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SERVICES

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SERVICES

6.1 Introduction for CPS on-going services

Services can be offered to families during the family assessment or investigation, but this section of the Child Protective Services (CPS) guidance manual primarily addresses services provided after a case is opened. The broad goals of CPS services are:

- Prevention of further abuse or neglect to the child.
- Assurance of the child's safety.
- Maintenance of the child in his family.

[The Virginia Children's Service Practice Model](#) sets forth a vision for the services that are delivered by all child serving agencies across the Commonwealth. Guided by this model, the Virginia Department of Social Services (VDSS) is committed to continuously improving services for children and families by implementing evidence based practices, utilizing the most accurate and current data available and improving safety and well-being of children and families.

6.1.1 Principles of CPS on-going services

The appropriate services for a particular family must be tailored to the family's unique strengths; the type of abuse or neglect that has been identified; and the CPS on-going worker's assessment of the child's safety and risk of future maltreatment. The CPS on-going worker should provide CPS on-going services to the family based on these principles:

- Social services should be delivered to the family as part of a total system, with cooperation and coordination occurring among administration, temporary assistance, and family services programs.
- Every effort should be made to maintain the family as a functioning unit and prevent its breakup, while keeping children safe.
- The worker/family relationship is a primary vehicle for change.
- Positive change is possible.
- The most effective way to address a family's needs is to recognize and support its strengths.

- CPS services are successful by virtue of how they are presented, understood, and used by the family to keep all children free from maltreatment.
- CPS services should empower families to function independent of the social services system while all members remain safe. The purpose of the direct services is to address identified individual and family needs while providing timely and continuing reassessment of child safety, risk of maltreatment, ability of the parents to provide a minimum standard of care, and progress toward achieving the outcomes and goals identified in the service plan.
- CPS services should be provided in a manner to reduce or eliminate re-traumatization to children and families. See [Appendix A: The Effects of Trauma](#) for additional information.

6.1.2 Legal authority to provide CPS services

The Code of Virginia §§ [63.2-1505](#) and [63.2-1506](#) provide statutory authority to provide or arrange for services to families at the conclusion of a family assessment or an investigation.

([22 VAC 40-705-150 A](#)). At the completion of a family assessment or investigation, the local department shall consult with the family to provide or arrange for necessary protective and rehabilitative services to be provided to the child and his family to the extent funding is available pursuant to § [63.2-1505](#) or [63.2-1506](#) of the Code of Virginia.

Services may also be provided to or arranged for the alleged abuser or neglecter when the abuser or neglecter is not a parent.

6.1.3 Training requirements for CPS on-going workers and supervisors

The Virginia Administrative Code (VAC) mandates uniform training requirements for all CPS workers and supervisors. The uniform training requirements establish minimum standards for all CPS workers and supervisors in Virginia, including CPS on-going workers. *Any course designated with a CWSE indicates an e-learning course and is available on-line in the [Virginia Learning Center \(VLC\)](#).*

([22 VAC 40-705-180 A](#)). The department shall implement a uniform training plan for child protective services workers and supervisors. The plan shall establish minimum standards for all child protective services workers and supervisors in the Commonwealth of Virginia.

6.1.3.1 First three (3) weeks training requirements

All CPS staff are required to complete the following on-line courses are within the **first three (3) weeks of employment** and are prerequisites for CPS mandated courses. The following on-line courses are available in the [Virginia Learning Center](#):

- CWSE1002: Exploring Child Welfare.

- CWSE1500: Navigating the Child Welfare Automated Information System: OASIS.
- CWSE5692: Recognizing and Reporting Child Abuse and Neglect – Mandated Reporter Training.

6.1.3.2 First three (3) months training requirements

The following instructor led courses are required to be completed no later than within the first three (3) months of employment:

- CWS2000.1: Child Protective Services New Worker Guidance Training with OASIS.
 - *Prerequisites: CWSE1002, CWSE1500-CPS, CWSE5692*
- CWS2010: CPS On-going Services.
 - *Prerequisites: CWSE1002, CWSE5692, CWS2000.1/CWS2000.1R*

The following on-line course is required to be completed no later than within the first three (3) months of employment:

- CWSE1510: Structured Decision making in Virginia (This course is available in the [Virginia Learning Center](#)).

The following on-line course is recommended to be completed within the first three (3) months of employment:

- CWSE1006: Reasonable Candidacy for Foster Care (This course is available in the [Virginia Learning Center](#)).

6.1.3.3 First 12 months training requirements

The following instructor led courses are required to be completed no later than within the first twelve (12) months of employment:

- CWS1021: The Effects of Abuse and Neglect on Child and Adolescent Development.
- CWS1041: Legal Principles in Child Welfare Practice.
 - *Prerequisites: CWSE1041 and SCV: Child Dependency Case Processing in JDR District Courts.*
- CWS1061: Family Centered Assessment.
 - *Prerequisites: CWSE1001, CWSE5692, CWSE1500-CPS, CWS2000.1/CWS2001R*

- CWS1071: Family Centered Case Planning.
- CWS1305: The Helping Interview.
- CWS4020: Engaging Families and Building Trust-Based Relationships.
 - *Prerequisites: CWSE1002, CWSE5692, CWSE1500-CPS, CWS2000.1/CWS2001R, CWS2021*
- CWS5307: Assessing Safety, Risk and Protective Capacity.
 - *Prerequisites: CWSE1002, CWSE5692, CWSE1500-CPS, CWS2000.1/CWS2001R*

6.1.3.4 First 24 months training requirements

The following instructor led courses are required to be completed no later than within the first 24 months of employment:

- CWS1031: Separation and Loss Issues in Human Services Practice.
- DVS1001: Understanding Domestic Violence.
- DVS1031: Domestic Violence and Its Impact on Children.
 - *Prerequisite: DVS1001*
- CWS2021: Sexual Abuse.
- CWS5305: Advanced Interviewing: Motivating Families for Change.

6.1.3.5 Additional training requirements for CPS supervisors

[\(22VAC40-705-180 B\)](#) Workers *and supervisors* shall complete skills and policy training specific to child abuse and neglect within the first two years of their employment.

In addition to the courses listed above, all CPS supervisors are required to attend the Family Services CORE Supervisor Training Series – SUP5701, SUP5702, SUP5703, and SUP5704. These courses are to be completed within the first two (2) years of employment as a supervisor.

6.1.4 Annual training requirements

(22VAC40-705-180 C) All child protective services workers and supervisors shall complete a minimum of 24 contact hours of continuing education or training annually. This requirement begins after completion of initial training mandates.

All CPS workers and supervisors, including on-going CPS workers, are required to attend a minimum of 24 contact hours of continuing education/training annually. The first year of this requirement should begin no later than three (3) years from the hire date, after the completion of the initial training detailed above.

Continuing education/training activities to be credited toward the 24 hours should be pre-approved by the local department of social services (LDSS) supervisor or person managing the CPS on-going services program. Continuing education/training activities may include, but are not limited to: *on-line and classroom training offered by VDSS*, organized learning activities from accredited university or college academic courses; continuing education programs; workshops; seminars; and conferences.

Documentation of continuing education/training activities is the responsibility of the LDSS.

6.1.5 LDSS must ensure worker compliance

It is the responsibility of the LDSS to ensure that staff performing CPS duties, including CPS on-going, within their agency have met the minimum standards. The supervisor or the person managing the CPS on-going services program at the local level shall maintain training documentation in the worker's personnel record. The supervisor shall assure that workers who report to them complete the required training within the given timeframes.

A training job aide is located on the VDSS [Division of Family Services Training website](#).

6.1.6 Additional training resources

Additional on-line training resources available for CPS on-going staff and supervisors can be located at the following websites. These resources offer free training opportunities.

- [Early Impact of Virginia](#) offers on-line courses on many topics including child development; screening for substance use, intimate partner violence, mental health and perinatal depression; engaging fathers; and personal safety.
- [The National Child Traumatic Stress Network](#) offers continuing education courses on a variety of topics. This organization offers current, science- based information in the areas of assessment, treatment and services for traumatized children and their families.
- [The National Alliance of Children's Trust and Prevention Funds](#) offers a series of courses which supports implementation of the Strengthening Families™ Protective Factors Framework.

6.2 Opening a case for CPS on-going services

6.2.1 Application for services

When the completed investigation or family assessment has a very high, high, or moderate risk assessment and there are services identified that will reduce risk for abuse or neglect, there is no requirement for the family to sign a [service application](#) or a [Family Service Agreement](#). However, a signed document, while not legally binding, does document the family's willingness to participate in services and allows for notification of their legal rights.

See [Section 6.9.2](#) for additional guidance if a family refuses services.

6.2.2 Case opening in the automated data system

When safety factors and/or risk factors have been identified, the opening of a CPS on-going services case should occur without delay. The case must be opened electronically in the automated data system through use of the case connect function within the family assessment or investigation.

6.2.2.1 Opening case narrative

An opening case narrative should be documented in the CPS on-going case within the automated data system. This summary should include a brief explanation about how the family became known to CPS and any issues relating to safety, risk, court and current status of the family's situation.

6.2.2.2 Case type

- CPS on-going services case type is used to identify a case that is associated with a concern of child maltreatment and should be used when opening a case as a result of a family assessment or investigation.
- Dual CPS & foster care case type is only used 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.

6.2.3 Transfer case within LDSS

When another worker 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 Family Strengths and Needs Assessment (FSNA) and begin service planning with the family. If the case is transferred to another worker, the first contact or attempted contact must occur **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, the CPS worker and the CPS on-going worker. This seamless transition helps to ensure a thorough assessment of strengths and needs of the 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. These meetings may include, at a minimum, the CPS worker, CPS supervisor, CPS on-going worker and CPS on-going supervisor. 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 issues that require CPS on-going services;
- recommendations from the Family Partnership Meeting (FPM), if held; and
- the "stage of change" of the family. (see [Appendix B: "Stages of Change"](#))

The CPS on-going worker should receive the entire electronic and hard copy record for the family. However, need for the entire record should not delay the transfer of enough information to begin essential services to prevent abuse or neglect and ensure compliance with any safety plan in place.

6.2.4 Family Partnership Meetings (FPM)

While a FPM may be scheduled at any time, it should be scheduled when the worker assesses a child to be at very high or high risk of abuse or neglect **and** the child is at risk of out of home placement. It is highly recommended to hold a FPM when a case is opened for CPS on-going services, prior to the development of the service plan. This meeting is scheduled to develop the plan with the family and their support systems to prevent the out of home placement and identify the circumstances under which a removal might be considered. The meeting should convene **within 30 calendar days** of opening a CPS on-going case and prior to the development of the CPS on-going service plan. The FPM must be documented in the automated data system in the CPS on-going case contacts. For additional guidance on conducting the FPM, refer to the VDSS Child and Family Services Manual, [Family Engagement chapter](#).

Additional guidance for holding a FPM when DV is present can be found in Section 1.9 of the [VDSS Child and Family Services Manual, Chapter H. Domestic Violence](#).

6.2.5 Domestic Violence (DV)

DV is an issue affecting many families receiving services through the LDSS. VDSS has added a chapter to the VDSS Child and Family Services Manual, [Chapter H. Domestic Violence](#). 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. Much of the specific information is applicable across program areas. This chapter also connects to the

existing chapters of the entire VDSS Child and Family Services Manual to ensure that specific DV information is readily available when needed.

Local DV programs provide services which focus on the safety of DV victims and their children. LDSS focus primarily on child safety. Both entities are focused on safety. LDSS and local DV programs work together, participate in multi-disciplinary teams together, occasionally are housed in the same buildings and often work with the same families.

Current data regarding the co-occurrence between DV and child maltreatment compel child welfare systems to re-evaluate existing philosophies, policies, and practice approaches towards families experiencing both forms of violence.

6.2.6 Services for children of Native American, Alaskan Eskimo or Aleut heritage

Children of Native American, Alaskan Eskimo or Aleut heritage are subject to the Indian Child Welfare Act (ICWA). Although there are no federally recognized tribes residing on reservations in Virginia, there are members of federally recognized tribes who do reside in Virginia. A list of recognized tribes and List of Indian Child Welfare Act Designates is provided by the [U. S. Department of the Interior Bureau of Indian Affairs](#).

A child is covered by ICWA when the child meets the federal definition of an 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; or
- Eligible for membership in a federally recognized tribe and is the biological child of a member of a federally recognized Indian tribe.

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

If there is any reason to believe a child is an Indian child and is at risk of entering foster care, the LDSS shall treat that child as an 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 shall make active efforts to reunite the Indian child with their family or tribal community if already in foster care. Active efforts shall 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 applies to providing remedial and rehabilitative services to the family prior to the removal of an Indian child from his or her parent or Indian custodian, and/or an intensive effort to reunify an Indian child with his/her parent or Indian custodian.

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

- Engaging the 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 Indian child's tribe to participate in shared decision-making meetings; and
- Involving and using available resources of the extended family, the child's Indian tribe, Indian social service agencies and individual caregivers.

An 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 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 [Section 1, Appendix A: Indian Child Welfare Act \(ICWA\)](#) of this guidance manual.

In the event an 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 Indian child can be found in [Section 4, Family Assessment and Investigation](#), of this guidance manual. If a child is removed and placed into foster care, see Section 3 of the [VDSS Child and Family Services Manual, Section E. Foster Care](#) and [Section 8, Judicial Proceedings, Appendix D](#), Guidelines for State Courts and Agencies in Indian Child Welfare Custody Proceedings of this manual.

6.3 Contact with the family in a CPS on-going case

6.3.1 Minimum contact

The frequency of contacts 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 CPS on-going worker and the child and family **at least one (1) time per month** and should occur in the home.

