Highly Vulnerable Children (HVC) Protocol

(Revised 10/31/25)

Related Policies

Additional information can be found in the following policies:

- Body Checks
- Case Consultation
- Child and Family Team Meetings
- Child Fatality and Near Fatality Protocol
- Child Protection Team Meeting
- Child Victim Witness Protocol
- Commercial Sexual Exploitation of Children (CSEC) Interagency Protocol
- Contacts - General
- Contacts - SW and Child
- Contacts - SW and Parents
- Contacts - SW and Other Service Providers
- Contacts - SW and Resource Parent(s)
- ER- Closing Referrals
- ER - Investigations
- Medical Opinions - Forensic Examinations/Interviews and Medical Consultations
- Mental Health Treatment and Services
- Petitions - Screening and Service
- Structured Decision Making (SDM)
- Visitation
- Voluntary Services Protocol
- WIC 300 Petitions - Descriptions and Documentation

Forms

The following forms are referenced in this policy:

- 04-184 CWS Suspected Child Abuse Report
- 04-449 Highly Vulnerable Children Tracking Form (*CWS/CMS Template*)
- 04-51A Critical Incident Report (CIR)

Resources

The following resources are available regarding referrals or cases that meet the Highly Vulnerable Child criteria:

- SDM Policy and Procedures Manual
- TEN-4-FACESp: is an acronym and clinical decision rule to help screen children 4 months and younger with marks or bruises, to identify when an injury is more likely to be caused by abuse than accidental injury.

Introduction

This policy provides guidance on processes, procedures, and timelines regarding the Highly Vulnerable Child protocol. The term "Highly Vulnerable Children" (HVC) within the scope of Child and Family Well-Being (CFWB) refers to children who have a significantly higher risk of being subjected to abuse and/or neglect. Criteria for HVC can span across children of all ages. When a child meets CFWB criteria for HVC , the social worker (SW) will take the additional steps outlined in this policy to ensure child safety, and support permanency and well-being. An increase in Office of Child Safety (OCS) oversight with HVC referrals or cases is to assist in supporting families through high risk circumstances while monitoring child safety to prevent further abuse from occurring.

A child's vulnerability to future abuse or neglect can be assessed from various standpoints. Factors that influence child vulnerability impact a child's ability to protect themselves and may stem from a child's age, developmental delays, medical disorders, and more.

SWs incorporate critical thinking and assessment tools such as Structured Decision Making (SDM) and the Child Adolescent Needs and Strengths (CANS) tool to assess for child safety and risk.

NOTE: A score of High or Very High does not automatically determine a referral or case meets HVC criteria as there are additional factors to consider.

When determining a child's vulnerability to future harm, consider the following:

- Child's age (0-5)
- Diminished mental capacity (i.e. developmental delay, non -verbal)
- Diminished physical capacity (i.e. non-ambulatory, limited mobility)
- Lack of involvement or connection to community supports (i.e. not school aged, home schooled or otherwise not visible in the community isolated from community or others not a part of the family)
- Fetal drug and alcohol exposure
- Significant diagnosis or mental health disorder

Introduction (cont.)

Regarding older children/youth, this can also include, but is not limited to, youth:

- with significant intellectual and/or developmental challenges which limit their own protective capacities
- who are offenders of sexual abuse towards other children
- severe mental health challenges that impact the child/youth's ability to make rational decisions or limit their own protective capacities
- engaging in violent acts towards caregivers, siblings, or others in their community
- with history of suicide attempts and method of lethality is increasing or requires ongoing medical care to address the suicide attempt
- who are actively using or receiving treatment for illicit substances such as methamphetamine or fentanyl
- who are victims of and/or engaging in commercial sexual exploitation

For more information on the CA SDM Tools see the Structured Decision Making (SDM) policy and the SDM Policy and Procedures Manual.

