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PART IV: FAMILY ASSESSMENT AND INVESTIGATION

**SUGGESTED PRACTICES WHEN AUDIO TAPING AN INTERVIEW WITH A CHILD:
INCLUDING STORAGE, RETENTION, DUPLICATION AND EDITING AUDIO TAPES**

1.0 CPS Worker's Immediate Objectives

In order to accomplish the task of audio taping, the worker should always remember to be patient, observant, flexible and a good listener during the interview with a child. In conducting an audio taped interview with a victim child, the following goals may be met:

- a. Minimize trauma to the child
- b. Maximize the amount and quality of the information obtained while minimizing any contamination of that information
- c. Maintain the integrity of the investigation process for the agencies involved.

2.0 General Operating Procedure & Equipment

The worker, before each interview with the subject child, should ensure the audio taping equipment is in operating order.

- a. A new tape is to be used for each incident investigated.
- b. The worker may record more than one interview with the subject child on the tape; however, care needs to be taken to leave sufficient space between each interview.
- c. If the investigation involves more than one child, each child shall have his own tape. Each tape should be labeled and identified by the child's name, the date of the complaint, complaint number, the worker's name, location of the interview, and show the dates of all interviews included on the tape.
- d. Whenever possible, the worker should note the location on the tape of information related to identification of the complainant. This can be done by looking at the number on the tape counter on the tape recorder.

3.0 Pre-Interview Information Gathering

Prior to conducting the interview, the worker should gain as much information about the child and the alleged incident as possible. The worker should know the child's age, verbal skills, developmental level, and vocabulary. For example, if the allegation is

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sexual abuse, the worker should know if the child has any prior founded reports of sexual abuse and what are the names the child uses to describe body parts. Never assume that you know what a child means by the use of a particular word. Always ask if the meaning is not obvious. Make certain that you are using words and concepts which the child understands.

1.0 Location of Interview

Determine the location of the interview. It is preferable to interview the child in a neutral setting that provides privacy and no inward or outward stimuli or cause for interruption. However, there may be no opportunity when dealing with an emergency situation to have all these elements in place. Should the worker be faced with this, every effort should be made to incorporate as many of the above elements as possible.

2.0 Prepare Questions

Given the time allowed, the worker should plan the interview and write down some of the questions that he/she wants to ask the child.

3.0 Who may be Present for the Interview

- a. The worker has the authority to determine who is to be present during the interview.
- b. If an interview room is equipped with a two-way mirror or a video monitor, the worker may permit a parent, guardian, or therapist to observe the interview. Be sure that support is given to the parent(s) observing the interview.
- c. If the worker is investigating with a law enforcement officer, a decision should be made prior to conducting the interview who will be the lead interviewer. The person not interviewing may, instead, operate the tape recorder.
- d. It is preferable if a joint investigation is no being conducted, that only the child and the worker be present at the interview; however, should the child's comfort depend on another person being present in the room during the interview, the worker should impress on the person the importance of not interfering with the interview.

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- e. All persons observing the interview should remain silent. Observers present in the room should be seated out of the visual site of the child. Observers be advised that they may hear information that could illicit a non-verbal reaction and that it is essential they show no reaction at all as it could contaminate the interview.

7.0 The Interviewing Worker Needs to be Aware of Circumstances

- a. The CPS worker should also be aware of their own reactions.
- b. The CPS worker should always be aware of the child's physical needs and capabilities such as:
 - (1) Attention span
 - (2) Nutritional requirements
 - (3) Body functions

For example, do not try to conduct the interview with a young child when they would normally nap or when it is time for them to eat.

- c. It is okay to allow the young child to draw, play with a toy, move about the room, etc. while the interview occurs.
- d. The CPS worker should always keep in mind that this is a fact finding interview not a therapeutic one, yet that does not mean the investigative interview needs to be a traumatic experience.

8.0 Beginning the Recording of the Interview

- a. After the recording device has been turned on, the interviewer should state the date, time, location, and names of those present in the room.
- b. The CPS worker should explain his/her role to the child and the role of anyone else present in the room and state the purpose of the interview.
- c. The worker should then engage the child in general conversation asking him to state his name and age. The worker may ask the child to talk about his favorite subject in school, a favorite hobby, or how they like to spend their free time. Have him describe a favorite event, i.e., last birthday or special trip. Here is where it is important to be flexible and know the child you are interviewing. For instance, if you are interviewing an older child, they may want to minimize this stage and get straight into the discussion of the allegation.

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9.0 General Interviewing Questions & Techniques

- a. If I misunderstand something you say, please tell me. I want to know. I want to get it right.
- b. If you don't understand something I say, please tell me and I will try again.
- c. If you feel uncomfortable at any time, please tell me or show me the stop sign (determine what that is to be).
- d. Even if you think I already know something, please tell me anyway.
- e. If you are not sure about an answer, please do not guess. Tell me you're not sure before you say it.
- f. Please remember when you are describing something to me that I was not there when it happened. The more you can tell me about what happened, the more I will understand what happened.
- g. Please remember that I will not get angry or upset with you.
- h. Only talk about things that are true and really happened.
- i. Stress that you, the interviewer, will follow these rules.

10.0 Determine the Child's Capacity for Truthfulness

The worker needs to determine the child's concept of telling the truth and lies. The worker should ask the child to describe the meaning of truth and the consequences of telling lies. If the child clearly does not have the concepts of truths and lies, the worker should continue the interview, but with caution.

11.0 Initiate Free Narrative

Introduce the topic of concern asking open-ended questions allowing the child to talk in a free narrative. Allow the child to go at their own pace. Do not interrupt the child. The child may be prompted by the worker by asking: "What happened next?" or "You were saying—relate the last thing they were saying." Do not interrupt the child no matter how verbose or inconsistent the story.

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12.0 Ask Open-Ended Questions

After the child has exhausted his/her free narrative for one incident the worker may begin to ask open-ended questions. This will enable the worker to assist the child in recalling more details. If the child discloses a new incident, the worker should again allow the child to talk in the free narrative style about the new incident. Then begin the process of the open-ended questions again. An example of an open-ended question is: Do you remember any more about the time it happened in the kitchen?

When the worker is asking open questions, it is absolutely imperative that the child knows that, "I don't remember" is an acceptable answer.

13.0 Keep Track of Multiple Incidents or Allegations

Should the child disclose several incidents of abuse the worker may want to label them so that the worker can refer the child back to them in order to get more detail. (Labeling incidents should become readily apparent for example where the incident occurred may provide a label, i.e., the kitchen incident or the park incident.)

