5

CONDUCTING CHILD AND FAMILY ASSESSMENT

TABLE OF CONTENTS

5

CONDUCTING CHILD AND FAMILY ASSESSMENT

5.1 Introduction

A comprehensive child and family assessment is the essential foundation for sound decision making in partnership with the child and family. Assessment involves the continuous process of gathering information from multiple sources over time using a strength-based approach to help evaluate, with the family, the most effective strategies for achieving safety, timely permanence, and well-being for their child.

The process should be driven by the strengths and needs of the child and family, rather than the availability of services. This approach expands the diverse resources available to support the child and family. It allows the strengths and natural supports of the child, family, and extended family, as well as the formal services of the child-serving agencies and community, to be creatively matched with the identified needs and issues. This process lays the foundation for creatively designing strategies, services, and supports during service planning and service delivery to improve outcomes.

5.2 Comprehensive assessment process

The assessment process begins with the family's first contact with the child welfare system and continues until the case is closed.

The comprehensive assessment is an ongoing process assessing the effectiveness of services provided to the child, birth parent or prior custodian, and foster and adoptive parents.

The effectiveness of services provided and the need for additional services shall be assessed every three (3) months if the goal is to return home and at least every six (6) months after placement for as long as the child or youth remains in foster care.

During a comprehensive family assessment, the service worker should:

- Engage and build relationships with the child, family, extended family, service providers, and other significant people to gather information.

- Observe patterns of child and family interactions over time and the impact on the child.

- Identify child and family strengths, protective factors, and resources that can be mobilized.

- Identify needs of the child and family that impact the child's safety, permanency, and well-being.

- Assess other factors that may have contributed to the child's placement in care such as: domestic violence; alcohol and drug abuse; mental health issues; chronic health problems; physical, intellectual, and cognitive disabilities; and poverty.

- Understand the broader issues impacting the family, such as employment, adequate housing, child care, transportation, needed services, and supports.

- Consider how the information gathered will guide service planning, decision making, and the efficient use of resources.

5.3 Engaging the child and family in the assessment process

As experts on their own family, the child and family are essential sources for information on what is impacting the safety, permanency, and well-being of the child. Involving the family and other significant individuals increases the effectiveness of decision making, service planning, and implementation. The service worker is more effective in gathering, analyzing, and determining the meaning of information. With better information, plans and decisions are more individualized and relevant to the family, thus increasing the likelihood of implementation and creating opportunities for lasting change.

The service worker should:

- Diligently seek out all extended family members as appropriate in the assessment process, including, but not limited to, the birth mother, birth father (including absent fathers), siblings, maternal and paternal family members, caretakers, and other individuals in the extended networks of the child and family (see Section 2 of this chapter).

- Strive to understand the family's perspectives, which are often affected by their life experiences and cultural and ethnic heritage.

- Involve the child and family in identifying their own strengths, needs, and motivation for changes.

- Explore the "natural supports" available to the child and family through their interpersonal, social, and community relationships.

- Utilize the Family Partnership Meetings to gather assessment information (see Section 2.9 of this chapter).

5.4 Understanding traumatic stress for children in foster care

Approximately 90 percent of children in foster care are exposed to trauma. Complex trauma is a common and serious concern for children in foster care. It occurs when the child is exposed to multiple or prolonged traumatic events which are often invasive and interpersonal in nature. It involves simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence, and physical and sexual abuse.[1]

In Virginia, children and youth in foster care often experience complex trauma, traumatic stress, multiple losses, and difficult challenges.

- Three out of four children in foster care are removed from their home due to child maltreatment (neglect, physical abuse, sexual abuse, and/or abandonment).

- Over half are removed due to their parents' situations (e.g., inability to cope, drug or alcohol abuse, inadequate housing).

Some children:

- Witness family violence or the victimization of close friends;

- Experience the death, loss, or separation of a significant person;

- Witness or are a victim of criminal activity (e.g., drug dealing; prostitution);

- Witness school or community violence;

- Experience serious accidents or medical trauma (e.g., surgeries, hospitalizations); and/or

- Have parents who experience their own significant challenges, including mental health or substance abuse issues, or incarceration.

