Date – April 1, 2021

Manual – Child and Family Services Manual, Chapter B, Prevention Services

Transmittal # – (290)

The purpose of this transmittal is to provide notice of new and revised guidance for Chapter B. Prevention Services of the VDSS Child and Family Services Manual. Unless otherwise stated, the provisions included in this transmittal are effective upon release.

The guidance presented in the prevention chapter is a reflection of the concept that prevention services are an integral part of the continuum of all child welfare services. Virginia Department of Social Services (VDSS) will continue to enhance prevention services and programs to ensure that all Local Department of Social Services (LDSS) have the resources needed to provide In-Home services for children and families, particularly those at risk of entering foster care.

The prevention chapter, which is incorporated into the larger VDSS Child and Family Services Manual, will be organized in the following order:

- Section 1: Overview of Prevention for Practice and Administration.
- Section 2: Prevention and In-Home Services to Families.

Significant changes in Section 1 and Section 2 include:

- Public education and awareness activities that LDSS offer and examples of national community outreach, education, and awareness programs.
- The concept of cultural humility as central to and an extension of culturally competent practice.
- Family First Prevention Services Act (Family First) and its impact on the provision of evidenced-based and trauma-informed prevention services in Virginia.
- The framework for In-Home services and foster care prevention throughout the casework process, to include guidance for initial assessment, service planning, reassessment, and decision-making in three (3) child safety scenarios.
- Guidance on use of the Child and Adolescent Needs and Strengths (CANS) to streamline the assessment process and utilization of a comprehensive assessment tool to create and inform individualized service plans.
- Guidance regarding the determination of a reasonable candidate and candidate for foster care and its documentation in the child welfare information system.
- Subsection that defines safety services in service planning.

This guidance was developed with the assistance of the statewide Prevention Advisory Committee which includes state and regional staff, community partners, and representatives from LDSS.

When the language in a section is italicized, it signifies new, revised, or clarified guidance. Additionally, all electronic links have been updated throughout the chapter.

This transmittal and guidance manual are available on FUSION: https://fusion.dss.virginia.gov/dfs/DFS-Home/Prevention-Services/Prevention-Services-Guidance

Significant changes to the manual are as follows:

Section 1 Overview of Prevention for Practice and Administration	
Subsection	**Significant Changes**
Numbering	Due to some sections and appendices being relocated or new heading titles added within the Overview section, the numbering sequence has changed.
Entire Section	Replaces the term "Early Prevention" with "Prevention" in the overview section.
1.6.1 Legal authority to provide prevention services,	Renames subsection to reflect new content. Adds further statutory authority for the provision of child welfare and others services by LDSS.
1.6.2 Definition of foster care prevention services,	Updates guidance to reflect a revision to the Virginia Administrative Code (22 VAC 40-201-20) that defines foster care prevention services.
1.6.3 Funding prevention,	Adds new federal authority that enables Virginia to provide title IV-E evidence-based prevention services.
1.8 Definitions,	Adds definitions for the following terms: • Alternate Caregiver • Candidate for foster care. • Imminent risk. • Reasonable candidate. • Safety services.
1.10 Vision for the future of prevention,	Highlights the passage of Family First Prevention Services Act (Family First) and its impact on the provision and oversight of prevention services in Virginia.

1.13.3 Cultural humility,	Introduces the concept of cultural humility as central to and an extension of culturally competent practice.
1.14 Levels of prevention services,	Adds revised information regarding the continuum and the levels of prevention services: primary, secondary, and tertiary.
1.15 Primary prevention: Public education and awareness activities for all families,	Relocates 2.3 Primary prevention: Public education and awareness activities for all families and incorporates into Section 1.
1.16 Secondary prevention: Early prevention services with at-risk families,	Relocates 2.4 Secondary prevention: Early prevention services with at-risk families and incorporates into Section 1.
1.17 Tertiary prevention: In-Home services and foster care prevention,	Adds new section that introduces the framework and principles of In-Home services and foster care prevention.
1.18 Group models for prevention education	Relocates group models to own section
1.20.3 Measuring program outcomes	Adds revised guidance regarding Continuous Quality Improvement (CQI) and achieving targets and outcomes
1.20.4 Professional development,	Adds revised guidance regarding training requirements for prevention and In-Home services staff.
1.21 Appendix C: Virginia's prevention initiatives,	Adds information regarding the Family First Prevention Services Act (Family First) and Three Branch Model initiative.
1.30 Appendix I: Online resources for information and funding,	Provides updated links for the identified online resources and adds a link for the Title IV-E Prevention Services Clearinghouse.
Section 2: Prevention and In-Home Services to Families	
Subsection	**Significant Changes**