6.3.2 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 CPS on-going worker/supervisor or service team may delegate 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. However, the CPS on-going worker must always maintain at least **one (1)** face-to-face *worker visit* with the parent/guardian and child per month.

6.3.3 Parental permission to speak to a child

The CPS on-going worker shall 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 automated data system.

6.3.4 Contact information

The following information is collected, assessed and documented in case contacts in the automated data system.

6.3.4.1 *Worker visit with the child*

- Address any safety concerns;
- The child's feelings/observations about the factors that led to CPS involvement and the impact of trauma;
- Issues pertaining to the child's needs, services and case goals;
- Education;
- Family interactions with parents/siblings;
- Extracurricular/cultural activity/hobby participation;
- Medical/ dental/mental health need; and
- Observation of the child's physical appearance.

6.3.4.2 *Worker visit with the parent/guardian*

- Address any safety concerns;
- 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; and
- 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 [Section 4.5.10.1 Safe sleep environment and practices](#) located in Section 4 of this guidance manual.

6.3.4.3 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; and
- Status of any criminal or civil court matters.

6.4 Roles and responsibilities of the CPS on-going worker

The responsibilities of the CPS on-going worker include:

- **Managing child safety**

The CPS on-going worker 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.

- **Managing permanency planning**

The CPS on-going worker 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 CPS on-going worker 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 CPS on-going worker provides necessary information to the judge, Guardian ad Litem (GAL), Court Appointed Special Advocate (CASA), agency attorney and Commonwealth attorney as needed. The CPS on-going worker ensures the family is informed and understands the court process.

- **Managing documentation**

The CPS on-going worker ensures the case record in the automated data 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.

- **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 CPS on-going worker 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.

Additional techniques for engaging the family, including building rapport and engaging resistant clients can be located in [Appendix C: Building Rapport Techniques](#).

6.5 Reasonable diligence to locate family in a CPS on-going case

The LDSS must use reasonable diligence to locate a missing child or family in a CPS on-going 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.

6.5.1 What constitutes reasonable diligence

The CPS on-going worker shall document all reasonable and prompt attempts to locate the child and family including, but not limited to, checking when applicable:

- Child welfare automated data system;
- Postal Service for last known or forwarding address;
- Neighbors, landlords, known relatives;
- School records;
- Department of Motor Vehicles;
- Department's Division of Support Enforcement;
- Department of Corrections, Probation and Parole;
- Law Enforcement;
- Telephone and utility companies;
- Employer;
- [Person locator tools](#) and/or SPIDeR searches;

- Internet searches including generic search engines such as Google, Yahoo, Bing, etc.;
- Social networks such as Facebook, MySpace or Twitter; or
- Other appropriate contacts.

6.5.2 Conducting periodic checks for missing child/family

If the victim child or family is not found, the CPS on-going worker must establish a timetable for making periodic checks. Periodic checks for the missing child/family must continue until the LDSS is satisfied with the resolution of the case. The CPS on-going worker shall document the timetable in a case contact in the automated data system as well as the results of the periodic checks.

6.6 Reasonable candidacy for foster care in a CPS on-going case

A critical assessment that must be completed in all CPS on-going cases is determining reasonable candidacy for foster care. The CPS on-going worker must evaluate whether or not a child is a reasonable candidate for foster care placement because the CPS on-going worker is either seeking the child's removal from the home or is making reasonable efforts through services to prevent the child's removal.

The CPS on-going worker must determine if the child is a Reasonable Candidate for Foster Care if they believe the child is at risk of foster care placement if services are not provided. 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.

The specific eligibility requirement for reasonable 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; **and**
- that the plan was developed jointly with the child, and the parents or guardians when appropriate; **and**
- a description of the services offered and/or provided to prevent the removal of the child from the home; **and**
- the case is actively being managed to maintain the child in the home and/or 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.

There is not a specified time limit for how long a child may be considered a reasonable candidate for foster care. The CPS on-going worker shall document in the automated data system its justification for maintaining a child as a reasonable candidate for foster care **at least once every six (6) months**.

The LDSS must use the Reasonable Candidacy Documentation Form in the automated data system to document eligibility for reasonable candidacy and for the LDSS's reimbursement for case management. Additional information regarding reasonable candidacy can be found in [Appendix D: Reasonable Candidacy Manual](#) and in the on-line course CWSE1006: Reasonable Candidacy for Foster Care found in the [Virginia Learning Center](#).

In CPS on-going services cases, the documentation for reasonable candidacy is a defined service plan that clearly states that absent effective preventative services, foster care will likely result. The CPS on-going services plan is an acceptable case plan to document reasonable candidacy and must clearly demonstrate that the case is actively managed by the CPS on-going worker to maintain the child in the home and to prevent the child's foster care placement.

It is important to note that reasonable candidacy eligibility and documentation are related to the fiscal reimbursement for case management provided by the LDSS and does not replace the requirement to determine the need for CPS on-going services.

6.7 Screening for sex trafficking victims in a CPS on-going case

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 sex 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. All children must be screened to determine if they are a victim of sex trafficking and the results must be documented in the automated data system prior to the development of service plan.

6.7.1 Signs of sex trafficking

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

- History of emotional, sexual or other physical abuse;
- Signs of current physical abuse and/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;
- Drug addiction;
- Withdrawal or lack of interest in previous activities; or
- Gang involvement.

6.7.2 When sex trafficking is identified

If the LDSS identifies or receives information that a child has been a victim of sex trafficking, they shall notify local law enforcement **within 24 hours** of identifying or receiving such information and document such notification in the automated data system.

The LDSS may contact the [National Human Trafficking Resource Center](#) (NHTRC) at 1-888-3737-888 if they suspect sex trafficking of a minor. NHTRC operates a 24 hour hotline to help identify and coordinate with local organizations that protect and serve victims of trafficking.

6.7.3 Additional information

- See [Section 4, Investigations and Family Assessments, Appendix M: Sex Trafficking of Children Indicators and Resources](#) of this guidance manual for additional information regarding screening and safety considerations for victims of human trafficking, which includes sex trafficking.
- Additional information regarding sex trafficking can be found in the on-line course, [CWSE4000: Identifying Sex Trafficking in Child Welfare](#). This course is also available on the [VDSS public website](#).
- See [Appendix I: Services for Sex Trafficking Victims](#) for additional service recommendations.

6.8 Strengths and needs assessment in a CPS on-going case

The Family Strengths and Needs Assessment (FSNA) must be completed in all CPS on-going cases and must be documented in the automated data system **within 30 calendar days** of opening the case for CPS on-going services and updated **every 90 days** if the case is to remain open until the case is closed.

6.8.1 FSNA

The FSNA is a systematic evaluation of elements to determine the family's strengths and needs and help identify contributing factors and underlying conditions that may influence child maltreatment. The FSNA helps identify family strengths as well as needs particularly in areas where the needs may be greater. The FSNA guides the development of the case plan. Use of the FSNA ensures there is consistency in assessment of caretakers and children across critical domains of functioning.

Within each domain, the CPS on-going worker will assess items as a strength (positive score), a neutral characteristic (zero score) or a moderate/severe (negative score) need.

6.8.1.1 Use of definitions is critical

For accurate completion of the FSNA, it is critical to refer to the definitions provided. Assessment responses must be based on supporting narrative documented in the automated data system. The FSNA tool with definitions is located in the automated data system, [Appendix E: Family Strengths and Needs Assessment](#) and on the [CPS forms page](#) on the VDSS website.

6.8.1.2 Caretaker information to be gathered for the FSNA

The CPS on-going worker must gather information from the family, child, case records, etc. in order to thoroughly assess each domain for both the primary and secondary caretaker. The caretaker domains include:

- **Substance use or abuse** (assesses the current and historical use of substances as well as how the caretaker teaches the child about substances)
- **Emotional stability** (assesses the caretaker's resilience and how their emotional health affects daily functioning)
- **Sexual abuse** (assesses the current and historical matter of sexual abuse as well as how the caretaker teaches the child about sexual abuse)
- **Resource management and basic needs** (assesses not only the adequacy of resources but how they are managed)
- **Parenting skills** (assesses knowledge, understanding of parenting skills)
- **Household relationships/ DV** (assesses dynamics of power and control and interaction between the adults in the home)
- **Caretaker abuse or neglect history** (assesses childhood abuse or neglect of the caretaker and its impact on the family)
- **Social or community support system** (assesses access and use of resources to include extended family, friends, and community resources)
- **Physical health** (assesses the caretakers' health and how this impacts family functioning)
- **Communications skills** (assesses the caretakers' level of communication and how it affects family functioning)

6.8.1.3 Child information to be gathered for the FSNA

The CPS on-going worker must gather information from the family, child, case records, etc. in order to thoroughly assess each domain for all the children in the family. The child domains include:

- **Emotional/behavioral** (assesses the child's mental health, emotional adjustment and coping skills)
- **Family relationships** (assesses the child's interactions with family members)
- **Medical/physical** (assesses the child's medical needs including routine health care)
- **Child development** (assesses the child's physical and cognitive development)
 - The CPS on-going worker may utilize many resources to assess child development. This assessment does not replace a formal developmental assessment. A developmental milestones chart can be located in [Appendix F: Developmental Milestones](#).
- **Cultural/community identity** (assesses the child's connection with his culture and or community)
- **Substance abuse** (assesses the child's use of substances)
- **Education** (assesses the child's academic achievement and identifies specialized educational needs when applicable)
- **Peer/adult social relationships** (assesses the child's relationships with peers and adults outside of the family)
- **Delinquent/CHINS behavior** (assesses behavior which if committed by an adult would be a crime or offenses unique to children)

6.8.1.4 Prioritize caretaker strengths and needs

In addition to help identify strengths and needs, the FSNA helps prioritize them. The "scoring" within each domain allows the strengths and needs to be listed from a greater to a lesser "score".

It is important to consider how the needs relate to identified safety threats and risk factors. The CPS on-going worker and the family will select three (3) of the greatest needs on which to develop objectives and focus services. When developing the service plan, the CPS on-going worker should build on the strengths already present in a family.

6.8.1.5 Child needs identified in FSNA

Unlike adult caretaker domains, the child needs are not prioritized. Any and all items identified as needs in the child assessment domains should be addressed in the service plan.

6.8.2 Child and Adolescent Needs and Strengths Assessment

All children who receive services through the Children's Services Act (CSA) must be assessed using the mandatory uniform assessment instrument, the Virginia Child and Adolescent Needs and Strengths Assessment (CANS) tool. Information on CANS, including policy manuals, fact sheets, score sheets, and training is available on the [CSA website](#).

6.9 Service planning in a CPS on-going case

6.9.1 Definition of service plan

The service plan documents all services to prevent further child abuse or neglect or to prevent placement of the child outside of the family. 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.

6.9.2 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** or sooner if safety, risk, or family circumstances change. The service plan must be documented in the automated data system.

6.9.3 Information needed to develop service plan

The service plan incorporates information about the caretakers, parents, legal guardians and children. It is important for the CPS on-going worker 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 safety plan developed with the family;
- CPS family assessment or investigation that prompted the opening of the CPS on-going case;

- Prior CPS history for the family, including any prior screened out reports, family assessments, investigations or service cases;
- The most recent CPS Family Risk Assessment completed for the family, noting the identified risk factors;
- The Family Service Agreement completed in the family assessment or investigation;
- The recommendations from the FPM (if conducted);
- The FSNA completed prior to developing or renewing the service plan, noting the top three (3) priority needs;
- Reports received from collateral sources such as psychological evaluations, forensic evaluations, parenting capacities, home studies, court reports, etc.; and
- Any court orders.

6.9.4 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 CPS on-going worker 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; and
- Follow through on interventions.

6.9.5 When parents are not engaged

When the CPS on-going worker cannot engage the parents in mutual goal setting, the CPS on-going worker must develop goals and objectives responsive to the issues identified and the expected outcomes. These objectives and goals represent the LDSS responsibility to address child safety issues.

See [Appendix C: Building Rapport Techniques](#) for additional techniques for dealing with resistant clients.

6.9.6 Service planning and DV

Additional guidance for service planning when DV is present can be found in Section 1.7 of the [VDSS Child and Family Services Manual, Chapter H. Domestic Violence](#).

6.9.7 Service plan components

The main components of the service plan are the goals, objectives, services and activities/tasks.

6.9.7.1 Goals

Goals are broad statements which 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.

6.9.7.1.1 Primary goals

There are two (2) primary goals in CPS on-going cases:

- Prevent removal.
- Prevent future abuse/neglect.

6.9.7.2 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 must 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 must have certain characteristics in order to measure success:

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

- **Objectives need to reflect behavioral change.** In CPS on-going 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. The objectives themselves should clearly describe specific behavioral changes parents/caretakers need to adopt.
- **Objectives should be derived from the FSNA, safety and risk factors identified.** Objectives are derived from, and must be consistent with the assessed problem. For example, if the assessment has found that no alcohol or drug problem exists in the family, an objective that the parent is “clean and sober” has no relevance. Conversely, if the assessed problem is that the parent has recently become dependent on prescription drugs and has successfully parented other children, learning new parenting skills is not likely to address the dependence on prescription drugs. In addition, an objective should be formulated for the identified safety threat(s) and each significant element contributing to risk as identified in the Family Risk 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 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 worker. 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.

Examples of objectives:

- 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.
- Mother will put food in the refrigerator immediately after breakfast, lunch and dinner. The floor will be free of trash and debris.
- Caretaker will leave the child with an adult who has a drug-free history and no prior CPS involvement.

6.9.7.3 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 evidenced based and trauma-informed. See [Appendix A: Trauma-Informed Care](#) for additional information regarding trauma informed services and [Appendix I: Services for Sex Trafficking Victims](#) for services related to sex trafficking victims.