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[1] Excerpted and adapted 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).

Upon entering foster care, children grieve the separation from their parents, caregivers, siblings, friends, significant other persons, and the loss of everything familiar. This traumatic experience is then often compounded by systemic issues in foster care that exacerbate the child's traumatic response through multiple changes in foster care placements, service workers, and school placements.

5.4.1 Consequences of trauma for the child

In addition to the traumatic event, the child's experience of the event can create wide-ranging and lasting adverse effects on the child's developmental functioning and physical, social, emotional, or spiritual well-being. The child's response to the trauma is significantly related to the child's development stage. Adverse effects can impact the child's physiological responses; emotional responses; ability to think, learn, and concentrate; impulse control; self-image; and relationships with others.

- The child can become emotionally overwhelmed by the intense fear, anger, shame, and helplessness that they feel following a traumatic experience.

- Seemingly innocuous events such as sounds, smells, places, and other trauma reminders may reconnect the child with the emotional states of fear, terror, and hopelessness produced by the trauma.

- The child's mistaken feelings of guilt and self-blame for the negative events in his or her life may lead to a sense of hopelessness.

- The child can have difficulty regulating emotions, knowing and describing feelings and internal states, and appropriately communicating wishes and desires to others.

- A child's traumatic experiences can alter his or her worldview, sense of safety, and ability to interpret the meaning of the behavior of others— including people who are trying to help. The child now sees the world as uncertain, untrustworthy, and unpredictable.

Sustained, chronic, or multiple exposures to trauma can impact the child's development and the child's ability to form attachments, to develop relationships, to self-regulate, and to learn. Traumatic events may create new or secondary problems in the child's life (e.g., difficulties in school, problems with substance abuse).These difficulties may be adaptive in the short term but have the potential to interfere with the child's long term recovery.

- The child's development of age-appropriate self-regulation may be delayed.

- The child's inability to regulate emotions may interfere with his or her ability to function in a family, in a traditional classroom, and with peers.

- "Bad behavior" is most often the traumatized child's attempt at self-regulation. When faced with trauma reminders, the child's resulting behaviors may be an appropriate response to internal turmoil but may seem inappropriate in the current situation.

- The child can isolate himself or herself from family, peers, and social and emotional support.

- The child's ability and motivation to succeed in social and educational settings may be impaired.

- The child may engage in reckless, high-risk, or destructive coping behaviors.

Without help and support, children often develop a variety of negative coping responses to traumatic stress. A child's response to traumatic stress may manifest across multiple domains of functioning and developmental processes, including emotional, behavioral, interpersonal, physiological, and cognitive functioning. These responses may have both short- and long-term consequences for the child's well-being in education, physical health, mental health, and life trajectory.

Across the life span, complex trauma has been linked to a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors and other psychiatric disorders.[2]

5.4.2 Observable behaviors of traumatic stress

Children manifest symptoms of traumatic stress through behaviors. Service workers and caregivers should be aware of various behaviors seen in children and youth who have experienced trauma and/or mental health issues. See **5.11** Additional Resources for more information.

5.5 Initial assessment process

A comprehensive initial assessment increases the likelihood of matching services, resources, and supports to address the critical needs and issues for the child and family, thus increasing the likelihood of safety, timely permanency, and well-being for the child.

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[2] Information in this section excepted and adapted from:
- 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).
- Child Welfare Trauma Training Toolkit: Trainer's Guide—1st Edition March 2008 The National Child Traumatic Stress Network. www.NCTSN.org

In conducting the initial assessment, the service worker should:

- Engage with the child, family members, and other significant individuals to:

  o Discuss the purpose, process, participants' roles, and any questions and concerns about the assessment process.

  o Identify language needs and any cultural and religious traditions that need to be respected and taken into account in planning and implementing services.

  o Explore strengths, interests, resources, and formal and informal supports.

  o Identify issues and needs they feel need to be addressed.

- Identify the child's trauma experiences and their impact on the child's behavior to guide services and supports.

