2

EARLY PREVENTION SERVICES TO FAMILIES

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EARLY PREVENTION SERVICES TO FAMILIES

2.1 Intended audience for Section 2

The intent of Section 2, Early Prevention Services to Families, is as follows:

- *To provide strategies for community outreach to the general public and for activities directed to individuals or groups who may be at risk of abuse or neglect.*
- To provide program managers, supervisors, and service workers involved in early prevention with best practice strategies for engaging families during an initial outreach contact, empowering families in decision making, maintaining family engagement and partnership when a family has requested services.

Section 2 includes the following information:

- *Guidelines for public education and awareness activities and services to individuals and groups at risk of abuse or neglect.*
- Guidelines for early prevention family assessments.
- Definitions of case types for prevention to facilitate consistent data collection.
- Early prevention oriented service planning.
- Principles of practice for strength-based, trauma informed family engagement practice and supervision in early prevention, using the protective factors as a framework.
- Guidelines for trauma informed case management.
- Tools to use for assessment and outcome measurements.

2.2 Definition of early prevention services to families

Early prevention services are an integral part of the continuum of all child welfare services. These services include, but are not limited to, providing information and services intended to: strengthen families and improve child well-being, minimize harm to children, maximize the abilities of families to protect and care for their own children and

prevent abuse, neglect, and the need for out-of-home care across the continuum of services within local departments of social services (LDSS).

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

- **Primary prevention**: Public education and awareness activities directed to the general public.
- **Secondary prevention**: Services to children and families who are considered to be at risk; and, services to families who have no current, valid Child Protective Services (CPS) referral, but may be at risk of maltreatment or out-of-home care.
- **Tertiary prevention**: Services provided to children and families after a current, valid child protective services referral through CPS on-going, foster care or adoption. These services prevent the reoccurrence of maltreatment and family disruption in foster care and adoption. They also provide an element of secondary prevention by preventing maltreatment in foster care and adoption.

Early Prevention services are the first step on this prevention continuum (Appendix D: The prevention continuum in Section 1). They are defined as services provided to families prior to, or in the absence of, a current, valid CPS referral. Section 2 of Chapter B is focused on Primary and Secondary Early Prevention Services which are designed to strengthen and support families and increase self-sufficiency and interdependence in their communities. Establishing collaborative partnerships within the community and engaging families in these volunteer services are essential to achieving desired outcomes.

2.3 Primary prevention: Public education and awareness activities for all families

The Pathway to the Prevention of Child Abuse and Neglect, a 2007 publication that is an outcome of the Project on Effective Interventions at Harvard University, underlines the fact that prevention is not the sole responsibility of any single agency or organization, but is a shared community concern. Effective prevention strategies require a range of actions at the individual, family, and community levels to reduce risk factors and strengthen protective factors.

LDSS provide public education and awareness activities and collaborate with a wide range of community partners, including schools, Community Services Boards (CSB), health departments, local or regional coalitions, and Prevent Child Abuse Virginia (PCAV), among others. The types of activities undertaken include the following:

- *Family Fun Days conducted in various communities.*
- *Substance abuse community forums.*

- *Presentations at church activities and other community groups on topics of interest to all parents.*
- *Including parenting tips and other parenting information on their local web page.*
- *Distributing pamphlets and other parenting information at health fairs, local festivals, community centers, libraries, and churches.*
- *Getting newspaper articles published on topics of interest to all parents during Child Abuse Prevention month.*
- *Playing looping videos on parenting in the waiting area of the LDSS.*

Some examples of national community outreach, education, and awareness programs include:

- *Safe Sleep 365.*
- *Safe to Sleep®.*
- *Shaken Baby Syndrome.*
- *Period of Purple Crying®.*
- *All Babies Cry.*
- *Child Passenger Safety.*
- *Where's Baby? Look Before You Lock.*
- *ZERO TO THREE®.*
- *Office of Child Care (OCC).*
- *Substance Abuse and Mental Health Services Administration (SAMHSA).*

Some examples of resources used to promote positive youth development include:

- *Family & Youth Services Bureau (FYSB).*
- *Adverse Childhood Experience (ACE) Study.*
- *READY BY 21®.*
- *The Developmental Assets Profile (DAP).*

- *National Mentoring Resource Center.*

2.3.1 Child Abuse and Neglect Prevention Month

Since the early 1980's, when the President and Congress made the initial designation of April as Child Abuse Prevention Month, each Virginia Governor has made the annual designation in Virginia. This observance has made a major difference in raising awareness in Virginia and across the country. Communities have been creative in building on the designation of Prevention Month to mobilize their citizens and make a difference on behalf of children and families.

Child Abuse Prevention Month is one of the most successful nationwide public education and awareness efforts in child abuse prevention. The observance of Child Abuse Prevention Month provides an opportunity for communities to highlight local prevention work and how individuals and communities can work to prevent abuse and neglect. Because Child Abuse Prevention Month is recognized nationally, it also provides an opportunity to gain media coverage. Although prevention efforts are ongoing, Prevention Month's observance provides a context in which to conduct the following activities:

- *Public awareness activities, such as distributing parenting tips in high risk neighborhoods or in hospitals, highlighting a particular prevention approach, such as All Babies Cry, or conducting a community wide public awareness campaign directed to all families and focused on positive parenting messages.*

- *Distributing pinwheels for prevention in various venues in the community (e.g., planting pinwheel gardens in the community).*

- *Activities that recognize the professionals, paraprofessionals, volunteers, and community members who contribute year round to prevention efforts.*

- *Fundraising efforts for prevention.*

- *Workshops and public education events.*

- *Promoting participation in workshops and seminars for parents that occur within the community (e.g., classes in hospitals for new parents).*

- *Reaching out to community partners to conduct collaborative activities, such as Celebrity Nights at local restaurants.*

- *Creating and distributing a community calendar that highlights daily activities during Prevention Month.*

In addition to engaging local coalitions or prevention teams in activities during Prevention Month, other resources for conducting activities and engaging the media include the following:

- *Prevention Resource Guide.*
- *Blue Ribbon Campaign.*
- *Prevent Child Abuse America.*
- *Prevent Child Abuse Virginia (PCAV).*
- *Child Welfare Information Gateway – Spread The Word.*
- *Children's Bureau.*
- *Library of Virginia.*
- *Virginia Cooperative Extension – local offices.*
- *Early Impact Virginia (EIV).*

2.3.2 Group models for prevention education

Group models for providing education, support, and information can be provided to parents or youth. Group members may share common characteristics that put them at risk of maltreatment. They can be as broad as mother's or father's groups or as specific as groups for parents of children with an autism spectrum disorder (ASD), kinship caregiver groups, spouses of deployed military, immigrant families, etc. These groups may be community-based or offered by the LDSS. The families participating may or may not have an open prevention services case.

2.3.2.1 Parent support groups

Support groups where parents and other caregivers can share ideas, celebrate successes, and assist each other in meeting the daily challenges of parenting are a vital resource for any early prevention effort. Parent support groups provide a safe place where anyone in a parenting role can openly discuss concerns and problems without judgment. To be most effective, the approach is strength-based and parents are partners in the process. Circle of Parents® and Parents Anonymous are examples of parent support groups. Both websites provide information about local groups in each community. PCAV can also provide information about parent support groups.

2.3.2.2 Parent education groups

Parent education is a process for helping parents understand children's development, needs and uniqueness, and their own roles and responsibilities in observing, interpreting, and responding to children's behavior. Parent education can offer specific strategies and tools to maximize positive outcomes for both children and families. Types of parent education programs parallel the types of prevention services described in guidance:

- ***Primary:*** *Programs offered to the general population focused on enhancing parenting knowledge and skills on a wide range of universal topics. Parents participating in these programs are not typically court involved.*

- ***Secondary****: Programs offered to children and families that may be at risk of abuse or neglect focused on enhancing parenting knowledge and skills in specific areas known to be associated with risk and that include building self-awareness about the parenting approaches and behaviors that have the potential for putting children at risk. Parents participating in these programs may or may not have court involvement.*

- ***Tertiary****: Programs offered to children and families who have experienced abuse or neglect and enhance parenting knowledge and skills and foster an understanding of how parents' early experiences and belief system influences their parenting. Such programs empower parents to use their new knowledge and insight to change their behavior. Parents participating in these programs are typically, though not always, court involved.*

In some instances, parent education groups can encompass a combination of primary, secondary, and tertiary topics and participants. The most effective programs consist of the following components:

- *Clearly defined program goals, objectives, and measurable outcomes.*

- *A focus on using family strengths to increase parental competence.*

- *Responsiveness to parents' learning needs, developmental, educational and language levels, and parents' attitude toward parent education.*