Numbering	Due to some sections and appendices being relocated or new heading titles added within the Prevention Services section, the numbering sequence has changed.
Entire Section	• Replaces the term "Early Prevention" with "Prevention" in the services section. • Replaces the term "CPS: Ongoing Services" with "In-Home services" in the services section. • Replaces "Relative/Kin" with "Relative/Fictive Kin"
2.2 Definition of prevention services to families,	Adds revised information regarding the levels of prevention services: primary, secondary, and tertiary.
2.3 Tertiary prevention: In-Home services and foster care prevention,	Adds new section that introduces the framework and principles of In-Home services and foster care prevention.
2.4 Opening a case,	Relocates section.
2.4.2 Information and referral only,	Relocates subsection.
2.4.4 Opening case narrative,	Adds subsection to provide guidance on the documentation of an opening case narrative in Family Support and In-Home services cases.
2.4.5 Case type,	Adds new guidance for the Family Support, In-Home, and Dual In-Home & Foster Care case types in the child welfare information system.
2.4.6 Transfer case within LDSS,	Adds subsection to provide guidance on the transfer of In-Home services cases within LDSS.
2.5 Child safety scenarios in an In-Home services case,	Adds new guidance for initial assessment, service planning, reassessment, and decision-making in the following child safety scenarios: • Child or youth living with parent(s) or relative/kin caregiver(s). • Child or youth temporarily living with relative/kin caregiver(s) and will return to the parent(s) or caretaker/guardian(s) within six (6) months. • Child or youth permanently living with relative/kin caregivers(s).

2.6 Initial contact and assessment in an In-Home services case,	Adds new, revised, and clarified guidance on providing services to individual families served by LDSS and presents a model for initial contact and assessment. • 2.6.1 Frequency of worker visits. • 2.6.2 Additional contacts defined. • 2.6.3 Parental permission to speak to a child. • 2.6.4 Contact information.
2.6.5 Consideration of safety at initial contact,	Adds subsection to provide guidance on assessing initial safety in an In-Home services case.
2.6.6 Determining risk level at initial contact,	Adds subsection to provide guidance on determining initial risk level in an In-Home services case.
2.6.6.5 Candidacy determination in an In-Home services case,	Adds revised guidance regarding the determination of a reasonable candidate or candidate for foster care and its documentation in the child welfare information system.
2.6.6.6 Family Partnership Meeting (FPM),	Relocates subsection.
2.6.6.7 Child and Family Team Meeting (CFTM),	Relocates subsection.
2.6.8 Reasonable diligence to locate family,	Adds subsection to provide guidance on reasonable diligence to locate family in an In-Home services case.
2.7 Comprehensive assessment of the family's needs and strengths,	Relocates section.
2.7.1 Child and Adolescent Needs and Strengths (CANS),	Relocates Section 2.8.4 Child and Adolescent Needs and Strengths (CANS). Adds revised guidance regarding use of the CANS.
2.8 Service planning,	Relocates section. Adds new and revised guidance regarding service planning. This section includes: • 2.8.1 Definition of service plan. • 2.8.2 Timeframe to complete service plan. • 2.8.3 Information needed to develop service plan. • 2.8.4 Develop the plan with the family.