All HVC referrals/cases require an in-depth knowledge of the family's history and risk factors as well as the current situation when making casework decisions. The SDM Risk Assessment is completed on most investigations to inform SWs how worries they should be as it identifies families with low, moderate, high, or very high probabilities of future abuse or neglect.

By completing the risk assessment, the SW obtains an objective appraisal of how likely it is that a child /youth will experience maltreatment in their home in the next 18 to 24 months. Families with a high or very high risk assessment score are more often involved in serious abuse or neglect incidents and have significantly higher rates of subsequent referrals that are substantiated than families with a low risk assessment score.

By identifying children who are at higher risk of future abuse or neglect, the SW can focus on providing targeted resources and services to those families. All services and agencies involved with the family should work collaboratively, understand each other's roles, and work towards maintaining children at home or in the lowest level placement possible to reduce subsequent maltreatment.

NOTE: The term "failed to reunify" is used throughout this policy and is often used in reference to criteria for HVC assignment. There are several circumstances to consider regarding caregivers who have failed to reunify with their child(ren). Assess circumstances where one parent completed reunification services quicker than another parent, or if one parent was granted custody of the children and jurisdiction was terminated. HVC designation should be considered if new circumstances against the parent who failed to reunify the children are brought to the attention of CFWB.

Mandatory HVC Designation Criteria

The table below lists when a referral or case requires mandatory designation of HVC. The HVC form will be completed by the SW or PSS, and the SW and/or PSS will consult with the PSPM manager for approval. The SW or PSS will also document that the consultation for HVC designation was completed in CWS/CMS by the following business day.

Mandatory HVC Designation Criteria (cont.)

If a family in a new referral has a prior HVC designation, this does not automatically designate the new referral as HVC. When a new referral is received on a family, HVC will be reassessed taking into consideration the current allegations, current family dynamics, and circumstances of the family along with the prior designation and family history.

The current SDM risk assessment and current family situation/circumstances must be reviewed for HVC criteria. Removing the HVC designation for a family on an open referral or case can be considered after consultation with a PSS and PSPM during the MDT meeting.

Child Characteristics	Description
Infants ages 0-12 months	• Any non-accidental injuries and/or bruises found on non-mobile children. Examples of non-accidental injuries and or bruises could include, but are not limited to: ○ Bruising to the to the torso, ears, neck, frenulum, angle of the jaw, cheeks, eyelids, subconjunctivae, or any presence of patterned bruising. ○ **NOTE:** Refer to TEN-4-FACESp when assessing for injuries and/or bruises found on infants. • Any fractures found on non-mobile children
Ages 0-2	• Any referral received in the household of a parent who failed to reunify with a child and current allegations: ○ are for the same concerns as the prior dependency case **or** ○ are in the same household as the parent who failed to reunify. Assess for circumstances where one parent may have completed services, and reunification services were not offered to the other parent. **NOTE:** If a child is in an open Family Reunification (FR) case and the child has supervised visits only, then assess whether HVC is appropriate based on the current circumstances of the family.
Ages 0-5, developmentally functioning at the level of ages of 0-5, or non-ambulatory child	Any serious injury, accidental, known or suspected non-accidental trauma(NAT), as shown by any one of the following, but not limited to: • Any act of abuse or neglect that if left untreated would cause permanent physical disfigurement, permanent physical disability, or death. • Torture. • Strangulation (the external compression of the neck, including the airway and blood vessels, causing reduced air and blood flow to/from the brain). • Inflicted burn marks by a caregiver/parent. • Bite marks caused by a parent/caregiver. • Broken bones, fractures, or significant bruising in high risk areas.

Mandatory HVC Designation Criteria (cont.)