- *Identification of the target population best served by the program (e.g., substance abuse, incarcerated parents, teen parents, co-parenting, etc.), and, if court ordered clients are served, how the curriculum addresses their unique needs.*

- *Utilization of trained, knowledgeable, compassionate, and engaging staff to provide parent education.*
- *Utilization of a curriculum that includes the following:*
  - *Enhances one or more of the protective factors (parental resilience, knowledge of parenting and child development, nurturing and attachment, concrete supports in times of need, social connections, and children's social and emotional competence).*
  - *Is culturally responsive to families' needs.*
  - *Provides an opportunity for parents to practice what they learn.*
- *Utilization of an evaluation component to assess the effectiveness of the program to achieve the outcomes for parents identified, preferably a pre- and post-test to measure change.*
- *Requirement that the total program be completed in order to be most effective.*
- *Follow up support and reinforcement of learning with families.*

The most effective parent education program is one that is responsive to the specific needs of the parent. When considering referrals to parenting classes, LDSS service workers should consider the level of intervention needed and the validity of the program being offered. Research indicates that using an evidence-based model for parent education increases the likelihood of increasing parental competence. Evidence-informed models can also be appropriate in tertiary programs that rely on a combination of research-based, evidence-informed, trauma-focused treatments, and are adaptable for individual parent needs. Examples of evidence-based models for parent education include the Nurturing Parenting Programs® and The Incredible Years®, among others.

The Virginia Statewide Parent Education Coalition (VSPEC) can provide more information about parent education programs. The Characteristics of Effective Parent Education Programs in Appendix A: Characteristics of effective parent education programs was created by VSPEC as part of a toolkit for judges and other practitioners who refer parents for parent education.

2.3.2.3 Educational/support groups for youth

Educational or support groups for at-risk youth groups can be helpful in building social and emotional competence in children, one of the six protective factors

that reduce the risk of child abuse and neglect. Youth groups that focus on protective factors (Appendix E: Protective Factors of Section 1) increase children's resilience, enhance parent child relationships, and contribute to reducing the risk of maltreatment. Youth groups and activities for youth can also reduce children's sense of isolation, increase their concrete supports, and build social connections.

Types of groups that have been provided to at-risk youth include, but are not limited to the following:

- *Teen parents to enhance parenting skills, build social supports, and problem solving skills.*
- *Children who are experiencing or exposed to violence in their community.*
- *Children who immigrate with or without their parents and experience language or cultural barriers.*
- *Youth in the juvenile justice system.*
- *Youth moving towards independence to teach independent living skills such as job search, interviewing skills, money management, dating, etc.*
- *Gay, lesbian, bisexual, and transgender youth to reduce isolation, build self-esteem, and reduce the risk of abuse.*
- *Youth who are being bullied to reduce the risk to them and help them problem solve.*
- *Children whose parents represent a population that may challenge family relationships, such as parents who struggle with substance use, parents who are experiencing domestic violence (DV), etc.*
- *Internet safety awareness for youth of all ages.*
- *Youth involved in gangs.*
- *Youth who have experienced abuse or neglect and foster/adopted children who are experiencing challenges related to complex trauma.*
- *Community services projects that involve at-risk youth (e.g., Habitat for Humanity; community clean up; services to seniors; serving in a food pantry, soup kitchen, homeless shelter, etc.).*

There are several evidence-based models that include child components such as Nurturing Parenting Programs®, The Incredible Years®, GirlPower & GoodGuys workshops, and Active Parenting of Teens programs that bring parents and youth together to create a common ground for conversation. For a more comprehensive list of evidence-based programs see the Substance Abuse and Mental Health Service Administration (SAMHSA).

2.4 Secondary prevention: Early prevention services with at-risk families

2.4.1 Characteristics of at-risk families

In this section, at-risk families are defined as parent or caregiver self-referrals or referrals to the LDSS from courts, schools, or other community-based organizations because of a specific concern that has or may impact the family's daily functioning.

2.4.2 Outreach to at-risk families

2.4.2.1 Distribution of educational materials and information on services

LDSS may distribute specific information to families who may be at-risk of abuse or neglect. Reaching them where they are is the most effective approach to providing information. Identifying the population at-risk and what messages to communicate are essential first steps. Answering the following questions can be helpful in determining the audiences who can most benefit from prevention information and the type of information to be shared:

- *What are the common characteristics and needs of families who are served through LDSS or community partners who provide prevention (e.g., court involved families, families with adolescents or very young children, homeless families, etc.)?*
- *Which of the risk factors (Appendix F: Risk Factors of Section 1) is most prevalent in the families served by LDSS and in the community (e.g., single parents, parents who were abused as children or in foster care, presence of DV or substance abuse, low income families, etc.)?*
- *Which of the protective factors (Appendix E: Protective Factors of Section 1) is most often the focus of services (e.g., knowledge of child development, concrete supports, strengthening parent child relationships, building social connections, etc.)?*
- *What information and resources are already available to the families identified?*

Once the target population is identified, the next step is to identify how and where the target population comes in contact with both the LDSS (e.g., benefit programs, intake, etc.) and organizations/agencies in the community that provide early prevention services or have frequent contact with the target population (e.g., schools, hospitals, low income neighborhoods, etc.). These natural points of contacts, often referred to as "touch points" can be used to communicate the information LDSS determines to distribute.

Knowing the referral sources most frequently identified in each locality can also provide direction for outreach and for distributing information about prevention services. In addition, these referral sources can also benefit from information and training about how to identify protective and risk factors at intake within their organization, what to expect when an appropriate referral of a family is made for early prevention services, how to approach families from a strength-based, trauma informed perspective, and how to engage families in planning and decision making.

2.4.2.2 Providing activities to at-risk populations within community-based settings

Some LDSS have initiated early prevention services in a range of community-based settings, including, but not limited to the following:

- *School based programs for caregivers and particular age groups at risk (e.g., preschool children, pregnant or parenting teens or young adults).*
- *Programs for incarcerated parents who will be returning home or involved with their children.*
- *Child care based programs for caregivers.*
- *DV shelters.*
- *Faith based programs in churches or places of worship.*
- *Community and culturally based resource centers.*
- *Providing information and workshops for new parents in hospitals or pediatricians offices.*
- *Providing Information and displays at libraries or other high traffic areas for the general public, such as public transportation stops.*
- *Housing assistance programs.*

- *Mobile outreach services.*
- *Partnering with other groups and organizations where services are provided to the target population (e.g., early childhood settings, mobile libraries, local YMCA or YWCA's, Boys & Girls Clubs, hospital classes for new parents, etc.).*

Families currently served by the LDSS are an additional resource for determining general activities that can be provided. They can also be a resource for contacting other families within their community. If community partners have been engaged in identifying the types of families to be served, they will be instrumental in outreach to families. Churches, schools, Community Service Boards (CSB), courts, medical providers, and other community groups can also be sources of referrals. Face-to-face presentations to groups, print material, and electronic communication are all possible ways to disseminate information. The content for outreach should include the type, purpose, and focus to include dates, time, duration, incentives provided, and contact information for registration.

2.5 Intake/Short-term Assessment

The remainder of this section of guidance is devoted to providing services to individual families served by LDSS and presents a model for assessment, planning, service delivery, and evaluation that can increase positive outcomes for families.

2.5.1 Intake: Initial contact

Intake is defined as the first point of contact with a family. Receptionists and voicemails should be family friendly, use a calm tone of voice, invite the caller to share information, be reassuring, and express the desire to help. In some local agencies, intake is the primary resource for prevention services and may include eligibility intake. The initial contact sets the stage for the parent's perception of the LDSS and how they will interact with staff. No matter where the first contact is within an LDSS, messages that staff can communicate include:

- We are concerned about your circumstance and will listen to what you have to say.
- We will be helpful.
- We will get you to the person who can best meet your needs.

Intake services should provide a timely, coordinated transition for the family to needed services or sufficient information to enable a family to utilize personal or community resources. The target population of intake services is anyone seeking

services of the LDSS. Families who believe they need help to care for their children should be encouraged to contact the LDSS and should be served to the extent that funds and staff are available.

In the past, the focus of the initial assessment has often been exclusively on the presenting problem. Though it usually begins there when the family first tells their story, the initial assessment should begin the process of shifting the power and responsibility for seeking solutions to the family.