	• 2.8.5 Components of an effective service plan. • 2.8.6 Living arrangement. • 2.8.7 Share and document the service plan. • Supervisory review of the service plan • 2.8.8 Supervisory review of the service plan. • 2.8.9 Funding the service plan. • 2.8.10 When parents and caregivers are not engaged.
2.9 Tools and strategies that can be utilized in the assessment process,	Relocates section.
2.9.4 Valid and reliable instruments,	Relocates the list of instruments to Appendix C: Valid and reliable instruments.
2.10 Service delivery,	Relocates subsection.
2.12.2 Safety services,	Adds subsection that defines safety services in service planning.
2.10.7 Trauma focused treatments,	Adds Multisystemic Therapy (MST) and Functional Family Therapy (FFT) as examples of trauma focused treatment services.
2.10.8 Evidenced-based programs,	Adds new subsection that defines evidenced-based programs.
2.10.9.1 Caretaker services,	Adds subsection that provides suggested services for a caretaker.
2.10.9.2 Child services,	Adds subsection that provides suggested services for a child.
2.10.10.1 Family refuses services,	Adds subsection that provides guidance regarding a family's refusal of services.
2.10.10.2 Court refuses request for assistance,	Adds subsection that provides guidance regarding a court refusal of a LDSS' request for assistance.

2.11 Service plan review and reassessment,	Renames and relocates section. Adds new and revised guidance regarding service plan review and reassessments in an In-Home services case.
	This section includes:
	• 2.11.1 Risk reassessment.
	  ○ 2.11.1.1 Risk reassessment considerations.
	  ○ 2.11.1.2 Risk reassessment decision.
	• 2.11.2 Update the CANS.
	• 2.11.3 Update service plan.
	• 2.13.4 Update candidacy determination.

2.12 Closing an In-Home services case,	Renames and relocates section. Adds new and revised guidance regarding the closure of an In-Home services case. This section includes: • 2.12.1 Update safety assessment. • 2.12.2 Update risk reassessment. • 2.12.3 Closing the CANS. • 2.12.4 Closing notification/summary. • 2.12.5 Supervisory approval.
2.13 Transferring an In-Home services case outside the LDSS,	Adds subsection that provides guidance regarding the transfer or an In-Home services case to another LDSS or another state.
2.19 Appendix D: Online resources for information and funding,	Provides updated links for the identified online resources and adds a link for the Title IV-E Prevention Services Clearinghouse.

Questions about this transmittal should be directed to: Morgan Nelson, Prevention Program Manager, Division of Family Services at 804-726-7521 or by email at morgan.nelson1@dss.virginia.gov.

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Commissioner

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OVERVIEW OF PREVENTION FOR PRACTICE AND ADMINISTRATION

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PREVENTION OVERVIEW

1.1 Intended audience for Section 1

The intent of this section is to provide an overview of prevention for administrative and direct service staff across all programs in the social services delivery system and their community partners in order to provide prevention services within local communities. This section provides the following information:

- A definition of prevention for local departments of social services (LDSS).
- Description of the types of prevention services to be addressed in this chapter of the manual.
- The conceptual framework used.
- Standards for effective early prevention and foster care prevention programs.
- Information from a variety of sources that document the need for an intentional focus on prevention in Virginia (for resources used in developing this guidance, see Appendix A: Resources used in developing guidance).
- A summary of the resources and evidence-based practices that can be used to support prevention services within LDSS (See Appendix I: Online resources for information and funding).

1.2 Definition of prevention

Prevention services are an integral part of the continuum of all child welfare services. They include, but are not limited to, providing information and services intended to accomplish the following goals:

- Strengthen families.
- Promote child well-being, safety, and permanency.
- Minimize harm to children.
- Maximize the abilities of families to protect and care for their children.
- Prevent the occurrence or reoccurrence of child maltreatment.
- Prevent out-of-home care, including preventing foster care.