6.9.7.3.1 Caretaker services by FSNA domains

Suggested services include but are not limited to:

- **Substance abuse:** 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.
- **Caretaker 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.

6.9.7.3.2 Child services by FSNA domains

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 abuse:** 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

6.9.7.4 Activities/tasks

The service plan must also specify the necessary activities or tasks 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.

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

- What steps or actions must 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 CPS on-going worker or LDSS will complete or provide; and
- How will any barriers be minimized?

Activities should be jointly formulated and agreed upon by the family and the CPS on-going worker. The family's commitment to following through with service plan activities is directly related to their involvement in the plan's development.

- Complex activities 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 issues 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.
 - When activities consist of a series of small steps, it is should be easier to prioritize them and to implement them in a specified order. There is also a greater opportunity for the family to succeed at carrying out smaller steps and often increases motivation to complete additional activities.

The CPS on-going worker should ensure that the family has the knowledge and ability to carry out assigned activities. If not, the activities should be reformulated.

When formulating activities to achieve objectives, the CPS on-going worker should consider and maximize any family strength identified by the worker and family during the assessment process.

Examples of activities:

- 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 caretaker with information about child development. Caretakers 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].

6.9.8 Share and document the service plan

The CPS on-going worker must document the service plan in the automated data system and include how the family was involved with its development. All goals, objectives, activities/tasks and services must be documented in the automated data system.

The completed service plan should 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.

6.9.9 Supervisory review of the service plan

The CPS on-going supervisor should review the service plan in the automated data system.

6.9.10 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 CPS on-going worker should consult with the county/city attorney to determine if court action is needed. The CPS on-going worker may petition the court to order the necessary services.

The CPS on-going worker 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.

See [Section 8, Judicial Proceedings](#), for more information on Protective Orders.

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 automated data system.

6.9.11 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 CPS on-going worker 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 CPS on-going case and document the reason for closure in the closing case summary in the automated data system.

6.10 Multidisciplinary teams and CPS on-going services

CPS is best provided in the context of community-based collaboration and support. The Code of Virginia [§ 63.2-1503 J](#) provides the statutory authority for LDSS to develop multidisciplinary teams and [22 VAC 40-705-150 E](#) provides regulatory authority for an LDSS to support the development of multidisciplinary teams.

([22 VAC 40-705-150 E](#)). Local departments shall support the establishment and functioning of multidisciplinary teams pursuant to § [63.2-1503 J](#) of the Code of Virginia.

The purpose of multidisciplinary teams shall be to promote, advocate, and assist in the development of a coordinated service system directed at the early diagnosis, comprehensive treatment, and prevention of child abuse and neglect.

6.10.1 Child Advocacy Centers

A Child Advocacy Center (CAC) provides comprehensive services to victims of child abuse and neglect throughout the investigation, intervention, treatment and prosecution of reported cases. A CAC responds to sexual abuse, physical abuse, witness to violence and serious physical neglect reports. CAC services may include forensic interviews of child victims; case review and recommendation for services from a multidisciplinary team (MDT); victim advocacy and support for the victim and non-offending parent; medical assessment; mental health services; and legal expertise.

For more information about the CAC model and program locations in Virginia, visit [Child Advocacy Centers of Virginia](#) (CACVA).

6.10.2 Child and Family Team Meeting

As discussed in [Section 6.2.4](#), a Family Partnership Meeting is a practice strategy for insuring that family engagement, voice, choice and teaming are part of the agency's day to day case work practice.

Another practice strategy is Child and Family Team Meetings (CFTM). CFTM includes the child, parents, extended family and all service providers. CFTM provide 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, CPS on-going worker and supervisor, any contracted service providers, health care providers, educational partners, child and parent advocates. When applicable, team members should also include mental health professionals, spiritual leaders, caretakers, Guardian ad Litem, 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 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 [Appendix G: Comparing FPM and Child and Family Team Meetings](#), 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. Additional information about CFTM and other evidence based practices can be located on Continuous Quality Improvement (CQI) page on the [VDSS internal website](#).

6.10.3 Cooperation and exchange of information

The Code of Virginia [§ 63.2-1503 J](#) establishes statutory authority for the LDSS to develop agreements that govern the work of the multidisciplinary teams including the exchange of information among team members. LDSS are encouraged to develop written protocols for the operation of local multidisciplinary teams.

Multidisciplinary teams involved in case consultation can have access to confidential case information. All members of a multidisciplinary team abide by laws and policies related to confidentiality. More information about confidentiality and CPS can be found in the [Section 9, Confidentiality](#).

6.11 New report in a CPS on-going case

When child abuse or neglect allegations are made in an open CPS on-going case, the report must be treated as a new CPS report and evaluated for validity and response as set out in CPS guidance for complaints and reports in Section 3. This includes situations where safety concerns necessitate the removal of a child. The LDSS may decide to have the CPS on-going worker respond to a valid report if that worker is qualified as a CPS worker, having received the mandated training for CPS as outlined in [Section 1, Introduction to CPS](#). The referral and results of a valid report shall be documented in the automated data system as a family assessment or an investigation.

If as a result of the new investigation or family assessment a new safety plan is implemented, it must be shared with all involved parties in the CPS on-going case. When a new Family Risk Assessment is completed, it does not affect the existing schedule for risk re-assessment and service plan updates in the open CPS on-going case. Any new safety or risk factors must be taken into consideration when the service plan is updated in the CPS on-going case.

6.12 Assessing safety in a CPS on-going case

Safety assessment is both a process and a document. The process of assessing child safety is ongoing throughout the life of the CPS referral and the CPS on-going case. The initial safety decision and safety

plan are documented in the automated data system by the CPS worker during the investigation or family assessment.

The following circumstances must be documented in a new Safety Assessment Tool in the CPS on-going case in the automated data system **within three (3) business days**:

- 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 ability of safety interventions to mitigate safety factors and require changes to the safety plan; or
- a case is recommended for closure.

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

CPS on-going workers must be familiar with the safety assessment process and tool. See [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 new or revised 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 [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 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 CPS on-going case type must be changed to foster care in the automated data system.

If any child is placed into foster care and other siblings/children remain in the home, the CPS on-going case type must be changed in the automated data system to reflect a dual case type (foster care and CPS on-going).

6.13 Service plan review of a CPS on-going case

The CPS on-going worker must review the CPS service plan with the family every **90 days** or more often if the safety/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; and
- Consider issues 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 FPM or CFTM may be held when the service plan is reviewed.

6.13.1 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 a CPS on-going 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 automated data system.

6.13.1.1 Risk reassessment considerations

The CPS on-going worker must use the Risk Reassessment Tool which is located in the automated data system, [Appendix H: Risk Assessment Tool](#) and on [the forms page](#) on the VDSS website. There are two (2) main sections of the tool. The first section, R1 through R4, captures information that should already be known and documented in the CPS investigation or family assessment. 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 caretaker childhood abuse or neglect;
- Characteristics of the child;
- New reports of abuse or neglect received;
- Issues related to substance abuse;
- Issues relating to adult relationships/DV;
- Providing care to the child consistent to their needs; and
- Progress with the service plan.

Each of these is clearly defined in [Appendix H: Risk Assessment Tool](#). The use of definitions with all SDM tools is critical.

6.13.1.2 Risk reassessment decision

The decision to keep a case open is the same as in the investigation or family assessment. The decision to close the CPS on-going case must be approved by the supervisor. The decision to 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

6.13.2 Update the FSNA

After the decision is made that the case will remain open, the next step in reviewing the service plan is to update the FSNA. Critical needs are likely to change as families engage in achieving the objectives in the service plan. For CPS on-going cases that have been reassessed at moderate risk, the FSNA guides the decision regarding case closing. The FSNA must be updated in the automated data system every **90 days**, after the service plan has been renewed.

6.13.3 Update service plan

After the Risk Reassessment Tool is completed, 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 automated data system.

If the decision is to keep the case open, the service plan must be renewed first and then a new FSNA is completed in the automated data 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. The updated service plan with original signatures must be maintained in the hard copy file.

6.13.4 Update reasonable candidacy status

The reasonable candidacy for foster care must be updated **every six (6) months** or sooner if circumstances change.

6.14 Closing a CPS on-going case

6.14.1 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 a CPS on-going case. The final safety assessment should 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 CPS on-going case in the automated data 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 for compliance.

6.14.2 Closing notification/summary

The CPS on-going worker should document a closing case summary in the automated data 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, FSNA, etc.;
- The outcomes of any criminal or civil court matters; and
- 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 automated data system.

6.14.3 Supervisory approval

The case closure must be approved by the CPS on-going supervisor in the automated data system.

6.15 Transferring a CPS on-going case outside the LDSS

6.15.1 Transfer open CPS on-going case to another LDSS in Virginia

When a family moves, the CPS on-going case shall be transferred to the LDSS in the locality where the family will reside.

[\(22 VAC 40-705-150 G\)](#). 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.

6.15.1.1 LDSS to initiate transfer immediately

The LDSS shall contact the receiving agency immediately to notify the agency that the family is moving to that locality and will need CPS on-going services. This notification should be done verbally.

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

- Automated Data System Case Number.
- Summary of the sending agency's involvement with the family, including the services currently being provided to the child or family.

6.15.1.2 All contacts must be current

When transferring a CPS on-going case to another LDSS, the sending agency should ensure that all contacts are current. The FSNA, Risk Reassessment Tool and service plan must be current and documented in the automated data system. Client demographics such as date of birth, address and phone numbers should also be updated.

6.15.1.3 LDSS shall send entire record to receiving LDSS

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

6.15.1.4 Receiving LDSS shall 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.

6.15.2 Transfer open CPS on-going case to another state

If a family in an open CPS on-going 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 CPS contact information for each state can be located on the [Child Information Gateway](#) website.

6.15.3 Transfer CPS case out of state; child in the custody of an LDSS

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

- The LDSS shall contact the [Interstate Compact for the Placement of Children \(ICPC\) unit](#) at VDSS for assistance to transfer to another state a CPS on-going case with at least one child in the home and at least one (1) child in the custody of an LDSS. (Dual CPS & Foster Care case type)
- The LDSS shall contact the ICPC unit at VDSS for assistance to transfer to another state a CPS on-going 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.

6.16 Prevention services

The Code of Virginia [§ 63.2-1501](#) provides the statutory definition of prevention.

([22 VAC 40-705-150 D](#)). Protective services also includes preventive services to children about whom no formal complaint of abuse or neglect has been made, but for whom potential harm or threat of harm exists, to be consistent with [§§ 16.1-251](#), [16.1-252](#), [16.1-279.1](#), [63.2-1502](#), and [63.2-1503 J](#), of the Code of Virginia.

LDSS are authorized to provide prevention services to families and children in CPS investigations or family assessments when risk has been assessed as low and no safety threats are present; when no CPS referral has been made; or an invalid report (screened out) has been made. The LDSS may provide services to the family or child to prevent child abuse and neglect, if the parent voluntarily agrees to such services, and signs a service application. See the VDSS Child and Family Services manual, [Chapter B, Prevention](#) for further guidance.

6.17 Retention requirements for CPS on-going case records

Closed CPS on-going case records are to be destroyed in accordance with [laws governing public records](#) in the Commonwealth. These rules allow for CPS on-going 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.

There are different purge requirements for screened out CPS reports, unfounded investigations, founded investigations and family assessments that are noted in [Section 4, Family Assessment and Investigation](#).

6.18 Appendix A: Trauma-Informed Care

The following was adapted from The Institute on Trauma and Trauma Informed Care (<http://socialwork.buffalo.edu/content/dam/socialwork/social-research/ITTIC/trauma-informed-care-infographic.pdf>)

- When an event is traumatic to children and adults, they may be negatively impacted emotionally, physically or spiritually by these adverse life events.
- Trauma-Informed Care is about ensuring ALL individuals feel physically and emotionally safe, are noticed and listened to, and are given a voice.

6.18.1 The effects of trauma

- Trauma impairs: memory; concentration; new learning; and focus.
- Trauma has been correlated to: heart disease; obesity, addiction; pulmonary illness; diabetes; autoimmune disorders; and cancer.
- Trauma impacts an individual's ability to: trust; cope; and form healthy relationships.
- Trauma disrupts: emotion identification; ability to self-soothe or control expressions of emotions; and one's ability to distinguish between what is safe and unsafe.
- Trauma shapes: a person's belief about self and others; one's ability to hope; and one's outlook on life.

6.18.2 Re-traumatization

What Hurts?

System (Policies; Procedures; “The way things are done”)	Relationship (Power; Control; Subversive)
Having to continually retell their story	Not being seen/heard
Being treated as a number	Violating trust
Procedures that require disrobing	Failure to ensure emotional safety
Being seen as their label (ie.: addict, schizophrenic)	Non-collaborative
No choice in service or treatment	Does things for rather than with
No opportunity to provide feedback about their experience with service delivery	Use of punitive treatment, coercive practices and oppressive language

What Helps?

Safety	Creating areas that are calm and comfortable
Choice	Providing an individual options in their treatment
Empowerment	Noticing capabilities in an individual
Collaboration	Making decisions together
Trustworthiness	Providing clear and consistent information

6.18.3 Engaging and supporting families who have experienced trauma

Taken from: [Birth Parents with Trauma Histories and the Child Welfare Systems](#), National Child Traumatic Stress Network.