14.0 Use Specific Questions

The CPS worker may use specific questions. This would clarify and extend previous answers. This form of questioning is used when previous types of questioning has not resulted in getting sufficient information to assess the credibility of the allegations.

15.0 Avoid Multiple Choice Questions

The CPS worker should avoid multiple choice questions, but if you must use this type of question, include more than two choices. For example, did the park incident happen in the fall, winter, spring, or summer?

16.0 Avoid Using Other Sources When Asking Questions

The CPS worker should never include information he/she has obtained from another source. For example, do not begin a question with, "I understand from your mother that your Uncle Sam took some pictures of you." If you have been informed that the child was photographed, yet that information has not been forthcoming in the child's free narrative or during open questioning, you may ask, "Do you remember anything about some pictures?"

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17.0 Address Inconsistencies Toward End of Interview

The CPS worker should address any inconsistencies in the child's statement toward the end of the interview. This is an area of questioning that should be approached cautiously and gently. If the child displayed language and/or knowledge that seems inappropriate for their age, this would be the time to determine where the child learned that knowledge of those words.

18.0 Ending the Interview

The worker should ask the child if he/she has any questions. The worker should explain to the child what will happen next in the investigation process.

19.0 Storing Audio Tapes

- a. Once the audio tape has been made, the worker should ensure it is properly labeled, as indicated earlier, then place the tape in an envelope, label the envelope with the case name, seal the envelope, and secure it to the case record.
- b. Tapes are to be stored in the case record for the same length of time as CPS policy requires for other case documentation. For example, in unfounded cases, tapes must be retained for one year from the complaint date. Tapes are required to be retained for longer periods in founded cases. (Level 3 – three years, Level 2 – seven years, and Level 1 – 18 years).

20.0 Who Can Receive Copies of the Taped Interviews?

- a. Interviews with the victim child can only be released during the appeals process. If a copy of the audio tape is needed, based on CPS policy governing the release of information during the appeal process, it must be determined if any statutorily protected information is contained on the tape. If so, a duplicate tape will be needed. (The original tape must never be redacted.) Identification of the area(s) to be edited, indicated by tape counter number(s), must be provided to the entity copying the tape. As an option, the local department may wish to type a transcript of the tape. This is not a requirement, however.
- b. Audio taped interviews with the alleged abuser can be duplicated by the local department by playing the audio tape on one tape recorder while recording the tape on a second tape recorder. Local departments also have the option of typing a transcript of the interview.

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21.0 Redacting/Editing Sensitive Information from a Tape

The Department is investigating the option of entering into a contract with a professional service to copy and/or redact (edit) audio tapes. Should this occur, procedures will be developed and distributed to all local agencies. Until that time, the local agency is responsible for the editing of duplicate tapes. The original tape must never be edited.

The worker is the most knowledgeable about the content of the tape and is therefore the most logical individual to edit the duplicate tape.

22.0 Reuse of Audio Tapes

Audio tapes are never to be reused. This would potentially compromise the tape being reused by possibly having the earlier interview “bleed through” on the next interview. It would also pose a privacy protection issue by having confidential tapes available for further use.

23.0 Destruction of Used Tapes

Once the length of time has passed for retaining the case record, from one to 18 years, depending on the disposition of the investigation, the audio tape(s) must be destroyed. A tape eraser box will be provided to each agency in order for tapes to be erased. Once erased, the tape cassettes should be broken, or the tape cut in order to ensure the complete eradication of information on the tape. Some tape recorders have an ‘erase’ feature that will void the information on the tape. This should be tested, however, to ensure it is actually erasing the tape.

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How To Proceed With Investigation When Initial Entry Into The Home Is Denied

1.0 Authority The worker has the authority to enter the home if permitted to enter by a person who resides in the home.

2.0 Alleviate Fear, Anxiety, Anger

The CPS worker should try to alleviate the fear and anxiety of the occupant, and/or defuse any anger. It is not appropriate to engage in a power struggle.

3.0 Alternatives to Immediate Entry

Should the CPS worker be denied entry, the CPS worker has several options:

- a. The CPS worker may suggest the occupant speak with them on the porch, deck, or in the yard, or even through the door, while at the same time acknowledging the feelings of the occupant (anger, fear, suspicion) in his reluctance to allow entry.
- b. The CPS worker may explain the law and the parameter of their responsibilities and mandates, and ask the occupant how the CPS worker may alleviate the skepticism or fear of the occupant so that then or in the future the CPS worker may be allowed to enter.
- c. The CPS worker may invite the occupant and any person of his choice (including an attorney) to meet with him first at the local DSS office, to further explain the CPS system.
- d. The CPS worker may suggest a first meeting at a neutral spot, such as a local fast-food restaurant, or other public place.
- e. The CPS worker may suggest a first meeting at a friend or family member's home, or a meeting in the occupant's home when a friend, neighbor or family member is present.
- f. The CPS worker may suggest mediation with the occupant to negotiate entry.
- g. The CPS worker may contact his supervisor for direction.
- h. The CPS worker may follow-up a denial of entry with a letter citing the Virginia Code responsibilities.

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**GUIDELINES FOR INVESTIGATIONS WHERE CHILDREN ARE ALLEGED TO BE PRESENT
DURING THE SALE OR MANUFACTURE OF DRUGS**

The intent of adding a clause to the definition of physical abuse, which was enacted by the General Assembly 2004, is to give recognition to the danger for children when a caretaker exposes the child to the manufacture or sale of drugs. The additional language in the definition references Schedule I & II controlled substances, which include, but are not limited to heroin, cocaine, and methamphetamines. Appendix A-11 provides a copy of Schedules I & II.

There is reason to be concerned about both the safety of the child and the CPS worker when there is the possibility that a “meth lab” is on the premises. The vapors may attack mucous membranes and some chemicals may react with water or other chemicals to cause a fire or explosion.

Since these situations may be dangerous, it is imperative that the local department of social services collaborate with local law enforcement and emergency services. CPS should not be the first on the scene if there is reason to believe someone may be manufacturing drugs on the premises. The following is a sample protocol developed by a locality in North Carolina that has experienced a large number of “meth lab” situations. It is offered for your consideration in developing your own local protocol.

