANS

A DSS-Enhanced CANS must be completed for any child(ren) and caregiver(s) in an In-Home services case who is identified in the service plan and receiving a direct or funded intervention or service, to include an evidence-based prevention service(s). At least one identified child and caregiver must be assessed with the DSS-Enhanced CANS in an In-Home services case. The CANS must be documented in the CANVaS online application **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.

2.7.1.3 Assessment areas

The CANS identifies and prioritizes the strengths and needs of the child in the following areas:

- Life domain functioning.
- Child strengths.
- School.
- Child behavioral/emotional needs.
- Child risk behaviors.

For child welfare cases, the CANS includes the following areas:

- An enhanced trauma module.
- A child welfare module.
- The ability to rate multiple Planned Permanent Caregivers for a child to be used in concurrent planning.
- New worker reports for *Family Services Specialists* and *Family Services Supervisors* to help assess progress and outcomes over time for children and their families on:
    - Child trauma.

- Caregiver permanency indicators.
- Parent/guardian/caregiver protective factors.
- CANS domains.

The CANS also identifies the strengths and needs of the family or caregiver:

- Current caregiver.
- Permanency planning caregiver strengths and needs.
- Residential treatment center.

Additional modules are available to assess specific situations, including:

- Developmental needs.
- Trauma.
- Substance use needs.
- Violence needs.
- Sexually aggressive behavior needs.
- Runaway needs.
- Juvenile justice needs.
- Fire setting needs.

2.7.1.4 CANS resources

The Children's Services Act (CSA) provides resource information on the CANS. Resources include:

- CANS Overview.
- CANS Training and Certification Information.
- CANS User Manual and Score Sheets.
- CANVaS Online Application.

2.7.2 Protective and risk factors as the framework for assessment

Using the protective factors framework in working with families can more effectively strengthen families and sustain the practice approaches such as those suggested in this chapter. Protective factors can be thought of as “family characteristics” that are framed in a positive manner. These characteristics (factors) have been identified as those needed by families to provide a buffer against abuse and neglect. The degree to which protective factors are present or absent is determined by an assessment of the family. Protective factors that are present in a family represent strengths that can be utilized by the family to help them overcome challenges the family may be experiencing. On the other hand, protective factors in a family that are totally absent, or present in insufficient degree, represent needs that have to be addressed.

These identified needs should be considered in conjunction with the risk factors (defined below) and protective factors when completing an assessment and service plan. Integrating these protective factors into LDSS policies and procedures that govern practice in both benefits and services programs can increase the likelihood for strengthening families at every point of contact within the LDSS. Training *Family Services Specialists* to recognize risk factors and protective factors during the assessment process can ensure that families are referred to for appropriate services within the LDSS or the community.

The National Alliance of Children’s Trust and Prevention Funds has developed an online training course: Strengthening Families™ Protective Factors Framework. It is an excellent basic overview of how the protective factors can be incorporated into prevention work.

2.7.2.1 Protective Factors

Parental Resilience

Although no one can eliminate stress from parenting, a parent’s capacity for resilience can affect how a parent deals with stress. Resilience is the ability to manage and recover from difficult life events and the ability to form positive relationships with one’s children. Resilient parents have empathy for themselves, their child, and others. Resilience requires the ability to communicate, recognize challenges, use healthy coping strategies, embrace a positive belief system, acknowledge feelings, and make good choices. Teaching resilience means supporting family driven services and decision-making. It means helping families find ways to solve their problems, to build and sustain trusting relationships including relationships with their children, to know how to seek help when necessary, and to be able to identify and use the resources available.

Examples of parental resilience include the following:

- Able to stay in control when a child misbehaves.
- Uses non-abusive disciplinary techniques and consequences.
- Feels competent in parenting roles.
- Manages stress and functions well when faced with challenges, adversity, and trauma.

Social Connections

Social connections are the antidote to social isolation, a primary risk factor for child abuse and neglect. Friends, family members, neighbors, and community members provide emotional support, help solve problems, offer parenting advice, and give concrete assistance to parents. Networks of support are essential to parents and offer opportunities for people to "give back", an important part of self-esteem as well as a benefit for the community. Isolated families may need extra help in reaching out to build positive relationships.

Examples of social connections include the following:

- Having others to talk to when about the ups and downs of parenting or when there is a problem or crisis.
- Extended family members who provide free child care for children or respite care.
- Parents who spend time with friends who are supportive.
- Neighbors who help each other with food, hand-me-down clothing, etc.

Concrete Support in Times of Need

Meeting basic economic needs like food, shelter, clothing, and health care is essential for families to thrive. Likewise, when families encounter a crisis such as DV, mental illness or substance use disorder, adequate services and supports need to be in place to provide stability, treatment, and help for family members to manage the crisis.

Examples of concrete support in times of need include the following:

- Knowledge of community resources and available supports.
- Adequate and stable housing.

- Access to health care and social services.
- Parental employment and financial solvency.
- Opportunities for education and employment.
- A range of community-based services for basic needs, respite, mental health services, legal assistance, health care, medical services, etc.

Knowledge of Parenting and Child Development

Accurate information about child development and appropriate expectations for children's behavior at every age help parents see their children and youth in a positive light and promote their healthy development. Information can come from many sources, including family members, parent education classes, and online resources. Research demonstrates that information is most effective when it comes at the precise time parents need it to understand their own children. Parents who experienced harsh discipline or other negative childhood experiences may need additional help to change the parenting patterns they learned as children.

Examples of knowledge of parenting and child development include the following:

- Parent demonstrates an understanding of child development, what is typical for each child and the reasons behind their child's behaviors.
- Parent embraces realistic expectations of child based on the child's developmental age.
- Parent engages in positive interactions with child.
- Parent uses praise.
- Parent disciplines their child in a safe way and demonstrates consistent supervision.

Social and Emotional Competence of Children

A child or youth's ability to interact positively with others, self-regulate their behavior and effectively communicate their feelings has a positive impact on their relationships with their family, other adults, and peers. Challenging behaviors or delayed development frequently creates added stress for families; thus, early identification and assistance for both parents and children can prevent negative results and promote healthy development.

Examples of social and emotional competence of children include the following:

- Ability to communicate clearly.
- Ability to recognize and regulate emotions.
- Ability to establish and maintain relationships with both peers and adults.
- Ability to solve problems and resolve conflict.

Nurturing and Attachment

Parents, who are nurturing, provide structure and consistently meet children's emotional and physical needs help children develop healthy attachments with their caregivers. This attachment provides the foundation for positive interaction, self-regulation, effective communication, and a positive self-concept.

Examples of attachment and nurturing include the following:

- Knows the child's likes and dislikes.
- Takes time to have fun with the child.
- Demonstrates empathy towards the child.
- Understands and is attuned to the child's needs.
- Enjoys being with child.
- Child enjoys being with the parent.
- Able to soothe child when they are upset.
- Child seeks out parent when upset.
- Nurtures the child and is affectionate.
- Positive, strong, stable, and caring parent child relationships.
- Open communication.

2.7.2.2 Risk factors

Research has indicated that there are certain demographic characteristics that are not predictive of abuse, neglect or the risk of out-of-home care but do tend to correlate with these risks. Childhood history of abuse or neglect is a significant

risk factor for abusing or neglecting one's own children. Other parent, family, child, and environmental risk factors include the following:

Parent related

- Parental history of child abuse or neglect in family of origin.
- Parental history of receiving DV services or involvement of law enforcement due to DV.
- Self-reported incident or exposure to DV.
- Parent substance use disorder or history of substance use disorder.
- History of child abuse or neglect involving parents' child.
- Current or history of depression.
- Parent physical and mental health concerns.
- Parent language barriers.
- Parent's unrealistic expectations of child.
- Parent antisocial behavior.
- Late, poor, or no prenatal care.
- Abortion unsuccessfully sought or attempted for pregnancy of a particular child.
- Parental attitude about becoming a parent.
- Relinquishment of custody sought or attempted for a particular child.
- History of psychiatric care.
- Education under 12 years.
- Low *paternal* self-esteem.
- Low parental IQ.
- Parents' negative view of the child in families where DV is present.
- Single parents.

- Nonbiological, transient caregivers in the home.
- Language barriers.

Child related

- Child younger than four (4) years of age.
- Child exposure to DV.
- Child's behavior and temperament.
- Child with disabilities or other special needs that may increase caregiver burden.
- Child antisocial behavior.

Family related

- History of family violence of any kind.
- Abnormal or nonexistent attachment and bonding.
- Family economic factors.
- Unemployment, inadequate income, unstable housing, etc.
- Marital or family problems.
- Single-parent family.
- Inadequate emergency contacts (excludes immediate family).

Community/environmental related

- Lack of social supports.
- Isolation.
- Few housing opportunities.
- High unemployment.
- High incidence of teen pregnancy.

- Lack of resources (e.g., lack of access to early infant and child services, day care, mental health resources, educational resources, after-school programs, parent support groups, and child development information).
- Availability of drugs in the community.
- Community violence.
- Community disorganization or low neighborhood attachment.

All of these characteristics should be considered in the context of the current family system and current family functioning and not used exclusively to determine risk of abuse and neglect or out-of-home care.

For questions to consider when assessing protective factors as strengths or needs, see Appendix B: Questions to raise to assess protective factors as strengths or needs. The questions are based on the protective and risk factors survey with additions from other models and approaches used by *Family Services Specialists* across the state. They are neither negative nor positive but are intended to be neutral.

2.7.3 Preliminary screening and assessment of trauma

For purposes of this chapter, screening for trauma refers to a brief, focused inquiry to determine whether an individual has experienced one (1) or more traumatic events, has reactions to such events, has specific mental or behavioral health needs, or needs a referral for a comprehensive trauma-informed mental health assessment. It is distinct from a comprehensive trauma-informed mental health assessment completed by a mental health professional.

A trauma-informed mental health assessment refers to a process that includes a clinical interview, standardized measures, or behavioral observations designed to gather an in-depth understanding of the nature, timing, and severity of the traumatic events, the effects of those events, current trauma-related symptoms, and functional impairment(s). This assessment is used to understand a child's trauma history and symptom profile; to determine whether a child is developmentally on target in the social, emotional, and behavioral domains; to inform case conceptualization and drive treatment planning; and to monitor progress over time.

The outcome of this initial screening is to determine how the present trauma symptoms can be addressed within the family and if a trauma-informed mental health assessment needs to occur. A comprehensive resource for trauma screening and assessment is the National Child Traumatic Stress Network (NCTSN) and Virginia HEALS model of service delivery.

2.7.3.1 Types of trauma

There are three broad types of trauma:

- **Acute trauma:** refers to a single adverse event.
- **Chronic trauma:** refers to multiple or repeated events, such as neglect.
- **Complex trauma:** refers to multiple, prolonged, and developmentally adverse events which most frequently involve the child's caregiver. Most children served by the child welfare system have experienced complex trauma.