The service workers' tasks are as follows:

- To demonstrate respect and a sincere interest in partnering with the family.
- To maintain a non-judgmental supportive tone and body language.
- To explain the purpose of the short-term assessment and the service worker's role, and to explore expectations of the parent or other family members.
- To help the family clarify the problem or challenge that brought them to the LDSS.
- To reinforce the strengths evident in parenting revealed throughout the assessment and provide behavior specific feedback to parents about what they have done well.
- To educate them about the LDSS' services and community resources.
- To be transparent about the legal obligations of the LDSS and what will happen if safety is a concern and how the service worker will help them through the process.
- To communicate a sincere and genuine desire for family to succeed.
- To raise questions that help them explore solutions and options to their challenges.
- To listen to cues from the family that indicate if trauma has occurred and how the family has responded (e.g., death in the family and one child who has become aggressive; family is homeless and father depressed; child who has witnessed family violence and is quiet and sullen or fearful, etc.). For more information about trauma symptoms, see Section 2.7.2.3.2.
- To find out what they want and expect from the LDSS and service worker.

- To help them identify familial and other supports, community, and LDSS resources that might be available to them.
- To gather information to help them and the service worker assess together how the family can best be served and by whom.

Parents' initial role in this process is:

- To share information about their family and situation.
- To make an informed decision about how they want to proceed.

If, in the process of completing the short term assessment, the LDSS and family decide that the family will be receiving services, the LDSS may proceed with the Comprehensive Family Assessment before the short-term assessment is completed. Regardless, the following decisions should be made before moving forward.

2.5.2 Consideration of risk factors at intake

Childhood history of abuse or neglect is the most powerful risk factor for abusing or neglecting one's own children.[1] A greater understanding of risk factors can help professionals working with children and families identify maltreatment and at-risk situations so they can intervene appropriately. It should be emphasized, however, that while certain factors often are present among families where maltreatment occurs, this does not mean that the presence of these factors necessarily lead to child abuse and neglect. Other characteristics of risk may be found in Appendix F: Risk Factors of Section 1.

Research also indicates that the following child, parent, and family factors may increase a child's risk for developmental delay. While the presence of one risk factor does not mean the child will have a developmental delay, multiple risk factors increase the cause for concern[2]:

- Biomedical risk conditions in a child (e.g., low birth weight, physical deformities, or chronic heart or respiratory problems).
- Child maltreatment, particularly before three (3) years of age.

[1] Prevent Child Abuse Virginia. (2014). Healthy Families Virginia - Statewide Evaluation Executive Report FY 2010-2014. Retrieved from http://pcav.org/wp-content/uploads/2015/09/Executive-Summary-2014-Draft.pdf.

[2] Hurlburt, M. S., Barth, R. P., Leslie, L., Landsverk, J. A., & McCrae, J. (2007). Building on strengths: Current status and opportunities for improvement of parent training for families in child welfare. In R. Haskins, F. Wulczyn & M. Webb (Eds.), Child protection: using research to improve policy and practice (pp. 81-106). Washington, DC: Brookings Institution.

- Parental substance use or mental health problem.
- Single or teenage parent.
- Low educational attainment of parent.
- Four or more children in the home.
- Family poverty.
- DV.
- *Signs of sex trafficking.*
- Involvement with the child welfare system.

All of these characteristics should be considered in the context of the current family system and level of functioning and not used exclusively to determine risk of abuse and neglect. At intake, however, if the family reveals several of these factors, the family may be referred for services and a short-term assessment should be conducted. For a detailed list of parent, child, family, and environmental risk factors, see Section 2.7.2.1.2.

2.5.2.1 Domestic violence (DV) and substance abuse as risk factors

Two (2) family issues that can have a major impact on safety and risk are DV and drug or alcohol involvement by the child's caretakers.

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

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

2.5.2.2 Screen all children for sex trafficking

Federal law, specifically Title 1 of the Preventing Sex Trafficking and Strengthening Families Act (HR 4980), requires child welfare agencies to identify, document, and determine appropriate services for children and youth at risk of 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.

2.5.2.2.1 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 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.*
- *Gang involvement.*

2.5.2.2.2 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 (OASIS).*

The LDSS may contact the National Human Trafficking Resource Center (NHTRC) at 1-888-373-7888 if they suspect sex trafficking of a minor. NHRTC operates a 24 hour hotline to help identify and coordinate with local organizations that protect and serve victims of trafficking.

Refer to the VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 4, Investigations and Family Assessments, Appendix M: Sex Trafficking of Children Indicators and Resources for

additional information regarding screening and safety considerations for victims of human trafficking, which includes sex trafficking.

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

2.5.2.3 Reasonable candidacy for foster care in early prevention

A critical assessment that should be completed in all early prevention cases is determining reasonable candidacy for foster care. The service worker should evaluate whether or not a child is a reasonable candidate for foster care placement because the service 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 service worker should 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.*
- *That the plan was developed jointly with the child, and the parents or guardians when appropriate.*
- *A description of the services offered or provided to prevent the removal of the child from the home.*
- *The case is actively being managed to maintain the child in the home 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 service worker shall document in the

automated data system (OASIS) its justification for maintaining a child as a reasonable candidate for foster care ***at least once every six (6) months****.*

The LDSS shall use the Reasonable Candidacy Documentation Form in the automated data system (OASIS) 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 F: Reasonable Candidacy Manual and in the on-line course CWSE1006: Reasonable Candidacy for Foster Care available in the Virginia Learning Center.

In early prevention 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 prevention service plan is an acceptable case plan to document reasonable candidacy and should clearly demonstrate that the case is actively managed by the service 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 prevention services.

2.5.3 Information and referral only

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

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

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

2.5.4 Short-term assessment/crisis intervention

Definition of Short-term Assessment/Crisis Intervention:

- Short-term services (within 45 days) to the family to stabilize the crisis.
- Brief assessment to determine the family's need for services and clarify the support they need. This assessment should be completed within 45 days.
- May be opened to services in the automated data system (OASIS) under the Intake: Short Term Assessment/Crisis Intervention case type.

Short-term assessment/crisis intervention should be solution focused. It begins with the presentation of a problem or concern either expressed by the family or a referral source. Strength-based, family focused assessment requires that, once the problem or concern is clarified and agreed upon by the service worker and the family, an assessment of the strengths of the family is conducted. The five protective factors outlined in Appendix E: Protective Factors of Section 1, provide the framework for assessing family strengths and building competency and self-sufficiency of families. The family and service worker's mutual identification of the family's strengths and concrete needs and resources can then be utilized to address the problem or concern.

Short-term assessment/crisis intervention should be accomplished within 45 days. A case may be opened for a family for the purpose of a short-term assessment or opening a case can be postponed until the outcome of the assessment is known and a family has decided to receive services from the LDSS.

If the LDSS opens a case for a short-term assessment during this 45 day period, it should be coded in the automated data system (OASIS) as Intake: Short Term Assessment/Crisis Intervention. If the decision is made with the family to initiate or continue services, the case type should be changed to one of the prevention case types or other appropriate case type. For more information on prevention case types, see Section 2.6.2.

Before the first meeting:

Before meeting with the family, it is helpful to gather whatever information is already available at the LDSS regarding the family, including (a) what, if any services the family has received in the past, (b) whether or not they receive public assistance and, if so, (c) what the eligibility worker's perception of their strengths and needs is, and any other history available through the LDSS.

Consistent with the principles of family engagement, the assessment begins with the family telling their story and continues with the service worker explaining their role and the services their LDSS has to offer. Suggested questions and considerations for the assessment are provided in Appendix B: The Family's Story – The First Step in Engagement and the Family Engagement Toolkit.

Purpose of short-term assessment/crisis intervention:

- Engage and establish a relationship with the family that will set the stage for future, positive interactions.
- Assist the family in managing a current crisis, if one is presented, and meeting their basic needs.
- Help them navigate the complicated systems with which they are involved (e.g., courts, mental health, education, etc.) and assist them in accessing resources in their community.
- Empower the family to seek solutions to the problem or concern they present.
- Begin the assessment of strengths and how they will be used to mitigate risk or solve the problem presented.
- Help families identify and prioritize their immediate needs.
- Help families identify and assess their familial and community-based support networks.
- Identify if any trauma has been experienced by the child or within the family.
- Assist the family in determining whether the LDSS will provide services or refer the family to another community resource.

2.5.5 Screening for trauma

Research demonstrates the relationships between trauma, child traumatic stress, and the risk of abuse or neglect. *Trauma screening refers to a tool or process that is a brief, focused inquiry to determine whether an individual has experienced one or more traumatic events, has reactions to such events, has specific mental or behavioral health needs, or needs a referral for a comprehensive trauma-informed mental health assessment.* At intake, if there is an indication that any of the traumatic events listed below are present in the family, a comprehensive trauma assessment is recommended via referral or agency approved tool (see Section 2.7.2.2):

- Sexual abuse or assault.
- Physical abuse or assault.
- Emotional abuse or psychological maltreatment.

- Chronic neglect.
- Serious accident or illness.
- Psychiatric hospitalization.
- Witness to DV.
- Victim or witness to community violence.
- Victim or witness to school violence.
- Natural or manmade disasters.
- Forced displacement or homelessness.
- War, terrorism, or political violence.
- Traumatic grief or separation.
- System induced trauma (e.g., removal, change in placements, etc.).