1.3 Virginia Department of Social Services (VDSS) Practice Model

The Virginia Department of Social Services Practice Model sets forth our standards of professional practice and serves as a values framework that defines relationships, guides thinking and decision-making, and structures our beliefs about individuals, families, and communities. We approach our work every day based on various personal and professional experiences. While our experiences impact the choices we make, our Practice Model suggests a desired approach to working with others and provides a clear model of practice, inclusive of all agency programs and services, that outlines how our system successfully practices. Central to our practice is the family. Guided by this model, we strive to continuously improve the ways in which we deliver programs and services to Virginia's citizens. The tenets of the model are as follows:

- All children, adults, and communities deserve to be safe and stable.
- All individuals deserve a safe, stable, and healthy family that supports them through their lifespan.
- Self-sufficiency and personal accountability are essential for individual and family well-being.
- All individuals know themselves best and should be treated with dignity and respect.

- When partnering with others to support individual and family success, we use an integrated service approach.

- How we do our work has a direct impact on the well-being of the individuals, families, and communities we serve.

Prevention services are designed to strengthen and support families and increase their self-sufficiency and personal accountability. Establishing collaborative partnerships within the community and engaging families in these services are essential to achieving desired outcomes.

1.4 Virginia Children's Services Practice Model

The Virginia's Children's Services Practice Model sets forth a vision for the services that are delivered by all child serving agencies across the commonwealth. The practice model is central to decision-making; present in all meetings; and in every interaction with a child and family. Guided by this model, VDSS is committed to continuously improving services for children and families by implementing evidence based practices, utilizing the most accurate and current data available and improving safety and well-being of children and families. The following fundamental principles guide prevention practice:

- We believe that all children and communities deserve to be safe.

- We believe in family, child, and youth-driven practice.

- We believe that children do best when raised in families.

- We believe that all children and youth need and deserve a permanent family.

- We believe in partnering with others to support child and family success in a system that is family-focused, child-centered, and community-based.

- How we do our work is as important as the work we do.

1.5 Guiding principles for prevention

Within the framework of these fundamental principles, the following beliefs guide prevention services:

- The most effective prevention efforts are those where the community takes the lead with the support of local, state, and federal governments; and, where the

emphasis is on strengthening the family's social network and utilizing the network as the primary source of support. LDSS has a key leadership role in opening dialogue and bringing stakeholders and organizations to the table to address prevention services.

- Families are fundamental to children's optimal development. Children do best when they can grow up in their own families and remain safely connected to their mother, father, siblings, and extended family members throughout their life.
- All families can benefit from information and help in connecting with resources as they meet the challenges of parenthood and family life.
- Building protective factors strengthens a family's ability to promote optimal development for their children and reduces the risk of abuse and neglect.
- Supporting the stability of the family, while maintaining the child's safety, is a more effective and less traumatic alternative than separating the child and family.
- Effective prevention programs build on family strengths and focus on fostering positive behaviors, increasing resiliency before problems develop, or reducing risk factors that may be present.
- The prevention of abuse, neglect, and out-of-home care requires a prevention network that links public and private programs and community-based organizations with the purpose of improving child safety, permanency, and well-being outcomes.
- Relationships – within families and communities, between families and providers, and across systems – are essential as agents for change.
- All services in child welfare should respond to the long-term impact of trauma as a result of abuse, neglect, multiple moves, and the child's separation from family.
- All families should have access to culturally responsive prevention programs, services, and resources regardless of their circumstances.
- When out-of-home care is needed, the first alternative should be exploration of extended family members and other individuals connected to the family before the child is removed and placed in foster care.

1.6 Legal basis for the provision of prevention services

1.6.1 *Legal authority to provide prevention services*

§ 63.2-1501 of the Code of Virginia. Definitions. "Prevention" means efforts that (i) promote health and competence in people and (ii) create, promote and strengthen environments that nurture people in their development.