**Response Protocol For Children Found In Clandestine Drug Lab Situations
Adopted by the Watauga County (North Carolina) Drug Endangered Child
Program on April 2, 2004**

1. In the event that a Clandestine Lab is about to be raided and there is a possibility of children in the residence law-enforcement will contact the Watauga County Department of Social Services to begin preparations for responding to the scene if children are found.
2. Watauga County DSS will place two social workers on standby prepared to respond to the scene if a lab is found and children are present.
3. After law-enforcement verifies a lab is found in a residence and children are present they will then contact Watauga County DSS to respond to the scene. Watauga County DSS will respond immediately.
4. Watauga County DSS will contact the Watauga County Fire Marshal's Office to report to the scene to assist in assessing for the need of on-site decontamination of the children.
5. The Watauga County Fire Marshal and Watauga County DSS will determine if decontamination on scene is needed by using The Decontamination Field Assessment.

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- 5A. If decontamination is needed on the scene for the children the Watauga County Fire Marshal will coordinate the needed procedures based on where the scene is in the county.
6. If decontamination is needed on scene and possibly if not needed Watauga County DSS will provide a change of clothes for the child.
7. Watauga County DSS will make a determination of whether a child needs to be placed into protective custody or if a placement with a safety agreement can be used.
- 7A. Placement in the home where a lab was found cannot occur under any circumstance until the home is cleaned, tested, and decontaminated using State prepared guidelines.
- 7B. The child will not be allowed to have contact with any item that was in the home where a meth lab was found due to contamination concerns.
8. After decontamination has been assessed or done the child will be transported to Watauga Medical Center for evaluation. Watauga County Medical Center requires decontamination at the emergency room prior to the child entering the hospital. Transportation will be provided either by Watauga County DSS, relative, or EMS (if there is a medical concern). The transportation concern will be assessed on a case-by-case basis.
- 8A. If the child is located at the scene and has been in the home within the past 72 hours or is displaying medical concerns the child does need to be taken to Watauga Medical Center for first or secondary decontamination and evaluation.
- 8B. If the child has not been in the home where the meth lab was located within the past 72 hours the child can be taken to their pediatrician for evaluation. 8B would be used in cases where the child was not found at the scene but was known to be living there and cases where the child has been out of the home for 72 hours. Also, 8B would be used in cases where children were found to be in the home with the lab but were unknown at the time the meth lab was found and 72 hours is passed.
- 8C. Someone with legal custody must be present at the emergency room or pediatrician office to sign for medical checks to be done. If parents are arrested then DSS may have to take custody to authorize medical evaluations.
9. Watauga County DSS will provide the physician at the Medical Center being used with a copy of the Medical Protocol developed by the Drug Endangered Child Program.
- 9A. Social Workers will need to make sure they get a copy of the Medical Protocol back after evaluations have completed. With each test that has been completed document the form. This is done so that social workers can provide information at the follow-up evaluations as to what testing was done for comparison data.
- 9B. All drug testing evidence will follow the chain of custody between physician/medical office and the drug testing lab they use.

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10. After the child is released from the medical center the following steps will take place:

10A. If DSS is not taking custody and using a Safety Plan a social worker will need to go to the placement resource and conduct the Kinship Care Assessment before allowing the child to stay there. This will also be done if DSS takes custody and places the child with a relative. Social Workers will explain to the foster placement all of the details as to what the child has been through. Social Workers will also explain all the items that will be taking place in the future

10B. If D.S.S. takes custody of the child and is not using a relative placement the foster placement will be decided at this time. Social Workers will explain to the foster placement all of the details as to what the child has been through. Social Workers will also explain all the items that will be taking place in the future.

11. Watauga County Department of Social Services accepts all cases where children are alleged to be in homes with meth labs as abuse. As soon as possible Watauga County DSS will submit written notification to the District Attorney a report of abuse.

12. Other steps that will be taken are:

- All the child's belongings will be replaced to protect from repeated contamination.
- The child will receive counseling services either through Individual Counseling, Family Counseling, or Family Preservation. Determination of which or all of the services to be used will be made on a case-by-case basis.
- The parents involved in meth lab production with their children present will take part in a Meth Lab Hazard Training provided by the Watauga County Fire Marshal. This needs to be done prior to any Substance Abuse Assessment.
- The parents will be required whether they are incarcerated or not to take part in a complete Substance Abuse Evaluation and follow all recommendations. If possible it is preferred that there be A Family Substance Abuse Assessment that includes the children. Use of the Family Substance Abuse Assessment will be determined based on relationship between child and parent and age of the child.
- Parents will have to take part in drug screens at DSS request and at the Substance Abuse Treatment provider's request.
- Children age 3 and under will need to have Developmental Evaluations performed.
- The child will need a follow-up medical evaluation at or around 30 days from the initial evaluation that was completed. At this evaluation hair samples will be taken if urine screens were negative at the initial medical evaluation.

Members of the response Team:

Watauga County Department of Social Services
Watauga County Sheriff's Department
New River Behavioral Health Care Substance Abuse Services
New River Behavioral Health Care Family Preservation
Watauga County Schools
The Watauga County Developmental Evaluation Center
New River Behavioral Health Care PACT Program
Blue Ridge Pediatric Clinic

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Northwestern Housing HUD
Watauga County Office of Juvenile Justice
Watauga County Fire Marshal
Mountain Times Newspaper
Watauga County District Attorney's Office
Watauga County Medical Center Emergency Room Staff
Watauga County Medical Center Infectious Disease Control
Watauga County EMS
Watauga County Health Department Early Childhood Intervention
Watauga County Health Department of Environmental Sciences
The Guardian ad Litem Program
Watauga County Foster Parents Representatives
Forensic Toxicologist Dr. Andrew Mason

Schedules I & II

(As referenced in §18.2-248)

§ 54.1-3446. Schedule I. The controlled substances listed in this section are included in Schedule I:

1. Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

Acetylmethadol; Allylprodine; Alphamethylfentanyl; Alphacetylmethadol (except levo-alphacetylmethadol, also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM); Alphameprodine; Alphamethadol;

Benzethidine; Betacetylmethadol; Betameprodine; Betamethadol; Betaprodine;
Clonitazene; Dextromoramide; Diampromide; Diethylthiambutene; Difenoxin;
Dimenoxadol; Dimepheptanol; Dimethylthiambutene; Dioxaphetylbutyrate; Dipipanone;

Ethylmethylthiambutene; Etonitazene; Etosexidine; Furethidine; Hydroxypethidine;
Ketobemidone; Levomoramide; Levophenacymorphan; Morpheridine; Noracymethadol;
Norlevorphanol; Normethadone; Norpipanone; Phenadoxone; Phenampromide;
Phenomorphane; Phenoperidine; Piritramide; Proheptazine; Properidine; Propiram;
Racemoramide; Trimeperidine.