Not all children experience trauma in the same way. Their response to trauma is affected by:

- Child's chronological age and developmental stage.
- Child's perception of the danger.
- Whether the child was a victim or witness.
- Child's past experience with trauma.
- Child's relationship to the perpetrator.
- Presence/availability of adults to help.

The effects of complex trauma are cumulative and, especially when parents or caregivers are the source of trauma, have the most pervasive effects. Complex trauma impacts the following areas of functioning for children:

- Health.
- Brain Development.
- Mood Regulation.
- Cognition and Learning.
- Behavioral Control.
- Memory.
- Cause and effect thinking.

- Self-concept.
- World view.
- Attachment.

2.7.3.2 Child traumatic stress symptoms

Child traumatic stress refers to the physical and emotional responses of a child to events that threaten the life or physical integrity of the child or someone important to the child. Traumatic events overwhelm a child's capacity to cope and elicit feelings of terror, powerlessness, and out of control physiological arousal. Symptoms which can develop include, but are not limited to, the following:

- Child continues to relive the traumatic experience through memories that interfere with daily tasks, avoids people or places associated with trauma, expresses less feeling towards others than prior to the trauma, problems sleeping or eating, difficulty concentrating, outbursts of anger, etc.
- Attachment challenges (e.g., getting close to caregivers and others or inappropriate boundaries with others, lack of eye contact, etc.).
- Child presents as fearful, anxious, and depressed.
- Child has difficulty regulating emotions (e.g., gravitates towards extremes of emotion or difficulties expressing feelings).
- Child has physical complaints with no apparent physical basis.
- Child has feelings of detachment, numbness, or spaced out.
- Child is anxious, clingy, over-compliant, or depressed.
- Child engages in provocative or high-risk behaviors such as oppositional behaviors, substance use disorder, self-harm, or suicide attempts.

When children experience a traumatic event, the entire family is affected. Often, family members have different experiences around the event and different emotional responses to the traumatic event. Awareness of each family member's experience of the event and helping them cope with possible feelings of fear, helplessness, anger, or even guilt in not being able to protect children from a traumatic experience, is an important component of a family's emotional recovery.

Conclude the trauma screening with a discussion of its implications for service planning and assist the caregivers with connecting trauma concerns with any other problems and change goals that have been identified by the family. If any of the trauma related symptoms surface during the *Family Services Specialist's* 's assessment, the child or family should be referred for a comprehensive clinical trauma-based assessment. For questions to consider when assessing the appropriateness or fit of a mental health provider for a family, see Appendix A: Questions to Ask Mental Health Providers.

2.8 Service planning

2.8.1 Definition of service plan

The service plan documents all services to prevent further child maltreatment, out-of-home care, or placement into foster care. The Virginia Administrative Code defines a service plan:

> (22 VAC 40-705-10). "Service Plan" means a plan of action to address the service needs of a child or his family in order to protect a child and his siblings, to prevent future abuse and neglect, and to preserve the family life of the parents and children whenever possible.

2.8.2 Timeframe to complete service plan

The initial service plan must be developed **within 30 calendar days** of opening the case. It must be re-evaluated **every 90 days thereafter** or sooner if safety, risk, or family circumstances change. The service plan must be documented in the child welfare information system.

2.8.3 Information needed to develop service plan

The service plan incorporates information about the parents, caregivers, legal guardians, and children. It is important for the *Family Services Specialist* to review all relevant documents prior to developing the service plan with the family. The following information should be reviewed and considered in developing a service plan with the family:

- The most recent safety assessment completed with the family, noting any safety factors that have been identified.
- The most recent Family Risk Assessment completed for the family, noting the identified risk factors.
- The CANS completed prior to developing or renewing the service plan.
- The most recent safety plan developed with the family.

- CPS family assessment or investigation that may have prompted the opening of the In-Home services case.
- Prior CPS history for the family, including any prior screened out reports, family assessments, investigations, or service cases.
- A Candidacy Determination that may identify a child as a reasonable candidate or candidate for foster care, noting whether or not the child is at imminent risk of out-of-home placement.
- The Family Service Agreement completed in the family assessment or investigation.
- The recommendations from the FPM (if conducted).
- Reports received from collateral sources such as psychological evaluations, forensic evaluations, parenting capacities, home studies, court reports, etc.
- Any court orders.

2.8.4 Develop the plan with the family

The child and family should have an active role and voice in identifying their strengths and needs, which guide the goals, objectives, and activities of the service plan. Engagement involves consistent use of strength-based, respectful, unbiased, non-judgmental, and empowering language in all communication. The *Family Services Specialist* should engage the family to:

- Identify their strengths.
- Recognize, explain, and prioritize their needs, preferences, and challenges.
- Understand, accept, and work toward any non-negotiable conditions that are essential for child safety and well-being.
- Attend team meetings and shape key decisions about goals, intervention strategies, special services, and essential supports.
- Advocate for their needs, supports, and services.
- Follow through on interventions.

2.8.5 Components of an effective service plan

An effective service plan is one that has been mutually developed and agreed on by all parties and is based on a comprehensive assessment of family strengths and needs. Integral to change is the individual understanding why change is needed, owning the need for change, identifying what they need to do differently, and knowing what it will look like when change occurs. These elements should guide service planning.

Below are the components of an effective service plan:

2.8.5.1 Goals

Goals are broad statements that express child welfare outcomes of safety, permanency, and child and family well-being. They represent the overall desired outcome toward which all case activities are directed. To achieve a goal often requires the coordinated implementation of many activities and the resolution of problems.

2.8.5.2 Objectives

An objective is a statement that describes a specific desired outcome or "end state." Objectives are more specific in scope than goals. An objective describes what should be done in order to achieve the desired goal.

Achievement of a goal generally requires the accomplishment of a series of objectives. An objective describes in measurable terms exactly what behavioral change is desired. The outcome described by an objective generally represents a resolution of a safety threat or decrease of risk through the elimination of a specific identified need or problem.

Objectives should have certain characteristics in order to measure success:

- **Objectives should be derived from the CANS assessment.** Objectives are derived from and should be consistent with the assessed problem. Each objective should be formulated for the presenting issue(s) and should seek to address the risk factor(s) as identified in the comprehensive assessment. This will assure that activities and services are properly directed at eliminating the underlying conditions or contributing factors and that they are individualized to meet each family's needs.

- **Objectives need to be measurable.** Objectives are very specific outcomes which should ultimately result in goal achievement. In order to determine whether these short-term outcomes have been completed, they

should be measurable. All parties to the plan should be able to agree whether the stated objectives have been accomplished. The objectives should include some criteria to measure achievement.

- **Objectives need to reflect behavioral change.** In In-Home services cases, many goals reflect the elimination of harmful parenting behaviors. If the goal is to prevent removal of the child from their home or reunite the child residing voluntarily outside of the home, intervention will be directed towards helping parents alter their behaviors or lifestyles to resolve safety threats and reduce the likelihood of future harm. Objectives should clearly describe specific behavioral changes parents/caregivers need to adopt.

- **Objectives should be time limited.** Each objective should have a time frame for completion. The assignment of a time frame provides an additional criterion by which achievement of the objective can be measured.

- **Objectives should be mutual.** In the casework engagement model, all planning activities are conducted mutually by the family and the *Family Services Specialist*. The more involved the family is in determining the objectives, the more likely family members will be committed to implementing them. Family members are more motivated to make changes if they have identified the changes needed.

Example objective:

- Parent will be able to identify three (3) developmental tasks of each child and determine if each child is on target with these tasks. Parent will identify safe ways to manage children's behaviors based on this knowledge.

2.8.5.3 Strengths used to achieve goals

It is important to both acknowledge and identify the strengths families possess that will contribute to achieving goals and objectives. This should include the protective factors and other strengths identified in the assessment process.

2.8.5.4 Barriers to achieving goals and objectives

Each contact with the family after a service plan is in place should explore what has been successful and what the challenges still are. The *Family Services Specialist* and the family can then brainstorm ways to remove any barriers. Role playing with the parents, identifying challenging situations, and talking through a different response are helpful strategies in providing the coaching needed to achieve certain goals and objectives.

2.8.5.5 Services

Services include information or referrals for tangible and intangible support. Services can be delivered in the home or in another environment that is familiar and comfortable for the family. Services may also be court-ordered. When possible, services should be evidence-based and trauma-informed. For more information on service delivery, see Section 2.10: Service delivery. In addition, for more information on evidence-based and trauma-informed prevention services, see Section 2.10.7 or Office on Trafficking in Persons for services available to victims of human trafficking.

2.8.5.6 Strategies

The service plan should also specify the necessary strategies to achieve each stated objective. This part of the service plan can be viewed as the "step-by-step implementation" or "action plan" which will structure and guide the provision of services.

Strategies should be written for each objective included in the service plan. This includes:

- What steps or actions should be performed, in what order, to achieve the objectives?
- Who in the family will be responsible for the implementation of each activity?
- When the activity is to occur, including desired time frames for beginning and completing each activity.
- Where each activity is to take place.
- What activities and services the *Family Services Specialist* or LDSS will complete or provide?
- How will any barriers be minimized?

Strategies should be jointly formulated and agreed upon by the family and the *Family Services Specialist*. The family's commitment to following through with service plan activities is directly related to their involvement in the plan's development.

- Complex strategies should be broken down into parts, and each part should be listed as a separate activity.

- For example, to meet the objective of father will give his child a "time out" or use an alternative method of discipline he has learned from his parenting class rather than hitting or slapping his child, a task/activity may be that he attends a parenting class. This may include a sequence of more discrete tasks such as, locating a class that addresses parenting challenges for the age and development of the child, enrolling in the next available session, attending each session, participating in the sessions, completing the sessions, and demonstrating use of alternative parenting techniques with the child.

The *Family Services Specialist* should ensure that the family has the knowledge and ability to carry out assigned activities. If not, the strategies should be reformulated.

When formulating strategies to achieve objectives, the *Family Services Specialist* should consider and maximize any family strength identified by the worker and family during the assessment process.

Examples of strategies:

- Father will enroll in and attend all seven (7) sessions of the parenting class held at the community hall starting on [date] and ending on [date].
- By [date] worker will develop a plan to provide the caregiver with information about child development. Caregivers will read the information provided and meet with worker to talk about the child's development, ask questions and assess whether each child is on target, ahead or behind developmentally by [date].
- Parent and worker will identify expectations for child's behaviors that reflect their level of development by [date]. Parent will identify what they will do to encourage expected behaviors and manage behavior when child does not do what is expected and practice those behaviors by [date]. Worker will meet with the parent to discuss progress, barriers that arose and any changes needed by [date].

2.8.6 Living arrangement

The child's living arrangement must be documented on the service plan in the child welfare information system. The child's living arrangement must be indicated as one of the following selections in the child welfare information system:

- Child living in own home.
- Child living temporarily with alternate caregiver.