Child Characteristics	Description
Ages 0-5, developmentally functioning at the level of ages of 0-5, or non-ambulatory child (cont.)	Sexual Abuse when: • There are prior sexual abuse substantiations, **and** the child resides with the perpetrator, or the perpetrator is any individual with continued access to the child, and the non-offending parent/caregiver is not taking protective actions. ○ This includes when there is evidence of sexual abuse regardless of disclosure (e.g. pictures, video, presence of sexually transmitted infection (STI), medical exam, etc.)
All children	Physical abuse by a parent/caregiver currently providing care for the child including: • Severe internal injuries (subdural hematoma, perforated bowel fractured liver, etc.) • An injury to a child of any age that if left untreated would cause permanent disfigurement, disability or death Any child with a referral/case that involves allegations of: • circumstances involving a near fatality, or fatality of a sibling, due to the parent/caregiver's lack of protection or infliction of harm to the child/youth • WIC 300(e), Severe Physical Abuse: The child is under the age of 5 and the child has suffered severe physical abuse by a parent, or by a person known by the parent, if the parent knew or reasonably should have known that the person was physically abusing the child. • WIC 300(f), Death of Another Child: The child's parent has caused the death of another child through abuse or neglect • A child who experienced a near fatality and the parent is unwilling to address the concerns that led to the incident (i.e. Child drowning and parent unwilling to put safety precautions in place to prevent a future incident, a child ingested fentanyl and the parent does not have a plan to ensure child safety) • WIC 300(i), Cruelty to a Child: The child has been subjected to an act or acts of cruelty by the parent or by a member of the child's household or the parent has failed to adequately protect the child from an act or acts of cruelty when the parent knew or reasonably should have known that the child was in danger of being subjected to such cruelty. • Or WIC 300(j), Sibling Petition Associated with an E, F, or I case

Mandatory HVC Designation Criteria (cont.)

Child Characteristics	Description
All children (cont.)	See the WIC 300 Petitions - Descriptions and Documentation for definitions of WIC 300(e), WIC 300(f) WIC 300(i) petitions.

Once a referral is identified as HVC, if a referral is promoted to a case, and the referral becomes a case, the HVC designation will follow the case unless HVC designation is removed by the Multidisciplinary Team (MDT) committee.

Situations to Assess for HVC Designation

In addition to the mandatory designations for HVC, there are many other risk factors that must be assessed to determine if a child is highly vulnerable and if the case/referral should be designated HVC. If a SW and PSS determine that HVC designation may be appropriate based on the considerations listed in table below, the HVC form will be completed and the PSS will consult with the PSPM for approval. The SW or PSS will also document in a contact that the consultation for HVC designation was completed in CWS/CMS.

The table below lists considerations that must be assessed for HVC designation but does not require mandatory HVC designation. Consider the number of factors that are present in the referral/case to determine whether HVC designation is needed. The SW or PSS will document that the assessment was completed in CWS/CMS.

Allegation Type	Considerations
Severe Neglect	A child who: • requires immediate care for a condition that could be life threatening, and the parent is unwilling or unable to get the child the necessary medical attention. • has a chronic condition who is not receiving appropriate treatment due to the parent(s) not seeking or authorizing appropriate treatment, and if left untreated could cause serious physical harm. • is severely malnourished or diagnosed with nonorganic growth faltering (failure to thrive).

Physical Abuse	• Any child with a WIC 300(a) petition.
	• Multiple incidents for excessive discipline causing injury.
	• Physical abuse by a parent/caregiver currently providing care for the child including:
	  ○ Broken bones or fractures in children over age 5
	  ○ Internal or external swelling
	  ○ Bleeding as a result of physical abuse
	  ○ Multiple bruises or patterned bruising
	  ○ Unconsciousness
	  ○ Non-accidental burns, poisoning, or bites

Situations to Assess for HVC Designation (cont.)