2.5.6 Decisions made at the completion of the short-term assessment

- Is this family an appropriate candidate for prevention services?
- What are the family's strengths that they can build on to solve the current problem?
- What type and level of service is needed to increase parental resilience, competency of the parents, and other protective factors?
- What trauma symptoms are present and how can they best be addressed (See Section 2.7.2.2.2)?
- What are the family's most immediate needs?
- Does the LDSS have the resources to respond to the needs identified?
- Is the parent ready to move forward? Are they open to change and willing to try new behaviors or do something different to change the situation?
- Will a case be opened?
- If not, what resources in the community can serve this person or family?

2.5.7 Outcomes expected

- As a result of meaningful family engagement, the family should leave feeling that they have been heard and that their concerns were addressed.
- The family will be able to identify some of the strengths they have successfully used in the past to manage problems.
- Both the service worker and the family will have a clear understanding of what will happen next.
- The stage has been set for establishing a positive relationship, empowering the family, building resilience, and teaching new skills.

Once the family decides to move forward with services, the service worker should explain the assessment and service provision process with the family, the expectations of the family and service worker during the assessment process, how the family can use the information to make an informed decision about how they want to proceed with services, what services are needed, and how services will be delivered and by whom.

2.6 Opening a case

2.6.1 Application for services

When a short-term assessment is completed (within 45 days) and services are identified that will strengthen the family or minimize risk, there is no mandate or 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. For more information on the use of the Family Service Agreement, refer to the VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 4, Investigations and Family Assessments, Appendix G: Family Service Agreement.

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

Both the Code of Virginia and federal law require that child welfare information be maintained in the state-approved automated data system (OASIS). This should

include early prevention cases. *It is important to enter prevention cases in the automated data system (OASIS) in order to obtain an accurate reflection of the work being done by LDSS. This documentation can be used to support requests for additional funding and other resources.*

2.6.2 Frequency of worker visits

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

2.6.3 OASIS case type

Below are definitions of case types for prevention services, provided to families prior to or in the absence of a current, valid CPS referral. For each case type, there is a reference to the case type used in the automated data system (OASIS) and a clear definition of the criteria to use to determine the case type. As the family's situation changes or more intensive services are needed, including foster care prevention, the case type may change.

2.6.3.1 Intake: Short Term Assessment/Crisis Intervention

- Brief assessment to determine the family's need for services and clarify the support they need. This assessment should be completed within 45 days.
- Short-term services (within 45 days) to the family to stabilize the crisis.

2.6.3.2 Early Prev/Fam Supp: No Court Order

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

- LDSS may or may not have received a previous or current, valid CPS referral. LDSS may or may not have conducted a family assessment or investigation. The family has been assessed at low risk of abuse or neglect but can benefit from voluntary services and will not be receiving CPS on-going services.

- No court order is in place.
- Family has agreed to services.

2.6.3.3 Early Prev/Fam Supp: Court Order

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

- LDSS may or may not have received a previous or current, valid CPS referral. LDSS may or may not have conducted a family assessment or investigation. The family has been assessed at low risk of abuse or neglect but can benefit from voluntary services and will not be receiving CPS on-going services.
- LDSS has received a court order from a Virginia court to provide services or a home study either of a birth parent or a caretaker identified as a potential placement, excluding adoption or foster care home studies. This case type can include a child in need of services (CHINS) disposition, petition for relief of care and custody, court ordered custody study, mediation, services ordered on behalf of a child committed to the department of corrections, or other services ordered by the court.
- A child's safety is not currently in jeopardy, although there may be minimal or low risk of abuse/neglect or out-of-home care.
- Family has agreed to services.

2.6.3.4 Early Prev/Fam Preserv

Services to a family under the following conditions:

- LDSS may or may not have received a previous or current, valid CPS referral. LDSS may or may not have conducted a family assessment or investigation. The family has been assessed at low risk of abuse or neglect but can benefit from voluntary services and will not be receiving CPS on-going services.
- LDSS has determined that the child may be at risk of out-of-home care unless immediate services are provided to preserve the family. The services provided are designed to help families alleviate crises, maintain the safety of children in their own homes, and assist families to obtain support to address their needs. This can include supervision or monitoring of a birth family whose child has been returned to them from foster care or from a diversion situation.

- No court order is in place.
- Family has agreed to services.

2.6.3.5 Early Prev/Int. Fam Preserv: High Risk of Foster Care

Services to a family under the following conditions:

- LDSS may or may not have received a previous or current, valid CPS referral. LDSS may or may not have conducted a family assessment or investigation. The family has been assessed at low risk of abuse or neglect but can benefit from voluntary services and will not be receiving CPS on-going services.
- Without intensive prevention services, the child is at imminent risk of out-of-home placement into foster care. This case type meets the eligibility for reasonable candidacy for foster care. LDSS should continue to complete the Reasonable Candidacy Documentation Form in the automated data system (OASIS). Additional information regarding reasonable candidacy can be found in Appendix F: Reasonable Candidacy Manual and in the online course CWSE1006: Reasonable Candidacy for Foster Care available in the Virginia Learning Center.
- Family has agreed to services.

Below are OASIS case types for prevention services provided to families after receipt of a current, valid CPS referral.

2.6.3.6 Prevention: Low or Mod risk (after CPS)

Services to families under the following conditions:

- LDSS has received a current, valid CPS referral.
- LDSS has conducted a Family Assessment or Investigation.
- The family has been assessed at low risk of abuse or neglect but can benefit from voluntary services and will not be receiving CPS on-going services.
- Family has agreed to services.

2.7 Comprehensive assessment of the family's needs

Once the family and the LDSS have made the decision to open a case, the next step is to conduct a comprehensive assessment with the family. This assessment is more in-depth than the short-term assessment and provides the foundation for continued engagement with the family and service planning and delivery.

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

2.7.1 Step 1: Ensuring mutuality in the assessment process

The comprehensive assessment should build on the short-term assessment (if one was completed) and explore, in greater depth, the strengths of the family and the change needed to keep the child safe and the family stable.

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

2.7.2 Step 2: Conducting the comprehensive assessment

Below are the components of a comprehensive assessment.

2.7.2.1 Protective and risk factors as the framework for assessment

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

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

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

2.7.2.1.1 Protective Factors

Parental Resilience

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

Examples of parental resilience include the following:

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

Social Connections

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

Examples of social connections include the following:

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

Concrete Support in Times of Need

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

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

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

Knowledge of Parenting and Child Development

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

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

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

Social and Emotional Competence of Children

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

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

- Ability to communicate clearly.
- Ability to recognize and regulate emotions.

- Ability to establish and maintain relationships with both peers and adults.
- Ability to solve problems and resolve conflict.

Nurturing and Attachment

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

Examples of attachment and nurturing include the following:

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

2.7.2.1.2 Risk factors

Research has indicated that there are certain demographic characteristics that are not predictive of abuse, neglect or the risk of out-of-home care but do tend to correlate with these risks. Childhood history of abuse or neglect is the most powerful risk factor for abusing or neglecting one's own

children.[3] Other parent, family, child and environmental risk factors include the following:

Parent related

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

3 Prevent Child Abuse Virginia. (2011). Healthy Families Virginia – State Evaluation Executive Report (FY 2007 – 2011). Retrieved from http://pcav.org/wp-content/uploads/2011/09/FINAL-Executive-Summary-2011-General-Assembly1.pdf.

- Parents' negative view of the child in families where DV is present.
- Single parents.
- Nonbiological, transient caregivers in the home.
- Language barriers.

Child related

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

Family related

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

Community/environmental related

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

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

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

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

2.7.2.2 Preliminary screening and assessment of trauma

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

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

The outcome of this initial screening is to determine how the present trauma symptoms can be addressed within the family and if a trauma-informed mental

health assessment needs to occur. A comprehensive resource for trauma screening and assessment is the National Child Traumatic Stress Network (NCTSN).

2.7.2.2.1 Types of trauma

There are three broad types of trauma:

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

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

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

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

- Health.
- Brain Development.
- Mood Regulation.
- Cognition and Learning.
- Behavioral Control.

- Memory.
- Cause and effect thinking.
- Self-concept.
- World view.
- Attachment.

2.7.2.2.2 Child traumatic stress symptoms

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

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

When children experience a traumatic event, the entire family is affected. Often, family members have different experiences around the event and

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

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

2.7.3 Step 3: Analyzing the information gathered

As information is being gathered throughout the assessment process, the service worker's role is to explore with the family how the information impacts the child's safety and stability. Some information may reveal strengths in each family member that have been utilized or are underutilized to solve problems and reduce risks. Furthermore, some information may raise additional concerns.