A history of traumatic experiences may:

- Compromise parents' ability to make appropriate judgments about their own and their child's safety and to appraise danger; in some cases, parents may be overprotective and, in others, they may not recognize situations that could be dangerous for the child.
- Make it challenging for parents to form and maintain secure and trusting relationships, leading to:
 - Disruptions in relationships with infants, children, and adolescents, and/or negative feelings about parenting; parents may personalize their children's negative behavior, resulting in ineffective or inappropriate discipline.
 - Challenges in relationships with child welfare workers, foster parents, and service providers and difficulties supporting their child's therapy.
 - Impairment of parents' capacity to regulate their emotions.
- Lead to poor self-esteem and the development of maladaptive coping strategies, such as substance abuse or abusive intimate relationships that parents maintain because of a real or perceived lack of alternatives.
- Result in trauma reminders, or "triggers", when parents have extreme reactions to situations that seem benign to others. These responses are especially common when parents feel they have no control over the situation, such as facing the demands of the child welfare system. Moreover, a child's behaviors or trauma reactions may remind parents of their own past trauma experiences or feelings of helplessness, sometimes triggering impulsive or aggressive behaviors toward the child. Parents also may seem disengaged or numb (in efforts to avoid trauma reminders), making engaging with parents and addressing the family's underlying issues difficult for caseworkers and other service providers.
- Impair a parent's decision-making ability, making future planning more challenging.
- Make the parent more vulnerable to other life stressors, including poverty, lack of education, and lack of social support that can worsen trauma reactions.

Although parents may experience the child welfare system as re-traumatizing because it removes their power and control over their children, there is potential for it to support their trauma recovery and strengthen their resilience. CPS on-going workers, as representatives of the child welfare system, can themselves serve as triggers to parents with trauma histories or can, through careful

use of non-threatening voice and demeanor, be bridges to hope and healing. Viewing birth parents through a “trauma lens” helps child welfare staff, and parents themselves, see how their traumatic experiences have influenced their perceptions, feelings, and behaviors.

6.18.4 How CPS on-going workers can use a trauma-informed approach

CPS on-going workers cannot reverse the traumatic experiences of parents, but they can:

- Understand that parents’ anger, fear, or avoidance may be a reaction to their own past traumatic experiences, not to the CPS on-going worker.
- Assess a parent’s history to understand how past traumatic experiences may inform current functioning and parenting.
- Remember that traumatized parents are not “bad” and that approaching them in a punitive way, blaming them, or judging them likely will worsen the situation rather than motivate a parent.
- Build on parents’ desires to be effective in keeping their children safe and reducing their children’s challenging behaviors.
- Help parents understand the impact of past trauma on current functioning and parenting, while still holding them accountable for the abuse and/or neglect that led to involvement in the system. For many parents, understanding that there is a connection between their past experiences and their present reactions and behavior can empower and motivate them.
- Pay attention to ways trauma can play out during case conferences, home visits, visits to children in foster care, court hearings, and so forth. Help parents anticipate their possible reactions and develop different ways to respond to stressors and trauma triggers.
- Refer parents to trauma-informed services whenever possible. Parents will be more likely to attend services that address their needs. Generic interventions that do not take into account parents’ underlying trauma issues—such as parenting classes, anger management classes, counseling, or substance abuse groups—may not be effective.
- Become knowledgeable about evidence-supported trauma interventions to include in service planning. Linkages with programs that deliver trauma-informed services can support CPS on-going workers in developing a plan that meets their clients’ needs.
- Advocate for the development and use of trauma-informed services in the community.

For more information about trauma-informed child welfare practice go to <http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008>.

6.19 Appendix B: Stages of Change

The Stages of Change Model describes five (5) stages of readiness and provides a framework for understanding the change process. By identifying where a person is in the change cycle, interventions and services can be tailored to the individual's "readiness" to progress in the service delivery process. Interventions and services that do not match the person's readiness are less likely to succeed and more likely to damage rapport, create resistance, and impede change.

- Pre-contemplation: (not ready to change). They do not actively pursue help. Problems are identified by others. They are reluctant, resigned, rationalizing or rebelling when it comes to their situation or change.
- Contemplation: (thinking about change). They are ambivalent, considering change and rejecting at the same time. They consider change but no commitment to change.
- Preparation: (getting ready to make change). This is a period of time where there is a window of opportunity to move into change. They may be modifying their current behavior in preparation for further change.
- Action: (ready to make change). They engage in particular actions intended to bring about change. There is continued commitment and effort.
- Maintenance: (continuing to support the behavior change). They have successfully changed behavior for at least 6 months. They may still use active steps to sustain behavior change and may require different skills and strategies from those initially needed to change behavior. They begin to resolve associated problems on their own.

Additional information on the stages of change can be found on the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) website and in CWS5305: Advanced Interviewing: Motivation Families for Change.

6.20 Appendix C: Building Rapport Techniques

Developing a helping relationship with abused and neglected children and their families is critical to changing conditions or patterns of behavior that contributed to maltreatment or risk thereof. 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 problems in family functioning, they may contribute more to their own growth and can make more productive changes.

6.20.1 Techniques for building rapport

- Approach each individual involved with an open mind.
- Find out what is important to the child and the family.
- Use mirroring. Take note of words used by the child and family and try to incorporate them into conversations.
- Listen to the child or parents' explanation of the situation without correcting or arguing.
- Ask questions rather than issue threats or commands.
- Clarify expectations and purposes. Clearly explain the helping process and the worker's role in working together toward solutions.
- Help the child and family retain a sense of control.
- Clarify commitment and obligations to the working relationship.
- Acknowledge difficult feelings and encourage open and honest discussion of feelings.
- Be consistent, persistent and follow through.
- Promote participatory decision-making for meeting needs and solving problems.

6.20.2 Engaging the resistant client

Due to the involuntary nature of the majority of CPS cases, it is not unusual for families to resist offers of help. Resistance is a normal and predictable response when people feel forced to change. Workers should not take this personally. To deal with resistance effectively, workers should first change their perspective of resistance and try to see the behavior as a potential strength. How the worker responds to resistance is crucial in avoiding continued abuse or escalation of inappropriate behavior.

In order to engage families and avoid resistance:

- Be clear, honest, and direct. Keep an open mind. Workers should maintain a non-defensive stance.
- Acknowledge the involuntary nature of the arrangement. Workers should explain the structure and content of the intervention to the child and caretakers.
- Be matter of fact and non-defensive in explaining the legal authority that permits intervention. Workers should not get into a debate about authority; instead workers should state what their legal authority is and what legal recourse the child and family may have to challenge it.
- Contact the child and family in a manner that is courteous and respectful, and assesses strengths as well as risks.
- Elicit the parents' concerns and wishes for assistance and convey understanding of the parents' point of view, including any reservations about CPS involvement.
- Reduce the child and family's opposition to interaction by clarifying available choices, even when choices are constrained, by emphasizing freedoms still available and by avoiding labeling.
- Earn the respect of the child and family (and gain psychological influence) by being a good listener who strives to understand their point of view.
- Respect the right of the child and the family to express values and preferences different from those of the worker.
- Acknowledge difficult feelings and encourage open and honest discussion of feelings.
- Reframe the family's situation. This is particularly useful when the child and family are making arguments that deny a safety threat, risk factor or other family problem or need; it acknowledges their statements, but offers a new meaning or interpretation for them. The child and family's information is recast into a new form and viewed in a new light that is more likely to be helpful and support change.

6.21 Appendix D: Reasonable Candidacy Manual

6.21.1 General

6.21.1.1 Statutory background

The Adoption Assistance and Child Welfare Act of 1980, P. L. 96-272, was enacted on June 17, 1980. Title IV of the Social Security Act (Act) was amended and a new Part E, federal payments for Foster Care and Adoption Assistance, was created.

Title IV-E provided for a phased repeal of Section 408 of the Act, which provided authority for federal matching in state foster care (FC) payments under the Title IV-A, Aid to Families with Dependent Children Foster Care program (AFDC-FC). States could continue to receive federal matching for AFDC-FC payments under Title IV-A of the Act until September 30, 1982, or the quarter in which the state implemented an approved State Plan under Title IV-E. The earliest implementation date for Title IV-E was October 1, 1980. In order to carry out the provisions of Title IV-E, appropriations made available for that program are to be used for making payments to those states which have approved state plans under Title IV-E (see Section 471; 42 U.S.C. 671; 45 CFR 1356.20).

45 CFR 1356.60 (c) allows federal financial participation (FFP) for administrative costs to be claimed for reasonable candidates for foster care regardless of whether the child is actually placed in foster care and receives Title IV-E foster care maintenance payments.

6.21.1.2 Purpose

As the designated Title IV-E agency, VDSS is responsible for supervising the Title IV-E Plan in Virginia and ensuring that costs claimed under Title IV-E are reasonable, necessary, and consistent with applicable Federal guidelines. Title IV-E reimbursement is allowed for administrative activities performed on behalf of children deemed to be a reasonable candidate for foster care regardless of whether these children are actually placed into foster care and become recipients of Title IV-E foster care maintenance payments. This manual outlines both federal and state regulations and policies which allow VDSS to claim Title IV-E administrative cost reimbursement on behalf of LDSS for reasonable candidates for foster care. For children who have been determined a reasonable candidate for foster care, VDSS, after applying the Title IV-E penetration rate, can claim 50 percent FFP for allowable administrative costs on behalf of the LDSS.

6.21.2 Reasonable Candidacy Program

6.21.2.1 Authority to make reasonable candidacy determinations

Only LDSS employees are authorized to make the determination of reasonable candidacy for foster care.

Contracted persons are not considered employees of the LDSS and may not make determinations with respect to reasonable candidacy. All other activities performed by contracted personnel associated with a documented reasonable candidate are permissible and should be captured during the Random Moment Sample (RMS) process.

6.21.2.2 Reasonable candidacy requirements

No exception or deviance to any applicable services' guidance (Foster Care Prevention/Stabilization, CPS, and/or Children's Service Act) should occur in the effort to determine a child as a reasonable candidate.

A child is a reasonable candidate when it is documented that he or she is at serious risk of removal from the home as evidenced by the CPS on-going worker either pursuing his or her removal from the home, or making reasonable efforts to prevent such removal.

There is not a specified time limit for how long a child may be considered a reasonable candidate for foster care. The CPS on-going worker shall document its justification for maintaining a child as a reasonable candidate for foster care at least once every six (6) months.

6.21.2.3 Types of reasonable candidates

- **Pre-Placement.** The LDSS is seeking to remove the child from the home and place the child in foster care; or the LDSS is making reasonable efforts to prevent the removal from the home and placement of the child in foster care.
- **Post-Placement.** The LDSS is making reasonable efforts towards preventing the child's re-entry into foster care by providing aftercare services to the reunited family.

If the LDSS determines that the finalized adoptive placement is in jeopardy and demonstrates that the adopted child is a candidate for foster care, the LDSS may claim allowable Title IV-E administrative costs under the foster care program for activities performed on behalf of the child as a reasonable candidate.

6.21.2.4 Exclusionary conditions of reasonable candidacy

Federal law and guidance clearly outline the following exclusionary conditions for reasonable candidacy:

- Children over the age of 18.
- Children who are no longer at risk of removal from home.
- Children who are currently placed in a foster care setting or a facility outside the scope of foster care such as detention, forestry camps, and psychiatric hospitals.

- An unborn, prenatal case.
- Children with which the LDSS does not have a case plan, or the case plan does not meet the requirements indicated in [Section 6.6](#).
- The CPS on-going worker did not re-determine, at least every six (6) months, that the child remains at serious risk of removal from the home.
- Children who are on a trial home visit (THV).

A child may not be considered a candidate for foster care solely because the LDSS is involved with the child and his or her family. The LDSS involvement with the child and family shall be for the specific purpose of either removing the child from the home or making reasonable efforts to prevent the child's removal from the home.

The child cannot simultaneously be considered in foster care and a reasonable candidate for foster care.

6.21.3 Establishing and maintaining reasonable candidacy

6.21.3.1 Establishing reasonable candidacy

The CPS on-going worker shall evaluate reasonable candidacy on a case-by-case basis. In situations which include several children within a sibling group, evaluation and documentation in the CPS on-going case record shall support a determination of reasonable candidacy for each child individually.

All necessary and appropriate documentation used in conjunction with the Documentation Form to establish reasonable candidacy should be maintained in the services case record.

Initial reasonable candidacy determination may not be made retroactively (see [Section 6.6](#)).

6.21.3.2 Maintaining reasonable candidacy

The CPS on-going worker shall clearly document continued reasonable candidacy no later than six (6) months from the initial determination and continue to make redeterminations no less frequently than once every six (6) months thereafter. This is done by updating the case plan or through updated court proceedings to show that the child remains a reasonable candidate for foster care and updating the reasonable candidacy documentation screen in the automated data system.

Once the child is no longer at risk of foster care placement, the CPS on-going worker shall cease classifying the child as a reasonable candidate for foster care (see [Section 6.6](#)). Case plans should be updated to reflect that the child is no longer a reasonable candidate and the reasonable candidacy documentation screen in the automated data system must be updated.

All necessary and appropriate documentation used to maintain reasonable candidacy status should be maintained in the services case record.

6.21.3.3 Reasonable candidacy documentation methods

Although the case plan developed by the CPS on-going worker with the family can be used as acceptable documentation to support reasonable candidacy, if a court order, petition, or transcript regarding removal/preventing removal of the child is available, the judicial documentation shall be maintained in the services case record.

The acceptable methods of documentation indicating that a child is a reasonable candidate for foster care are:

- **Defined Case Plan.** A defined case plan which clearly indicates that, absent effective preventive services, foster care is the planned arrangement for the child.

The decision to remove a child from his or her home is significant and should not be entered into lightly. Therefore, a case plan that indicates that foster care is the planned placement for the child absent effective preventive services is an indication that the child is at serious risk of removal from his or her home because the LDSS believes that a plan of action is needed to prevent that removal.

Case plans shall be individualized for a specific child, developed jointly with the child (when appropriate), the parents or guardians, and include a description of the services to be offered and provided to prevent removal of the child from the home. The case plan and documentation should clearly show that the case is actively being managed to maintain the child at home and to prevent placement of the child in foster care.