2. Any of the following opium derivatives, their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers and salts of isomers is possible within the specific chemical designation:

Acetorphine; Acetyldihydrocodeine; Benzylmorphine; Codeine methylbromide; Codeine-N-Oxide; Cyprenorphine; Desomorphine; Dihydromorphine; Drotebanol; Etorphine;
Heroin; Hydromorphanol; Methyl-desorphine; Methyl-dihydromorphine; Morphine methylbromide; Morphine methylsulfonate; Morphine-N-Oxide; Myrophine;
Nicocodeine; Nicomorphine; Normorphine; Phoclophine; Thebacon.

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3. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this subdivision only, the term "isomer" includes the optical, position, and geometric isomers): Alpha-ethyltryptamine (some trade or other names: Monase; a-ethyl-1H-indole-3-ethanamine; 3-[2-aminobutyl] indole; a-ET; AET);

4-Bromo-2,5-dimethoxyphenethylamine (some trade or other names: 2-[4-bromo-2,5-dimethoxyphenyl]-1-aminoethane; alpha-desmethyl DOB; 2C-B; Nexus);

3,4-methylenedioxy amphetamine; 5-methoxy-3,4-methylenedioxy amphetamine; 3,4,5-trimethoxy amphetamine; Bufotenine; Diethyltryptamine; Dimethyltryptamine; 4-methyl-2,5-dimethoxyamphetamine; 2,5-dimethoxy-4-ethylamphetamine (DOET);

Ibogaine; Lysergic acid diethylamide; Mescaline; Parahexyl (some trade or other names: 3-Hexyl-1-hydroxy-7, 8, 9, 10-tetrahydro-6, 6, 9-trimethyl-6H-dibenzo [b,d] pyran; Synhexyl); Peyote; N-ethyl-3-piperidyl benzilate; N-methyl-3-piperidyl benzilate; Psilocybin; Psilocyn; Tetrahydrocannabinols, except as present in marijuana and dronabinol in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the U.S. Food and Drug Administration;

Hashish oil (some trade or other names: hash oil; liquid marijuana; liquid hashish); 2,5-dimethoxyamphetamine (some trade or other names: 2,5-dimethoxy-a-methylphenethylamine; 2,5-DMA); 3,4-methylenedioxymethamphetamine (MDMA), its optical, positional and geometric isomers, salts and salts of isomers; 3,4-methylenedioxy-N-ethylamphetamine (also known as N-ethyl-alpha-methyl-3,4 (methylenedioxy)phenethylamine, N-ethyl MDA, MDE, MDEA); 4-bromo-2,5-dimethoxyamphetamine (some trade or other names: 4-bromo-2,5-dimethoxy-a-methylphenethylamine; 4-bromo-2,5-DMA); 4-methoxyamphetamine (some trade or other names: 4-methoxy-a-methylphenethylamine; paramethoxyamphetamine; PMA); N-ethyl analog of phencyclidine; Pyrrolidine analog of phencyclidine; Thiophene analog of phencyclidine.

4. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:

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Gamma hydroxybutyric acid (some other names include GHB; gamma hydroxybutyrate; 4-hydroxybutyrate; 4-hydroxybutanoic acid; sodium oxybate; sodium oxybutyrate); Mecloqualone; Methaqualone.

5. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers and salts of isomers:

Aminorex (some trade or other names; aminoxaphen; 2-amino-5-phenyl-2-oxazoline; 4, 5-dihydro-5-phenyl-2-oxazolamine); Fenethylamine; Ethylamphetamine; Cathinone (some trade or other names: 2-amino-1-phenyl-1-propanone, alpha-aminopropiophenone, 2-aminopropiophenone, norephedrone), and any plant material from which Cathinone may be derived; Methcathinone (some other names: 2-(methylamino)-propionophenone; alpha-(methylamino) propionophenone; 2-(methylamino)-1-phenylpropan-1-one; alpha-N-methylaminopropiophenone; monomethylpropion; ephedrone; N-methylcathinone; methylcathinone; AL-464; AL-422; AL-463 and UR 1432).

6. Any material, compound, mixture or preparation containing any quantity of the following substances:

3-methylfentanyl-(N-[3-methyl-1-(2-phenylethyl)-4-piperidyl] N-phenylpropanamide), its optical and geometric isomers, salts, and salts of isomers; 1-methyl-4-phenyl-4-propionoxypiperidine (MPPP), its optical isomers, salts and salts of isomers; 1-(2-phenylethyl)-4-phenyl-4-acetyloxypiperidine (PEPAP), its optical isomers, salts and salts of isomers; N-[1-(1-methyl-2-phenylethyl)-4-piperidyl]-N-phenylacetamide (acetyl-alpha-methylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(1-methyl-2-(2-thienyl)ethyl)-4 piperidyl]-N-phenylpropanamide (alpha-methylthiofentanyl), its optical isomers, salts and salts of isomers; N-[1-benzyl-4-piperidyl]-N-phenylpropanamide (benzylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(2-hydroxy-2-phenyl) ethyl-4-piperidyl]-N-phenylpropanamide (beta-hydroxyfentanyl), its optical isomers, salts and salts of isomers; N-[3-methyl-1-(2-hydroxy-2-phenyl)ethyl-4-piperidyl]-N-phenylpropanamide (beta-hydroxy-3-methylfentanyl), its optical and geometric isomers, salts and salts of isomers; N-[3-methyl-1-(2-2-thienyl)ethyl-4-piperidyl]-N-phenylpropanamide (3-methylthiofentanyl), its optical and geometric isomers, salts and salts of isomers; N-[1-(2-thienyl)methyl-4-piperidyl]-N-phenylpropanamide(thenylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(2-2-thienyl)ethyl-4-piperidyl]-N-phenylpropanamide(thiofentanyl), its optical isomers, salts and salts of isomers.

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§ 54.1-3448. Schedule II.

The controlled substances listed in this section are included in Schedule II:

1. Any of the following substances, except those narcotic drugs listed in other schedules, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by combination of extraction and chemical synthesis:

Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextrorphan, nalbuphine, nalmefene, naloxone naltrexone and their respective salts, but including the following:

Raw opium; Opium extracts; Opium fluid extracts; Powdered opium; Granulated opium; Tincture of opium; Codeine; Ethylmorphine; Etorphine hydrochloride; Hydrocodone; Hydromorphone; Metopon; Morphine; Oxycodone; Oxymorphone; Thebaine.

Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in this subdivision, but not including the isoquinoline alkaloids of opium.