- Child living permanently with alternate caregiver.

2.8.7 Share and document the service plan

The *Family Services Specialist* must document the service plan in the child welfare information system and include how the family was involved with its development. All goals, objectives, strategies, and services must be documented in the child welfare information system.

The service plan is also utilized to document a candidacy determination. It is important to note that the documentation of reasonable candidate and candidate for foster care determinations are related to fiscal reimbursement for case management provided by the LDSS and provision of evidenced-based and trauma-informed prevention services respectively. Furthermore, failure to meet documentation requirements regarding candidacy determinations, redeterminations, and preventive services provided in the child welfare information system can result in the child being ineligible for federal funding for prevention services.

The completed service plan must include the signatures of all participating parties and a copy given to the family. The original service plan, with signatures, must be maintained in the hard copy file.

2.8.8 Supervisory review of the service plan

The *Family Services Supervisor* should review the service plan in the child welfare information system. The service plan should describe the complement of services and supports required to address ongoing well-being, safety, and permanency for the child. The plan should address the unique needs of the child and family and should build upon their strengths, resources, and natural supports, as identified through the comprehensive assessment process. Services should be for a planned period of time to meet specific needs.

2.8.9 Funding the service plan

Agencies use a range of funding sources to help meet family needs. A vital part of service planning is exploring with the family the plan for funding the services. Public assistance funds, CSA funding for prevention services, PSSF funds and SSBG funds, health insurance, and government and foundation grants are all possible funding sources.

Access to CSA funds is governed by state and local policies which require multiagency planning, uniform assessment, utilization review, and authorization of funds. The *Family Services Specialist* should become familiar and comply with policies established by their local Community and Policy Management Team (CPMT) for access to CSA funding. The LDSS must refer the child and family to the Family

Assessment and Planning Team (FAPT) or approved multi-disciplinary team, consistent with CPMT policies.

In addition, Appendix H: Funding Sources for Prevention of Section 1 identifies a range of funding sources utilized by LDSS.

2.8.10 When parents and caregivers are not engaged

When the *Family Services Specialist* cannot engage the parents in mutual goal setting, the *Family Services Specialist* must develop goals and objectives responsive to the concerns identified and the expected outcomes. These objectives and goals represent the LDSS responsibility to address child safety concerns.

A family-centered approach to engaging the family may increase their readiness and ability to change. By involving families in the processes of assessment, case planning, and service delivery, families are more likely to be receptive to service provision. When families are able to identify strengths and concerns in family functioning, they may contribute more to their own growth and can make more productive changes.

For more guidance regarding family engagement, please refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.

2.9 Tools and strategies that can be utilized in the assessment process

The following tools and strategies can be helpful in assessing the strengths and needs of the child or the family:

2.9.1 Genograms

The genogram was first developed and popularized in clinical settings by Monica McGoldrick and Randy Gerson. A genogram (pronounced: jen-uh-gram) allows the *Family Services Specialist* and family members to quickly identify and understand patterns in the family history. The genogram is a tool that helps map out relationships and traits in the family. Most genograms include basic information about number of families, number of children of each family, birth order, and deaths. Some genograms also include information on disorders running in the family, such as alcoholism, depression, diseases, alliances, and living situations. For additional information on basic genogram components, see the GenoPro website.

2.9.2 Ecomaps

An ecomap is a pictorial representation of a family's connections to persons or systems in their environment. It can illustrate three separate dimensions for each connection:

- The **STRENGTH** of the connection (weak; tenuous/uncertain; strong).
- The **IMPACT** of the connection (none; draining resources or energy; providing resources or energy).
- The **QUALITY** of the connection (stressful; not stressful).

The purpose of an ecomap is to support classification of family needs and decision-making about potential interventions. Further, it is to create shared awareness (between a family and the *Family Services Specialists*) of the family's significant connections, and the constructive or destructive influences those connections may be having. Ecomaps enable a structured, consistent process for gathering specific, valuable information related to the current state of a family or individual being assessed. They support the engagement of the family in a dialogue that can build rapport and buy-in, while heightening the awareness of the *Family Services Specialist* and family.

Ecomaps can be used to:

- Identify and illustrate strengths that can be built upon and weaknesses that can be addressed.
- Summarize complex data and information into a visual, easy to see and understand format to support service planning and delivery.
- Illustrate the nature of connectedness and the impact of interactions in predefined "domain" areas, indicating whether those connections and interactions are helping or hurting the family. Part of this value is in supporting the concept of observing "resource and energy flow" to and from a family as a result of its connections and interactions with its environment.
- Allow objective evaluation of progress, as *Family Services Specialists* can observe the impact of interventions, both on the family and on other elements of their environment.
- Support discussion of spiritual and value-related considerations in a constructive way.

- Help support integration of the concept of comprehensive assessment as an ongoing process.
- Support effective presentation of families' challenges for case staffings, service referrals, and court proceedings.
- Promote the building of interviewing and other skills for *Family Services Specialists*.

Ecomaps can be particularly helpful in prevention work to identify possible family supports, and to assist families in managing stressful relationships and negotiating systems. More information on the use of ecomaps is available on the SmartDraw website.

2.9.3 Motivational interviewing

Motivational interviewing (MI), a counseling approach built on engaging ambivalent clients and motivating them to change, offers a valuable tool for *Family Services Specialists* in their interactions with families. Involvement with the child welfare system necessitates opening intimate details of one's life to strangers, with inhibiting emotions such as fear and shame informing each interaction, along with other isolating factors such as DV, substance use disorder, and poverty. Therefore, *Family Services Specialist* engagement through MI techniques can promote client engagement and positive case outcomes.

For more information on advanced interviewing techniques, see the following instructor led course in the VLC. The course is available to *Family Services Specialists* and *Family Services Supervisors* across all child welfare program areas.

- CWS5305: Advanced Interviewing: Motivating Families for Change.

2.9.4 Valid and reliable instruments

The following instruments in Appendix C: Valid and reliable instruments can be helpful in facilitating the family's and *Family Services Specialist's* understanding of their circumstances. The list is not intended to be all inclusive but will provide links to helpful resources.

2.10 Service delivery

As described in Section 1: Overview of Prevention for Practice and Administration, an increasing body of evidence indicates maltreatment can alter brain functioning and consequently affect mental, emotional, and behavioral development. When *Family Services Specialists* provide prevention services, they have a unique opportunity to identify potential concerns and help families receive the support they need to reduce any

long-term effects. This should occur in the context of trauma-informed practice. For more information on trauma-informed practice, see Section 1.12.4: Emphasis on trauma-informed practice.

2.10.1 Goal of supportive services

Regardless of the level and type of services provided, the primary goals of all supportive services are as follows:

- To respect and support the integrity of the child's family unit.
- To strengthen and promote protective factors in families.
- To foster an emotionally and physically safe environment for children and their parents.
- To increase families' understanding of trauma and its impact and to help reduce trauma related symptoms in family members.
- To prevent placement of a child away from his or her caregiver.
- To assist families in utilizing community resources to foster independence.
- To maintain personal and professional boundaries with families.

2.10.2 Safety services

Child and family safety must be continuously assessed in every child welfare program area throughout the life of a case. Safety assessment is both a process and a product (i.e., when a SDM tool is used). A continuum of immediate protective interventions and safety services must be initiated throughout the life of an In-Home services case anytime safety concerns are identified.

- **Safety services definition:** Formal or informal services provided to or arranged for the family with the explicit goal of ensuring the child's safety. These services must be immediately available and accessible and may be provided by professionals, family members, or other willing parties as long as each involved individual understands their role and responsibility. The safety services must be clearly documented (i.e., safety plan, service plan, court order, SDM plan, etc.) for the involved parties and in the case record.

As with all aspects of service planning, the family should be engaged in providing input and joint decision-making throughout the process of identifying, implementing, and evaluating these interventions and safety services. Documentation in the child welfare information system must clearly demonstrate how the actions taken, provided the child

with immediate protection from the safety issue and how each safety service contributes to addressing or eliminating the safety matters specific to the child.

2.10.3 Definition of strength-based practice

Strength-based practice is an approach that emphasizes families' self-determination and strengths. It is family led, with a focus on future outcomes using the family's strengths to solve problems or resolve a crisis.

2.10.4 Role of the *Family Services Specialist*

The responsibilities of the *Family Services Specialist* include:

- **Managing child safety**

The *Family Services Specialist* maintains a focus on child safety at all points of the case including reassessing child safety, developing plans to control threats to child safety, and ensuring safety plan participants understand and fulfill their roles.

- **Engaging the family**

Family engagement is a relationship focused approach that provides structure for decision-making and empowers the family in the decision-making process. Success in the provision of services depends on the quality and durability of relationships among agency workers, service providers, children, and families. The *Family Services Specialist* is involved in developing strategies to engage the family in case planning and goal achievement and to the extent possible, establishing a partnership with the family to assure child safety and facilitate change. Strategies for engaging families reflect the family's language; cultural background; and balance family-centered, strength-based practice principles with use of protective authority. The worker should:

  - Approach the family from a position of respect and cooperation.
  - Engage the family around strengths and utilize those strengths to address concerns for the health, safety, education, and well-being of the child.
  - Actively involve the child and family in the case planning process, including establishing goals and objectives in the case plan and the service plan review.
  - Engage the child and family in decision-making about the choice of services and the reasons why a particular service might be effective.
  - When appropriate and/or necessary, respectfully conclude the relationship when the case is closed, or the case plan goals are achieved.

- **Managing permanency planning**

The *Family Services Specialist* maintains an overall focus on the importance of safe, stable living arrangements for the child including taking steps to assure that the family and service providers understand the importance of permanence for the child, the timeframe for change and the consequences for lack of progress.

- **Managing the case plan**

The *Family Services Specialist* engages the family in decision-making and the treatment process, formulates goals, identifies appropriate services and service providers, monitors service provision to assure it supports the case plan, communicates with all service providers, and evaluates family progress and service plan appropriateness.

- **Managing the court process**

If court is involved, the *Family Services Specialist* provides necessary information to the judge, Guardian ad Litem (GAL), Court Appointed Special Advocate (CASA), agency attorney, and Commonwealth attorney as needed. The *Family Services Specialist* ensures the family is informed and understands the court process.

- **Managing documentation**

The *Family Services Specialist* ensures the case record in the child welfare information system is accurate and current, that all decisions and the basis for those decisions is well documented and maintains copies of all court documents and other vital reports in the hard case file.

2.10.5 Using teaming in child welfare practice

In Virginia, several models of teaming are used to engage children, youth, and their families as partners in shared decision-making in child welfare. For example:

- FPMs are used at specific decision points and are facilitated.
- Family Assessment and Planning Teams (FAPTs) are used with the CSA process.
- Teams jointly determine whether the child's best interest is to remain in the same school when the child's placement changes.
- Youth teams work collaboratively with older youth as they prepare for adulthood and establish permanent lifelong connections with significant adults.