Acceptable types of case plans include, but are not limited to:

- Prevention – Services Plan.
- Child Protective Services – On-going Services Plan.
- Individual Family Services Plan (IFSP).

When the child exits foster care and is receiving aftercare services and meets the reasonable candidacy requirements, a case plan shall be developed that would indicate that foster care is the planned placement for the child absent effective aftercare services. For example, the service worker may develop a case plan that demonstrates its intent to remove the child from the home and return him or her to foster care if the aftercare services prove unsuccessful.

- **Court Proceedings.** Evidence of court proceedings in relation to the removal of child from the home.

If the LDSS has initiated court proceedings to remove the child from his or her home, copies of the petition, court order, or transcript of court proceedings are sufficient to deem this child to be at serious risk of removal.

6.21.3.4 Reasonable Candidacy Documentation

6.21.3.4.1 Purpose and use

The Reasonable Candidacy Documentation Form in the automated data system shall be used to document the initial reasonable candidacy determination and every redetermination thereafter.

6.21.3.4.2 Effective date

The child is considered to be a documented reasonable candidate when all requirements are met and the documentation form is completed in the automated data system. The initial reasonable candidacy begin date is the day the CPS on-going worker completes the form. Supervisory approval is recommended but not required in the automated data system.

6.21.3.4.3 Initial and redetermination dates

The initial reasonable candidacy determination date begins the six (6) month “clock” for when the first redetermination is due. Every redetermination thereafter is due within six (6) months of the CPS on-going worker’s signature date. The redetermination must be completed in the automated data system.

6.21.3.5 Records retention and destruction

Reasonable candidacy documentation is to be retained in accordance with The Library of Virginia’s Records Retention and Disposition Schedule – General Schedule No. 15 for service case records.

- “Retain 3 years after last action.”

Destruction of reasonable candidacy documentation should be conducted in accordance with The Library of Virginia’s Records Retention and Disposition Schedule – General Schedule No. 15

- “Custodian of records shall ensure that information in confidential or privacy protected records is protected from unauthorized disclosure through the ultimate destruction of the information. Normally, destruction of confidential or privacy-protected records will be done by shredding or pulping.”

6.21.4 Claiming administrative costs for reasonable candidates

6.21.4.1 Random Moment Sampling

The administrative costs for children determined to be reasonable candidates are claimed through the Random Moment Sampling (RMS) observation process. RMS observations are used to document the specific program activity the worker is engaged in at a randomly selected moment in time.

Administrative costs for activities performed by a worker in association with reasonable candidates may be indicated during the RMS observation only when the LDSS has documented that the child is a reasonable candidate for foster care.

Examples of such activities are:

- Case management and supervision.
- Referral to services.
- Preparation for and participation in judicial determinations.
- Placement of the child.
- Development of the case plan.
- Case reviews.

Any LDSS worker performing activities in association with a documented reasonable candidate may indicate such during the RMS observation.

6.21.4.2 Completing the RMS Observation

6.21.4.2.1 RMS Observation Form and Certification Page

When the worker is performing reasonable candidacy related activities and is selected to complete the RMS Observation Form and Certification Page; the worker will indicate the corresponding program and activity codes on the Certification Page. Only one (1) program code can be selected and subsequently only one (1) accompanying activity code can be selected from the activities listed for the selected program code.

6.21.4.2.2 Program code

Other Child Welfare Services (Child Still in the Home) program code (360) is indicated on the RMS Observation Form by circling the program name and code on the selection list and recording the program code in Step 3 on the Certification Page.

6.21.4.2.3 Activity code

The Pre-placement Prevention activity code (420) is indicated on the on the RMS Observation Form by circling the activity name and code on the selection list and recording the activity code in Step 3 on the Certification Page.

The activity code 420 – Reasonable Candidacy can only be used in conjunction with program code 360 – Other Child Welfare Services (Child Still in the Home).

6.22 Appendix E: Family Strengths and Needs Assessment (FSNA)

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
 FAMILY STRENGTHS AND NEEDS ASSESSMENT

A. CARETAKER		<u>Caretaker Score</u>	
		Primary	Secondary
SN1.	Substance Use or Abuse (Substances: alcohol, illegal drugs, inhalants, and prescription or over-the-counter drugs.)		
	a. Teaches and demonstrates healthy understanding of alcohol and drugs+3		
	b. Alcohol or prescribed drug use or no use..... 0		
	c. Alcohol or drug abuse -3		
	d. Alcohol or drug dependency -5	_____	_____
If C or D, indicate which substances caretaker abuses:			

SN2.	Emotional Stability		
	a. Positive emotional stability.....+3		
	b. No evidence or symptoms of emotional instability.....0		
	c. Mild to moderate emotional instability -3		
	d. Chronic or severe emotional instability -5	_____	_____
SN3.	Sexual Abuse		
	a. Teaches and demonstrates healthy understanding of sexuality and sexual boundaries+3		
	b. No evidence that caretaker sexually abuses or fails to protect child from sexual abuse.....0		
	c. Moderate problems related to sexuality in family; unclear sexual boundaries..... -3		
	d. Caretaker has abused a child sexually OR has failed to protect a child from sexual abuse..... -5	_____	_____
SN4.	Resource Management and Basic Needs		
	a. Resources sufficient to meet basic needs and are adequately managed+2		
	b. Resources may be limited but are adequately managed0		
	c. Resources are insufficient or not well-managed -2		
	d. No resources, or resources severely limited and/or mismanaged..... -4	_____	_____
SN5.	Parenting Skills		
	a. Strong skills+2		
	b. Adequately parents and protects child0		
	c. Inadequately parents and protects child -2		
	d. Destructive or abusive parenting..... -4	_____	_____
SN6.	Household Relationships/Domestic Violence		
	a. Supportive.....+2		
	b. Minor or occasional discord.....0		
	c. Frequent discord or some domestic violence -2		
	d. Chronic discord or severe domestic violence..... -3	_____	_____
SN7.	Caretaker Abuse or Neglect History		
	a. Abuse or neglect as a child, demonstrates good coping ability.....+2		
	b. No abuse or neglect as a child.....0		
	c. Minor problems related to abuse or neglect as a child -2		
	d. Serious problems related to abuse or neglect as a child -3	_____	_____

SN8. Social or Community Support System			
a. Strong support system.....	+1		
b. Adequate support system.....	0		
c. Limited or somewhat negative support system.....	-1		
d. No support system or negative support system.....	-3	_____	_____
SN9. Physical Health			
a. Preventive health care is practiced.....	+1		
b. Health issues do not affect family functioning.....	0		
c. Health concerns or disabilities affect family functioning.....	-1		
d. Serious health concerns or disabilities result in inability to care for child.....	-2	_____	_____
SN10. Communication Skills			
a. Strong skills.....	+1		
b. Functional skills.....	0		
c. Limited skills.....	-1		
d. Severely limited skills.....	-2	_____	_____

B. CHILD - Rate each child according to the current level of functioning.

		Child 1	Child 2	Child 3	Child 4	Child 5	Child 6
		<u>Score</u>	<u>Score</u>	<u>Score</u>	<u>Score</u>	<u>Score</u>	<u>Score</u>
CSN1. Emotional/Behavioral							
a. Strong emotional adjustment.....	+3						
b. Adequate emotional adjustment.....	0						
c. Limited emotional adjustment.....	-3						
d. Severely limited emotional adjustment.....	-5	_____	_____	_____	_____	_____	_____
CSN2. Family Relationships							
a. Nurturing/supportive relationships.....	+3						
b. Adequate relationships.....	0						
c. Strained relationships.....	-3						
d. Harmful relationships.....	-5	_____	_____	_____	_____	_____	_____
CSN3. Medical/Physical							
a. Preventive health care is practiced.....	+2						
b. Medical needs met.....	0						
c. Medical needs impair functioning.....	-2						
d. Medical needs severely impair functioning.....	-4	_____	_____	_____	_____	_____	_____
CSN4. Child Development							
a. Advanced development.....	+2						
b. Age-appropriate development.....	0						
c. Limited development.....	-2						
d. Severely limited development.....	-4	_____	_____	_____	_____	_____	_____
CSN5. Cultural/Community Identity							
a. Strong cultural/community identity.....	+1						
b. Adequate cultural/community identity.....	0						
c. Limited cultural/community identity.....	-1						
d. Disconnected from cultural/community identity.....	-3	_____	_____	_____	_____	_____	_____
CSN6. Substance Abuse							
a. No substance use by active decision.....	+1						
b. Experimentation/use or no use.....	0						
c. Alcohol or other drug use.....	-1						
d. Chronic alcohol or other drug use.....	-3	_____	_____	_____	_____	_____	_____
CSN7. Education							
Does child have a specialized educational plan? _____ No _____ Yes, describe: _____							
a. Outstanding academic achievement.....	+1						
b. Satisfactory academic achievement.....	0						
c. Academic difficulty.....	-1						
d. Severe academic difficulty.....	-3	_____	_____	_____	_____	_____	_____

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6
	<u>Score</u>	<u>Score</u>	<u>Score</u>	<u>Score</u>	<u>Score</u>	<u>Score</u>
CSN8. Peer/Adult Social Relationships						
a. Strong social relationships +1						
b. Adequate social relationships 0						
c. Limited social relationships -1						
d. Poor social relationships -2	_____	_____	_____	_____	_____	_____
CSN9. Delinquent/CHINS Behavior						
(Delinquent behavior includes any action which, if committed by an adult, would constitute a crime.)						
a. Preventive activities +1						
b. No delinquent/CHINS behavior 0						
c. Occasional delinquent/CHINS behavior -1						
d. Significant delinquent/CHINS behavior -2	_____	_____	_____	_____	_____	_____

C. PRIORITY NEEDS AND STRENGTHS

Enter item number and brief description of up to three most serious needs and greatest strengths for the caretaker (items SN1-SN10).

Caretaker: Priority Needs

1. _____
2. _____
3. _____

Caretaker: Priority Strengths

1. _____
2. _____
3. _____

D. Does family identify areas of needs or strengths that are not included in the categories assessed by this tool?

1. _____ No
2. _____ Yes, describe: _____

E. Comments regarding caretaker's or child's needs and strengths

6.22.1 Definitions used in FSNA

The following definitions are to be used when assessing the caretakers.

- **SN1. Substance Use or Abuse** (substances: alcohol, illegal drugs, inhalants, prescription or over-the-counter drugs)
 - a. Teaches and demonstrates healthy understanding of alcohol and drugs. The caretaker may use alcohol or prescribed drugs, however, his or her use does not negatively affect parenting skills and functioning, and the caretaker teaches and demonstrates an understanding of the choices made about use or abstinence and the effects of alcohol and drugs on behavior and society.
 - b. Alcohol or prescribed drug use or no use. The caretaker may have a history of substance use and/or may currently use alcohol or prescribed drugs; however, such use does not negatively affect parenting skills and functioning, or the caretaker does not use alcohol or prescribed drugs.
 - c. Alcohol or drug abuse. The caretaker uses alcohol and/or drugs resulting in negative consequences in some areas such as family, social, health, legal, or financial; and/or the caretaker needs (or continues to need) treatment to alleviate negative consequences to the family.
 - d. Alcohol or drug dependency. The caretaker uses alcohol and/or drugs resulting in behaviors that impede his or her ability to meet his or her own and/or their child's basic needs; or caretaker experiences impairment in most areas including family, social, health, legal, and financial; or caretaker needs (or continues to need) intensive structure and support to achieve abstinence from alcohol or drugs
- **SN2. Emotional Stability**
 - a. Positive emotional stability. The caretaker demonstrates the ability to deal with adversity, crises, and conflicts in a positive, proactive, and/or constructive manner.
 - b. No evidence or symptoms of emotional instability. Based on available evidence, it does not appear that the caretaker's emotional stability interferes with his/her or the family's functioning. The caretaker demonstrates emotional responses that are consistent with his or her circumstances.
 - c. Mild to moderate emotional instability. Based on available evidence, the caretaker's emotional stability appears problematic in that it interferes to a mild or moderate degree with family functioning, parenting, or employment or other aspects of daily living. May include:

- repeated observations or multiple reliable reports of low self-esteem, apathy, withdrawal from social contact, flat affect, somatic complaints, changes in sleeping or eating patterns, difficulty in concentrating or making decisions, low frustration tolerance, or hostile behavior;
- frequent conflicts with co-workers or friends;
- speech is sometimes illogical or irrelevant;
- frequent loss of work days due to unsubstantiated somatic complaints;
- diagnosis of a mild to moderate disorder; and
- difficulty coping with crisis situations such as loss of a job, divorce or separation, or an unwanted pregnancy.

d. Chronic or severe emotional instability. The caretaker appears to have severe problems that prohibit adequate functioning and are seriously disruptive to family functioning, or are incapacitating. May include:

- observed, reported, or diagnosed chronic depression, paranoia, excessive mood swings, impulsive or obsessive or compulsive behavior, or other severe mental, emotional, or psychological disorders;
- inability to keep a job or friends;
- suicide ideation or attempts;
- recurrent violence;
- stays in bed all day; completely neglects personal hygiene;
- grossly impaired communication (i.e., incoherent);
- reports hearing voices or seeing things;
- repeated referrals for mental health or psychological evaluations; and
- recommended or actual hospitalization for emotional problems within the past year.