Opium poppy and poppy straw. Concentrate of poppy straw, the crude extract of poppy straw in either liquid, solid or powder form, which contains the phenanthrene alkaloids of the opium poppy.

Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions which do not contain cocaine or ecgonine; cocaine or any salt or isomer thereof.

2. Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

Alfentanil; Alphaprodine; Anileridine; Bezitramide; Bulk dextropropoxyphene nondosage forms); Dihydrocodeine; Diphenoxylate; Fentanyl; Isomethadone; Levo-alpha-acetylmethadol (levo-alpha-acetylmethadol) (levomethadyl acetate) (LAAM); Levomethorphan; Levorphanol; Metazocine; Methadone; Methadone - Intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane; Moramide - Intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid; Pethidine; Pethidine - Intermediate - A, 4-cyano-1-methyl-4-phenylpiperidine; Pethidine - Intermediate - B, ethyl-4-

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phenylpiperidine-4-carboxylate; Pethidine - Intermediate - C, 1-methyl-4-phenylpiperidine-4-carboxylic acid; Phenazocine; Piminodine; Racemethorphan; Racemorphan; Remifentanyl.

3. Any material, compound, mixture or preparation which contains any quantity of the following substances having a potential for abuse associated with a stimulant effect on the central nervous system:

Amphetamine, its salts, optical isomers, and salts of its optical isomers; Phenmetrazine and its salts; Any substance which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers; Methylphenidate.

4. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

Amobarbital; Glutethimide; Secobarbital; Pentobarbital; Phencyclidine.

5. The following hallucinogenic substance: Nabilone.

6. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances which are immediate precursors to amphetamine and methamphetamine or phencyclidine: Phenylacetone; 1-phenylcyclohexylamine; 1-piperidinocyclohexanecarbonitrile.

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Additional Guidelines Or Suggested Practices

SAFETY ASSESSMENT Checklist

Family _____ **Worker** _____ **Date Completed** _____

Definition of Safety: The social worker perceives no immediate threat of severe harm to the child.

Elements underlying safety: THREAT, HARM, SEVERITY, VULNERABILITY, and IMMINENCE

SAFETY FACTORS	PROTECTIVE FACTORS
<p><input type="checkbox"/> Caretaker cannot meet child's basic needs for food, clothing and/or safe shelter.</p> <p><input type="checkbox"/> One or both caretakers cannot control behavior and/or are violent.</p> <p><input type="checkbox"/> Child sexual abuse is suspected.</p> <p><input type="checkbox"/> One or both caretakers perceive Child in predominately negative or unrealistic terms.</p> <p><input type="checkbox"/> Injury to child or threat of injury is severe.</p> <p><input type="checkbox"/> Caretaker(s) lacks knowledge, skill, or motivation to keep the child safe.</p> <p><input type="checkbox"/> Caretaker(s) refuses access to child or there is reason to believe they may flee.</p> <p><input type="checkbox"/> Living arrangements seriously endanger physical health of child.</p> <p><input type="checkbox"/> One or both caretakers failed to benefit from previous professional help related to safety issues</p> <p><input type="checkbox"/> Child is 0 to 6 years old.</p> <p><input type="checkbox"/> Child cannot protect self due to health or disability factors.</p> <p><input type="checkbox"/> Child has exceptional medical or emotional needs that caretaker cannot/will not meet.</p> <p><input type="checkbox"/> Child shows serious physical symptoms of maltreatment.</p> <p><input type="checkbox"/> Caretaker(s) overtly rejects any intervention.</p> <p><input type="checkbox"/> Explanation of child's injury is _____</p>	<p style="text-align: center;">• That Enable Caretakers to Protect:</p> <p><input type="checkbox"/> Caretaker can defer his/her own needs in order to meet the child's needs in timely, consistent, and effective manner.</p> <p><input type="checkbox"/> Caretaker intended to hurt child but shows remorse and expresses desire to prevent any future injury to child.</p> <p><input type="checkbox"/> Caretaker accepts and demonstrates the responsibility to nurture and provide for the well being of the child – shows skills associated with meeting these needs.</p> <p><input type="checkbox"/> Caretaker has the physical ability to intervene and/or has intervened in past to keep child safe from others.</p> <p><input type="checkbox"/> Caretaker demonstrates control of negative impulses or personal behaviors</p> <p><input type="checkbox"/> One caretaker can and will protect child from violent behavior or other caretaker.</p> <p><input type="checkbox"/> One or both caretakers demonstrate healthy emotional bonding with child</p> <p><input type="checkbox"/> At least one caretaker perceives child in predominately positive or realistic terms.</p> <p><input type="checkbox"/> Caretaker is facilitating access by CPS to child.</p> <p><input type="checkbox"/> Caretaker(s) is receptive to intervention.</p> <p><input type="checkbox"/> Caretaker can identify actions that are required to prevent harm to child</p> <p><input type="checkbox"/> Caretaker has capacity to learn from an experience and apply it to a new situation.</p> <p style="text-align: center;">• That Decrease Child's Vulnerability:</p> <p><input type="checkbox"/> Child is over 6 years old and has access to at least one person willing</p>

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<p>unconvincing or inconsistent.</p> <p><input type="checkbox"/> Child is fearful of caretaker(s) or home situation.</p> <p><input type="checkbox"/> Caretaker(s) whereabouts are unknown.</p> <p><input type="checkbox"/> Paramour or other adult unrelated to child is serving as caretaker.</p> <p><input type="checkbox"/> Caretaker's alleged/observed substance use may affect his/her ability to protect or care for the child.</p> <p><input type="checkbox"/> Caretaker's alleged/observed mental illness may affect his/her ability to protect or care for the child.</p> <p><input type="checkbox"/> Caretaker may be perpetrator or victim of DV to extent that child is at risk of serious, imminent harm.</p> <p><input type="checkbox"/> Caretaker intended to hurt child and does not show remorse.</p>	<p>to provide protection</p> <p><input type="checkbox"/> Explanation of child's injury is convincing and consistent.</p> <p><input type="checkbox"/> Injury to child is not severe or imminent.</p> <p><input type="checkbox"/> Observation of interactions of the child and the adult are appropriate.</p> <p><input type="checkbox"/> Living arrangements that endangered physical health of child have been ameliorated.</p> <p><input type="checkbox"/> Child with special needs is connected to appropriate services to meet those needs</p> <p style="text-align: center;">• That Enable Others to Protect:</p> <p><input type="checkbox"/> Paramour or other adult unrelated to child and serving as caretaker expresses strong attachment to the child.</p> <p><input type="checkbox"/> Child sexual abuse is suspected but uninvolved caretaker is supportive and will protect child.</p> <p><input type="checkbox"/> Family can meet child's basic needs for food, clothing and/or safe shelter</p> <p><input type="checkbox"/> Family member or friend has agreed to take an active part in protection of the child.</p> <p style="text-align: center;">• Other Protective Factors:</p>
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SAFETY DECISION:

A. Safe

There are no children likely to be in immediate danger of moderate to serious harm.