Keep in mind that protective factors are "family characteristics" that are framed in a positive manner. These characteristics (factors) have been identified as those needed by families to provide a buffer against abuse and neglect. Protective factors that are present in a family represent strengths that can be utilized by the family to help them overcome issues the family may be experiencing. On the other hand, protective factors in a family that are totally absent, or not present to sufficient degree, represent needs that have to be addressed.

2.7.3.1 Mutual agreement on the issues or concerns

The comprehensive assessment should begin with agreement between the service worker and family on the issues to be addressed. The issues agreed upon may or may not be what was initially presented by the family or the referral source. The summary of issues should be stated clearly in language the family understands.

2.7.3.2 Prioritizing the issues

Once the issues to be addressed have been clarified, they need to be prioritized by the family. Not every issue needs to be resolved in the initial service plan nor is every issue equally critical to safety or stability of the family.

2.7.3.3 Managing concerns the service worker identifies

If there are concerns that the family does not identify as needs, the service worker should talk with the family respectfully and honestly to assist them in knowing the potential consequences of not addressing the concern.

2.7.3.4 Transparency

Transparency implies openness, communication, and accountability. Transparency is operating in such a way that it is easy for others to see what actions are performed. Transparency in interactions with the family is essential and includes the following actions:

- Clarifying the family's and service worker's role in a mutual assessment process and the purpose of gathering information.
- Using interpersonal skills to establish an atmosphere of openness, respect, and partnership.
- Recognizing that resistance (demonstrated through suspicion, anger, or passivity) is normal and can be expected from some families.
- Guarding against the tendency to establish partnership by minimizing the full role and responsibilities of the service worker to assess safety and family functioning.

2.7.3.5 Exploring needs

As information is being gathered, the following questions begin the process of identifying needs:

- What have you learned about your family from going through this process?
- What are the concerns or problems you feel are the most important to address at this point?
- Where would you like to start?
- What changes do you think you can make or what do you think you need to do differently?

The focus is on gaining a holistic understanding of the family’s functioning, through a comprehensive assessment of safety, risk, strengths, and needs.

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

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

2.8.1 Genograms

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

2.8.2 Ecomaps

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

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

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

Ecomaps can be used to:

- Identify and illustrate strengths that can be built upon and weaknesses that can be addressed.

- Summarize complex data and information into a visual, easy to see and understand format to support service planning and delivery.
- Illustrate the nature of connectedness and the impact of interactions in predefined "domain" areas, indicating whether those connections and interactions are helping or hurting the family. Part of this value is in supporting the concept of observing "resource and energy flow" to and from a family as a result of its connections and interactions with its environment.
- Allow objective evaluation of progress, as service workers can observe the impact of interventions, both on the family and on other elements of their environment.
- Support discussion of spiritual and value-related issues in a constructive way.
- Help support integration of the concept of comprehensive assessment as an ongoing process.
- Support effective presentation of families' issues for case staffings, service referrals, and court proceedings.
- Promote the building of interviewing and other skills for service workers.

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

2.8.3 Family Partnership Meeting (FPM)

Family engagement is a relationship-focused approach that provides structure for decision making that empowers both the family and the community in the decision making process. Family partnership meetings (FPM) are grounded by value-driven principles that include:

- All families have strengths.
- Families are the experts on themselves.
- Families deserve to be treated with dignity and respect.
- 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 often more capable of creative and high quality decision making than an individual.

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

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

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

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

- Prior to *the development of a foster care plan for the foster care review and permanency planning hearings to discuss permanency options and for concurrent planning as well as consideration of* a change of goal.

- When requested by parent (birth, foster, adoptive or legal guardian), youth, or service worker.

Families at risk of foster care or out-of-home care can be served through early prevention and would be part of the mandated population to convene a FPM. FPMs can also be helpful at the short term assessment/crisis intervention stage to gather potential community resources, extended family members, and other community members that the family can utilize to either stabilize the crisis or support the family.

The service worker and supervisor should discuss the convening and timing of a FPM at these critical decision points. All FPMs shall be documented in the automated data system (OASIS). For more guidance regarding FPMs, please refer to the VDSS Child and Family Services manual, Family Engagement chapter on the VDSS public website. Additionally, course CWS4030: Virginia Family Partnership Meeting Facilitator Training available in the Virginia Learning Center is designed for individuals within the locality that will be responsible for facilitating FPMs.

2.8.4 Child and Adolescent Needs and Strengths (CANS)

CANS is a comprehensive, multi-domain, standardized assessment instrument which helps plan and manage services at both an individual and system of care level. It helps guide service planning, track child and family outcomes, promote resource development, and support decision making. Use of the CANS for children served by LDSS permits analysis of state-wide trends in strengths and needs, and

can inform state and regional policy and community action, particularly in regards to service provision and evaluation of efforts to improve outcomes.

2.8.4.1 Who should be assessed with CANS

All children who receive services and funding through the Children's Services Act (CSA), and their families shall be assessed using the mandatory uniform assessment instrument (§ 2.2-5212). The schedule for assessment for CSA is determined by the local CPMT, but shall occur no less than annually.

- *For children and youth, use of the CANS is mandatory to receive services through CSA.*

2.8.4.2 Assessment areas

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

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

For child welfare, the CANS includes the following areas:

- *An enhanced trauma module.*
- *A new child welfare module.*
- *The ability to rate multiple Planned Permanent Caregivers for a child to be used in concurrent planning.*
- *New worker reports for service workers and supervisors to help assess progress and outcomes over time for children and their families on:*
  - *Child trauma.*
  - *Caregiver permanency indicators.*
  - *Parent/guardian/caregiver protective factors.*
  - *CANS domains.*

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

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

Additional modules are available to assess specific situations, including:

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

2.8.4.3 CANS resources

The CSA website provides:

- *Information on CANS, including policy, manuals, fact sheets, score sheets, training, and super users.*
- *CANS training and certification information.*
- *CANS user manual and score sheets.*
- *Frequency of CANS administration.*
- *CANVaS, the web-based system for completing the CANS tool online.*

2.8.5 Motivational interviewing

Motivational interviewing (MI), a counseling approach built on engaging ambivalent clients and motivating them to change, offers a valuable tool for service workers in their interactions with families. Involvement with the child welfare system

necessitates opening up intimate details of one's life to strangers, with inhibiting emotions such as fear and shame informing each interaction, along with other isolating factors such as DV, substance abuse, and poverty. Therefore, service worker engagement through MI techniques can promote client engagement and positive case outcomes.

For more information on advanced interviewing techniques, see the following instructor led course in the Virginia Learning Center (VLC). The course is available to service workers and supervisors across all child welfare program areas.

- *CWS5305: Advanced Interviewing: Motivating Families for Change.*

2.8.6 Parent leadership and involvement

Parent leadership is promoted on a meaningful level when parents are given the opportunity for personal growth, to gain the knowledge and skills to function in leadership roles, and represent a "parent voice" to help shape the direction of their families, programs, and communities. Parent leadership is successfully achieved when parents and service workers build effective partnerships based upon mutual respect and shared responsibility, expertise and leadership in the decisions being made that affect their own families, other families, and their communities.

Parent education and support programs are good first steps in fostering leadership in parents. They provide parents with the tools they need to become more confident parents and to bond with other parents. This confidence and connection to other families, can then be supported and encouraged, to move parents towards more meaningful roles in programs by giving them opportunities to become a part of the team developing the programs rather than simply the persons benefiting from the services provided. A great resource in this area is Making the Link – Parent Organizing.

2.9 Valid and reliable instruments

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

2.9.1 Protective Factors Survey

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

attachment, and knowledge of parenting/child development. Service workers can administer the survey before, during, or after services.

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

- A snapshot of the families they serve.
- Changes in protective factors.
- Areas where service workers can focus on increasing individual family protective factors.

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

2.9.2 Kempe Family Stress Checklist

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

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

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

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

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

2.9.4 Adult Adolescent Parenting Inventory (AAPI-2)

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

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

2.9.5 A Measure of Family Well-being

The University of Georgia, Family and Consumer Sciences developed an outcome accountability tool for family support programs that was adapted from the Institute for

Family Support and Development of MICA, Inc. The tool includes "A Measure of Family Well-being" comprised of four (4) sets of instruments that measure a client's perception of family well-being both before and after receiving services. The four (4) sets of instruments include the following:

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

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

2.9.6 Social Skills Improvement System (SSIS)

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

- Social Skills: Communication, Cooperation, Assertion, Responsibility, Empathy, Engagement, and Self-Control.
- Competing Problem Behaviors: Externalizing, Bullying, Hyperactivity/Inattention, Internalizing, and Autism Spectrum.
- Academic Competence: Reading Achievement, Math Achievement, and Motivation to Learn.