- **SN3. Sexual Abuse**

a. Teaches and demonstrates healthy understanding of sexuality and sexual boundaries. Based on agency records, self-report, observation, and/or reliable reports from others, caretaker practices developmentally appropriate sexual boundaries (e.g., respect of child's need for personal space, teaches about

inappropriate touching of private parts/genitals, and educates on sexual decision-making).

b. No evidence that caretaker sexually abuses or fails to protect child from sexual abuse. Based on agency records, self-report, and/or reliable reports from others, there is no reason to believe that the caretaker has ever sexually abused a child or has ever failed to protect a child from sexual abuse.

c. Moderate problems related to sexuality in family; unclear sexual boundaries. Based on agency records, self-report, and/or reliable reports from others, caretaker demonstrates unclear sexual boundaries considering developmental and cultural issues (i.e., exposed child to pornography, practicing nudity with child).

d. Caretaker has abused a child sexually OR has failed to protect a child from sexual abuse. Based on agency records, self-report, and/or reliable reports from others, there is evidence that the caretaker has sexually abused a child or has failed to protect a child from sexual abuse.

- **SN4. Resource Management and Basic Needs**

a. Resources sufficient to meet basic needs and are adequately managed. The caretaker has a history of consistently providing safe, healthy, and stable housing; nutritional food; appropriate clothing; health care; and transportation.

b. Resources may be limited but are adequately managed. The caretaker provides adequate housing, food, clothing, health care, and transportation.

c. Resources are insufficient or not well-managed. The caretaker provides housing but it does not meet the basic needs of the child due to such things as inadequate plumbing, heating, wiring, or housekeeping. Food and/or clothing do not meet basic needs of the child. Insufficient resources to provide for adequate routine health care for caretaker and/or child. Periodic lack of access to transportation negatively affects caretaker's ability to meet child's needs. The family may be homeless; however, there is no evidence of harm or threat of harm to the child as a result.

- d. No resources, or resources severely limited and/or mismanaged. Conditions exist in the household that have caused illness or injury to family members such as inadequate plumbing, heating, wiring, and housekeeping. There is no food, food is spoiled, or family members are malnourished. Child chronically presents with clothing that is unclean, not appropriate for weather conditions, or in poor repair. Child has a significant medical condition that cannot be adequately treated due to caretaker's lack of financial resources to obtain needed care. Lack of access to transportation severely hinders/prevents caretaker's ability to

meet child's basic needs. The family is homeless, which results in harm or threat of harm to the child.

- **SN5. Parenting Skills**

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

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

c. Inadequately parents and protects child. Improvement of basic parenting skills are needed by the caretaker. The caretaker has some unrealistic expectations and gaps in parenting skills, demonstrates poor knowledge of age-appropriate disciplinary methods, and/or lacks knowledge of child development that interferes with effective parenting. Exclude issues regarding sexuality and sexual abuse.

d. Destructive or abusive parenting. The caretaker displays destructive or abusive parenting patterns that result in harm to the child. Exclude issues regarding sexuality and sexual abuse.

- **SN6. Household Relationships/DV**

a. Supportive. Internal or external stressors (i.e., illness, financial problems, divorce, special needs) may be present but the household maintains positive interactions (i.e., mutual affection, respect, open communication, empathy), and shares responsibilities that are mutually agreed upon by the household members. Household members mediate disputes and promote non-violence in the home. Individuals are safe from threats, intimidation, or assaults by other household members. The caretaker may have past history of domestic violence and demonstrate an effective or adequate coping ability regarding any past abuse.

b. Minor or occasional discord. Internal or external stressors are present but the household is coping despite some disruption of positive interactions. Conflicts may be resolved through less adaptive strategies such as avoidance, however, household members do not control each other or threaten physical or sexual assault within the household, or there is no history of DV.

c. Frequent discord or some domestic violence. Internal or external stressors are present and the household is consistently experiencing increased disruption of positive interactions coupled with lack of cooperation and/or emotional or verbal abuse. Custody and visitation issues are characterized by frequent conflicts. The caretaker's pattern of adult relationships creates significant stress for the child. Adult relationships are characterized by occasional physical outbursts that may result in injuries; and/or controlling behavior that results in isolation or restriction of activities. Both the offender and the victim seek help in reducing threats of violence.

d. Chronic discord or severe DV. Internal or external stressors are present and the household experiences minimal or no positive interactions. Custody and visitation issues are characterized by harassment and/or severe conflict, such as multiple reports to law enforcement and/or CPS. The caretaker's pattern of adult relationships place the child at risk for maltreatment and/or contribute to severe emotional distress. One (1) or more household members use regular and/or severe physical violence. Individuals engage in physically assaultive behaviors toward other household members. Violent or controlling behavior has or may result in injury.

Additional information regarding assessing DV can be found in the VDSS Child and Family Services Manual, [Chapter H. Domestic Violence](#) Section 1.5.

- **SN7. Caretaker Abuse or Neglect History**

a. Abuse or neglect as a child, demonstrates good coping ability. The caretaker has experienced physical or sexual abuse or neglect as a child, and demonstrates effective or adequate coping ability regarding his or her abuse or neglect history.

b. No abuse or neglect as a child. No caretaker has experienced physical or sexual abuse or neglect as a child.

c. Minor problems related to abuse or neglect as a child. The caretaker was abused and/or neglected as a child and this history is related to problems in family functioning or impairs positive familial relationships.

d. Serious problems related to abuse or neglect as a child. The caretaker was abused or neglected as a child and this history severely interferes with family functioning, seriously impedes positive familial relationships, or is related to destructive parenting patterns.

- **SN8. Social or Community Support System**

a. Strong support system. The caretaker regularly engages with a strong, constructive, mutual-support system. The caretaker interacts with extended

family, friends, cultural, religious, and/or community support or services that provide a wide range of resources.

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

c. Limited or somewhat negative support system. The caretaker has a limited support system, is isolated, or is reluctant to use available support. The caretaker perceives services and supports as unavailable or inaccessible. The informal resources that are used for support by the caretaker (e.g. friends, relatives, neighbors) may have some negative impact on the family by supporting inappropriate caretaker practices/behaviors or by introducing negative influences. Individuals may experience conflict with cultural or community identity that creates difficulties and internal conflict.

d. No support system or negative support system. The caretaker has no support system and does not utilize extended family and community resources, or the informal resources used by the caretaker as a support system have a significant negative impact on the caretaker and/or on family members (e.g., boyfriend who encourages substance abuse). Connections with potential support networks are unavailable or perceived as unavailable due to the lack of understanding of cultural or community and/or language differences. Household members experience conflict with cultural or community identity that is reflected in behavior.

- **SN9. Physical Health**

a. Preventive health care is practiced. The caretaker manages health concerns, and teaches and promotes good health.

b. Health issues do not affect family functioning. The caretaker has no current health concerns that affect family functioning. The caretaker accesses regular health resources for himself or herself (i.e., medical or dental care).

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

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

- **SN10. Communication Skills**

a. Strong skills. The caretaker's communication skills facilitate successful accessing of services and resources to promote family functioning. If the caretaker requires translation services, he or she obtains such services whenever needed.

b. Functional skills. The caretaker's communication skills are no barrier to effective family functioning, accessing resources, or assisting the child in the community or school. If the caretaker requires translation services, he or she uses such services when provided.

c. Limited skills. The caretaker has limited communication skills resulting in difficulty accessing resources, which interferes with family functioning. If the caretaker requires translation services, he or she experiences difficulty accessing such services or is reluctant to use services.

d. Severely limited skills. The caretaker has severely limited communication skills resulting in an inability to access resources, which severely affects family functioning. If the caretaker requires translation services, he or she is unwilling or unable to communicate even when provided with such services.

The following definitions are to be used when assessing the child.

- **CSN1. Emotional/Behavioral**

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

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

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

d. Severely limited emotional adjustment. Child's ability to perform in one (1) or more areas of functioning is severely impaired due to chronic/severe mental health symptoms such as fire-setting, suicidal behavior, or violent behavior toward people and/or animals.

- **CSN2. Family Relationships**

For a child in voluntary or court-ordered placement, score child's family, not placement family. For a child in permanent placements, continue to score child's family, basing assessment on visits and other contact such as telephone contact or letters. If the child has no contact with his/her family, score "-3."

a. Nurturing/supportive relationships. Child experiences positive interactions with family members. Child has sense of belonging within the family. Family defines roles, has clear boundaries, and supports child's growth and development.

b. Adequate relationships. Child experiences positive interactions with family members and feels safe and secure in family, despite some unresolved family conflicts.

c. Strained relationships. Stress/discord within the family interferes with child's sense of safety and security. Family has difficulty identifying and resolving conflict and/or obtaining support and assistance on their own.

d. Harmful relationships. Chronic family stress, conflict, or violence severely impedes child's sense of safety and security. Family is unable to resolve stress, conflict or violence on their own and are not able or willing to obtain outside assistance.

- **CSN3. Medical/Physical**

a. Preventive health care is practiced. Child has no known health care needs. Child receives routine preventive and medical/dental/vision care and immunizations.

b. Medical needs met. Child has no unmet health care needs. Special conditions (including need for prescribed medications) may exist but are adequately addressed.

c. Medical needs impair functioning. Child has medical condition(s) that may impair daily functioning. Special conditions exist that are not adequately addressed and/or routine medical/dental/vision care is needed.

d. Medical needs severely impair functioning. Child has serious, chronic, or acute medical condition(s) (including need for prescribed medications) that severely impairs functioning, and needs are unmet.

- **CSN4. Child Development**

For this item, base the assessment on developmental milestones as described in [Appendix F: Developmental Milestones](#).

a. Advanced development. Child's physical and cognitive skills are above chronological age level.

b. Age-appropriate development. Child's physical and cognitive skills are consistent with chronological age level.

c. Limited development. Child does not exhibit most physical and cognitive skills expected for chronological age level.

d. Severely limited development. Most physical and cognitive skills are two (2) or more age levels behind chronological age expectations.

- **CSN5. Cultural/Community Identity**

a. Strong cultural/community identity. Child identifies with cultural and community heritage and beliefs and is connected with people who share similar belief systems. Child knows cultural/community resources, both formal and informal, and accesses them as needed.

b. Adequate cultural/community identity. Child identifies with cultural/community heritage and beliefs, practices, and traditions within the family. Child recognizes how to access resources in the greater community. Child may experience some conflict and may struggle with cultural/community identity, yet is able to cope.

c. Limited cultural/community identity. Child experiences inter-generational and/or societal conflict surrounding values and norms related to cultural/community differences. Child perceives services and supports as unavailable or access as limited. Conflicts with cultural/community identity create difficulties for child.

d. Disconnected from cultural/community identity. Child is disconnected from cultural/community heritage and beliefs resulting in isolation, lack of support, and lack of access to resources. Connections are unavailable, or perceived as unavailable, due to lack of understanding of cultural and language differences of support networks. Conflicts with cultural/community identity result in problematic behavior.

- **CSN6. Substance Abuse**

a. No substance use by active decision. Child does not use alcohol or other drugs and is aware of consequences of use. Child avoids peer relations/social

activities involving alcohol and other drugs, and/or chooses not to use despite peer pressure/opportunities to use.

b. Experimentation/use or no use. Child does not use alcohol or other drugs. Child may have experimented with alcohol or other drugs, but there is no indication of sustained use. No demonstrated history or current problems related to substance use.

c. Alcohol or other drug use. Child's alcohol or other drug use results in disruptive behavior and discord in relationships in school/community/family or work. Use may have broadened to include multiple drugs.

d. Chronic alcohol or other drug use. Child's chronic alcohol or other drug use results in severe disruption of functioning, such as loss of relationships, job, school suspension/expulsion/drop-out, problems with the law, and/or physical harm to self or others. Child may require medical intervention to detoxify.

- **CSN7.Education**

Does child have a current specialized educational plan? (Specialized educational plan includes IEP, study team, etc.)

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

b. Satisfactory academic achievement. Child is working at grade level and/or is meeting the expectations of the child's specific educational plan.

c. Academic difficulty. Child is working below grade level in at least one (1), but not more than half, of academic subject areas and/or child is struggling to meet the goals of the existing educational plan. Existing educational plan may need modification.

d. Severe academic difficulty. Child is working below grade level in more than half of academic subject areas and/or child is not meeting the goals of the existing educational plan. Existing educational plan needs modification. Also score "d" for a child who is required by law to attend school and is not attending.

- **CSN8.Peer/Adult Social Relationships**

a. Strong social relationships. Child enjoys and participates in a variety of constructive, age-appropriate social activities. Child enjoys reciprocal, positive relationships with others.

b. Adequate social relationships. Child demonstrates adequate social skills. Child maintains stable relationships with others; occasional conflicts are minor and easily resolved.

c. Limited social relationships. Child demonstrates inconsistent social skills; child has limited positive interactions with others. Conflicts are more frequent and serious and child may be unable to resolve them.

d. Poor social relationships. Child has poor social skills as demonstrated by frequent conflictual relationships or exclusive interactions with negative or exploitive peers, or child is isolated and lacks a support system.

- **CSN9.Delinquent/CHINS Behavior** (Delinquent behavior includes any action which, if committed by an adult, would constitute a crime.) CHINS behavior includes offenses that are unique to children (e.g., truancy, runaway).

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

b. No delinquent/CHINS behavior. Child has no arrest history and there is no other indication of criminal or CHINS behavior, or child has successfully completed probation and there has been no criminal or CHINS behavior in the past two (2) years.

c. Occasional delinquent/CHINS behavior. Child is or has engaged in occasional, non-violent delinquent behavior or CHINS behavior and may have been arrested or placed on probation within the past two (2) years.

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

6.22.2 FSNA guidance and procedures

The FSNA is used to systematically identify critical family needs and help develop effective service plans. The FSNA serves several purposes:

- It ensures that all on-going CPS workers and family members consistently consider each family's strengths and needs in an objective format;
- It provides an important service planning reference for workers and supervisors;
- It serves as a mechanism for monitoring service referrals made to address identified family and child needs; and

- The initial FSNA, when followed by regular strengths and needs reviews, permits staff and supervisors to easily assess change in family functioning and evaluate the impact of services on the case.