- Review previous records for existing information related to strengths, needs, services, family history, and potential supports to the family and child.

- Incorporate information gathered from other assessments, including any safety and risk assessments from other programs and agencies.

- Talk with other service providers and key individuals from places where the child spends time, such as school, sports, work, and religious organizations.

- Determine whether other specialized assessments are needed.

- Identify strengths of child and family, including formal and informal supports.

- Identify immediate issues, concerns, and needs.

- Identify broader issues that create challenges and opportunities.

- Consider services that will meet immediate needs of the child and family.

- Begin identifying ways to address the broader needs of the child and family.

5.5.1 Identifying child and family strengths and resources

The strengths, resources, and natural supports of the child, extended family, community, and agencies should be explored. Examples may include:

- Child complies with rules at grandmother's home.

- Mother can identify when child is going to explode with anger.

- Aunt is willing to help.

- Neighbor's older child is a positive influence.

- An older sibling is working with a therapist on anger management.

- Child enjoys basketball and has strong relationship with coach.

- Child wants to be a car mechanic like an uncle.

After the strengths are identified, creative strategies should be brainstormed and explored on how to use these strengths to address identified needs. This approach allows the family to improve their capacity to meet their own needs. Continuing the example above: after a safety plan is developed, the child could go to the grandmother's house in the afternoon to do homework since the child complies with her rules, the aunt could drive the child to her house, the completed homework could be celebrated by the child's choice of playing basketball, playing with the neighbor's child, or working on a car with his uncle; the grandmother could mentor the mother on enforcing rules.

5.5.2 Identifying child and family strengths to help address trauma

Children often have a variety of strengths, protective factors, and coping strategies that promote positive adjustment to traumatic experiences and complex trauma. Service workers and caregivers should identify these strengths and support the child and family in further developing and using these strengths and strategies.

Examples of protective or ameliorating factors that can moderate the impact of traumatic stress include:

- Child's strengths:

  o Easygoing temperament.

  o Social and emotional competence of child.

  o High intellectual ability.

  o Problem solving-skills.

  o Coping skills and self-regulation.

  o Social connections and support.

  o Promotion of self care.

   o Sense of control.

- Parent and family strengths:

   o Secure attachment to adult figures who are present on a day to day basis.

   o Stable, permanent environment.

   o Structure and routine.

   o Concrete supports available to family.

   o Social connections and supports available to family.

   o Temperament match with caregivers.

5.5.3 Identifying needs and issues prior to services

The needs of the child and family should be identified before considering service and placement options. Rather than first identifying the service or placement type that is expected to meet most of the child's and family's needs, service workers should first identify the immediate needs and issues for the child and family, and then identify alternative strategies, services, and supports for addressing each one. This approach allows creative brainstorming and leads to more effective and successful strategies for working with families.

Needs are separate from services. Children do not need anger management services or treatment foster care. While these services may become part of the complement of services and strategies to address identified needs, they are not needs. Examples of needs may include:

- Being safe from abuse and neglect.

- Living with a stable and permanent family.

- Managing free time after school before parent comes home.

- Reacting to disappointments without aggressive behavior.

- Doing homework to improve grades at school.

- Learning effective parenting skills.

- Increasing positive social and peer supports.

- Developing specific independent living skills.

Defining needs before identifying services allows more creative solutions to be explored through mobilizing family and community strengths.

5.5.4 Identifying needs of child who has experienced trauma

The traumatized child needs to:

- Develop a sense of physical and psychological safety in a caring, stable and permanent family.

- Maximize his or her sense of internal safety.

- Understand his or her reactions through psycho-education.

- Understand that the trauma is only part of who he or she is.

- Reduce overwhelming emotions.

- Work through his or her emotions and learn to manage them effectively.

- Integrate the traumatic experience(s).

- Make new meaning of his or her trauma history and current experiences.

- Feel stable or organized in his thinking so he can function optimally.

- Reclaim age-appropriate power and make sound decisions through skill enhancement and future orientation.

- Communicate with those who advocate and make decisions on his behalf.