2.9.7 North Carolina Family Assessment Scale (NCFAS)

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

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

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

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

2.9.8 Child Welfare Trauma Training Toolkit

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

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

2.9.9 Child Welfare Trauma Referral Tool

A comprehensive resource for trauma screening and initial assessment is the Child Welfare Trauma Referral Tool (CWT). This tool is designed to help service workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. It is to be completed by the service worker through record review and key informants (i.e., natural parent, foster parent, child therapist, school-aged children or adolescents if appropriate, and other significant individuals in the child's life). The CWT includes a referral flowchart and referral guidelines for making recommendations to trauma-specific or general mental health

services by linking the child's experiences to their reactions. The tool also includes definitions of different trauma and loss exposure history categories.

2.9.10 Adverse Childhood Experience (ACE) Questionnaire

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

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

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

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

- *Recurrent physical abuse.*
- *Recurrent emotional abuse.*
- *Contact sexual abuse.*
- *An alcohol or drug abuser in the household.*
- *An incarcerated household member.*
- *Family member who is chronically depressed, mentally ill, institutionalized, or suicidal.*
- *Mother is treated violently.*
- *One (1) or no parents.*
- *Physical neglect.*
- *Emotional neglect.*

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

2.10 Service planning

Integral to creating realistic, achievable family service plans is the active involvement of parents, children, other family members and other significant individuals in the development of the plan, and in decision making. When families are fully engaged in these processes, the following outcomes can be achieved:

- Active involvement of the family helps family members think through the best course of action to achieve the goals they've selected and the steps to be taken to achieve the goals.
- The likelihood that the services, objectives, and activities, will be implemented and achieved.
- Service plans and decisions will be more individualized and relevant to the family.
- There is greater probability of creating more opportunity for lasting change.
- When family members and other individuals who have significant relationships with the child and family are able to provide resources and support for the family and are included in the service plan (e.g., through FPMs or other teaming meetings), sustaining change over the long-term is more likely to occur.

Best practice supports engaging the family to develop a service plan **within 30 calendar days** of opening a case. When preparing to develop the service plan, it is important to review all available information from the assessment, including information gained through engaging and partnering with the family.

2.10.1 Components of an effective service plan

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

Below are the components of an effective service plan:

2.10.1.1 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.

2.10.1.2 Objectives

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

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

Objectives should have certain characteristics in order to measure success:

- ***Objectives need to be measurable.*** *Objectives are very specific outcomes which should ultimately result in goal achievement. In order to determine whether these short term outcomes have been completed, they should be measurable. All parties to the plan should be able to agree whether the stated objectives have been accomplished. The objectives should include some criteria to measure achievement.*

- ***Objectives need to reflect behavioral change.*** *Objectives should clearly describe specific behavioral changes parents/caretakers need to adopt.*

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

- ***Objectives 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 service 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.*

Example objective:

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

2.10.1.3 Strengths used to achieve goals

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

2.10.1.4 Barriers to achieving goals and objectives

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

2.10.1.5 Services

Services include information or referrals for tangible and intangible support. Services can be delivered in the home or in another environment that is familiar and comfortable for the family. Services may also be court-ordered. When possible, services should be evidence-based and trauma-informed. For more information on service delivery, see Section 2.11.

2.10.1.6 Activities/tasks

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

Activities should be jointly formulated and agreed upon by the family and the service 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.*

2.10.2 Share and document the service plan

The service worker should document the service plan in the automated data system (OASIS) and include how the family was involved with its development. All goals, objectives, activities/tasks, and services should be documented in the automated data system (OASIS).

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, should be maintained in the hard copy file.

2.10.3 Funding the service plan

Agencies use a range of funding sources to help meet family needs. A vital part of service planning is exploring with the family the plan for funding the services. Public assistance funds, CSA funding for prevention, PSSF funds and SSBG funds, government and foundation grants, and local businesses are all possible funding sources. Appendix I: Funding Sources for Prevention of Section 1 identifies a range of funding sources utilized by LDSS.

2.11 Service delivery

As described in Section 1, an increasing body of evidence indicates maltreatment can alter brain functioning and consequently affect mental, emotional, and behavioral development. When service workers provide early prevention services, they have a unique opportunity to identify potential concerns and help families receive the support they need to reduce any long-term effects. This should occur in the context of trauma informed practice. For more information on trauma informed practice, see Section 1.12.4.

2.11.1 Goal of supportive services

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

- To respect and support the integrity of the child's family unit.
- To strengthen and promote protective factors in families.
- To foster an emotionally and physically safe environment for children and their parents.
- To increase families' understanding of trauma and its impact and to help reduce trauma related symptoms in family members.

- To prevent placement of a child away from his or her caregiver.
- To assist families in utilizing community resources to foster independence.
- To maintain personal and professional boundaries with families.

2.11.2 Definition of strength-based practice

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

2.11.3 Role of the service worker

The role of the service worker in service delivery may be different in each locality, depending on whether or not there is a formal prevention program within the LDSS and the level and types of services the LDSS provides. The role of the service worker after intake can include, but not be limited to, the following:

- Family engagement.
- Information and referral.
- Assessment.
- Case management.
- Crisis intervention.
- Service coordination and collaboration.
- Parent education and support.
- Advocacy, both internally and externally on behalf of the family.

An effective role for the service worker in facilitating change in early prevention is the role of consultant or coach. This role facilitates the parent identifying the need for change and directing the change process with the assistance and guidance of the service worker.

2.11.4 Using teaming in child welfare practice

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

- *FPMs are used at specific decision points and are facilitated.*

- *Family Assessment and Planning Teams (FAPTs) are used with the CSA process.*
- *Teams jointly determine whether the child's best interest is to remain in the same school when the child's placement changes.*
- *Youth teams work collaboratively with older youth as they prepare for adulthood and establish permanent lifelong connections with significant adults.*
- *Child and family-specific teams (CFTs) are used in some communities to provide continuity in communication and goal setting with team members over time, adding key partners as needed.*

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

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

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

2.11.4.1 Values and key principles of effective teaming

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

- *A group of committed persons, both formal and informal supports, come together to form a working team to collaborate with the child and family. Team members have sufficient knowledge, skills, cultural awareness, authority to act, flexibility to respond to specific needs, and the time necessary to work effectively with the child and family.*

- *The language, culture, family beliefs, traditions, and customs of the child and family are identified, valued, and addressed in culturally appropriate ways via special accommodations in the engagement, assessment, planning, and service delivery processes.*

- *The child, parents, family members, and caretakers are active, ongoing participants with the team. They each have a significant role, voice, and influence in shaping decisions made about child and family strengths and needs, goals, supports, and services.*

- *Everyone on the team has a voice in expressing their perspective on child and family strengths, needs, supports, and services.*

- *Conflicts are discussed and resolved by focusing on the specific needs of the child and family.*

- *The child, family, and team collaborate to develop meaningful service plans that address the child's and family's needs and enhance their strengths.*

- *The team monitors the status, progress, and effectiveness of interventions, making adjustments to the service plan when needed.*

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

2.11.4.2 Benefits of teaming

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

2.11.5 Trauma informed case management

An understanding of the impact maltreatment has had on children when they come to the attention of the child welfare system allows service workers, administrators, and providers to be more proactive, knowing what to look for, and anticipating the services that may be needed. This skill set is critical to preventing the chronic and

severe problems that may result from the trauma children and their families have experienced and to ensuring child safety, permanence, and well-being.

Case management includes the following tasks:

- Ongoing feedback to the family about their strengths and the positive changes the family demonstrates.
- Connecting the family to concrete supports within the community such as, transportation, cash assistance to meet financial and medical needs, parent education about child development, effective discipline, nurturing, co-parenting, and other parenting skills.
- Engaging fathers, extended family, and others important to the family in the helping process.
- Advocating for the family to receive needed services in their community.
- Presenting the family to FAPT and coordinating services.
- Documenting service provision.
- Consistently review the service plan with the family to the evaluate progress and explore any barriers.

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

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

- Manage professional and personal stress.