Allegation Type	Considerations
Sexual Abuse	• Sexual abuse to a child or children 6 years and older and the perpetrator continues to have access to the child, or non-offending parent does not believe or blames the child
Exploitation	• Child/youth with high CANS score due to risky/harmful behaviors • Child/youth with a high CSE-IT score • Prior substantiated allegations of exploitation for the parent/caregiver • Concerns regarding the parent/caregivers ability to protect child who is a victim of exploitation **NOTE:** MDT consultations should address HVC circumstances in addition to CSEC concerns so as to not duplicate meetings or assessments. See the Commercial Sexual Exploitation of Children (CSEC) Interagency Protocol for more information.
Severe Intimate Partner Violence	Intimate partner violence that includes: • A child involved directly in the violence • Parents who have no empathy for the impact of the violence on their child • Family that isolates the children, does not engage in acts of protection, or minimizes severe incidents. • Elevated risk for lethality, such as strangulation or use of weapons • The alleged perpetrator has a long history of violent behavior

The table below lists other risk factors that must be assessed and considered for HVC referral/case designation:

Risk Factors	Considerations
SDM Risk Assessment Outcome	All referrals with a "Very High" risk assessment outcome must be evaluated to determine if the referral should be designated as HVC
Child/Youth Vulnerabilities	• High sibling set (4 or more), or requiring consistent care/supervision due to age or developmental level • Prior injury due to abuse/neglect • Youth with significant intellectual and or developmental challenges which limits their own protective capacities • Youth who are offenders of sexual abuse towards other children

Situations to assess for HVC Designation (cont.)

Risk Factors	Considerations
Child/Youth Vulnerabilities (cont.)	• Youth engaging in violent acts towards caregivers, siblings, or others in their community • Youth who are actively using or receiving treatment for illicit substances such as methamphetamine or fentanyl • A child who has a mental health diagnosis with current symptoms (active auditory hallucinations, visual hallucinations, disorganized thinking, delusions), **and** child is not seeking treatment/medications **or** is exhibiting progressively worsening severe mental health symptoms as evidenced by: • Increasingly disruptive behaviors • Functional decline • Increase in psychotic symptoms • Multiple mental health assessments (PERT, MCRT, etc.) • Increase in self-harm behaviors • Suicidal ideation • Suicide attempt that required medical attention • Dual diagnosis • Engaging in criminal behaviors or has criminal charges • Behaviors that are attributing to disruption of placement

Parental Risk Factors	• A parent responsible for high number of children (4 or more)
	• A parent with prior abuse or neglect investigations
	• A parent with prior or current open Voluntary Case (VS) or Court Ordered case
	• A parent with severe and/or chronic mental illness, cognitive impairment, or developmental delay that indicate the child is at risk of serious physical harm due to their actions/inactions. Examples include, but are not limited to:
	  ○ Suicide attempts with severe risk of lethality in the presence of the child
	  ○ Ongoing medical care to address the suicide attempt
	  ○ Parent's decline in health to the point that they can no longer care for the child alone or without assistance
	• A parent with alcohol and/or drug use that interferes with family functioning, including fentanyl use where a parent required life saving measures after fentanyl use
	• Prior incidents of domestic violence or increase in frequency and severity of domestic violence incidents, or domestic violence incidents where weapons were used or the child(ren) interfered

Situations to assess for HVC Designation (cont.)

Risk Factors	Considerations

Parental Risk Factors	• A parent with violent felony convictions, especially against children, such as:
	  ○ Rape
	  ○ Murder
	  ○ Attempted murder
	• A parent who:
	  ○ is currently in an investigation regarding the abduction of the victim child or previously abducted a child
	  ○ has history of failing to reunify with a child (**Note: consider circumstances for failed reunification or if jurisdiction terminated after other parent completed services first, etc.)**
	  ○ caused severe injury or death to a child
	  ○ has abused or neglected a child and caused serious non-accidental injuries
	  ○ uses excessive or inappropriate discipline
	  ○ refuses to accept a child/youth's sexual orientation/gender identity/expression and acts towards the child in a way that could cause serious physical injury or emotional harm
	• A parent's willful behavior that resulted in harm or injury to the child (i.e. driving under the influence with the child, leaving child with a known sexual offender, etc.)
	• The pattern or frequency of behaviors resulting in numerous referrals or cases with child welfare agencies
	• Caregiver's history of abuse or neglect as a child
	• A parent/caregiver who blames the child for the abuse/neglect
	• Substantiated allegations of Severe Neglect
	• Reason to know that the family is going to flee during an ongoing investigation or during a case when the child remains with the parent/caregiver
	• Prior substantiations of Severe Neglect against the parent/caregiver