- Engage in positive and stable relationships.

The service worker should help identify resources and strategies to assist the child's family and caregivers in helping the child heal through:

- Regulating their emotional response to the child's behavior.

- Assisting the child in regulating his emotions.

- Talking with the child about the trauma in appropriate ways.

- Providing structure and nurturing.

- Challenging the child in developmentally appropriate ways to increase age appropriate skills and abilities.

- Shifting the child's negative world and self view by giving the child positive messages through language and behavior (e.g., communicate "It wasn't your fault; you're a good child; you deserve to be taken care of by parents who will keep you safe; your needs are important").

5.6 Initial assessment requirements

The initial assessment is the basis for developing a foster care plan that addresses immediate child and family needs and selecting a specific foster care permanency goal.

The initial assessment shall:

- Incorporate information contained in the Child Protective Services Safety Assessment and Family Risk Assessment completed when the child was removed from the home.

- Include a comprehensive social history of the child and family.

- Address the initial foster care goal and incorporate beginning exploration of relative resources and the formulation of a concurrent goal.

- Include a description of how the child, youth, birth parent or prior custodian, and other interested individuals were involved in the decision making process.

- Be entered into OASIS **within 30 days** of LDSS acceptance of the child for placement, using the assessment screen (unless otherwise noted) and completing all the required elements of appropriate screens.

5.6.1 Safety factors

The completed Child Protective Services Safety Assessment shall be copied and pasted into the appropriate element of OASIS assessment screen. Identified safety factors shall be taken into consideration in transferring the child's custody or placement to the LDSS such as:

- The child's vulnerability (conditions that result in the child's inability to protect self) including:

  o Whether the child is fearful of the caretaker or other household members.

  o The child's age.

  o The child's developmental and mental health needs.

- Caregiver behaviors such as:

- o   Having caused serious harm to the child or threats to cause harm.

- o   Previous maltreatment of a child.

- o   Failure to protect or provide the necessary supervision to protect the child from serious harm.

- o   Explaining any injury inflicted on the child in such a way that is questionable or inconsistent with the nature of the injury.

- o   Refusing the LDSS workers access to the child.

- o   Failure to meet the child's need for food, clothing, shelter, and/or medical and/or mental health care.

- o   Providing physical living conditions are hazardous and threatening to the child.

- o   Substance use that is or has seriously affected their ability to supervise, protect, or care for the child.

- o   Behavior toward the child that is or has been violent or out-of-control.

- o   Descriptions about or acts towards the child that are predominately negative.

- o   A history of or suspected child sexual abuse.

- o   Physical, intellectual, or mental health status that seriously affects their ability to supervise, protect, or care for the child.

5.6.2 Comprehensive social history

In addition to basing the initial assessment on the Child Protective Services Safety Assessment, a comprehensive social history is critical for understanding the strengths, needs, and experiences of the child entering care. A social history also allows the service worker to explore the full range of assets the family brings, as well as additional needs to address that may increase the likelihood of a safe and stable reunification.

A comprehensive social history including well-being information should be based on consideration of at least the following factors

- •   Background history about the child including but not limited to:

   - o   Family relationships.

o Peer/adult social relationships including the child's relationship to previous caretakers or other adults with whom the child might live.

- Parent, child, family, and community strengths and risk factors present.

- Child health information. The service worker should use the health information screens in OASIS to document the information below. This information should be based on all available health assessments, evaluations, and reports by qualified professionals knowledgeable of the child's health and/or health history. Information to be recorded includes:

  o Child demographics and physical description of the child.

  o Birth information.

  o Disability information.

  o Child's health care providers.

  o Child's current medical information, including: health insurance; whether the child's immunizations are up-to-date as of the child's last medical appointment; and dates of the child's last physical and dental exam.

  o Child's medications, including psychotropic medications.

  o Child's current medical and mental health conditions, allergies and special diet requirements.

  o Child's health history, including: birth and early development issues; prior accidents, illnesses, or conditions that no longer exist; prior hospitalizations.

  o Health history of child's birth family, to the extent known.