Which cases: The FSNA is completed on all open CPS on-going cases. The child assessment portion is completed for each child who will be included in the service plan.

Who: The CPS on-going worker completes the FSNA.

When: The FSNA must be completed prior to the development of the service plan and no later than **30 calendar days** from the date *the case was opened*. Review in on-going CPS cases should be done every 90 days after completion of the service plan.

Decision: The FSNA is used to identify family needs that must be addressed in the family's service plan. The on-going CPS worker identifies the need areas for the family through scoring the primary caretaker (and, if present, the secondary caretaker) and the child. Priority need areas are those with negative point values as scored by the worker for either the primary or secondary caretaker. For the child, priority needs areas are also determined by those need areas with negative point values. The CPS on-going worker also identifies family and child strengths, as scored on the tool and any other strengths identified through the assessment process. After scoring the strengths and needs items, the CPS on-going worker lists the three (3) greatest needs and strengths identified. (Consider both the primary and secondary caretaker when identifying these priority needs.) Priority items must then be incorporated into the service plan and addressed immediately. For the child, all needs should also be incorporated into the service plan. For CPS on-going cases reassessed at moderate risk, the FSNA guides the decision regarding closing the case.

Appropriate completion: Only one (1) household can be assessed on the FSNA. The household assessed must be the same household for which the Family Risk Assessment was completed. Whenever possible, the family should be involved in the process of gathering information used to complete the FSNA.

The household is assessed by completing all items. If there are two (2) caretakers, each is assessed and scored separately. For the caretakers, list in order of greatest to least the top three (3) needs identified. List in order the top three (3) strengths identified. For the child, all needs should be addressed in the

service plan. A negative score (i.e., -3) indicates a need, while a positive score (i.e., +3) indicates a strength. Scoring must be done in accordance with the item definitions provided. It is the use of the definitions that helps provide consistency in the assessment process.

6.23 Appendix F: Developmental Milestones

Physical and Cognitive Developmental Milestones ¹		
Age Level	Physical Skills	Cognitive Skills
0-4 Weeks	Lifts head when on abdomen. Head momentarily to midline when on back. Equal extremity movements. Sucking reflex. Grasp reflex (no reaching and hand usually closed). Increasing body tone and stabilization of basic body functions, growing capacity to stay awake.	Looks at face transiently. By three to four weeks, smiles selectively to mother's voice and human voice lead to quieting of cries. Cries if uncomfortable or in a state of tension; undifferentiated initially, but gradually varies with cause (i.e. hungry, tired, pain).
1-3 Months	Head to 45 degrees when on abdomen, erect when sitting. Bears fraction of weight when held in standing position. Uses vocalizations. By two to three months, grasps rattle briefly. Puts hands together. By three to four months, may reach for objects, suck hand or fingers. Head is more frequently to midline and comes to 90 degrees when on abdomen. Rolls side to back.	Increased babbles and coos. Most laugh out loud, squeal and giggle. Smiles responsively to human face. Increased attention span.
3-6 Months	Rolls from abdomen to back then from back to abdomen. Bears increasing weight when held upright. No head lag when pulled to sitting. Head, eyes and hands work well together to reach for toys or human face. Inspects objects with hands, eyes and mouth. Takes solid food well.	Spontaneously vocalizes vowels, consonants and a few syllables. Responds to tone and inflection of voice. Smiles at images in mirror.

¹ Adapted from "Developmental Milestones Summary," Institute for Human Services, (1990); "Developmental Charts" provided by Jeffery Lusko, Orchards Children's Service, Southfield, MI; "Early Childhood Development from two to six years of age," Cassie Landers, UNICEF HOUSE, New York.

Age Level	Physical Skills	Cognitive Skills
6-9 Months	Sits without support. Increasingly mobile. Stands while holding on. Pushes self to sitting. Grasps objects, transfers objects. Feeds own self finger foods, puts feet to mouth and may hold own bottle. Approaching nine months, pulls self to standing position.	Says mam/dada randomly. Begins to imitate speech sounds. Many syllable sounds (ma, ba, da). Responds to own name, beginning responsiveness to “no, no”.
9-12 Months	Crawls with left-right alternation. Walks with support, stands momentarily and takes a few uneasy steps. Most have neat pincer grasp. Bangs together objects held in each hand. Plays pat-a-cake. Fifty percent drink from cup by themselves.	Imitates speech sounds. Correctly uses mam/dada. Understands simple command (“give it to me”). Beginning sense of humor.
12-15 Months	Stands well alone, walks well, stoops and recovers. Neat pincer grasp. Can put a ball in a box, and a raisin in a bottle. Can build a tower of two cubes. Spontaneous scribbling with palmer grasp of crayon. Fifty percent use spoon with minimal spilling. Most drink from cup unassisted.	Three to five word vocabulary. Uses gestures to communicate. Vocalizing replaces crying for attention. Understands “no.” Shakes head for no. Sense of me and mine. Fifty percent imitate household tasks.
15-18 Months	Runs stiffly. Walks backwards. Attempts to kick. Climbs on furniture. Crude page turning. Most use spoon well. Fifty percent can help in little household tasks. Most can take off pieces of clothing.	Vocabulary of about ten words. Uses words with gestures. Fifty percent begin to point to body parts. Vocalizes “no.” Points to pictures of common objects (i.e., dog). Knows when something is complete such as waving bye-bye. Knows where things are or belong. More claiming of mine. Beginning distinction of you and me, but does not perceive others as individuals like self. Resistant to change in routine. Autonomy expressed as defiance. Words are not important discipline techniques.

Age Level	Physical Skills	Cognitive Skills
18-24 Months	While holding on, walks up stairs, then walks down stairs. Turns single pages. Builds tower of four-six cubes. Most copy vertical line. Strings beads or places rings on spindles. Helps dress and undress self. Can wash and dry hands. Most can do simple household tasks.	Markedly increased vocabulary (mostly nouns). Consistently points to body parts. Combines two to three words. Names pictures of common objects. Follows simple directions. Matches colors frequently, but uses color names randomly. Uses number words randomly. May indicate wet or soiled diapers. Asks for food or drink. Understands and asks for "another." Mimics real life situations during play. Self-centered, but distinguishes between self and others. Conscious of family group.
2 Years	Jumps in place with both feet. Most throw ball overhead. Can put on clothing, most can dress self with supervision. Can use zippers, buckles, and buttons. Most are toilet trained. Good steering on push toys. Can carry a breakable object. Can pour from one container to another. By 30 months, alternates feet on stair climbing, pedals tricycle, briefly stands on one foot; builds eight-cube tower, proper pencil grasp, imitates horizontal line.	Learns to avoid simple hazards (stairs, stoves, etc.). By 30 months, vocabulary reaches 300 words. Identity in terms of names, gender, and place in family are well established. Uses "I," but often refers to self by first name. Phrases and three-four word sentences. By 36 months, vocabulary reaches 1,000 words, including more verbs and some adjectives. Understands big versus little. Interest in learning, often asking "What's that?"
3 Years	Most stand on one foot for five seconds. Most hop on one foot. Most broad-jump. Toilets self during daytime. By 38 months, draws picture and names it. Draws two-part person.	Counts to three. Tells age by holding up fingers. Tells first and last name (foster children may not know last name). Most answer simple questions. Repeats three or four digits or nonsense syllables. Readiness to conform to spoken word. Understands turn-taking. Uses language to resist. Can bargain with peers. Understands long versus short. By end of third year, vocabulary is 1,500 words.

Age Level	Physical Skills	Cognitive Skills
4-5 Years	<p>Most hop on one foot, skip alternating feet, balance on one foot for ten seconds, catch bounced ball, do forward heel-toe walk. Draws three-part person. Copies triangles, linear figures (may have continued difficulty with diagonals, and may have rare reversals). Most dress independently other than back buttons and shoe tying. Washes face and brushes teeth. Laces shoes.</p>	<p>By end of fifth year, vocabulary is over 2,000 words including adverbs and prepositions. Understands opposites (day/night). Understands consecutive concepts (big, bigger, and biggest). Lots of why and how questions. Correctly counts five to ten objects. Correctly identifies colors. Dogmatic and dramatic. May argue about parental requests. Good imagination. Likes silly rhymes, sounds, names, etc. Beginning sense of time in terms of yesterday, tomorrow, sense of how long an hour is, etc. Increasingly elaborate answers to questions.</p>
6-11 Years	<p>Practices, refines, and masters complex gross and fine motor and perceptual skills.</p>	<p>Concrete operational thinking replaces egocentric cognition. Thinking becomes more logical and rational. Develops ability to understand others' perspectives.</p>
12-17 Years	<p>Physiological changes at puberty promote rapid growth, maturity of sexual organs, and development of secondary sex characteristics.</p>	<p>In early adolescence, precursors to formal operational thinking appear, including limited ability to think hypothetically and to take multiple perspectives. During middle and late adolescence, formal operational thinking becomes well developed and integrated in a significant percentage of adolescents.</p>

6.24 Appendix G: Comparing FPM and Child and Family Team Meetings

Comparison of FPM and CFTM	
Family Partnership Meetings (FPM)	Child and Family Team Meetings (CFTM)
<p>Purpose: To involve birth families (parents and extended family members) in all critical case decisions and to insure a network of support for the child and the adults who cares for him/her.</p>	<p>Purpose: To involve birth families (parents and extended family members) in on-going case planning, monitoring and adjusting; to insure that all team members have access to all information about the case; to insure that all team members understand the goal(s) of service provision and the current plan to protect the child and to achieve permanency; and to insure a network of support for the child and the adults who cares for him/her.</p>
<p>When: At the point that a critical case decision must be made: potential child removal; potential child placement change (placement disruption or change in FC goal); or reunification.</p>	<p>When: Regularly or as often as needed, whichever is soonest. Ideally, meetings will be held at least quarterly and the next one will be scheduled at the end of the current one.</p>
<p>Who: family and extended family; youth; family services specialist; supervisor; family supports as identified by the family; providers (maybe); attorneys (maybe); CASA (maybe); community representative; FPM facilitator.</p>	<p>Who: family and extended family; youth; family services specialist; supervisor (maybe); family supports as identified by the family; resource family or placement representative; school representative; all treatment providers ; attorneys; CASA; Probation officer (if applicable), etc.</p>
<p>Logistics: scheduling to maximize parent and family participation; ideally held in neutral location; consider use of conference calling; and transportation and child care should be provided by LDSS.</p>	<p>Logistics: scheduling to maximize full team participation, including parents, resources parents and critical extended family members; usually held at LDSS or service provider office; consider use of alternative meeting space and/or conference calling; and transportation and child care should be addressed (meetings are scheduled in advance, so community based or natural resources can be engaged.)</p>
<p>Values based upon:</p> <ul style="list-style-type: none"> • All families have strengths • Families are the experts on themselves • Families can make well-informed decisions about keeping their children safe when supported • Outcomes improve when families are involved in decision-making • A team is more capable of creative and high quality decision-making than an individual 	<p>Values based upon:</p> <ul style="list-style-type: none"> • All families have strengths • Families are the experts on themselves • Families can make well-informed decisions about keeping their children safe when supported • Outcomes improve when families are involved in decision-making • A team is more capable of creative and high quality decision-making than an individual

Comparison of FPM and CFTM	
Family Partnership Meetings (FPM)	Child and Family Team Meetings (CFTM)
<p>Stages of the Meeting/ Agenda:</p> <ul style="list-style-type: none"> • Introduction: purpose and goal; introduction of participants; and meeting guidelines. • Identify the situation: Define the concern/ decision to be made. • Assess the situation: safety needs; risk concerns; strengths and supports; hx of services; participants' perception of the situation; and worker recommendation(s). • Develop ideas: brainstorm in three categories, placement/custody, actions to provide safety, and services to reduce risk. • Reach a decision: consensus based decision (if possible) and addressing agency safety concerns, action plan, and linkage to services. • Recap/closing: review of decision and who will do what; any questions. 	<p>Stages of the Meeting/ Agenda:</p> <ul style="list-style-type: none"> • Introductions: names and roles • Review of progress: each team member (starting with parents) provides an update of progress made in the last month and which services have been completed and/or treatment goals have been met • Identification of concerns/ services needing adjustment: each member (starting with parents) addresses areas of concern and/or what is not working well or may need to be adjusted • Review of goal(s): team explores fit between progress, services and goals; team members (including family) make recommendations as to improving fit or clarifying goal(s); next steps identified • Action plan is developed • Next meeting is scheduled
<p>Summary of Differences:</p> <ul style="list-style-type: none"> • Led by a facilitator • Supervisor as well as worker attend • Family participation is the most critical aspect • Extensive pre-work ensures family is engaged in the meeting process • Formal and informal supports are invited and are part of the team • Agenda and meeting process are standardized and more formal (reflect importance of decision being made) • Outcome is a particular case decision required at that point in the "life of the case" 	<p>Summary of Differences:</p> <ul style="list-style-type: none"> • Led by family services specialist • Supervisor does not always attend • Parent participation is critical • Agenda is informal • Outcome is action plan for the next several months leading to permanency

6.25 Appendix H: Risk Reassessment Tool

**VIRGINIA DEPARTMENT OF SOCIAL SERVICES
 FAMILY RISK REASSESSMENT FOR CPS CASES**

OASIS Case Name: _____ Case #: _____
 Worker Name: _____ Supervisor: _____
 Reassessment Date ___/___/___

- | | | |
|--|--------------|--|
| R1. Number of prior neglect or abuse CPS investigations/assessments | Score | |
| a. None..... | 0 | |
| b. One..... | 1 | |
| c. Two or more..... | 2 | |
| R2. Household has previously received child welfare services (voluntary/court-ordered) | | |
| a. No | 0 | |
| b. Yes | 1 | |
| R3. Primary caretaker has a history of abuse or neglect as a child | | |
| a. No | 0 | |
| b. Yes | 1 | |
| R4. Child characteristics (check applicable items and add for score) | | |
| a. ___No child has any of the characteristics listed below | 0 | |
| b. ___One or more children in household is developmentally or physically disabled..... | 1 | |
| c. ___One or more children in household is medically fragile or diagnosed with failure to thrive | 1 | |

The following case observations pertain only to the period since the last risk assessment/reassessment.