MDT Policy

For HVC referrals/cases, MDT consultations are required at each critical decision-making point. Critical decision points may include, but are not limited to:

- Prior to screening for a dependency petition (consider consultation with the PSS and/or PSPM in the event that the SW cannot wait to schedule the MDT consultation prior to screening the petition).
- Pre-Jurisdiction (before the report is submitted to the court), including the decision to offer services, recommend no services or recommend a change in services

MDT Policy (cont.)

- Prior to submitted the report/notice to the court for the 6-Month, 12-Month and 18-Month Review Hearings
- Considering lowering a high risk visitation
- Changing the level of visitation
- Change of placement
- Placement with parents
- Reunifying the child(ren) and parents and/or recommending a 60-day trial visit
- After the .26 hearing when discussing if the child is still in contact with the parent who has the HVC designation
- Closing the referral
- Prior to offering a family Voluntary Services

The SW will continue to present the case at the MDT consultation and will not combine any of the critical decision points unless authorized by a PSS or PSPM (ie. Requesting multiple changes in the level of supervision during one MDT consultation .

See the Case Consultation policy to find all critical points when an HVC referral/case requires an MDT consult.

Identifying/ Transferring/ Receiving HVC Referrals/Cases

The table below instructs SWs on their roles and responsibilities when being assigned or identifying a new HVC referral/case.

Who	Actions
Assigned SW	• Ensure HVC designation in CWS/CMS in the Alert Text Box on the ID page of the Referral/Case. • Ensure the case notes indicate the case has HVC designation as an "ALERT" in CWS/CMS . • Complete the HVC tracking form (04-449), located in CWS/CMS county specific templates. • Complete and sign the HVC form within 24 hours of HVC designation being made.
Assigned PSS	• Review and sign the HVC tracking form (04-449). • Discuss HVC cases/referrals with the assigned SW during supervision, consultation, etc. • Inform the program PSPM via the Highly Vulnerable Children tracking form (04-449) that a family designated as a HVC case has been assigned to the unit and which SW it has been assigned to within 48 hours of determining the referral is HVC or upon assignment of a HVC referral or case.

Identifying/ Transferring/ Receiving HVC Referrals/Cases (cont.)

Who	Actions
PSPM	• Review and sign HVC Tracking form and confirm referral/case meets HVC designation. • Return to PSS or the SW to import into the referral/case.

Reviewing the referral/case

When assigned a referral/case designated HVC, the SW and PSS will:

- Review the file and discuss factors that led to the case being designated as HVC including:
  - the Emergency Response Referral Document (ERD)
  - all prior referrals
  - all prior cases
  - SDM assessments
  - all court reports
  - all medical and mental health treatment and evaluation reports, including inpatient psychiatrist admission and discharge summaries
- Review the HVC tracking form (04-449).
- Ensure a warm handoff between staff is completed and there is documentation indicating the referral/case is HVC when promoting the referral to a case.
- Ensure the required documents are submitted to ERMS.

Transferring and Receiving a Highly Vulnerable Children referral/case

See table below for guidelines on identifying, transferring, and receiving HVC referrals/cases.

Who…	What…
Transferring SW	• In the Alert Text Box on the ID page of the referral/case in CWS/CMS, document the HVC designation and rationale for HVC designation. • Include case status, risk factors, and any concerns that require immediate attention in the Investigation Narrative and/or Case Notes. • Review the Highly Vulnerable Children Tracking form (04-449), making sure it is complete and has updated information.
Transferring SW and PSS	Verbally communicate with the receiving SW & PSS (regarding the current case status, risk factors and any concerns that require immediate attention.