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

2.11.6 Trauma focused treatments

Complex trauma affects a child's sense of safety, ability to regulate emotions, and capacity to relate well to others. Since complex trauma often occurs in the context of the child's relationship with a caregiver, it interferes with the child's ability to form a secure attachment. Consequently, an important goal of service delivery is to help children and youth develop positive social emotional functioning, restore appropriate developmental functioning, and reestablish healthy relationships.[4]

Trauma-informed care redirects attention from treating symptoms of trauma (e.g., behavioral problems, mental health conditions) to treating the underlying causes and context of trauma. Trauma-specific interventions include medical, physiological, psychological, and psychosocial therapies provided by a trained professional that assist in the recovery process from traumatic events. Treatments are designed to maximize a child's sense of physical and psychological safety, develop coping strategies, and increase a child's resilience.[5]

Examples of evidence-based therapies for trauma include:

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

Examples of other types of therapy used with trauma include:

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

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

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

For resources to address trauma, see:

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

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

2.11.7 Family services and supports

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

- *Information and referral.*
- *Crisis intervention.*
- *Home visiting and in-home services.*
- *Mental health counseling.*
- *Parent education and training.*
- *Substance abuse services.*
- *Financial assistance.*

- *Employment services.*
- *School based services.*
- *Mentoring.*
- *Child care.*
- *Transportation.*
- *Support groups.*
- *Short-term respite.*
- *800-CHILDREN (800-244-5373) (statewide, toll-free parent helpline).*
- *Other community-based services.*

These services may be provided by the LDSS or by other service providers. The types of models of in-home services that are most effective are those that address the individual needs of the family based on a comprehensive assessment. Evidence-based models for in-home services include Healthy Families America (HFA) and Parents as Teachers (PAT), among others. For a comprehensive list of evidence-based models, see SAMHSA's NREPP.

2.11.8 Authority of LDSS

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

2.12 Reassessment and service plan adjustment

If an early prevention case is open for 90 days, a service plan should be completed. If the case is open for more than 90 days, the service plan should be assessed and revised accordingly every 90 days, if not closed. This review should include what it will take to achieve the goals and objectives set by the family and service worker.

2.13 Goal achievement and case closure

Because services to families in early prevention cases are voluntary, if the family requests to close the case prior to the goals and objectives being met, the case may be closed. If the goals, objectives, and tasks are clear, behavioral outcomes have been established and embraced by the family, and ongoing evaluation of the service plan is occurring, case closure will be indicated when the family has achieved the outcomes. The service worker should meet with the family and facilitate a discussion about whether the family feels ready for closure and if not, what else needs to happen. During this discussion, the service worker can ask the following questions:

- What are you doing differently now than before we began our work together?
- How is your family different?
- What have you learned that you can use when the next problem arises?
- What supports do you have in place to help you with problems?
- On a scale of 1 to 10, how ready do you feel to manage on your own without help (10 is I feel confident I have learned what to do differently and I do not need help anymore; 1 is I do not know how to proceed and I need help)?
- What would it take to get you to the next step?

Depending on the answers to these questions, the service worker and family can discuss when the case will be closed and what, if any, ongoing support the LDSS will provide.

2.13.1 Reasons for case closure

If the decision is made to close the case, all services should be ended in the automated data system (OASIS). The following reasons for closure are appropriate:

- *Child welfare service not needed.*
- *Cannot locate.*
- *Client's failure to cooperate.*
- *Client's request.*
- *Completed treatment.*
- *Court action.*

- *Death.*
- *Duplicate.*
- *Family moved out of area.*
- *Family no longer participating in services.*
- *Moved out of state.*
- *Reopened existing.*
- *Services given by others.*
- *Services completed.*
- *Services no longer available.*
- *Other.*

The service worker should document a closing case summary in the automated data system (OASIS).

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.*
- *The outcomes of any criminal or civil court matters.*
- *Any recommendations or referrals for the family after case closing, such as the use of formal and informal support systems.*

The family should be informed that the case is closed both orally and in writing. This notification should be documented in the automated data system (OASIS).

2.14 Appeals and fair hearings

Dissatisfied families applying for or receiving early prevention services can request a local conference to discuss their concerns about services or payments and request a change in action. During the conference the LDSS should examine reasons for their

actions or recommendations and consider additional information presented by the family to determine if the LDSS' services or payment decisions should be changed.

2.15 Record retention and purging the case record

Closed prevention case records are to be destroyed in accordance with the Library of Virginia's Records Retention and Disposition Schedule – General Schedule No. 15 for service case records. Records shall be retained for three (3) years after last action and destroyed only when there are no litigations, audits, or investigation of Freedom of Information Act requests.

2.16 Appendix A: Characteristics of effective parent education programs

CHARACTERISTICS	LEVEL		
	PRIMARY	SECONDARY	TERTIARY
DEFINITION	*Designed to:* • *Increase individuals' and families' parenting knowledge, skills, and strategies* • *Empower them in strengthening their foundation and belief system for consistent, positive parenting*	*Designed to:* • *Prevent the occurrence of child maltreatment* • *Increase individuals' and families' parenting knowledge, skills, strategies, and self-awareness* • *Empower parents to examine their parenting beliefs and practices and to improve and strengthen their foundation for consistent, positive parenting*	*Designed to:* • *Prevent the reoccurrence of child maltreatment* • *Increase individuals' and families' parenting knowledge, skills, strategies, and self-awareness* • *Assist parents in acknowledging their strengths while recognizing their behaviors that put their children at risk of maltreatment* • *Empower parents to use their new knowledge and insight to change their behavior* • *Help parents recognize how their own childhood or belief system influences their parenting*
POPULATION SERVED	• *Anyone who wants to improve or update parenting knowledge and skills*	• *Families with low or moderate risk of abuse or neglect, and the presence of one (1) or more risks factors*	• *Families where abuse or neglect or family violence has already occurred or who are at high risk of abuse or neglect and the presence of one (1) or more risk factors and limited protective factors*
DURATION/INTENSITY	• *One or more sessions on general parenting topics*	• *Number and length of sessions depend on the topic and needs of the families. To be most effective, the recommended number of sessions is 12 or more at one and a half (1.5) hours each,*	• *Most intensive level of parent education. To be most effective the recommended number of sessions is 15 or more, resulting in 30 or more hours for group or home-based*

		resulting in 18 or more hours (§ 16.1-278.15 and § 20-103 require a minimum of 4 hours in contested child custody, visitation and support)	*programs*
METHOD OF DELIVERY	• *Face-to-face (individual or group), and web-based interactive*	• *Face-to-face (individual or group, including in-home)*	• *Face-to-face (individual or group, including in-home)*
SUGGESTED COMPONENTS	***Knowledge and skills of parent educator:*** • *Adult learning principles* • *Child development* • *Nurturing & attachment* • *Group facilitation* • *Parenting resources* • *Signs and symptoms of child abuse and neglect and how to report it* • *Aware of current recommendations on the topics presented* • *Aware of personal beliefs* • *Responsive to cultural diversity* • *Non-judgmental and compassionate* • *Risk factors present in families that may indicate the need for additional support* • *Training experience on the curriculum or content area* • *Experience working with children or families*	***Knowledge and skills of facilitator:*** • *Adult learning principles* • *Child development* • *Nurturing & attachment* • *Group facilitation* • *Parenting resources* • *Signs and symptoms of child abuse and neglect and how to report it* • *Aware of personal beliefs* • *Responsive to cultural diversity* • *Non-judgmental and compassionate* • *Aware of current recommendations and research on the topics presented* • *Risk factors present in families that may indicate the need for additional support* • *Training experience on the curriculum or content area* • *Understanding of family systems and how change occurs* • *Experience with high risk parents* • *Risk and protective factors and how to strengthen protective factors* • *Signs and symptoms of traumatic stress and how to respond to*	***Knowledge and skills of facilitator:*** • *Adult learning principles* • *Child development* • *Nurturing & attachment* • *Group facilitation* • *Parenting resources* • *Signs and symptoms of child abuse and neglect and how to report it* • *Aware of personal beliefs* • *Responsive to cultural diversity* • *Non-judgmental and compassionate* • *Aware of current recommendations and research on the topics presented* • *Risk factors present in families that may indicate the need for additional support* • *Training experience on the curriculum or content area* • *Understanding of family systems and how change occurs* • *Experience with high risk parents* • *Risk and protective factors and how to strengthen protective factors* • *Signs and symptoms of traumatic stress*

		children and parents once symptoms are identified	*and how to respond to children and parents once symptoms are identified* • *Recent Trauma Informed Practice training* • *Training on risk and protective factors* • *Graduate degree with experience in clinical work with high risk families preferred; or college degree with experience in working with high risk families*
	Evaluation of educator: • *Ongoing review of participant feedback/ evaluations of the class(es)/ workshop(s)*	***Evaluation of facilitator:*** • *Ongoing review of participant feedback/ evaluations of the class(es)/workshop(s)* • *Access to support through supervision, mentoring, collaboration with professionals or* • *feedback provided by observers and evaluation of training*	***Evaluation of facilitator:*** • *Ongoing review of participant feedback/ evaluations of the class(es)/ workshop(s)* • *Access to support through supervision, mentoring, collaboration with professionals or* • *feedback provided by observers and evaluation of training*
	Assessment: • *May occur based on class content and the needs of the participants.*	***Assessment:*** • *Initial intake interview prior to the first group session with families to determine the fit between their needs and what the program offers and to determine if additional services should be provided* • *Should be face to face and include an assessment of parenting attitudes and*	***Assessment:*** • *Initial intake interview prior to the first group session with families to determine the fit between their needs and what the program offers and to determine what additional services should be provided. Should be face to face and includes an assessment of: parenting attitudes;*