§ 63.2-319. Child welfare and other services. Each local board shall provide, either directly or through the purchase of services subject to the supervision of the Commissioner and in accordance with regulations adopted by the Board, any or all child welfare services herein described when such services are not available through other agencies serving residents in the locality. For purposes of this section, the term "child welfare services" means public social services that are directed toward:

1. Protecting the welfare of all children including handicapped, homeless, dependent, or neglected children;
2. Preventing or remedying, or assisting in the solution of problems that may result in the neglect, abuse, exploitation or delinquency of children;

3. Preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving these problems and preventing the break up of the family where preventing the removal of a child is desirable and possible;

4. Restoring to their families children who have been removed by providing services to the families and children;

5. Placing children in suitable adoptive homes in cases where restoration to the biological family is not possible or appropriate; and

6. Assuring adequate care of children away from their homes in cases where they cannot be returned home or placed for adoption.

Each local board is also authorized and, as may be provided by regulations of the Board, shall provide rehabilitation and other services to help individuals attain or retain self-care or self-support and such services as are likely to prevent or reduce dependency and, in the case of dependent children, to maintain and strengthen family life.

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

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

§ 63.2-905 *Foster Care Services:* Foster care services are the provision of a full range of casework, treatment and community services, including but not limited to independent living services, for a planned period of time to a child who is abused or neglected as defined in § 63.2-100 or in need of services as defined in § 16.1-228 and his family when the child (i) has been identified as needing services to prevent or eliminate the need for foster care placement, (ii) has been placed through an agreement between the local board or the public agency designated by the community policy and management team and the parents or guardians where legal custody remains with the parents or guardians, or (iii) has been committed or entrusted to a local board or licensed child placing agency. Foster care services also include the provision and restoration of independent living services to a person who is over the age of 18 years but who has not yet reached the age of 21 years, in accordance with § 63.2-905.1 *the Code of Virginia*.

1.6.2 Definition of foster care prevention services

22 VAC 40-201-20. Foster Care Prevention Services.

A. The local department shall first make reasonable efforts to keep the child in his home.

B. The local department shall make diligent efforts to locate and assess relatives or other alternative caregivers to support the child remaining in his home or as placement options if the child cannot safely remain in his home.

C. The local department shall provide services pursuant to § 63.2-905 of the Code of Virginia to the child and birth parents or custodians to prevent the need for foster care placement when the child is abused and neglected as defined in § 63.2-100 of the Code of Virginia or has been found to be a child in need of services as defined in § 16.1-228 of the Code of Virginia by the court or as determined by the family assessment and planning team.

D. Any services available to a child in foster care shall also be available to a child and his birth parents or custodians to prevent foster care placement and shall be based on an assessment of the child's and birth parents' or custodians' needs.

E. Appropriate services shall be provided to prevent foster care placement or to stabilize the family situation provided the need for the service is documented in the local department's written plan or in the IFSP used in conjunction with accessing CSA funds.

F. Children at imminent risk of entry into foster care shall be evaluated by the local department as reasonable candidates for foster care based on federal regulations, 45 CFR 1356.60(c).

G. The local department shall develop a written plan for the implementation of wrap around services prior to removing a child from his home. As long as the risk of removal from the home continues, services shall be provided to address identified needs. In the event that the child can no longer be safely maintained in the home, the local department shall document why the support and services considered and provided were not sufficient to maintain the child in his home.

H. Prior to removing the child from the custody of his parents, the local department shall make diligent efforts to notify in writing all adult relatives that the child is being removed or is likely to be removed and explain the options to relatives to participate in the care and placement of the child including eligibility as a kinship foster parent and the services and supports that may be available for children placed in such a home.

1.6.3 Funding prevention

§ 2.2-5211. State pool funds for community policy and management teams.

B. The state pool shall consist of funds that serve the target populations identified in subdivisions 1 through 5 of this subsection…, State Pools Funds for CPMT 3. Children for whom foster care services, as defined by § 63.2-905 are being provided to prevent foster care placements…, for purposes of placement in suitable family homes, child-caring institutions, residential facilities or independent living arrangements as authorized by § 63.2-900.

C. The General Assembly and the governing body of each county and city shall annually appropriate such sums of money as shall be sufficient to (1) provide special education services and foster care services for children identified in subdivision B1, B2 and B3 and (ii) meet relevant federal mandates for the provision of these services.