B. Conditionally Safe

Safety interventions are in place and have resolved the Unsafe situation for the present time. (See required SAFETY PLAN)

C. Unsafe

Without controlling intervention(s) a child is in immediate danger of moderate to serious harm. Emergency removal or court action is required to insure safety of the child(ren).

Action(s) Taken:

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SAFETY ASSESSMENT CHECKLIST
INSTRUCTIONS

How to use this form: All valid CPS reports must have a Safety Assessment Checklist on file after the first meaningful contact of the Investigation or Family Assessment. (A copy may be given to the family, but this is not required.) The purpose of the checklist is to provide a quick and consistent method of documenting the initial safety assessment that has been required in all Investigations in Virginia for over a decade.

1. The Date Completed of the Initial Assessment is documented in OASIS and must be the date on the form. The checklist is to be completed as soon as possible after receiving a valid report.
2. The Definition communicates that the Safety Assessment is about imminent threats of severe harm that need to be controlled in order for the child to be safe now and for the short-term.
3. Safety Factors are behaviors or conditions that cause a threat of immediate harm. Any factors identified should be checked. If none are identified, simply check the "Safe" Safety Decision below.
4. Protective Factors are behaviors or resources within a family or community that can control the threats of harm, at least for the short-term. If any Safety Factor is checked, there must be a Protective Factor to balance it in order for the child to be deemed Safe or Conditionally Safe.
5. One of the Safety Decisions must be checked and must be supported by the items checked in the Safety and Protective Factor columns. If all children in the home are "Safe" no other action is required. If any child in the home is "Conditionally Safe" there must be a Safety Plan. If any child is "Unsafe" a Safety Plan documenting immediate action or a Court Order is required.
6. The Actions Taken section can be used to describe activities of the parent or social worker that prevent the need for intervention or precede the initiation of the Safety Plan.
7. The form is carbonized so that a copy may be given to the family, but this is not required if it is not in the best interests of the child.

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SAFETY PLAN

AGENCY: _____ DATE: _____

PARENT(S)/CARETAKER(S): _____

CHILD(REN): _____

Child Safety Concerns (from the Initial CPS

Report): _____

Initial Assessment of Safety (Based on safety issues identified and any protective factors that address the safety concerns):

Immediate Needs (Identified by family and social worker):

Steps to Be Taken by Caretaker (Actions/referrals/etc.):

Social Worker Plans/Actions:

Caretaker(s) _____ Date _____

Social Worker _____ Date _____

Others _____

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SAFETY PLAN INSTRUCTIONS

How to use this form: This form is intended to be used with the family to determine and document what is needed to keep a child or all the children in the home safe for a limited amount of time. It is designed to be used in conjunction with the Safety Assessment Checklist, and is required to be completed if the Safety Decision is Conditionally Safe or Unsafe. (A court order can substitute for the Plan when the child is deemed Unsafe and court intervention is needed.)

1. The first Date should correspond to the Date on the Safety Assessment Checklist.
2. The Child Safety Concerns will usually briefly state the allegations in the complaint. However, if the CPS worker immediately identifies other concerns upon first meaningful contact, these should be included here.
3. Initial Assessment of Safety provides space to briefly note the primary safety concerns and any balancing protective factors identified on the Safety Assessment Checklist.
4. Immediate Needs should relate to needs that must be met in order to keep the children safe, not generic needs that may be expressed by family members and met through a prevention case opening or referral.
5. Steps to Be Taken by Caretaker again refers to steps or actions needed to keep the children safe, not a full-blown service plan that may address a multitude of needs and services.
6. Social Worker Plans/Actions should list any actions the worker has agreed to take to keep the child(ren) safe. This is also the place to note any consequences the worker must take if the Caretaker does not follow through on agreed upon steps listed in # 5.
7. Signature lines are provided so that this form can be an agreement for short-term actions to be taken by all parties to keep the child(ren) safe.
8. A copy of the form shall be provided to the caretaker and any other parties to the plan. (It has an original and two copies and can be photocopied.)

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FAMILY NEEDS ASSESSMENT

I. IDENTIFYING INFORMATION

Family Name: _____ Number: _____
Referral Date: _____ Assessment Date: _____
Social Worker: _____ Locality: _____

II. REASON FOR ASSESSMENT

III. MAJOR ASSESSMENT FACTORS

CHILD(REN)

Address at least child's age, development, functioning, temperament, relations with caretaker and others, any history of A/N, other significant child-related issues.

Strengths or Protective Factors:

Services Needs or Interventions:

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PARENT/CARETAKER(S)

Address at least parents' physical, emotional and intellectual status, any history of A/N, any DV, any substance abuse, parenting strengths & concerns, other significant parent-related issues

Strengths or Protective Factors:

Services Needs or Interventions:

ENVIRONMENT

Address living conditions, including the home, neighborhood

Strengths or Protective Factors:

SERVICES NEEDS OR INTERVENTIONS:

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SUPPORT SYSTEMS

Address formal and informal supports, such as family, neighbors, community organizations and service providers. Also address resource utilization issues, such as finances, transportation, child care, etc.

Strengths or Protective Factors:

SERVICES NEEDS OR INTERVENTIONS:

IV. RISK ASSESSMENT

CONSIDERING ALL THE IDENTIFIED STRENGTHS AND NEEDS, WHAT IS THE LIKELIHOOD OF PHYSICAL, EMOTIONAL, OR SEXUAL HARM TO THE CHILD(REN) IN THIS FAMILY? (EXPLAIN AND CHECK THE APPROPRIATE DEGREE OF RISK BELOW.)

___ **No Reasonably Assessable Risk**

Child(ren) not in jeopardy; no intervention needed

___ **Moderate Risk**

Possible jeopardy; possible change likely to occur with minimal intervention

___ **High Risk**

Child(ren) in jeopardy; intervention needed in order for child to be protected from abuse/neglect

Is a plan needed to ensure the protection of one or more children and/or to prevent future abuse/neglect?