- Child's educational achievement and challenges. The service worker should use the child's educational screens in OASIS to document the following:

  o School information

  o Best Interest Determination meeting(s)

  o Educational information (grade level, school performance, special education status, and strengths/needs)

- Background history about the child's family and/or previous custodians including but not limited to:

    o   Substance use or abuse.

    o   Emotional stability.

    o   Sexual abuse.

    o   Resource management and basic needs.

    o   Parenting skills.

    o   Household relationships/domestic violence.

    o   Caretaker abuse or neglect history.

    o   Social or community support system.

    o   Physical health.

    o   Communication skills.

5.7 Role of Family Assessment and Planning Team

When a child is referred to the Family Assessment and Planning Team (FAPT), the FAPT assessment should be used to complement and inform the comprehensive assessment process. It may substitute for the initial foster care assessment as long as the requirements for the initial foster care assessment are met. The FAPT assessment information shall be entered into OASIS.

In addition to the above assessment requirements, all children receiving CSA-funded services shall have a standardized assessment using a tool approved by the State Executive Council. See (Section 5.9.1) of this chapter for information on the Child and Adolescent Needs and Strength Assessment (CANS).

5.8 Types of assessment tools

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

- Trauma assessments, including Virginia's Child and Adolescent Needs and Strengths (CANS) Assessment modules to screen for trauma, sexual abuse, and violence needs.

- Developmental assessments.

- Risk and safety assessments.

- Reunification assessments.

- Child and family comprehensive assessments.

- Life skills assessments.

- Educational assessments.

- Behavioral health assessments.

The following tools are often used by service workers to gather information from family members and other individuals in order to gather a comprehensive picture of the family. These tools are designed to be helpful in the assessment process but are not the actual assessment itself. Genograms and ecomaps in particular should be used after discussion with and training from others experienced in their use.

- **Genogram**. The genogram was first developed and popularized in clinical settings by Monica McGoldrick and Randy Gerson. The genogram (pronounced: jen-uh-gram) lets the worker and family members quickly identify and understand patterns in the family history. The genogram is a tool that helps map out relationships and traits in the family. There are many books on this topic as well as many websites. Genograms can vary significantly and are only limited by your imagination. 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. Basic Genogram components can be accessed on the GenoPro website.

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

  o The STRENGTH of the connection (Weak; tenuous/uncertain; Strong).

  o The IMPACT of the connection (none; draining resources or energy; providing resources or energy).

  o The QUALITY of the connection (Stressful; Not stressful).

  As with genograms, there are many books that discuss the purpose and use of ecomaps including social work textbooks on assessment. The internet and public library are additional sources for information on ecomaps.

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 caseworker and family. Ecomaps are used to:

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

- o Summarize complex data and information into a visual, easy-to-see-and understand format to support understanding and planning.

- o 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.

- o Provide a consistent base of information to inform and support intervention decisions

- o Allow objective evaluation of progress; workers can observe impact of interventions, both on the family and on other elements of their environment.

- o Support discussion of spiritual and value-related issues in a constructive way.

- o Help support integration of the concept of family assessment as an ongoing process.

- o Integrate the values and concepts – and the real power of System Theory – in a practical way.

- o Force the building of interviewing and other skills for staff.

- o Support effective presentation of families' issues for court.

- **Timelines**. Timelines are another assessment tool that depicts the development and history of an individual and or family along a continuum from birth to the present. Similar to genograms and ecomaps, a timeline is a graphic representation of patterns, traits, and the chronology of events in the life of the individual and/or family.

5.9   State required and recommended assessments

The following assessment or screening tools are currently either required or recommended for use in Virginia.

5.9.1 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 all children in foster care 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.

5.9.1.1 Who should be assessed with CANS

All children in foster care shall be assessed using the CANS. Initial assessment should be completed within 30 days of entry into foster care. Reassessment shall be completed at least annually, and within 90 days of discharge from foster care, although may be completed more often.

All children who receive services and funding through 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. The CANS shall be used for title IV-E children and non-title IV-E children who receive CSA-funded services.