- | | | |
|---|---|--|
| R5. New investigation/assessment of abuse/neglect since the initial risk assessment or last reassessment | | |
| a. No | 0 | |
| b. Yes | 2 | |
| R6. Caretaker has not addressed alcohol or drug abuse problem since last risk assessment/reassessment (check one) | | |
| a. ___No history of alcohol or drug abuse problem..... | 0 | |
| b. ___No current alcohol or drug abuse problem; no intervention needed..... | 0 | |
| c. ___Yes, alcohol or drug abuse problem; problem is being addressed | 0 | |
| d. ___Yes, alcohol or drug abuse problem; problem is <u>not</u> being addressed | 1 | |
| R7. Problems with adult relationships | | |
| a. None of the following apply | 0 | |
| b. Yes, harmful/tumultuous relationships with adults | 1 | |
| c. Yes, domestic violence | 2 | |
| R8. Primary caretaker provides physical care inconsistent with child needs | | |
| a. No problems..... | 0 | |
| b. Yes, problems | 1 | |
| R9. Caretaker’s progress with service plan (if two caretakers in household, base score on the caretaker who demonstrates the least progress) | | |
| a. ___Not applicable; all services unavailable..... | 0 | |
| b. ___Successfully completed all services recommended or actively participating in services; pursuing objectives detailed in service plan | 0 | |
| c. ___Minimal participation in pursuing objectives in service plan | 2 | |
| d. ___Has participated but is not meeting objectives; refuses involvement in services or failed to comply/participate as required..... | 4 | |

TOTAL SCORE SCORED RISK LEVEL. Assign the family’s risk level based on the following chart:

<u>Score</u>	<u>Risk Level</u>	
0-2	_____	Low
3-5	_____	Moderate
6-8	_____	High
9-16	_____	Very High

POLICY OVERRIDES. Circle yes if condition is applicable in the case. If any condition is applicable, override final risk level to very high.

- Yes No 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
Yes No 2. Non-accidental injury to a child under age 3.
Yes No 3. Severe non-accidental injury.
Yes No 4. Parent/caretaker action or inaction resulted in death of a child due to abuse or neglect.

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

Yes No 5. If yes, override risk level (circle one): Low Moderate High Very High
Reason: _____

Supervisors review/approval of discretionary override: _____
Date: __/__/_____

FINAL RISK LEVEL (circle final level assigned): Low Moderate High Very High

Not included on electronic version:

CASE STATUS (at close of review):

- Case remains open for CPS services
- Case transferred to foster care services
- Case closed. If closed, reason: _____
Closure Date: _____

6.25.1 Family risk reassessment definitions

- R1. Number of prior neglect or abuse CPS investigations/assessments.

Score the item based on the count of all investigations/assessments for any type of abuse or neglect prior to the investigation/assessment resulting in the current case. In counting investigations/assessments, the conclusion (i.e., founded or not) does not matter. Where possible, history from other jurisdictions should be checked. Exclude screened-out referrals and investigations/assessments of out-of-home perpetrators (e.g., daycare) unless one (1) or more caretakers failed to protect.

- R2. Household has previously received child welfare services (voluntary/court-ordered)

Score 1 if the household has previously received child welfare services prior to the current event. Service history includes voluntary or court-ordered family services, but does not include delinquency or CHINS services. This does not include prior investigations/assessments as they are captured in R1.

- R3. Primary caretaker has a history of abuse or neglect as a child

Score 1 if credible statements by the primary caretaker or others indicate that the primary caretaker was maltreated as a child (maltreatment includes neglect or physical, sexual, or other abuse).

- R4. Child characteristics

Score the appropriate amount for each characteristic present and record the sum as the item score.

- Score 0 if no child in the household exhibits characteristics listed below.
- Score 1 if any child is developmentally or physically disabled, including any of the following: intellectual disability, learning disability, other developmental problem, or significant physical handicap.
- Score 1 if any child in the household is medically fragile, defined as having a long-term (six (6) months or more) physical condition requiring medical intervention, or is diagnosed as failure to thrive.
- R5. New investigation/assessment of abuse/neglect since the initial risk assessment or last reassessment

Score 2 if at least one (1) investigation/assessment has been initiated since the initial risk assessment or last reassessment. This includes open or completed

investigations/ assessments, regardless of investigation/assessment conclusion, that have been initiated since the initial risk assessment or last reassessment.

- R6. Caretaker has not addressed alcohol or drug abuse problem since last risk assessment/reassessment

Indicate whether or not the primary and/or secondary caretaker has a current alcohol/drug abuse problem that interferes with the caretaker or the family functioning and he/she is not addressing the problem. If both caretakers have a substance abuse problem, rate the more negative behavior of the two (2) caretakers. Not addressing the problem is evidenced by the following:

- Substance use that affects or affected caretaker's employment; criminal involvement; marital or family relationships; or his/her ability to provide protection, supervision, and care for the child;
- An arrest since the last assessment/reassessment for driving under the influence or refusing breathalyzer testing;
- Self-report of a problem;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use;
- Child diagnosed with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE) or child had positive toxicology screen at birth and primary or secondary caretaker was birthing parent.

Score as follows:

- Score 0 if there is no history of an alcohol or drug abuse problem.
 - Score 0 if there is no current alcohol or drug abuse problem that requires intervention.
 - Score 0 if there is an alcohol or drug abuse problem and the problem is being addressed.
 - Score 1 if there is an alcohol or drug abuse problem and the problem is not being addressed.
 - Legal, non-abusive prescription drug use should not be scored.
- R7. Problems with adult relationships

Score this item based upon current status of adult relationships in the household.

- Score 0 if there are no problems observed.
- Score 1 if yes, there are harmful/tumultuous adult relationships that are harmful to domestic functioning or the care the child receives (but not at the level of DV). An example is a live-in boyfriend who encourages the mother's use of drugs.
- Score 2 if yes, DV is present. Household has had, since the most recent assessment, physical assault(s) or periods of intimidation/threats/harassment between caretakers or between a caretaker and another adult.

Additional information regarding assessing DV can be found in the VDSS Child and Family Services Manual, [Chapter H. Domestic Violence](#) Section 1.5.

- R8. Primary caretaker provides physical care inconsistent with child needs

Score 1 if physical care of child (age-appropriate feeding, clothing, shelter, hygiene, and medical care of child) threatens the child's well-being or results in harm to the child. Examples include the following:

- Repeated failure to obtain required immunizations;
- Failure to obtain medical care for severe or chronic illness;
- Repeated failure to provide child with clothing appropriate to the weather;
- Persistent rat or roach infestations;
- Inadequate or inoperative plumbing or heating;
- Poisonous substance or dangerous objects lying within reach of small child;
- Child is wearing filthy clothes for extended periods of time; or
- Child is not being bathed on a regular basis, resulting in dirt caked on skin and hair and a strong odor.

- R9. Caretaker's progress with service plan

Score this item based on whether the caretaker has demonstrated or is beginning to demonstrate skills learned from participation in services. If there are two (2) caretakers in the household, base the answer on the caretaker who demonstrates the least progress.

- Score 0 if not applicable. All desired services were unavailable during the last assessment period.
- Score 0 if caretaker successfully completed all services recommended or is actively participating in services; or is pursuing objectives detailed in the service plan. Caretaker applies learned skills in interaction(s) between child/caretaker, caretaker and other caretaker, and caretaker and other significant adult(s); self-care; home maintenance; financial management; or demonstrates skills toward reaching the behavioral objectives agreed upon in the service plan.
- Score 2 if there was minimal participation in pursuing objectives in the service plan. The caretaker is minimally participating in services, has made progress but is not fully complying with the objectives in the service plan, or has not yet demonstrated the skills learned from participation in services.
- Score 4 if caretaker has participated in services but is not meeting service plan objectives, refused involvement in services, or failed to comply/participate as required. The caretaker refuses services, sporadically follows the service plan, or has not demonstrated the necessary skills due to a failure or inability to participate.

6.25.2 Family risk reassessment guidance and procedures

The family risk reassessment combines items from the original family risk assessment with additional items that evaluate a family's progress toward service plan goals. Research has demonstrated that, for the reassessment, a single index best categorizes risk for future maltreatment. Unlike the initial risk assessment, which contains separate indices for risk of neglect and risk of abuse, the risk reassessment tool is composed of a single index.

Which Cases: All open CPS cases in which all children who are receiving case management services remain in the home.

Who: The CPS on-going worker.

When: In conjunction with every service plan review, every 90 days after completion of the initial service plan.

A risk reassessment should be completed sooner if there are new circumstances or new information that would affect risk.

If a new referral is received while a case is open, an initial risk assessment (not a risk reassessment) will be completed during the investigation/assessment, according to risk assessment guidance

and procedures.

Decisions: The risk reassessment guides the decision to close a case.

All cases in which risk is reduced to low should be considered for closure unless special circumstances exist.

Cases in which risk remains or is reduced to moderate should be considered for closure if there is a corresponding reduction in priority needs as indicated in the family strengths and needs review (see FSNA review guidance and procedures).

High or very high risk cases should remain open unless special circumstances exist.

Appropriate Completion: Items R1–R4: Using the definitions, determine the appropriate response for each item and enter the corresponding score. Note that items R1 and R2 refer to the period of time PRIOR to the investigation/assessment that led to the opening of the current case. Scores for these two (2) items should be identical to corresponding items on the initial risk assessment unless additional information has become available.

Item R3 may change if new information is available or if there has been a change in primary caretaker.

Item R4 may change if a child's condition has changed, or if a child with a described condition is no longer part of the household (children in foster care with a plan to return home are considered part of the household).

Items R5–R9: These items are scored based ONLY on observations since the most recent assessment or reassessment.

Using the definitions, determine the appropriate response for each item and enter the corresponding score.

After entering the score for each individual item, enter the total score and indicate the corresponding risk level.

Policy Overrides: As on the initial risk assessment, the agency has determined that there are certain conditions that are so serious that a risk level of very high should be assigned regardless of the risk assessment score. The policy overrides refer to incidents or conditions that

occurred since the initial risk assessment or last reassessment.

Policy overrides require supervisor review and approval.

**Discretionary
Override:**

Discretionary overrides are used by the CPS on-going worker whenever the worker believes that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment in which the worker could only increase the risk level, the risk reassessment permits the worker to increase or decrease the risk level by one (1) step. The reason a worker may now decrease the risk level is that after a minimum of three (3) months, the worker has acquired significant knowledge of the family. If the worker applies a discretionary override, the reason should be documented.

Discretionary overrides require supervisory review and approval.

6.26 Appendix I: Services for Sex Trafficking Victims

The following is taken from Child Welfare and Human Trafficking, Child Welfare Information Gateway and available [here](#).

Children and youth who have been victims of trafficking have many needs similar to those of children who enter the child welfare system because of substantiated abuse or neglect by their parents.

Consider the following service needs when dealing with children and youth who have been victims of trafficking, including sex trafficking:

- **Physical health:** Victims often have experienced physical abuse or neglect, mental abuse and/or sexual abuse. Associated with this maltreatment may be physical injuries including untreated internal or external injuries; sexually transmitted diseases, including HIV; and malnutrition. They may be addicted to drugs and/or alcohol either as a result of being forced to use substances by their trafficker or as a coping mechanism. Their overall health may show the consequences of long periods of poor or no medical or dental care. Child welfare workers can help by ensuring that victims have access to medical screenings and treatment to address both immediate and long-term concerns.
- **Mental health and trauma:** It is hard to overstate the complex mental health needs of trafficking victims. The traumatic experiences of being trafficked have often come at the expense of the youth's childhood. Severe abuse experiences may cause alterations in brain development, as the child or youth learns to operate from a "survival" mode. In addition, victims may not have experienced a secure and trusting relationship with a parent or other caretaker, which makes it difficult to build other relationships. In extreme maltreatment cases, such as being trafficked, a victim may experience posttraumatic stress syndrome.

Most children who have been trafficked have a need for long-term, intensive mental/behavioral health services that can help them move forward into a new, healthier life. Research has suggested the benefits of cognitive-behavioral therapy for children who have been trafficked.

- **Education:** Trafficked youth will likely require educational screening and may require remedial services. Child welfare workers can help by collecting records, exploring education options and facilitating enrollment.
- **Legal services:** There are a number of circumstances that might require a trafficked youth to hire/need legal help. Victims may need legal help if they have been charged with prostitution or other crimes. They may need legal help to get protection for themselves from the trafficker(s).

- **Other needs:** Trafficked victims will often need help with basic life skills (e.g. opening a bank account, keeping medical records) as well as training for a job and basic job skills. For many youth, having a mentor or someone who is willing and available to provide guidance over the long-term is essential to ensure that the youth is able to pursue a life away from trafficking.

6.26.1 Additional resources

- [Services Available to Victims of Human Trafficking- A Resource Guide for Social Service Providers](#) published by the Department of Health and Human Services.
- Volume 102 of the Virginia Child Protection Newsletter Spring 2015 Edition: [Sex Trafficking of Children](#).
- The Department of Criminal Justice Services website: [Human Trafficking Resources for Victim Services](#).