		the family's risk of abuse or neglect. If high risk factors are apparent, referral to CPS or a tertiary program should be made • *Includes completion of a reliable and valid instrument that measures strengths and risk levels*	*family's risk of abuse or neglect;* *the level of traumatic stress experienced by family members; and identification of risk and protective factors* • *Includes completion of a reliable and valid instrument that measures strengths and risk levels*
	Program Evaluation • *Written evaluation by participants or feedback forms completed at the end of the training or workshop*	***Program Evaluation*** • *Written evaluation by participants that measures parental change in beliefs and skills* • *Can be self-report, pre- and post-test or other tool if providing an evidence-based program, use associated tools.*	***Program Evaluation*** • *Written evaluation by participants that measures parental change in beliefs and skills* • *Can be self-report, pre- and post-test or other tool* • *Direct observation of the parent-child relationship with feedback provided by facilitator or opportunities for parents to practice acquired skills or modeling by trained staff. If providing an evidence-based program, use associated tools*
	Case Management • *N/A*	***Case management*** • *Provided based on family's expressed needs*	***Case Management:*** *Ongoing assessment and evaluation of family's need for additional services, including but not limited to: individual counseling, family counseling, in-home services, foster care prevention services and other appropriate client services and support within the community*

(Adapted from: Lundahl, B. W., Nimer, J., & Parsons, B. (2012). Preventing child abuse: A meta-analysis of parent training programs. In J. E. B. Myers (Ed.), Child maltreatment: A collection of readings (pp. 268–285). Thousand Oaks, CA: Sage Publishing.)

2.17 Appendix B: The Family's Story – The First Step in Engagement

An important step in engaging and empowering the family is giving them the opportunity to tell their story, regardless of the how they have come to the LDSS:

- Tell me what brings you here today?
- Tell me your understanding of why we are here talking today?

Let the family create the flow of information. As their story unfolds:

- Identify where you emotionally connect with the parent and look for opportunities to establish that connection during the interview.
- Express empathy and understanding of the family's situation and acknowledge how difficult or hard this is for them.

  For example:

  - This must be very overwhelming, scary, difficult, etc.
  - How have you been managing all of this?
  - It must take a lot of control, strength, support, etc. to handle all that is going on.

- Avoid challenging information at this point.
- Keep focused on strengths and successes that you can identify from the family's story and acknowledge those with the parent.
- Look for opportunities to communicate the following messages to parents:
  - You're a good parent.
  - Your feelings and needs are as important as your child's needs.
  - You know best about what you, your child, and your family needs.
  - I know how difficult/challenging this situation must be.
  - Together we will find the answers that work best in your family.

- Once the family has told their story, identify what risk factors may be present and seek additional information. Suggested questions include the following:
    - What other challenges are you experiencing (parent, child, family, or community related)?
    - What help or services have you received for these challenges?
    - What was the outcome of those services?

The assessment includes how the parent sees the problem, the level of understanding the parent demonstrates for how this problem surfaced and their role in that, the degree to which both parents are together on this issue or problem, what, if any, themes seem to be emerging that it will be important to address.

2.18 Appendix C: Questions to Ask Mental Health Providers

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

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

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

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

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

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

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

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

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

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

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

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

2.19 Appendix D: Questions to raise to assess protective factors as strengths or needs

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

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

Protective Factor	Areas to assess for each protective factor
Child and parents' relationship	• What is the parents' view of this child? What words do they use to describe the child? • What is the relationship between the child and parents? • Do the parents enjoy being with the child? • How do parents soothe the child when the child is upset? • How much time do they spend with the child in play? To what extent are both parents involved? What roles do each parent play? • What barriers exist to involving the absent or other parent? • How have the parents managed those barriers? • What behaviors challenge the parents the most and how do they manage those behaviors? • How does the parent express empathy toward the child? • What is the temperament match between the parent and child? • To what extent do family members listen to each other? • How does the family solve problems, manage conflict or pull together in times of stress?

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

2.20 Appendix E: On-line resources for information and funding

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

- *Attachment.*
- *Child abuse and neglect (national).*
- *Child abuse and neglect (state).*
- *Child care.*
- *Data and statistical.*
- *Evidence-based clearinghouses.*
- *Evidence-based programs.*
- *Evidence-based tools.*
- *Funding.*
- *Protective factors.*
- *Publications.*
- *Strengthening families.*
- *Trauma.*

2.20.1 Attachment

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

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

2.20.2 Child abuse and neglect prevention (National)

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

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

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

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

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

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

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

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

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

2.20.3 Child Abuse and Neglect (State)

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

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

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

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

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

Prevent Child Abuse Virginia (PCAV): Statewide, nonprofit, non-partisan organization that works to prevent child abuse and neglect by valuing children, strengthening families and engaging communities.

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

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

2.20.4 Child care

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

2.20.5 Children and youth programs

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

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

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

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

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

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

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

2.20.6 Court services

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

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

2.20.7 Data and other statistical information

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

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

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

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

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

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

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

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

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

Virginia Performs: Shows how Virginia is doing in areas that effect quality of life for people and their families.

2.20.8 Evidence-based clearinghouses

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

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

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

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

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

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

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

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

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

2.20.9 Education

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

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

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

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

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

2.20.10 Family supports and services

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

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

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

2.20.11 Fatherhood

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

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

2.20.12 Funding

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

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

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

Virginia Community Based Child Abuse Prevention (CBCAP) – State Report: Community-based child abuse prevention state reports.

2.20.13 Mental and behavioral health

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

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

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

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

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

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

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

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

2.20.14 Parent education and support

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

KidsPriorityOne: Resource center where families, and those working with families, find local resources and valuable information related to raising healthy children. The website hosts a database of more than 1,000 organizations serving children and families across Hampton Roads--Southside and Peninsula. You'll find services for all ages of children, youth and their parents; those with disabilities and other special needs; families with basic and emergency needs, youth development, parenting support, and much more.

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

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

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

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

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

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

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

2.20.15 Protective Factors

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

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

2.20.16 Publications

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

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

Virginia Child Protection Newsletter (VCPN): Focuses on one or more topics in child welfare. The articles provide a survey of literature and also address current practice issues.

2.20.17 Strengthening families

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

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

2.20.18 Trauma

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

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

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

2.21 Appendix F: Reasonable Candidacy Manual

2.21.1 General

2.21.1.1 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.

2.21.1.2 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.

2.21.2 Reasonable Candidacy Program

2.21.2.1 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.

2.21.2.2 Reasonable candidacy requirements

No exception or deviance to any applicable services' guidance (Prevention, CPS, 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 service 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 service worker shall document its justification for maintaining a child as a reasonable candidate for foster care at least once every six (6) months.

2.21.2.3 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.

2.21.2.4 Exclusionary conditions of reasonable candidacy

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

- *Children over 18 years of age.*
- *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 2.5.2.3.*
- *The service 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.

2.21.3 Establishing and maintaining reasonable candidacy

2.21.3.1 Establishing reasonable candidacy

The service 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 prevention services 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 2.6.2.3).

2.21.3.2 Maintaining reasonable candidacy

The service 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 (OASIS).

Once the child is no longer at risk of foster care placement, the service worker shall cease classifying the child as a reasonable candidate for foster care (see Section 2.5.2.3). 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 should be updated.

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

2.21.3.3 Reasonable candidacy documentation methods

Although the case plan developed by the service 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.*
- *CPS – 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.

2.21.3.4 Reasonable candidacy documentation

2.21.3.4.1 Purpose and use

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

2.21.3.4.2 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 (OASIS). The initial reasonable candidacy begin date is the day the service worker completes the form. Supervisory approval is recommended but not required in the automated data system (OASIS).

2.21.3.4.3 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 service worker's signature date. The redetermination shall be completed in the automated data system.

2.21.3.5 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 three (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."*

2.21.4 Claiming administrative costs for reasonable candidates

2.21.4.1 Random Moment Sampling (RMS)

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.

2.21.4.2 Completing the RMS Observation

2.21.4.2.1 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.

2.21.4.2.2 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.

2.21.4.2.3 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).

For more information on RMS, see the following courses available in the Virginia Learning Center:

- *FIN1007: Random Moment Sampling (RMS) Observation Form Training.*
- *FIN1008: Random Moment Sampling - The Observer.*

- *FIN1013: RMS - More Than a Paper Drill.*