If Yes – see Family Service Agreement

If No – Note any referrals or services requested that do not relate to protection of children

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Additional Guidelines Or Suggested Practices

V. PARENT/CARETAKER PERCEPTIONS OR OPINIONS REGARDING THE FAMILY'S SITUATION, NEEDS & RESOURCES

VI. PARENT/CARETAKER COLLABORATION
Check the following as appropriate:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	FNA discussed/reviewed with caretaker
<input type="checkbox"/>	<input type="checkbox"/>	Copy of FNA given to caretaker
<input type="checkbox"/>	<input type="checkbox"/>	Caretaker desires services
<input type="checkbox"/>	<input type="checkbox"/>	Family Service Agreement attached
<input type="checkbox"/>	<input type="checkbox"/>	Caretaker declines services
<input type="checkbox"/>	<input type="checkbox"/>	No services needed

Parent/Caretaker: _____	Date: _____
Parent/Caretaker: _____	Date: _____
Social Worker: _____	Date: _____
Other Person Involved in the Assessment: _____	Date: _____
Other Person Involved in the Assessment: _____	Date: _____
Social Work Supervisor: _____	Date: _____

APPENDIX
Additional Guidelines Or Suggested Practices

**FAMILY NEEDS ASSESSMENT
INSTRUCTIONS**

How to use this form: This is a form developed by the Virginia Department of Social Services to facilitate the Family Assessment process. Its use is optional, but agencies that choose to use it should be clear with staff about its purpose. The space for writing is designed for brevity. If the worker will be using the form as a note-taking tool, there is ample space. If the form will be used with the family and signed by participants in the assessment process, the worker will need to give thought as to wording and capturing only the most important points discussed and agreed upon.

I. IDENTIFYING INFORMATION

The items in this section are self-explanatory. The Assessment Date should be no later than 45 days (or 60 days if extended) from the Referral Date.

II. REASON FOR ASSESSMENT

Summarize the report and any additional information that provides the rationale for completing an assessment with the family.

III. ASSESSMENT FACTORS

A comprehensive family assessment should address at least the family's strengths and needs related to the following issues:

- Child(ren): age and ability to self-protect; presence of any disability or developmental delay; temperament; responsiveness to caretaker(s); prior history of abuse/neglect.
- Parent/caretaker: physical, emotional, and intellectual status; prior history of abuse/neglect; potential for violence; substance abuse or dependency; neglectful acts or omissions, allegations of abuse/neglect.
- Environment: any hazardous living conditions. Domestic violence may be included here or in the Caretaker section.
- Support Systems: informal and formal available or needed; resource utilization.

Information in this section is provided as a result of interviews with and/or observation of the child(ren) in the home, the alleged abuser, other household members and pertinent collaterals.

Describe behaviors, interactions, conditions that increase or decrease the likelihood of abuse or neglect of any or all children in the home, as reported by family or collaterals or observed by the social worker. There is space to record the strengths or protective capacities currently being utilized to protect the child(ren) or that could be mobilized to ensure child safety and enhance family functioning. There is also space to identify any needs for services or other interventions to reduce the risk of abuse or neglect. If no need is identified, Not Applicable (N/A) is acceptable.

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The Family Service Agreement will be based on the needs identified. Services and expected results should directly relate to the needs.

IV. RISK ASSESSMENT

The decision on risk of future harm should be based on the assessment of individual, family, and other risk factors. Any service planning with and service provision to the family should be based on the needs and resources identified in the overall Family Assessment. The outcome of the Risk Assessment will influence the type and intensity of services to be provided.

V. PARENT/CARETAKER PERCEPTIONS OR OPINIONS

The purpose of this section is to provide a description of the caretaker's views and response to the allegations, the assessment, and the proffered services, if any.

VI. PARENT/CARETAKER COLLABORATION

This section provides an opportunity to document the caretaker(s)' involvement in the needs assessment. It also provides a place to document the acceptance or refusal of services or that no services appear to be needed at this time.

SIGNATURES

Since this is an optional form, all the signatures are optional. If the form is used as a base for the Family Service Agreement or to document that the caretaker declined services, signatures of at least the caretaker and worker are needed. The others are provided to be used at the discretion of the agency.

APPENDIX
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FAMILY SERVICE AGREEMENT

Family Name:
Social Worker:
Date Initiated:

Case #:
Locality:
Revised:

Check (√) Primary Goal:	
<input type="checkbox"/> Prevent Abuse/Neglect	<input type="checkbox"/> Preserve/Strengthen Family
<input type="checkbox"/> Family Reunification	<input type="checkbox"/> Child Safety/Protect Child
<input type="checkbox"/> Other	Date Goal to Be Achieved _____

IMMEDIATE NEEDS:

- 1.
- 2.
- 3.

LONG-TERM NEEDS:

- 1.
- 2.
- 3.

Services to Be Obtained or Provided to Meet These Needs				
Who	What	When	Where	Why

APPENDIX
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Who	What	When	Where	Why

Comments or other information:

This **agreement will be reviewed on** _____ (date) or sooner if requested earlier by local department, family, or service provider.

This is not a legally binding document. However, it is:

_ A statement of mutually identified child and family service needs, agreed to by the family and the local department of social services and others.

And/Or

_ Notice to the family of child safety concerns and needed actions/services to protect the child(ren), prevent abuse or neglect, and/or strengthen the family.

Parent/Caretaker Date

Parent/Caretaker Date

Social Worker Date

Service Provider Date

Other Resource Date

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**FAMILY SERVICE AGREEMENT
INSTRUCTIONS**

How to use this form: This form is required when services are to be provided as a result of a CPS Family Assessment. All parties to the plan should sign and date the agreement and receive a copy of the agreement. This form may be used as a Service Application Form.

Family Name: Complete name of head of household.
CASE NUMBER: OASIS OR LOCALLY ASSIGNED NUMBER
Social Worker: Name of the assigned social worker
Locality: Name of the local department of social services

Check Primary Goal: Check one goal and write in the anticipated date of achievement.

Immediate and Long-Term Needs:

Although the worker and the family may identify many needs, the worker must assist the family to prioritize so that the family is not overwhelmed. Addressing no more than three short-term and three long-term needs at any given time will enhance the likelihood of a successful outcome.

Immediate needs will describe actions or services needed to keep the child(ren) safe or to address an issue the family has identified as very important to them.

Long-term needs will describe actions or services that cannot be accomplished quickly but are essential to address underlying causative factors, such as drug treatment.

Who: Write in the name or initials of the person(s) who is to participate in the service or action

What: Describe the service or name the service provider

When: Note the date the service is to begin

Where: Either write "in home" or give the location where the service will be delivered

Why: Describe the expected change or result related to this service

Comments or other information:

May use this space for any pertinent information needed to expedite the plan, such as transportation arrangements, who to call to set up the service, etc.