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

- A CANS is required for those youth that receive an IL stipend paid for through CSA funds.

5.9.1.2 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 and

- New worker reports for service workers and supervisors to help assess progress and outcomes over time for children in foster care and their families on:

    o Child trauma.

    o Caregiver permanency indicators.

    o Parent/guardian/caregiver protective factors and

    o CANS domains.

It 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.

5.9.1.3   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.

5.9.2   Casey Life Skill Assessment (CLSA)

CLSA is the state recommended assessment and planning tool for evaluating the life skills of all youth age 14 and older and all young adults in foster care. It is youth-centered, strength-based, and expert-focused in evaluating the independent living skills and needs of youth in foster care. (See Section 13.5 on Independent Living Needs Assessment in this chapter).

5.9.2.1 Frequency of administration

The assessment should initially be administered:

- For youth in foster care, **within 30 days** after the youth's 14th birthday.

- For youth entering foster care after the age of 14, **within 30 days** after the youth's entry into the system.

The assessment should be re-administered every 12 months to youth 14 years and older.

5.9.2.2 Assessment areas

The CLSA identifies the youth's strengths and needs in nine domains:

- Career planning.

- Communication.

- Daily living.

- Home life.

- Housing and money management.

- Self care.

- Social relationships.

- Work life.

- Work and study skills.

Domain scores indicate areas of strength and opportunities for improvement.

5.9.2.3 Resources

- The [Casey Life Skills Website](#) provides a free suite of comprehensive online assessments, learning plans, and learning resources to help engage youth in developing life skills that are needed to exit foster care successfully.

- The [CLSA](#) is completed online and automatically scored within seconds. Tools are available in English, Spanish, and French.

5.9.3 Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT is a comprehensive and preventive child health program for all individuals under age 21 and who are Medicaid eligible. EPSDT includes periodic screening, vision, dental, and hearing services. In addition, it provides any medically necessary health services listed at section 1905 (a) of the Social Security Act to correct and ameliorate physical and mental conditions, even if the service is not included under the state's Medicaid plan.

See the Virginia Department of Medical Assistance Services' (DMAS) website for:

- Information and resources on the [EPSDT program](#) in English and Spanish.

- [EPSDT Program Fact Sheet](#).

- [EPSDT English Brochure](#).

- The EPSPT manual on the [Provider Manuals](#) website page.

5.9.3.1 When EPSDT screenings shall be conducted

The service worker shall ensure EPSDT screenings are provided for the child. EPSDT screening services are covered by the managed care organization (MCO) for members who are enrolled with an MCO. When the child is not covered by Medicaid, the service worker shall ensure the child receives the same screenings. See Section 12.11.2 Medical Care and treatment to be provided to a child in foster care for additional information.

5.9.4 Assessment by managed care organization

When the child is enrolled in managed care, the managed care organization shall make a best effort to conduct an assessment within 60 calendar days of enrollment and every two (2) years thereafter. An assessment should include review of physician, hospital, and pharmacy utilization, providing referral policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for members to self-refer for a needs assessment (Virginia Department of Medical Assistance Services' contract with managed care organizations).

5.9.5   Best interest determination for school placement

Federal and state law require that the LDSS and local school divisions work together to determine the best interest of children in foster care for school placement and to ensure educational stability for the children. Children in foster care should remain in the same school in which they were enrolled at the time of placement, or if this is not in the children's best interests, immediately enroll them in a new school.

The VDSS and the Virginia Department of Education have developed joint guidance and a joint tool to assist the LDSS service worker and the school representative in determining the child's best interest for school placement. The form provides a series of questions that should be considered during the determination process.

The determination of the child's best interests for school placement by the LDSS and the local school, in consultation with the child and other key partners, should be made as quickly as possible (e.g., **within three (3) business days**) after the service worker has notified the child's current school of the placement decision.

For more information on determining the child's best interest for school placement, see Section 12.12.1 of this chapter.