Identifying/ Transferring/ Receiving HVC Referrals/Cases (cont.)

Who…	What…
Receiving SW and PSS	Discuss the reasoning for HVC designation, the case plan and the risk assessment with the transferring SW and/or PSS.

Investigations

When an investigating SW is assigned an HVC referral, they will follow the procedures listed in the table below and all procedures outlined in ER - Investigations policy:

Step	Action
1	Daily attempts at different times of the day must be made and documented to make face-to-face contact with the family until all avenues to locate/interview them have been exhausted.
2	Interview at least 3-5 direct collaterals. These are individuals who have an interest in the children's well-being and knowledge of the current family situation (school, medical professional, neighbors, landlord, family friends, relatives, service providers, law enforcement, etc.).
3	The SW must complete a same day consult with the PSS after each interview is complete. If interviews are completed at different locations on the same day, consult with PSS prior to leaving each location (i.e. School interviews prior to making a first attempt at the home).
4	After PSS consult, complete safety assessment and discuss next steps prior to leaving the home. **NOTE:** If the SW is planning on releasing a child from custody, it must be done within the legal custody time limits for a child in protective custody (see ER - Time Limits). The SW will present the case at MDT consult prior to release whenever possible within the required release timeframes..

Investigations (cont.)

The SW will consider the following options upon closing the referral:

If…	Then…
Closing the investigation with no further involvement	• Take the referral to MDT consultation prior to closing and follow up with any recommendations provided during the MDT meeting. Discussion during MDT consultation must include if the referral will be closed with HVC designation remaining in effect. • Consider sending referrals on behalf of the family to pre-preventative placement services. • Follow all procedures in the ER- Closing Referrals policy
Opening a Voluntary Services Case	• Take the referral to MDT consultation prior to closing and follow up with any recommendations provided. • Complete warm handoff between the ER and VS teams upon transferring the case. • VS SW- Schedule a CFT meeting within one week of receiving the case and invite previous ER SW. For more information, see Child and Family Team Meetings policy and Voluntary Services protocol.
Screening a petition	• Follow all procedures in the Petitions - Screening and Service policy. • If CC does not believe sufficient evidence is present to demonstrate current risk to a child(ren) and a petition will not be filed on a HVC referral, SW will immediately elevate this to PSS. • The PSS will elevate this to the PSPM and/or Chief for further discussion with CC.
Leaving the child in the home or releasing the child from protective custody	Document household strengths and protective actions that promote safety including assessment of: • Steps the family has taken to mitigate the risk to the child. • How the child's safety will be monitored. • Who is a part of the safety network and what actions they will take supporting the family. • What supports/resources/or services are in place or provided to the family to address their specific needs. • Culturally specific services/resources to meet the needs of the family.

Insufficient Evidence for a Petition

Upon screening a petition with County Counsel (CC) on an HVC referral/case, if CC does not believe sufficient evidence is present to demonstrate current risk to a child(ren) and a petition will not be filed, the PSS and PSPM will follow these procedures:

- Consult with the screening CC, and if needed, PSPM will request review by the Chief Deputy County Counsel.
- Ensure the SW follows up on any recommendations made by CC for additional evidence.
- Assess for potential Voluntary Services case (see Highly Vulnerable Children Referrals/Cases and Voluntary Services below).
- Review any recommendation a SW makes, after an assessment, to leave a child with the parent(s) or to release the child from custody.

Expert Opinion

It is critical that on HVC referrals, the SW have a same-day consultation with their PSS and obtain an expert medical opinions as necessary.

See the Body Checks, Medical Opinions - Forensic Examinations/Interviews and Medical Consultations, and the Child Victim Witness Protocol for all situations that require children to be seen by a child abuse expert or interviewed by a Forensic Interviewer at a Child Advocacy Center (CAC).

To schedule a medical exam with a Child Advocacy Center during business hours and after-hours see the Medical Opinions - Forensic Examinations/Interviews and Medical Consultations policy.