> *Public Law (P.L.) 115-123. Family First Prevention Services Act (Family First).*
>
> *42 U.S. Code § 670. Congressional declaration of purpose; authorization of appropriations. For the purpose of enabling each State to provide, in appropriate cases, foster care and transitional independent living programs for children who otherwise would have been eligible for assistance under the State's plan approved under part A (as such plan was in effect on June 1, 1995), adoption assistance for children with special needs, kinship guardianship assistance, and prevention services or programs specified in section 671(e)(1) of this title, there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the provisions of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans under this part.*

1.7 Outline of the prevention chapter

The guidance presented in the prevention chapter is an outgrowth of VDSS' efforts to transform child welfare services and embrace a family engagement practice model. It is consistent with accepted strengthening families' principles and practices and with recognized best practices in the prevention of child maltreatment and foster care prevention services.

The prevention chapter, which is incorporated into the larger VDSS Child and Family Services Manual, is organized in the following order:

- Section 1: Overview of Prevention for Practice and Administration
- Section 2: Prevention and In-Home Services to Families

1.8 Definitions

The following words and terms must have the following meaning as used in this chapter, unless the context clearly indicates otherwise:

Term	Definition
Adoption	*The legal process that entitles the person being adopted to all of the rights and privileges, and subjects the person to all the obligations of a birth child.*

Term	Definition
Alternate Caregiver	*OASIS term for living arrangements in which children are cared for by relatives or fictive kin in a temporary or permanent setting.*
Best Practice	A best practice is a method or technique that has consistently demonstrated results superior to those achieved with other means, and is used as a benchmark. It is a practice that is either evidence based or evidence informed, incorporates practice wisdom from the field and clinical experience, and is consistent with family/client values. Best practice can be used as an alternative in the absence of mandatory legislated standards, and, when such standards are present, to support and enhance them.
Candidate for Foster Care	*A service worker must determine if a child is a candidate for foster care if they assess that the child can remain safely in the child's home or in a kinship placement as long as an evidenced-based and trauma-informed prevention service(s) (e.g., mental health, substance use disorder, or in-home parent skill-based program services) is provided. The service(s) necessary to prevent the entry of the child into foster care must be identified in Virginia's approved federal Prevention Plan.*
Child Protective Services (CPS)	The identification, receipt and immediate response to complaints and reports of alleged child abuse or neglect for children under 18 years of age. It also includes assessment, and arranging for and providing necessary protective and rehabilitative services for a child and his family when the child has been found to have been abused or neglected or is at risk of being abused or neglected. (22 VAC 40-705-10 et seq.).

Term	Definition
Children's Services Act (CSA)	A collaborative system of services and funding that is child centered, family focused, and community based when addressing the strengths and needs of troubled and at-risk youth and their families in the commonwealth. (22 VAC 40-705-10 et seq.).
Child Well-being	Child well-being can be conceptualized as social and emotional function of a child that promotes healthy development, resiliency, relational competency, and protective factors.
Collaboration	A mutually beneficial and well-defined relationship entered into by two or more organizations that are committed to achieve common goals.
Community	Groups of individuals, entities, and organizations who live in or serve a common area and group of people.
Community Policy and Management Team (CPMT)	A team appointed by the local governing body to receive funds pursuant to Chapter 52 (§ 2.2-5200 et seq.) of Title 2.2 of the Code of Virginia. The powers and duties of the CPMT are set out in § 2.2-5206 of the Code of Virginia.
Complex Trauma	The experience of multiple, chronic, and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (maltreatment, loss of caregivers, violence, war, etc.) and early-life onset.
Domestic Violence (DV)	A pattern of abusive behaviors used by one individual intended to exert power and control over another individual in the context of an intimate or family relationship.
Prevention Services	A full range of services provided to families that includes: primary prevention programs, directed at the general population (universal) in an effort to prevent maltreatment before it occurs; secondary prevention programs, targeted to individuals or families in which maltreatment is more likely (high risk); and tertiary prevention programs, targeted toward families in which maltreatment has occurred.