5.10   Documenting the assessment

Documenting the assessment process and findings is important for permanency planning, developing and implementing services, and monitoring and evaluating progress. Documentation provides essential information for sharing with the child and family, the court, and service providers. It also provides an important vehicle for ensuring continuity in implementation, particularly when service workers change.

All information gathered during the assessment process shall be documented in the assessment screens in OASIS. Supporting documents (e.g., psychological and other clinical assessments; social work reports) shall be maintained in the paper case file for use throughout the child's involvement with the child welfare system.

5.11   Additional resources

- The National Child Traumatic Stress Network has a comprehensive website that provides many resources on trauma to help children, parents, caregivers, professionals, and others. It also includes a section on resources for the child welfare system.

- 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) provides information and guidance around developing a trauma informed system.

- "Comprehensive Family Assessment Guidelines for Child Welfare." United States Health and Human Services, Administration for Children and Families, describes a comprehensive family assessment in child welfare.

- Additional information about trauma symptoms:

  o As the child gets older the symptoms of both trauma and mental health increase (see following chart).

Overlap of Trauma and Mental Health Symptoms
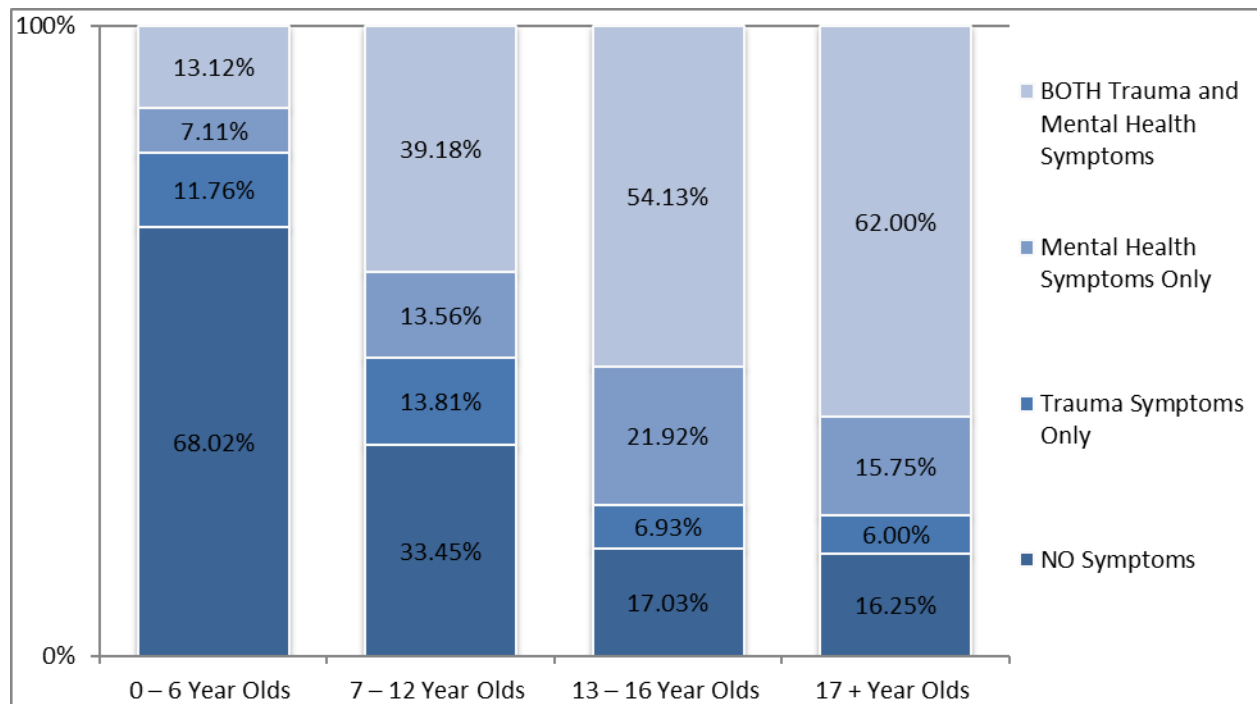
(Griffin, McClelland, Holzberg, Stolbach, Maj, & Kisiel , 2012)