An MDT consultation with the Child Protection Team Meeting may be scheduled to discuss the investigation further. If the CPT calls for an CPT consultation, the SW and PSS are required to attend. The PSPM will be notified of any CPT consultations scheduled on any HVC referrals or cases by the CPT. PSPMs are encouraged to attend the CPT consultation when it involves an HVC referral/case.

Fatality/Near-Fatality

For information on documentation requirements for fatalities/near fatalities see the Child Fatality and Near Fatality Protocol.

Fatal and near-fatal conditions caused by abuse or neglect occur when a caregiver fails to adequately provide for a child's basic needs, including appropriate supervision for a child's age and developmental ability, failure to provide adequate nourishment, lack of necessary medical care for a treatable condition or failure to protect a child from a person known to be violent.

Fatality/Near-Fatality (cont.)

Regarding fatalities and near-fatalities, the California Department of Social Services (CDSS) indicates the following factors:

- The leading causes of child maltreatment near fatalities were abusive head trauma, blunt force trauma, ingested substances, vehicular negligence, and drowning.
- The majority of child maltreatment fatalities and near fatalities continue to occur in infants under the age of one and children between one to four years old.
- Child maltreatment and fatalities continue to reflect racial disproportionality as black and multi-racial children account for a larger proportion of fatality and near fatality victims than their share of the general child population
- Biological parents are the most prevalent among primary individuals responsible
- Twenty percent of combined fatality and near fatalities had an open OCS emergency response referral or open case at the time of the incident. Among those, 25 percent of the child fatalities and 44 percent of near fatalities occurred in families receiving out-of-home services. Seventeen percent of fatalities and 16 percent of near fatalities occurred in families receiving in-home services at the time of the critical incident.

Consider the circumstances surrounding the fatality/near fatality, the willful intent of the parent/caregiver that resulted in harm to the child, the risk of the incident re-occurring to that child or other children in the household. Consider preventative services and lower levels of intervention whenever possible. The SW will consult with the PSS, PSPM, and/or County Counsel when making a determination.

Highly Vulnerable Children Voluntary Services

CFWB makes efforts to ensure child safety with the lowest level of agency intervention. Due to the complexity of circumstances a family with an HVC referral may have, a Voluntary Services case may not be appropriate. If a SW is considering opening a VS case in lieu of screening a petition with the Juvenile Court, the SW should present the referral to MDT for consultation on next steps after having a CFT meeting to discuss the family's ability and willingness to address the protective issues.

See Voluntary Services Protocol for additional information.

Court Involvement

The CI SW and PSS must assess all referrals and cases they receive for HVC designation.

When a CI PSS receives a referral or case identified as HVC, or identifies a referral/case requiring HVC designation, the PSS will:

- Ensure HVC designation in CWS/CMS in the Alert Text Box on the ID page of the Referral/Case.
- Make sure the case notes contain an indicator that the case is HVC.
- Have a warm-handoff when receiving/transferring a referral/case.
- Follow all steps in the case management chart when a new referral/case identified as HVC has been assigned to CI.
- Ensure MDT is scheduled as needed/required. See Case Consultation policy for more information.

Court Involvement (cont.)

Factor	Consider
Placement	For emergency placement, consider the type of case and the caregiver's protective capacities. Ensure a CFT is held to ensure this is discussed and the caregiver is aware of their responsibility to ensure the child is safe. For HVC cases, any major decision points that include placement decisions/change of placement will be discussed at MDT. This includes but is not limited to: • Change of placement • Placement with parents See the Case Consultation policy for more information on major decision points that trigger an MDT consultation.
Visitation	On any HVC designated case, level of visitation supervision must be assessed for potential "high risk visit" classification. See Visitation for additional information. On any HVC designated case, MDT consultation is require for any major decision points, for visitation this includes: • Changing the level of visitation, including going from CFWB supervised visits to a relative/NREFM level of supervision • Starting a 60 day trial visit • Lower high risk visits **NOTE:** A court hearing is required change visitation from supervised to unsupervised (unless given discretions by the court). For more information review the Visitation policy.