- Child and family-specific teams (CFTs) are used in some communities to provide continuity in communication and goal setting with team members over time, adding key partners as needed.

These teams often share a common set of values and goals, including:

- Achieving safety, permanency, and well-being for the child.
- Engaging the family and its natural, informal, and community supports.
- Building upon the strengths of the child and family.
- Identifying the needs of the child and family.
- Sharing decision-making.
- Developing the service plan, ensuring appropriate services and supports are provided, and assessing progress and making adjustments over time.

One (1) team should be utilized to meet multiple purposes when feasible, as long as the activities of the team are consistent with law and guidance.

2.10.5.1 Values and key principles of effective teaming

The core value of teaming is that the entire team shares the responsibility to strengthen the family and help support children and youth to reach their fullest potential. Families are the core members of the team. Some key principles of effective teaming:

- A group of committed persons, both formal and informal supports, come together to form a working team to collaborate with the child and family. Team members have sufficient knowledge, skills, cultural awareness, authority to act, flexibility to respond to specific needs, and the time necessary to work effectively with the child and family.
- The language, culture, family beliefs, traditions, and customs of the child and family are identified, valued, and addressed in culturally appropriate ways via special accommodations in the engagement, assessment, planning, and service delivery processes.
- The child, parents, family members, and caregivers are active, ongoing participants with the team. They each have a significant role, voice, and influence in shaping decisions made about child and family strengths and needs, goals, supports, and services.

- Everyone on the team has a voice in expressing their perspective on child and family strengths, needs, supports, and services.
- Conflicts are discussed and resolved by focusing on the specific needs of the child and family.
- The child, family, and team collaborate to develop meaningful service plans that address the child's and family's needs and enhance their strengths.
- The team monitors the status, progress, and effectiveness of interventions, making adjustments to the service plan when needed.

The teaming process and its membership evolve over time as the needs of the child/youth and family change.

2.10.5.2 Benefits of teaming

Families, staff, and other team members have the opportunity to work together in planning, coordinating, and decision-making. Research supports that child, youth, and family interventions are more effective when the family provides their input as to what decisions are made. When a child or youth and family share ownership in identifying their unmet needs as well as the interventions that may address these needs, their commitment to change is evident. Team members then begin to take responsibility for contributing to the family's outcomes and team members exhibit more effective and functional cooperation as the team works toward addressing safety, permanence, and well-being for the child or youth.

2.10.6 Trauma-informed case management

An understanding of the impact maltreatment has had on children when they come to the attention of the child welfare system allows *Family Services Specialists*, administrators, and providers to be more proactive, knowing what to look for, and anticipating the services that may be needed. This skill set is critical to preventing the chronic and severe problems that may result from the trauma children and their families have experienced and to ensuring child safety, permanence, and well-being.

Case management includes the following tasks:

- Ongoing feedback to the family about their strengths and the positive changes the family demonstrates.
- Connecting the family to concrete supports within the community such as, transportation, cash assistance to meet financial and medical needs, parent

education about child development, effective discipline, nurturing, co-parenting, and other parenting skills.

- Engaging fathers, extended family, and others important to the family in the helping process.
- Advocating for the family to receive needed services in their community.
- Presenting the family to FAPT and coordinating services.
- Documenting service provision.
- Consistently review the service plan with the family to the evaluate progress and explore any barriers.

Trauma-informed case management requires the understanding of and the response to both the long and short-term impact of trauma on children's development and helping parents understand that impact as well. Tasks related to reducing trauma include the following:

- Understanding the impact of trauma on children and families, identifying the presence of trauma related symptoms among family members, and providing services to reduce those symptoms.
- Maximizing the child's and parents' sense of safety.
- Assisting children and parents in reducing overwhelming emotions.
- Helping children and parents make new meaning of their trauma history and current experiences.
- Referring families to providers who understand the impact of trauma on families and use strategies to help families heal.
- Providing support and guidance to the child's parents or other caregivers.
- Manage professional and personal stress.

There are several additional areas that *Family Services Specialists* can address in the context of effective, trauma-informed case management. For more information on trauma-informed practice see the Child Welfare Trauma Training Toolkit.

2.10.7 Trauma-focused treatment programs

Complex trauma affects a child's sense of safety, ability to regulate emotions, and capacity to relate well to others. Since complex trauma often occurs in the context of the child's relationship with a caregiver, it interferes with the child's ability to form a secure attachment. Consequently, an important goal of service delivery is to help children and youth develop positive social emotional functioning, restore appropriate developmental functioning, and reestablish healthy relationships.[1]

Trauma-informed care redirects attention from treating symptoms of trauma (e.g., behavioral problems, mental health conditions) to treating the underlying causes and context of trauma. Trauma-specific interventions include medical, physiological, psychological, and psychosocial therapies provided by a trained professional that assist in the recovery process from traumatic events. Treatments are designed to maximize a child's sense of physical and psychological safety, develop coping strategies, and increase a child's resilience.[2]

Examples of evidence-based programs for trauma include:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS).
- Parent-Child Interactive Therapy (PCIT).
- Child-Parent Psychotherapy (CPP).
- Dialectical behavioral therapy (DBT).
- Trauma and Grief Component Therapy for Adolescents (TGC T-A).
- Multisystemic Therapy (MST).
- Functional Family Therapy (FFT).

Examples of other types of therapy used with trauma include:

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1 Excerpted from the Tri-Agency Letter on Trauma-Informed Treatment dated July 11, 2012 from the United States Department of Health and Human Services' Administration for Children and Families (ACF), Centers for Medicare & Medicaid Services (CMS), and Substance use disorder and Mental Health Services Administration (SAMHSA).

2 Information in this section accepted and adapted from Implementing Trauma-Informed Practices in Child Welfare. Klain, Eva J. White, Amanda R. State Policy Advocacy and Reform Center (SPARC). First Focus. American Bar Association Center on Children and the Law. 2013.

- Behavioral therapy.
- Play therapy.
- Group therapy.
- Parent coaching.

For resources to address trauma, see:

- The NCTSN and the NCTSN Empirically Supported Treatments and Promising Practices.
- SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) searchable online registry of mental health and substance interventions available for implementation.
- National Institute of Justice (NIJ): Children Exposed to Violence.

Providing trauma-specific interventions is one component of serving children who have experienced traumatic stress. The LDSS and child-serving systems need to collaborate in instituting trauma-informed practices. All stakeholders (e.g., the child, parents, caregivers, *Family Services Specialists*, *Family Services Supervisors*, administrators, service providers, judges, attorneys) should be involved in recognizing and responding to the impact of traumatic stress on children and their caregivers. They should all be involved in helping to facilitate resiliency and recovery.

2.10.8 Evidenced-based programs

Evidenced-based programs refers to the quality of the program being offered. To be called evidence-based, a program must meet a series of rigorous standards that show it is effective. Research of the program must illustrate that it helps children and families meet their treatment goals.

Evidence-based refer to programs that:

- Have a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer it.
- Have no first-hand basis suggesting risk of harm.
    - The risks to participants are reasonable in relation to the potential benefits to participants. The benefits of these services outweigh the possible risks.
- Have reliable and valid outcome measures.

- Are administered consistently and accurately across all those receiving the practice.

2.10.9 Family services and supports

Services and supports to consider as appropriate resources for children and families may include, but are not limited to:

- Information and referral.
- Crisis intervention.
- Home visiting.
- Mental health counseling.
- Parent education and training.
- Substance use disorder treatment.
- Financial assistance.
- Employment services.
- School based services.
- Mentoring.
- Child care.
- Transportation.
- Support groups.
- Short-term respite.
- 800-CHILDREN (800-244-5373) (statewide, toll-free parent helpline).
- Other community-based services.

These services may be provided by the LDSS or by other service providers. The types of models of services that are most effective are those that address the individual needs of the family based on a comprehensive assessment. For a comprehensive list of evidence-based models, see SAMHSA's NREPP.

2.10.9.1 Caregiver services

Suggested services include but are not limited to:

- **Substance use disorder**: evaluation and treatment; support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).
- **Emotional stability**: mental health evaluation and treatment; and/or individual or group counseling.
- **Sexual abuse**: individual or group counseling.
- **Resource management and basic needs**: concrete assistance with food, clothing, shelter/housing; transportation; and/or budgeting.
- **Parenting skills**: parental capacity evaluation; parent education; coaching; and/or parent support group.
- **Household relationships/DV**: individual or group counseling; DV Program/Shelter; DV Batterer Intervention; and/or marital counseling.
- **Caregiver abuse/neglect history**: individual or group counseling.
- **Social or community support system**: support groups; faith-based support programs.
- **Physical health**: EPSDT; family planning; maternity services; medical services; nutritional counseling; occupational/physical/speech therapy; residential maternity services.
- **Communications skills**: individual counseling; coaching; and/or mentoring.

2.10.9.2 Child services

Suggested services include but are not limited to:

- **Emotional/behavioral**: mental health evaluation and treatment; and/or individual or group counseling.
- **Family relationships**: individual or family counseling.
- **Medical/physical**: medical services; nutritional counseling; dental care.

- **Child development**: developmental assessment; Part C Early Intervention referral; occupational therapy; and/or speech therapy.
- **Cultural/community identity**: community support groups; faith-based support programs; and/or after school programs.
- **Substance use disorder**: evaluation and treatment; support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).
- **Education**: educational services; educational/vocational training; tutoring.
- **Peer/adult social relationships**: individual or family counseling.
- **Delinquent/CHINS behavior**: individual counseling; legal services; probation services.

2.10.10 Authority of LDSS

Prevention or In-Home services provided to an individual or family are voluntary. The LDSS has no authority to enforce the provision of services when a family, or other individual, refuses to accept those services. If at any time in providing prevention or In-Home services, the LDSS determines that the family's circumstances meet the definition of a valid CPS referral or the child is in imminent danger, the LDSS should follow guidance in VDSS Child and Family Services Manual, Chapter C., Child Protective Services to determine if an investigation or family assessment is appropriate.

2.10.10.1 Family refuses services

The LDSS has no authority to enforce the provision of services when a family, or other individual, refuses to accept those services. When services are refused, the LDSS must consider whether alternative action is necessary. The decision to seek alternative action to compel the acceptance of services should be based on the risk of harm to the child and/or immediate safety factors.

> (22 VAC 40-705-150 B). Families may decline services offered as a result of family assessment or an investigation. If the family declines services, the case shall be closed unless there is an existing court order or the local department determines that sufficient cause exists due to threat of harm or actual harm to the child to re-determine the case as one that needs to be investigated or brought to the attention of the court. In no instance shall these actions be taken solely because the family declines services.

If a parent, or any individual, refuses to accept services, the *Family Services Specialist* should consult with the county/city attorney to determine if court action is needed. The *Family Services Specialist* may petition the court to order the necessary services.