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Agreement review date:

Note the date that the worker and family will evaluate the plan - should be no later than three months from the date the plan is initiated.

Check statement when all parties agree to the plan. Check notice when parties cannot agree but a plan is required to protect the child.

APPENDIX
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INITIAL SCREENING ASSESSMENT

Domestic Violence

Ask the client:

Is there a person in your life who might do any of the following:

1. Physically hurt you or threaten to hurt you or someone else close to you?

Yes No Don't know

2. Check up on you or follow you?

Yes No Don't know

3. Make all or most decisions for you?

Yes No Don't know

4. Withhold money for food, clothing, or other needs?

Yes No Don't know

5. Tell you who you can see or talk to?

Yes No Don't know

6. Tell you where you can go?

Yes No Don't know

If the client answers YES to any of these questions, a referral for a more complete assessment or for domestic violence services is indicated.

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AOD SCREENING TOOL

(CAGE Instrument adapted to include Drugs – CAGEAID)

Ask:

- Have you ever felt you ought to cut down on your drinking or drug use?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

A “yes” answer to any of these questions indicates the probable need to refer for a more in-depth evaluation of drug and/or alcohol use.

APPENDIX
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INITIAL SCREENING ASSESSMENT
Domestic Violence

Ask the client:

Is there a person in your life who might do any of the following:

7. Physically hurt you or threaten to hurt you or someone else close to you?

Yes No Don't know

8. Check up on you or follow you?

Yes No Don't know

9. Make all or most decisions for you?

Yes No Don't know

10. Withhold money for food, clothing, or other needs?

Yes No Don't know

11. Tell you who you can see or talk to?

Yes No Don't know

12. Tell you where you can go?

Yes No Don't know

If the client answers YES to any of these questions, a referral for a more complete assessment or for domestic violence services is indicated.



COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

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JAMES S. REINHARD, M.D.
COMMISSIONER

MEMORANDUM

To: Community Services Board Executive Directors
Mental Retardation Directors
Child and Family Supervisors
Department of Social Services Local Directors
CPS Supervisors
CPS Workers
Local Part C Systems Managers

From: James S. Reinhard, M.D. Commissioner *JSR*
Department of Mental Health, Mental Retardation and Substance Abuse Services

Maurice A. Jones, Commissioner *MAS*
Department of Social Services

Date: January 11, 2005

Subject: Part C Procedures for Child Abuse Prevention and Treatment Act (CAPTA) Referrals

Amendments to the federal Child Abuse Prevention and Treatment Act (CAPTA) that were signed into law in 2003 require States to assure that the State has in place, among other things, provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under part C of the Individuals with Disabilities Education Act. The Virginia Departments of Social Services (DSS) and Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) have been working together for several months to develop effective policies and procedures for implementing this new CAPTA requirement.

In response to the CAPTA legislation, the Virginia Department of Social Services issued a requirement in July 2004 indicating that "when an investigation results in a disposition of founded on any child under the age of three or if a family assessment determines any child under the age of three to be in need of services to prevent risk of child abuse or neglect, that child shall be referred to the local Infant & Toddler Connection of Virginia (Part C Early Intervention System)." DMHMRSAS provided feedback to DSS that the requirement to refer children based on the family assessment posed a number of problems for the Part C system, including the following:

1. This policy would result in a significant increase in the number of referrals to local Part C systems;
2. Since the family assessment does not examine children's developmental status, there would be a significant increase in the number of referrals for which the local Part C system would have to complete a developmental screening in order to determine the need for evaluation and assessment;
3. There would be a significant cost impact on the Part C system, and existing funding in the Part C system is not adequate to support these additional costs;
4. Virginia's Part C system does not serve at-risk children; and
5. Virginia's Part C system does not provide services designed "to prevent risk of child abuse or neglect."

In response to the concerns of the Part C system, DSS has changed its policy (effective November 16, 2004) and no longer requires a referral for children in Family Assessments. In the November 16, 2004 Broadcast to local departments of social services, DSS reminds local CPS supervisors and workers that, even for children for whom there is not a founded disposition, referrals should still be made on any children under three who appear developmentally delayed or who have a physical or mental condition that has a high probability of resulting in delay.

DSS policy now states that, "If an investigation results in a disposition of founded on any child under age three, that child shall be referred to the local Infant & Toddler Connection of Virginia Part C Early Intervention System." When making a referral to the local Part C system through CAPTA, the local department of social services will also send a copy of the referral to the family and will inform the family verbally of the referral and provide an opportunity to discuss the referral process.

The Part C policies and procedures to be followed for referrals received through CAPTA are as follows:

POLICY

The State Lead Agency ensures that local policies, procedures and mechanisms are in place statewide to receive referrals through DSS, in accordance with federal and state CAPTA regulations, and to make an individualized determination about the child's need for evaluation and assessment under Part C.

(34 CFR 303.32 1(d) (1) and 303.322)

PROCEDURES

Local lead agencies have in place policies and procedures for referrals received through CAPTA of children who have experienced documented substantiated abuse or neglect. Local policies and procedures must include the following:

- a. The single point of entry determines what, if any, developmental screening has been completed by DSS and whether DSS has any developmental concerns about the child.
- b. The single point of entry determines whether there is a need for a surrogate parent to be assigned.
- c. A service coordinator is assigned.
- d. If the child has a diagnosed physical or mental condition that makes the child eligible under Virginia's Part C definition of eligibility, then no developmental screening is needed.
- e. If developmental screening has been conducted prior to referral and since the substantiated instance of abuse or neglect, then those prior screening results are used to determine the need for evaluation and assessment.
- f. If developmental screening has not been conducted prior to referral or was conducted prior to the allegation of abuse or neglect, then the local Part C system conducts a developmental screening to determine the need for evaluation and assessment.
- g. If the family decides not to receive an evaluation and assessment, then the service coordinator is responsible for ensuring that the family's signature is obtained on the *Declining Early Intervention Services* form and that the family receives a copy and explanation of the Notice of Child and Family Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System.
- h. With parent consent, the service coordinator contacts DSS to inform the CPS worker of whether or not the child will receive a Part C evaluation and assessment.

Local Part C system managers and local CPS program managers are strongly encouraged to meet to share information and discuss specific questions or issues that will facilitate an effective local CAPTA referral process and ongoing communication.

JSR/MAJ/rk

c: Vickie Johnson-Scott
Rita Katzman
Raymond R. Ratke
Frank Tetrick
Shirley Ricks