Contact Requirements for Highly Vulnerable Children Cases

For monthly contact requirements see the following policies:

- Contacts - SW and Child
- Contacts - SW and Parents
- Contacts - General
- Contacts - SW and Other Service Providers
- Contacts - SW and Resource Parent(s)

If the SW is not allowed access to the child on an HVC case, the SW will immediately elevate the situation to their PSS and immediate action will be taken to ensure the safety of the child.

Treatment

Treatment should be matched to each parent's particular circumstances. Consider incorporating the Child Adolescent Needs and Strengths (CANS) tool, cultural considerations, and behaviorally specific actions for the parent.

See the Mental Health Treatment and Services policy for more information on considerations for treatment and how to refer parents and child/youth for mental health services. The policy includes an overview of:

- Group treatment policy for parents
- Individual therapy for parents
- Conjoint treatment for parents
- Service modalities to address safety and risk factors
- Therapeutic interventions for children/youth
- Authorizing mental health services
- SW responsibilities
- Documentation of progress

Removing the Designation of "Highly Vulnerable Children"

When considering removing the designation of HVC, SW staff must consider all circumstances surrounding the initial conduct necessitating the designation of HVC and all of the current circumstances as they relate to the family's ability to address the initial conduct. Before a SW removes the designation of HVC of a referral/case, the SW must:

- attend MDT and obtain approval from the MDT committee to remove HVC designation
- obtain approval from the PSPM
- document in a contact in CWS/CMS that the HVC designation was removed and the reasons supporting removing the HVC designation

Program specific considerations should be made regarding the following:

Program	Special Considerations
Emergency Response	• Consider keeping HVC designation when current circumstances involve fentanyl use by a caregiver, or a child exposed to fentanyl • Consider keeping HVC designation in circumstances of severe domestic violence or in circumstances where domestic violence incidents are increases in volatility

CI/CS	• If jurisdiction is terminated or the family reunifies successfully, consider removal of HVC designation if the child remains in the care of the parent who successfully reunified or protective parent who mitigated safety concerns
	• Keep HVC designation throughout the life of a case for the following:
	  ○ WIC 300 (e)
	  ○ WIC 300 (f)
	  ○ WIC 300 (i)

Removing the Designation of "Highly Vulnerable Children" (cont.)

Program	Special Considerations

Residential	• Consider HVC designation for:
	  ○ WIC 300 (c) cases
	  ○ Mental health or substance use that impacts daily functioning

Extended Foster Care (EFC)	• HVC designation is not mandatory, but should be assessed and considered for NMDs with mental health or substance use that impacts daily functioning
Adoptions	• Discuss the need for HVC designation at first MDT discussing permanent plan • Consider removal of HVC designation when parental rights have been terminated and the child is placed with a non-relative

Juvenile Court Exit Orders in HVC Cases

In HVC cases where the Juvenile Court is making exit orders regarding custody and visitation upon termination of jurisdiction, the SW will ensure the following is completed first:

- SDM Risk Reassessment
- SDM Reunification Assessment
- A Child and Family Team (CFT) meeting
- MDT consultation
- Review visitation progress
- Review case plan goals and progress
- Consider any safety threats identified and progress towards safety goals
- Consider cultural factors that contribute to the family's circumstances

NOTE: If at a court hearing it is recommended to make changes regarding the child's placement, visitation and custody and a Multi-disciplinary Case Consultation has not occurred, then County Counsel will ask for a continuance or at least a recess so the PSS and PSPM may be contacted.

Alignment with SET

This protocol supports SET Value 1 by holding a clear understanding of the definition of safety and continuously focusing on how the abuse/neglect impacts the child/youth. It also supports engaging the family in safety planning and developing case plans that reflect specific behavioral detail to achieve the safety goal.