The *Family Services Specialist* may also petition the court to require, not only a child's parent(s), but also guardian, legal custodian, other person standing in loco parentis or other family or household member of the child to cooperate in the provision of reasonable services or programs designed to protect the child's life, health, or normal development pursuant to Code of Virginia § 16.1-253.

> (Code of Virginia § 16.1-253.) A. Upon the motion of any person or upon the court's own motion, the court may issue a preliminary protective order, after a hearing, if necessary to protect a child's life, health, safety or normal development pending the final determination of any matter before the court. The order may require a child's parents, guardian, legal custodian, other person standing in loco parentis or other family or household member of the child to observe reasonable conditions of behavior for a specified length of time. These conditions shall include any one or more of the following:
>
> 1. To abstain from offensive conduct against the child, a family or household member of the child or any person to whom custody of the child is awarded;
>
> 2. To cooperate in the provision of reasonable services or programs designed to protect the child's life, health or normal development;
>
> 3. To allow persons named by the court to come into the child's home at reasonable times designated by the court to visit the child or inspect the fitness of the home and to determine the physical or emotional health of the child;
>
> 4. To allow visitation with the child by persons entitled thereto, as determined by the court;
>
> 5. To refrain from acts of commission or omission which tend to endanger the child's life, health or normal development; or
>
> 6. To refrain from such contact with the child or family or household members of the child, as the court may deem appropriate, including removal of such person from the residence of the child. However, prior to the issuance by the court of an order removing such person from the residence of the child, the petitioner must prove by a preponderance of the evidence that such person's probable future conduct would constitute a danger to the life or health of such child, and that there are no less drastic

> alternatives which could reasonably and adequately protect the child's life or health pending a final determination on the petition.

For more information on Protection Orders, see VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 8, Judicial Proceedings.

When services are determined to be necessary to prevent abuse or neglect, but services are refused, both the offering and refusal must be fully documented in the child welfare information system.

2.10.10.2 Court refuses request for assistance

If the court does not issue an order compelling the family to accept services and the parents, other guardian, legal custodian, other person standing in loco parentis or other family or household member of the child continue to refuse critical services, the *Family Services Specialist* should consult legal counsel to determine if any other alternatives are available in working with the court. If no other legal recourse is available, the worker should close the In-Home services case and document the reason for closure in the closing case summary in the child welfare information system.

2.11 Service plan review and reassessments

The *Family Services Specialist* must review the service plan with the family **every 90 days** or more often if the safety or risk changes. The purposes of a service plan review are to:

- Assess and manage child safety.
- Assess objectives to ensure they are helping attain goals.
- Assess family progress toward establishing and maintaining a safe environment.
- Keep all parties involved with the case plan informed and focused on common goals.
- Review performance and appropriateness of services and service providers.
- Determine the need to revise the case plan.
- Determine whether case closure is appropriate.
- Consider challenges and concerns related to permanency and well-being as applicable.

Changes to the service plan must be based on the family progress toward attaining the goals and specific objectives in the service plan and reduction of risk of future maltreatment. A CFTM should be held when the service plan is reviewed.

2.11.1 Risk reassessment

The first step in reviewing the service plan is to reassess the risk of future maltreatment. The Risk Reassessment Tool informs whether the future likelihood of maltreatment has been reduced, increased, or remained the same following the provision of services or changing circumstances within the family. Reassessing risk in an In-Home services case measures the progress of the family towards meeting the goals and objectives of the service plan. Reassessing risk guides decisions about case closure. The risk reassessment must be completed **every 90 days** until the case is closed. It must be completed before renewing or ending a service plan in the child welfare information system.

2.11.1.1 Risk reassessment considerations

The *Family Services Specialist* must use the Risk Reassessment Tool, which is located in the child welfare information system, and on the forms page on the VDSS public website. There are two (2) main sections of the tool. The first section, R1 through R4, captures information that should be previously known and documented by the *Family Services Specialist*. The second section, R5 though R9, assesses information obtained during the period since the last Family Risk Assessment done during the investigation or family assessment or the last Risk Reassessment, otherwise known as the period under review. The Risk Reassessment Tool assesses the following:

- Prior history of child abuse or neglect.
- Prior history of child welfare services.
- History of caregiver childhood abuse or neglect.
- Characteristics of the child.
- New reports of abuse or neglect received.
- Concerns related to substance use.
- Concerns relating to adult relationships/DV.
- Providing care to the child consistent to their needs.
- Progress with the service plan.

Each of these is clearly defined in the Risk Assessment Tool. The use of definitions with all SDM tools is critical.

2.11.1.2 Risk reassessment decision

The decision to keep a case open or close a case is based on the following suggestions.

Low Risk	Close case
Moderate risk	Remain open OR close case
High Risk	Remain open
Very High Risk	Remain open

The decision to close the In-Home services case must be approved by the *Family Services Supervisor*.

2.11.2 Update the CANS

After the decision is made that the case will remain open, the next step in reviewing the service plan is to update the CANS. Critical needs are likely to change as families engage in achieving the objectives in the service plan. For In-Home services cases that have been assessed at moderate risk, the CANS should guide the decision regarding case closing. The CANS must be updated in CANVaS **every 90 days**, in conjunction with the renewal of the service plan for any child(ren) and caregiver(s) in an In-Home services case who is identified in the service plan and receiving a direct or funded intervention or service, to include an evidence-based prevention service(s).

2.11.3 Update service plan

After the Risk Reassessment Tool, and CANS reassessment are updated, the service plan must be revised.

If the decision is to close the case, all services must be ended in the service plan in the child welfare information system.

If the decision is to keep the case open, the service plan must be renewed and completed in the child welfare information system. The updated service plan must be shared with the family. The updated service plan should include the signatures of all participating parties and a copy be given to the family.

2.11.4 Update candidacy determination

Candidacy Determination must be updated **every 90 days** or sooner if circumstances change and documented in the child welfare information system.

2.12 Closing an In-Home services case

2.12.1 Update safety assessment

A new Safety Assessment Tool must be completed any time new safety threats are identified and must be completed prior to closing an In-Home services case. The final safety assessment must be completed **within 30 days of case closure**. The safety assessment should be safe in order to close a case. The safety assessment must be documented in the In-Home services case in the child welfare information system.

There may be occasions when the final closing safety assessment is still conditionally safe and a safety plan is developed with the family with the understanding that once the case is closed the plan will no longer be monitored by the LDSS. For more information on the process of assessing child safety throughout the life of an In-Home services case, refer to Section 2.7.6.2: Assessing safety in an In-Home services case.

2.12.2 Update risk reassessment

A final Risk Reassessment Tool must be completed **within 30 days of case closure**. The risk reassessment should be low or moderate in order to close a case. The risk reassessment must be documented in the In-Home services case in the child welfare information system. There may be occasions when the final closing risk reassessment is still high or very high and justification for case closure must be documented in the child welfare information system.

2.12.3 Closing the CANS

The CANS should guide the decision regarding case closing or the end of service provision. After the decision is made that the case will close, the CANS must be closed in the CANVaS online application.

2.12.4 Closing notification/summary

The *Family Services Specialist* should document a closing case summary in the child welfare information system. This closing case summary details the rationale for closing the case and should include:

- The reason the case was opened.
- The services provided to the child and family.

- The results of any assessments completed to include but not limited to: Risk Reassessment, Safety Assessment, CANS, Candidacy Determination, etc.
- The outcomes of any criminal or civil court matters.
- Any recommendations or referrals for the family after case closing, such as the use of formal and informal support systems.

The family must be informed that the case is closed both orally and in writing. This notification must be documented in the child welfare information system.

2.12.5 Supervisory approval

The case closure must be approved by the *Family Services Supervisor* in the child welfare information system. The *Family Services Specialist* and *Family Services Supervisor* should discuss the decision to close a case for services, the summation of services in place at closure, child and family adjustment, and overall case progress.

2.13 Transferring an In-Home services case outside the LDSS

2.13.1 Transfer open In-Home services case to another LDSS in Virginia

When a family moves, the In-Home services case must be transferred to the LDSS in the locality where the family will reside.

> 22 VAC 40-705-150 H. When an abused or neglected child and persons who are the subject of an open child abuse services case have relocated out of the jurisdiction of the local department, the local department shall notify the child protective services agency in the jurisdiction to which such persons have relocated, whether inside or outside of the Commonwealth of Virginia, and forward to such agency relevant portions of the case records pursuant to § 63.2-1503 G of the Code of Virginia.

2.13.1.1 LDSS to initiate transfer immediately

The LDSS must contact the receiving agency immediately to notify the agency that the family is moving to that locality and will need In-Home services. This notification should be done verbally.

At a minimum, the LDSS must provide to the receiving LDSS the following information:

- Child welfare information system Case Number.
- Summary of the sending agency's involvement with the family, including the services currently being provided to the child or family.

2.13.1.2 All contacts must be current

When transferring an In-Home services case to another LDSS, the sending agency should ensure that all contacts are current. The CANS, Risk Reassessment Tool, Candidacy Determination, and service plan must be current and documented in the child welfare information system. Client demographics such as date of birth, address, and phone numbers should also be updated.

2.13.1.3 LDSS must send entire record to receiving LDSS

A copy of the entire In-Home services case record, including the fully documented automated record and any additional hard copy reports or files, must be forwarded to the new locality **within 30 days**. The automated case record must be forwarded electronically, and any other record information must be mailed or faxed. The sending LDSS retains all originals of the hard copy record, including the required notifications.

2.13.1.4 Receiving LDSS must provide services

> (22 VAC 40-705-150 H). The receiving local department shall arrange necessary protective and rehabilitative services pursuant to § 63.2-1503 G of the Code of Virginia.

The receiving LDSS must complete or attempt the first contact **within five (5) business days** of assignment. The first contact should be a face-to-face worker visit with the parents, custodians or legal guardians, the children, and the sending LDSS worker (if possible.)

2.13.2 Transfer open In-Home services case to another state

If a family in an open In-Home services case moves to another state and services are still needed to prevent abuse and neglect, the LDSS must contact the receiving state for information and instructions. A complete listing of contact information for each state can be located on the Child Welfare Information Gateway website.

2.13.3 Transfer In-Home services case out of state; child in the custody of an LDSS

2.13.3.1 Involving Interstate Compact for the Placement of Children (ICPC)

- The LDSS must contact the Interstate Compact for the Placement of Children (ICPC) Unit at VDSS for assistance to transfer to another state an In-Home services case with at least one child in the home and at least

one (1) child in the custody of an LDSS. (Dual In-Home & Foster Care case type).

- The LDSS must contact the ICPC unit at VDSS for assistance to transfer to another state an In-Home services case where there is a Virginia court which has an open child abuse/neglect or dependency case that established court jurisdiction to supervise, remove and/or place the child in another state.