Observable indicators of traumatic stress may include challenges in:

- **Biobehavioral functioning.**

  o Unexplained physical symptoms such as stomach or headaches and fatigue.

  o Poor impulse control and impulsive behavior.

  o Over or under active sensory responses (e.g. high sensitivity to noise, low awareness of pain).

  o Hypersensitivity to physical contact.

  o Hyper physical arousal (e.g., constant physical activity).

  o Underarousal (e.g., lack of movement and facial expressions, slowed walking and talking.)

  o Problems with movement, coordination, and balance. Excessive body movements, excessive and chronic silly behavior.

  o Nightmares, flashbacks, intense reliving, or distressing recollections of the trauma.

- o   Hypervigilance or exaggerated startle response.

- o   Exaggerated emotional and physical reactions to reminders of the event.

- o   Dissociation: frequent daydreaming or trance-like behavior, spacing or blanking out, amnesia-like states, loss of "time," forgetfulness, avoidance, detachment, feeling emotionally detached or depersonalized as if "observing" something happening to self, withdrawing from the outside world.

- o   Refusal to eat, eating disturbances.

- o   Difficulty falling or staying asleep.

- o   Bedwetting. Wetting/soiling pants after having achieved previous bowel and bladder control

- o   Developmental delays, often of more than 4 years.

- o   Increased medical problems.

- **Attachment.**

  - o   Delays in social and emotional development.

  - o   Difficulty with physical or emotional boundaries with others.

  - o   Socially isolated.

  - o   Difficulty trusting others; suspicious.

  - o   Difficulty relating to and empathizing with others.

  - o   Underlying fear of getting close.

  - o   Lack of eye contact.

  - o   Anxious or clingy behavior in the absence of obvious cues of danger.

  - o   Push-pull response to relationships (e.g. intense likes and dislikes without good reason).

  - o   Dismisses, avoids, or detaches intentionally from others.

  - o   Difficulties in interpersonal relationships.

- **Cognitive development.**

o   Distorted cause and effect thinking.

o   Perceptual errors, often misreading situations and thus appearing paranoid.

o   Hyperactivity: difficulty paying attention or concentrating, forgetful in daily activities, extreme distraction, difficulty focusing on and completing tasks.

o   Problem processing information.

o   Difficulty planning and anticipating.

o   Learning difficulties.

o   Problem with language development.

o   Difficulty in progressing and succeeding in school.

o   Impaired memory, unable to recall important aspects of the trauma.

- **Behavior.**

    o   Excessive crying.

    o   Excessive compliance.

    o   Outbursts of anger.

    o   Severe, frequent tantrums.

    o   Inability to manage behavior in all arenas.

    o   Intentional misbehavior.

    o   Defiance, arguing.

    o   Self-destructive behavior.

    o   Running away.

    o   Substance abuse.

    o   Destruction of property.

    o   Aggressive behavior.

    o   Sexual acting out.

- o Inability to shift from feeling to thinking.

- o Absence of cause and effect thinking.

- o Poor problem solving skills.

- o Unable to learn from consequences.

- **Affect and mood regulation.**

  - o Mood swings, rapid shifts in emotions (e.g., from sadness to irritability to anxiety).

  - o Jumpy, irritable, outbursts of anger.

  - o Emotional numbing, blunted or flat emotions, difficulty experiencing intense emotions.

  - o Profound sadness.

  - o Diminished interest or participation in significant activities.

  - o Lack of eye contact.

  - o No or few expressions of joy.

  - o Avoiding feelings or unable to have loving feelings.

  - o Lethargy, loss of motivation.

  - o Suicidal ideation.

  - o Difficulty describing emotions and internal experiences.

  - o Difficulty managing emotions.

  - o Difficulty communicating needs.

  - o Shame and guilt.

  - o Feelings of anxiety, fear, hopelessness.

- **Self and world concept.**

  - o Internal and external lack of feeling safe.

  - o Lack of a continuous, predictable sense of self.

o Poor body image.

o Low self-esteem.

o Shame and guilt.

o No future orientation.