2.14 Appeals and fair hearings

Dissatisfied families applying for or receiving prevention services can request a local conference to discuss their concerns about services or payments and request a change in action. During the conference the LDSS should examine reasons for their actions or recommendations and consider additional information presented by the family to determine if the LDSS' services or payment decisions should be changed.

2.15 Record retention and purging the case record

Closed In-Home services case records are to be destroyed in accordance with laws governing public records in the Commonwealth - Library of Virginia's Records Retention and Disposition Schedule. These rules allow for In-Home services case records to be destroyed or purged three (3) years from the date the case was closed if an audit has been performed. If no audit has been performed, the record may be destroyed five (5) years from the date the case was closed.

2.16 Appendix A: Questions to Ask Mental Health Providers

1. Does the individual/agency that provides therapy conduct a comprehensive trauma assessment?

- What specific standardized measures are given?
- What did your assessment show?
- What were some of the major strengths or areas of concern?

2. Is the clinician/agency familiar with evidence-based treatment models?

3. Have clinicians had specific training in an evidence-based model (when, where, by whom, how much)?

4. Does the individual/agency provide ongoing clinical supervision and consultation to its staff, including how model fidelity is monitored?

5. Which approach(es) does the clinician/agency use with children and families?

6. How are parent support, conjoint therapy, parent training, or psychoeducation offered?

7. Which techniques are used for assisting with the following?

- Building a strong therapeutic relationship.
- Affect expression and regulation skills.
- Anxiety management.
- Relaxation skills.
- Cognitive processing/reframing.
- Construction of a coherent trauma narrative.
- Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience.
- Personal safety/empowerment activities.
- Resiliency and closure.

8. How are cultural competency and special needs considerations addressed?

9. Is the clinician or agency willing to participate in the multidisciplinary team (MDT) meetings and in the court process, as appropriate?

(Adapted from Child Welfare Trauma Training Toolkit: Questions for Mental Health Providers. (2013). The National Child Traumatic Stress Network.)

2.17 Appendix B: Questions to raise to assess protective factors as strengths or needs

Protective Factor	Areas to assess for each protective factor
Parental resilience	• What was the parent's attitude about becoming a parent? • What strengths has the family presented in terms of the ability to cope and bounce back from past challenges? • How is the family able to stay in control when problems arise or child misbehaves? • What are the pervasive feelings of the parents (e.g., contented, happy, depressed, angry, hopeful, etc.)? • What are the parents' views of themselves as parents (i.e., their feelings of competence in parenting roles)? • What is the relationship between the child's parents? • What, if any, problems within the parental relationship impact child safety, well-being, and stability? • What if, any special needs do the parents have that impact safety, stability, or well-being (e.g., substance use, family violence, physical or mental health concerns, language barriers, managing their own behavior, history of psychiatric care)? • To what extent have the parents been able to identify problems, solve them, connect with resources, and learn from their experiences? • What other caregivers are in the home, how and what parental role do they play? • What other strengths do the parents bring to parenting?
Social connections	• Who has provided support to the family in the past or is available to provide emotional support and concrete assistance to parents in times of need or crisis

Protective Factor	Areas to assess for each protective factor
	(friends, family members, and other members of the community)? • Does the family know where to go for help?
Knowledge of parenting and child development	• What information does the family know and demonstrate about raising young children and how the children develop? • To what extent are the parents' expectations realistic of their child? How able are the parents to identify their child's physical and emotional needs? • What did the parents learn from their parents that they want to repeat? That the parents want to do differently? • When does the parent use praise with the child for compliance and success? • What techniques do the parents use to discipline their children?
Concrete support in times of need	• How is the family able to maintain financial security to cover daily expenses and unexpected costs that come up from time to time? • What access to formal supports (TANF, early infant and child services, day care, mental health resources, education resources, after school programs, parent support groups, child development information, etc.) and informal support from social networks does the family have? • Does the family have adequate and stable housing and child care? • Does the family have access to health care and social services? • Is the family aware of the local resources they can utilize?

Protective Factor	Areas to assess for each protective factor
	• What opportunities are there for education and employment? What access to services does the family have, including transportation? • What risk factors exist within the community (drugs, violence, teen pregnancy, isolation, etc.) that impact this child's safety, well-being, and stability?
Child and parents' relationship	• What is the parents' view of this child? What words do they use to describe the child? • What is the relationship between the child and parents? • Do the parents enjoy being with the child? • How do parents soothe the child when the child is upset? • How much time do they spend with the child in play? To what extent are both parents involved? What roles do each parent play? • What barriers exist to involving the absent or other parent? • How have the parents managed those barriers? • What behaviors challenge the parents the most and how do they manage those behaviors? • How does the parent express empathy toward the child? • What is the temperament match between the parent and child? • To what extent do family members listen to each other? • How does the family solve problems, manage conflict, or pull together in times of stress?

Protective Factor	Areas to assess for each protective factor
Children's social and emotional development	• What prenatal care was provided to the child? • What is the child's ability to interact positively with others and communicate his or her emotions effectively? • What is the child's social and emotional competence? • What is the child's ability to protect themselves should the need arise? • To what extent does the child express pleasure in being with the parents? • How resilient is the child? • What is the child's temperament? • What provocative behaviors does the child exhibit? • What other special needs does the child have that may increase caregiver burden?
Past history of success	• What has happened in the parents' past that cause them to feel like they are a good parent? • How have the parents been able to solve problems in the past? • Despite the problem or concerns the parents now have, what is currently working well or good enough?
Spiritual or cultural values	• What values and beliefs guide the parents' view of their role, their child's role, and of their parenting? • What community values and beliefs impact this family and their safety, well-being, and stability? • What is the family's view of themselves?

2.18 Appendix C: Valid and reliable instruments

The following instruments can be helpful in facilitating the family's and *Family Services Specialist*'s understanding of their circumstances. The list is not intended to be all inclusive but will provide links to helpful resources.

2.18.1 Protective Factors Survey

The Protective Factors Survey (PFS) was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research and Public Service. The PFS is designed for use with caregivers receiving child abuse prevention services. The instrument measures protective factors in five (5) areas: family functioning/resiliency, social emotional support, concrete support, nurturing and attachment, and knowledge of parenting/child development. *Family Services Specialists* can administer the survey before, during, or after services.

The primary purpose of the PFS is to provide feedback to agencies for continuous improvement and evaluation purposes. The survey results are designed to provide agencies with the following information:

- A snapshot of the families they serve.
- Changes in protective factors.
- Areas where *Family Services Specialists* can focus on increasing individual family protective factors.

The PFS is not intended for individual assessment, placement, or diagnostic purposes. Agencies should rely on other instruments for clinical use. A one-page overview of the tool can be viewed at Protective Factors Survey Overview.

2.18.2 Kempe Family Stress Checklist

The Kempe Family Stress Checklist (FSC) is used by Healthy Families America® to assess strengths and needs of families who have been screened in for services and referred for the Healthy Families Program. The FSC can be administered by *Family Services Specialists* to identify a client's experiences, expectations, beliefs, and behaviors that place parents at risk of child abuse, neglect, and maltreatment. To complete an assessment using the ten (10) item checklist, a *Family Services Specialist* would meet face-to-face with the family, either prenatally or within two (2) weeks of the birth of their baby. The FSC covers the following of domains:

- Psychiatric history.

- Criminal and substance use disorder history.
- Childhood history of care.
- Emotional functioning.
- Attitudes towards and perception of child.
- Discipline of child.
- Level of stress in the parent's life.

2.18.3 Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ:SE-2™)

Ages & Stages Questionnaires: Social Emotional, Second Edition (ASQ:SE-2) is a low-cost developmental screening system made up of age-specific questionnaires completed by parents or primary caregivers of young children. The questionnaires can assist *Family Services Specialists* in identifying children at risk for social or emotional difficulties, identifying behaviors of concern to caregivers, and identifying any need for further assessment. Areas screened by the ASQ:SE-2 include the following:

- Self-regulation.
- Compliance.
- Social communication.
- Adaptive functioning.
- Autonomy, affect, and interaction with people.

2.18.4 Adult Adolescent Parenting Inventory (AAPI-2)

The Adult Adolescent Parenting Inventory (AAPI-2) is an inventory designed to assess the parenting and child rearing attitudes of adolescents and adult parent and pre-parent populations. Based on the known parenting and child rearing behaviors of abusive parents, responses to the inventory provide an index of risk for practicing behaviors known to be attributable to child abuse and neglect. The AAPI-2 is the revised and re-normed version of the original AAPI first developed in 1979. Responses to the AAPI-2 provide an index of risk in five (5) specific parenting and child rearing behaviors:

- Construct A – Expectations of Children.

- Construct B – Parental Empathy towards Children's Needs.
- Construct C – Use of Corporal Punishment.
- Construct D – Parent-Child Family Roles.
- Construct E – Children's Power and Independence.

2.18.5 A Measure of Family Well-being

The University of Georgia, Family and Consumer Sciences developed an outcome accountability tool for family support programs that was adapted from the Institute for Family Support and Development of MICA, Inc. The tool includes "A Measure of Family Well-being" comprised of four (4) sets of instruments that measure a client's perception of family well-being both before and after receiving services. The four (4) sets of instruments include the following:

- An Overall Assessment of My Family's Well-being.
- An Overall Assessment of Family Well-being (Educator Version).
- A Measure of Family Well-being (Educator Version).
- A Measure of My Family's Well-being.

The first and fourth sets of instruments are to be completed by the family member receiving services. The second and third sets of instruments, labeled "educator version" are to be completed by the *Family Services Specialist* who is best able to evaluate this family.

2.18.6 Social Skills Improvement System (SSIS)

The Social Skills Improvement System (SSIS) enables targeted assessment of individuals and small groups to help evaluate social skills, problem behaviors, and academic competence. Teacher, parent, and student forms help provide a comprehensive picture across school, home, and community settings. The multi-rater SSIS helps measure:

- Social Skills: Communication, Cooperation, Assertion, Responsibility, Empathy, Engagement, and Self-Control.
- Competing Problem Behaviors: Externalizing, Bullying, Hyperactivity/Inattention, Internalizing, and Autism Spectrum.

- Academic Competence: Reading Achievement, Math Achievement, and Motivation to Learn.

2.18.7 North Carolina Family Assessment Scale (NCFAS)

The North Carolina Family Assessment Scale (NCFAS) for General Services and Reunification (NCFAS-G+R) is a comprehensive family functioning and outcome measurement developed by providers, policy makers, and evaluators. It is used with families at the beginning of service provision and at the conclusion of services to measure change. The tool measures change in five domains: environment, parental capabilities, family interactions, family safety and child well-being.

The NCFAS-G+R examines family functioning in the following domains:

- Environment.
- Parental Capabilities.
- Family Interactions.
- Family Safety.
- Child Well-being.

The three (3) additional domains of the NCFAS-G (Social/Community Life, Self-Sufficiency, and Family Health) and the two (2) domains of the NCFAS-R (Caregiver/Child Ambivalence and Readiness for Reunification) is a combined scale that is intended for use by agencies that provide a wide variety of services for both intact and reunifying families.

2.18.8 Child Welfare Trauma Training Toolkit

The Child Welfare Trauma Training Toolkit is designed to teach basic knowledge, skills, and values about working with children who are in the child welfare system and who have experienced traumatic stress. It also teaches *Family Services Specialists* how to use this knowledge to support children's safety, permanency, and well-being through case analysis and corresponding interventions tailored for them and their biological and resource families. The toolkit was developed by the NCTSN, in collaboration with the following organizations:

- Rady Children's Hospital, Chadwick Center for Children and Families.
- Child and Family Policy Institute of California (CFPIC).
- California Social Work Education Center (CalSWEC).

- California Institute for Mental Health (CIMH).

2.18.9 Child Welfare Trauma Referral Tool

A comprehensive resource for trauma screening and initial assessment is the Child Welfare Trauma Referral Tool (CWT). This tool is designed to help *Family Services Specialists* make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. It is to be completed by the *Family Services Specialist* through record review and key informants (i.e., natural parent, foster parent, child therapist, school-aged children or adolescents if appropriate, and other significant individuals in the child's life). The CWT includes a referral flowchart and referral guidelines for making recommendations to trauma-specific or general mental health services by linking the child's experiences to their reactions. The tool also includes definitions of different trauma and loss exposure history categories.

2.18.10 Adverse Childhood Experience (ACE) Questionnaire

The Adverse Childhood Experience (ACE) Study conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente from 1995 to 1997, examined the effect of ten (10) categories of negative experiences in childhood on more than 17,000 participants. The ACE study found that adverse childhood experiences are strongly correlated with:

- Chronic illness – including heart disease, diabetes, and depression.
- Premature death.
- Economic strain on the economy.

These adverse childhood experiences also result in social, emotional, and cognitive impairment, are linked to higher risks for medical conditions (e.g., heart disease, severe obesity, chronic obstructive pulmonary disease (COPD)) and higher risk for substance use disorder, depression, and suicide attempts.

The ACE Questionnaire uses a simple scoring method to determine the extent of each individual's exposure to the following categories of childhood trauma, prior to 18 years of age:

- Recurrent physical abuse.
- Recurrent emotional abuse.
- Contact sexual abuse.
- An alcohol or drug abuser in the household.

- An incarcerated household member.
- Family member who is chronically depressed, mentally ill, institutionalized, or suicidal.
- Mother is treated violently.
- One (1) or no parents.
- Physical neglect.
- Emotional neglect.

Administration of the ACE questionnaire provides a snapshot of the extent of adverse childhood experiences, which in turn can provide an opportunity to talk with clients about their trauma histories and how they can reduce ACE scores for their children. The questionnaire can be used as a screening tool that informs treatment and service interventions. ACE findings are a complement to other tools *Family Services Specialists* use to understand what is working for different populations with whom they serve.

2.19 Appendix D: Online resources for information and funding

The resources below are listed alphabetically by content area. Within each content area there is a combination of national, state, and local resources. Content areas include the following:

Attachment.

Child abuse and neglect (national).

Child abuse and neglect (state).

Child care.

Data and statistical.

Evidence-based clearinghouses.

Evidence-based programs.

Evidence-based tools.

Funding.

Protective factors.

Publications.

Strengthening families.

Trauma.

2.19.1 Attachment

Association for the Treatment and Training in the Attachment of Children (ATTACh): An international coalition of professionals and families dedicated to helping those with attachment difficulties by sharing our knowledge, talents, and resources.

Attachment Parenting International (API): Promotes parenting practices that create strong, healthy emotional bonds between children and their parents.

2.19.2 Child abuse and neglect prevention (National)

Annie E. Casey Foundation: The primary mission of the Annie E. Casey Foundation is to foster public policies, human-service reforms, and community supports that more effectively meet the needs of today's vulnerable children and families. In pursuit of this goal, the Foundation makes grants that help states, cities, and neighborhoods fashion more innovative, cost-effective responses to these needs.

Child Welfare Information Gateway: Child Welfare Information Gateway promotes the safety, permanency, and well-being of children, youth, and families by connecting child welfare, adoption, and related professionals as well as the general public to information, resources, and tools covering topics on child welfare, child abuse and neglect, out-of-home care, adoption, and more.

Children's Bureau: works with State and local agencies to develop programs that focus on preventing the abuse of children in troubled families, protecting children from abuse, and finding permanent placements for those who cannot safely return to their homes.

FRIENDS (Family Resource Information, Education, and Network Development Service) - National Center for Community-Based Child Abuse Prevention.

Healthy Families America: Evidence-based, nationally recognized home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences.

National Alliance of Children's Trust and Prevention Funds (Alliance): Membership organization that provides training, technical assistance, and peer consulting opportunities to state Children's Trust and Prevention Funds and strengthens their efforts to prevent child abuse.

National Child Support Enforcement Association (NCSEA): Serves child support professionals, agencies, and strategic partners worldwide through professional development, communications, public awareness, and advocacy to enhance the financial, medical, and emotional support that parents provide for their children.

National Survey of Child and Adolescent Well-Being (NSCAW): Nationally representative, longitudinal survey of children and families who have been the subjects of investigation by Child Protective Services.

Prevent Child Abuse America: Provides leadership to promote and implement prevention efforts at both the national and local levels.

2.19.3 Child Abuse and Neglect (State)

Casey Family Programs: Works in all 50 states, the District of Columbia and Puerto Rico to influence long-lasting improvements to the safety and success of children, families, and the communities where they live. This resource offers an extensive library of child welfare research, best practices, and policy tools.

Virginia Children's Advocacy Organization (CAC): Membership organization dedicated to helping local communities respond to allegations of child abuse and neglect in ways that are effective and efficient and put the needs of children first- provides training, support, technical assistance, and leadership on a statewide level to local children's and child advocacy centers and communities throughout Virginia.

Children's Trust Roanoke Valley: Provides parent education to new or inexperienced parents, high risk parents experiencing homelessness or drug and alcohol abuse treatment, and teen parents and expectant teen parents living in the greater Roanoke Valley.

Family and Children's Trust Fund (FACT) of Virginia: Works to prevent and treat family violence in Virginia. Family violence includes child abuse and neglect, domestic violence, dating violence, sexual assault, and elder abuse and neglect.

Greater Richmond SCAN (Stop Child Abuse Now): local nonprofit organization dedicated solely to the prevention and treatment of child abuse and neglect in the Greater Richmond area.

Families Forward Virginia: Statewide, nonprofit, non-partisan organization that works to prevent child abuse and neglect by valuing children, strengthening families, and engaging communities.

SCAN of Northern Virginia: Non-profit organization whose mission is to promote the well-being of children, improve parent-child relations and prevent child abuse and neglect.

Champions For Children: Prevent Child Abuse Hampton Roads: A 501 (c) 3 organization that has served the Hampton Roads region since 1983 in the quest to prevent child abuse and neglect. Champions For Children focuses its efforts and resources on public awareness, education, and advocacy for the prevention of all forms of child abuse and neglect.

Voices for Virginia's Children: Statewide, privately funded, non-partisan awareness and advocacy organization that builds support for practical public policies to improve the lives of children.

2.19.4 Child care

Child Care Aware® of Virginia: Community-based network of early care and education specialists whose purpose is to deliver services to families, child care professionals and communities to increase the accessibility, availability and quality of child care in Virginia.

2.19.5 Children and youth programs

Boys & Girls Clubs of America: National organization of local chapters which provide after-school programs for young people.

Commission on Youth: Bi-partisan legislative commission of the General Assembly which provides a legislative forum in which complex issues related to youth and their families can be explored and resolved.

Incredible Years: Evidence-based programs and materials that develop positive parent-teacher-child relationships and assist in preventing and treating behavior problems and promoting social, emotional, and academic competence before a child becomes an adult.

STRYVE (Striving To Reduce Youth Violence Everywhere): National initiative led by the Centers for Disease Control and Prevention (CDC) to prevent youth violence. STRYVE works to increase public health leadership to prevent youth violence; promote the widespread adoption of youth violence prevention strategies based on the best available evidence; and reduce the rates of youth violence on a national scale.

Virginia High School League (VHSL): An alliance of Virginia's public and approved non-boarding, non-public high schools that promotes education, leadership, sportsmanship, character, and citizenship for students by establishing and maintaining high standards for school activities and competitions.

Virginia RULES: Virginia’s state-specific law-related education program for middle and high school students. The purpose of Virginia Rules is to educate young Virginians about Virginia laws and help them develop skills needed to make sound decisions, to avoid breaking laws, and to become active citizens of their schools and communities.

Youth.gov: Youth.gov (formerly FindYouthInfo.gov) was created by the Interagency Working Group on Youth Programs (IWGYP), which is composed of representatives from 19 federal agencies that support programs and services focusing on youth.

2.19.6 Court services

Court Appointed Special Advocate Program (CASA) - Virginia: CASA is the Court Appointed Special Advocate Program. CASA is a child advocacy organization that seeks to provide trained volunteers to speak for abused and neglected children who are the subjects of juvenile court proceedings. CASA volunteers advocate for safe, permanent homes for children.

Virginia State Bar - Virginia Lawyer Referral Service (VLRS): Quickly and efficiently supports procurement of legal services, encourages preventive law, and furthers the education of the public to the legal profession by connecting qualified, competent, fully licensed practitioners in specific areas of need with members of the public with legal challenges; businesses; and other licensed practitioners.

2.19.7 Data and other statistical information

Casey Family Programs: Works in all 50 states, the District of Columbia and Puerto Rico to influence long-lasting improvements to the safety and success of children, families, and the communities where they live. Offers an extensive library of child welfare research, best practices, and policy tools.

Child Abuse and Neglect Statistics – Child Welfare Information Gateway: These resources present statistics and data on the different types of abuse and neglect as well as the abuse and neglect of children with disabilities, abuse and neglect in out-of-home care, recurrence, and fatalities.

Child Trends: Nonprofit, nonpartisan research center that studies children at all stages of development.

Census Data – Children's Defense Fund (CDF): CDF is affiliated with the United States Bureau of the Census as a Census Information Center for data on children and families. In this role, CDF analyzes and disseminates Census data in a variety of formats to concerned citizens, advocates, policy makers and the media.

Family and Children's Trust Fund (FACT) of Virginia – FACT Data Portal: Repository for data on family violence across Virginia.

KIDS COUNT Data Center – Voices for Virginia's Children: Serves as a powerful tool for viewing and comparing statewide and locality-level data on demographics, employment and income, public assistance, poverty, housing, test scores, and more.

National Data Archive on Child Abuse and Neglect (NDACAN): Aims at facilitating the secondary analysis of research data relevant to the study of child abuse and neglect and seeks to provide an accessible and scientifically productive means for researchers to explore important issues in the child maltreatment field.

National Fatherhood Initiative's Father Facts: The latest statistics on families and fatherhood.

Supplemental Nutrition Assistance Program (SNAP): Program participation and activity in Virginia.

Virginia - State Agency Planning & Performance Measures: Shows how Virginia is doing in areas that effect quality of life for people and their families.

2.19.8 Evidence-based clearinghouses

Blueprints for Healthy Youth Development: Identifies evidence-based positive youth development prevention and intervention programs.

California Evidence-Based Clearinghouse for Child Welfare (CEBC): Seeks to advance the effective implementation of evidence-based practices for children and families involved with the child welfare system.

Centers for Disease Control and Prevention (CDC) – Division of Violence Prevention: Seeks to prevent injuries and deaths caused by violence. The site includes evidence-based programs to stop child maltreatment.

Community Preventive Services Task Force (Task Force): Established in 1996 by the U.S. Department of Health and Human Services to identify population health interventions that are scientifically proven to save lives, increase lifespans, and improve quality of life. The Task Force produces recommendations (and identifies evidence gaps) to help inform the decision-making of federal, state, and local health departments, other government agencies, communities, healthcare providers, employers, schools, and research organizations.

FRIENDS, the National Center for Community-Based Child Abuse Prevention (CBCAP): Provides training and technical assistance to federally funded CBCAP Programs. FRIENDS serves as a resource to those programs and to the rest of the Child Abuse Prevention community.

National Registry of Evidence-based Programs and Practices (NREPP): Supplies a searchable online registry of mental health and substance use disorder interventions that have been assessed and rated by independent reviewers.

Office of Juvenile Justice and Delinquency Prevention (OJJDP): Collaborates with professionals from diverse disciplines to improve juvenile justice policies and practices.

Promising Practices Network (PPN): Resource that offers credible, research-based information on what works to improve the lives of children and families.

Title IV- E Prevention Services Clearinghouse: Developed in accordance with the Family First Prevention Services Act (FFPSA) as codified in Title IV-E of the Social Security Act, rates programs and services as well-supported, supported, promising, or does not currently meet criteria.

Virginia Commission on Youth's Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs (Collection): The 2002 General Assembly, through Senate Joint Resolution 99, directed the Virginia Commission on Youth to coordinate the collection of treatments recognized as effective for children and adolescents, including juvenile offenders, with mental health disorders. The resulting publication, the Collection, was compiled by the Commission on Youth with the assistance of an advisory group of experts.

2.19.9 Education

Early Childhood Special Education: Early Childhood Special Education (Part B of IDEA) and Early Intervention (Part C of IDEA), in Virginia, provide services for children from birth to kindergarten age who qualify according to state and federal law. All localities in the state have services available for children in this age group who are eligible.

Project HOPE - Virginia: Virginia's Program for the Education of Homeless Children and Youth, is a federally funded grant authorized by the McKinney-Vento Homeless Education Assistance Program. Project HOPE ensures the enrollment, attendance, and the success of homeless children and youth in school through public awareness efforts across the commonwealth and sub-grants to local school divisions.

The Family Engagement for High School Success Toolkit: Designed to support at-risk high school students by engaging families, schools, and the community. Created in a joint effort by United Way Worldwide (UWW) and Harvard Family Research Project (HFRP) as part of the Family Engagement for High School Success (FEHS) initiative.

Virginia Department of Education (VDOE): The mission of Virginia's public education system is to educate students in the fundamental knowledge and academic subjects that they need to become capable, responsible, and self-reliant citizens. Therefore, the mission of the Virginia Board of Education and the superintendent of public instruction, in cooperation with local school boards, is to increase student learning and academic achievement.

Virginia Head Start Association, Inc.: Head Start is a national child development program for children from birth to age 5, which provides services to promote academic, social, and emotional development for income-eligible families.

2.19.10 Family supports and services

Early Impact Virginia (EIV) (formerly Virginia Home Visiting Consortium): A collaboration of statewide early childhood home visiting programs that serve families of children from pregnancy through five (5) years of age.

Healthy Families America (HFA): Nationally recognized evidence-based home visiting program model designed for parents facing challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or previous issues related to substance use disorder, mental health issues, or domestic violence.

Infant & Toddler Connection of Virginia: Provides early intervention supports and services to infants and toddlers from birth through age two (2) who are not developing as expected or who have a medical condition that can delay normal development.

2.19.11 Fatherhood

National Fatherhood Initiative (NFI): Seeks to transform organizations and communities by equipping them to intentionally and proactively engage fathers in their children's lives.

Nurturing Fathers Program (NFP): An evidence-based, 13-week training course designed to teach parenting and nurturing skills to men. Each 2 ½ hour class provides proven, effective skills for healthy family relationships and child development.

2.19.12 Funding

eVA - Virginia's eProcurement Portal: Virginia's online, electronic procurement system where VDSS grant opportunities are posted.

Children's Services Act (CSA) - Commonwealth of Virginia: Establishes a single state pool of funds to purchase services for at- risk youth and their families. The state funds, combined with local community funds, are managed by local interagency teams who plan and oversee services to youth.

Promoting Safe and Stable Families Program (PSSF): Designed to assist children and families resolve crises, connect with necessary and appropriate services, and remain safely together in their own homes whenever possible.

2.19.13 Mental and behavioral health

Mental Health America (MHA): National community-based nonprofit dedicated to helping Americans achieve wellness by living mentally healthier lives. MHA's work is driven by a commitment to promote mental health as a critical part of overall wellness, including prevention for all, early identification and intervention for those at risk,

integrated health, behavioral health, and other services for those who need them, and recovery as a goal.

National Alliance on Mental Illness (NAMI): Nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

National Institute of Mental Health – Child and Adolescent Mental Health: Lead federal agency for research on child and adolescent mental disorders. The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.

Substance Abuse and Mental Health Services Administration (SAMHSA): Agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance use disorder and mental illness on America's communities.

The ARC of Virginia: Promotes and protects the human rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes.

Virginia Association of Community Services Boards (VACSB): Represents Virginia's Community Services Boards and Behavioral Health Authorities who provide mental health, intellectual disability, and substance use disorder services management and delivery in Virginia's communities.

Virginia Department of Behavioral Health & Developmental Services (DBHDS): Virginia's public mental health, intellectual disability, and substance use disorder services system is comprised of 16 state facilities and 40 locally run community services boards. The CSBs and facilities serve children and adults who have or who are at risk of mental illness, serious emotional disturbance, intellectual disabilities, or substance use disorder disorders.

Virginia Department for Aging and Rehabilitative Services (DARS): DARS, in collaboration with community partners, provides and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.

2.19.14 Parent education and support

Circle of Parents®: Circle of Parents is a national network of parent leaders, statewide and metropolitan regional non-profit organizations dedicated to using a peer-to-peer, self-help model of parent support to carry out their mission of preventing child abuse and neglect and strengthening families.

National Resource Center for Healthy Marriage and Families: NHMRC is a clearinghouse for high quality, balanced, and timely information and resources on healthy marriage. The NHMRC's mission is to be a first stop for information, resources, and training on healthy marriage for experts, researchers, policymakers, media, marriage educators, couples and individuals, program providers, and others.

NewFound Families Virginia: Non-profit membership organization whose mission is to provide a united voice of families caring for children and youth living in foster, adoptive, and kinship homes so that families and children receive the support and services they need. NewFound Families Virginia provides educational, advocacy, and support services to families caring for children unable to live with their birth parents.

Nurturing Parenting Programs®: A family-centered trauma-informed initiative designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices. The long-term goals are to prevent recidivism in families receiving social services, lower the rate of multi-parent teenage pregnancies, reduce the rate of juvenile delinquency and alcohol abuse, and stop the intergenerational cycle of child abuse by teaching positive parenting behaviors.

Parent Educational Advocacy Training Center (PEATC): PEATC builds positive futures for Virginia's children by working collaboratively with families, schools, and communities in order to improve opportunities for excellence in education and success in school and community life – with a special focus on children with disabilities.

Parent Resource Centers – Virginia: Virginia's Parent Resource Centers are committed to a positive relationship between parents and schools for students' sake. PRCs assist parents with questions and planning, as well as provide resources and training sessions.

Virginia Division for the Aging (VDA): The Virginia Division for the Aging (VDA) works with 25 local Area Agencies on Aging (AAAs) as well as various other public and private organizations to help older Virginians, their families and loved ones find the service and information they need. The Division is a central point of contact for information and services.

Virginia Cooperative Extension: An educational outreach program of Virginia's land-grant universities: Virginia Tech and Virginia State University, and a part of the National Institute for Food and Agriculture, an agency of the United States Department of Agriculture. Building local relationships and collaborative partnerships, we help people put scientific knowledge to work through learning experiences that improve economic, environmental, and social well-being.

2.19.15 Protective Factors

Prevention Resource Guide: A guide for preventing child maltreatment and promoting child well-being that includes guidelines for working with families around the protective factors and tips for parents to increase protective factors.

Strengthening Families™ Protective Factors Framework: An online training course that provides a basic overview of how the protective factors can be incorporated into prevention work.

2.19.16 Publications

Center for the Study of Social Policy (CSSP): Publications, documents, and other resources that have helped stimulate new directions and guide planning and implementation work from the ground to the policy level.

Child Welfare Information Gateway: Provides access to print and electronic publications, website, databases, and online learning tools for improving child welfare practice.

2.19.17 Strengthening families

Center for the Study of Social Policy (CSSP): Works to secure equal opportunities and better futures for all children and families by improving public policies, systems, and communities by building protective factors, reducing risk factors, and creating opportunities that contribute to well-being and economic success.

Child Welfare Information Gateway: Connects child welfare and related professionals to comprehensive information and resources to help protect children and strengthen families.

2.19.18 Trauma

ACEs Connection: Social network that accelerates the global movement toward recognizing the impact of adverse childhood experiences in shaping adult behavior and health and reforming all communities and institutions -- from schools to prisons to hospitals and churches – to help heal and develop resilience rather than to continue to traumatize already traumatized people.

Child Welfare Information Gateway: Resources and information on trauma experienced by children who have been abused, neglected, and separated from their families; secondary trauma experienced by child welfare workers; and mental health issues in child welfare during traumas and disasters.

National Child Traumatic Stress Network (NCTSN): Focused on raising the standard of care and improving access to services for traumatized children, their families, and communities throughout the United States. Also includes the Child Welfare Trauma Training Toolkit, which presents a summary of the research on the impact of trauma.

Virginia HEALS: A model of service delivery that that has been developed to assist service providers in better linking systems of care and providing support and care to children, youth, and families impacted by trauma and/or victimization. This model, and the toolkit which supports it, is intended to be adopted and implemented at the community level by child, youth, and family serving organizations and service providers from child welfare, advocacy, education, juvenile justice, behavioral health, and public health.