Term	Definition
Family Assessment and Planning Team (FAPT)	The local team created through the Children's Services Act to assess the strengths and needs of troubled youth and families who are referred to the team. The team identifies and determines the complement of services required to meet these unique needs (§ 2.2-5208).
Family Focused Practice	A service approach that focuses on the entire family rather than selected individuals within a family. This holistic approach is designed to strengthen and empower families to protect and nurture their children, preserve family relationships and connections, maintain the stability of the family, enhance family autonomy and respect the rights, values, and cultures of families.
Family Engagement	A relationship focused approach that provides structure for decision-making and that empowers both the family and the community in the decision-making process.
Family Partnership Meetings (FPM)	A team approach for partnering with family members and other partners in decision-making throughout the family's involvement with the child welfare system. The meeting is facilitated by a trained individual who is not the service worker for the child or family. The team builds upon the strengths of the child, family, and community to ensure safety, a permanent family, and lifelong connections for the child.
Fictive Kin	Persons who are not related to a child by blood or adoption but have an established relationship with the child or the family system (§ 63.2-100).
Foster Care	Twenty-four-hour substitute care for children placed away from their parents or guardians and for whom the local board has placement and care responsibility. Placements may be made in foster family homes, foster homes of relatives, pre-adoptive homes, group homes, emergency shelters, residential facilities, and child care institutions. Foster care also includes children under the placement and care of the local board who have not been removed from their home.

Term	Definition
Foster Care Prevention Services	A full range of casework, treatment and community services, for a planned period of time to a child who is abused or neglected as defined in § 63.2-100 or in need of services as defined in § 16.1-228 and his family when a child has been identified as needing services to prevent or eliminate the need for foster care placement.
Imminent Risk	*Means a child and family's circumstances demand that a defined case plan is put into place within 30 days. The plan must identify interventions, services, and/or supports, and absent these interventions, services, and/or supports, foster care placement is the planned arrangement for the child.*
Individual Family Service Plan (IFSP)	The plan for services developed by the family assessment and planning team under the Children's Services Act.
Kinship Care	Code of Virginia § 63.2-100 "Kinship care" means the full-time care, nurturing, and protection of children by relatives. Formal: All living arrangements in which children are cared for by relatives of the children's parents who have been approved as foster parents. Informal: Living arrangements in which parents, or whoever is the primary caretaker for a child, have placed children with relatives who are not approved as foster parents for these children. These substitute caregivers are providing voluntary informal care for the original caregivers.
Local Department of Social Services (LDSS)	The local department of social services of any county or city in this commonwealth.

Term	Definition
Out-of-home Care	Substitute care provided to children who, for whatever reason, are unable to remain with the families with whom they are residing. This includes children residing with birth, foster, adoptive, relative, and non-relative families.
Permanency	A nurturing relationship between a child or youth and a caretaking adult which builds emotional ties and attachments that are sufficient to maintain the continuity of the relationship throughout the child's life.
Person Locator Tool	A web-based search program that allows people searches, address searches and phone number searches in real-time. Specifically, it provides a comprehensive view of public records; an individual's associations and relatives; help for localities to connect children/youth with living relatives or other potential caregivers or mentors; and a means to meet the diligence requirements specified by the Fostering Connections Act of 2008.
Prevention	Services provided to any caregiver and child to strengthen families and enhance child well-being, to prevent child abuse/neglect from occurring or reoccurring and to eliminate the need for out-of-home care.
Primary Prevention Services	Universal strategies that direct activities to the general population with the goal of strengthening families and preventing child maltreatment and the need for out-of-home care.
Protective Factors	Conditions in families and communities that, when present, provide a buffer against abuse and neglect and increase the health and well-being of children and families.

Term	Definition
Reasonable Candidate	*A service worker must determine if a child is a reasonable candidate when they assess that 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. It is important to note that reasonable candidate eligibility and documentation are related to the fiscal reimbursement for case management provided by the LDSS and do not replace the requirement to determine the need for preventive services.*
Risk Factors	Conditions in families and communities that, when present, increase the vulnerability and risk of child abuse and neglect and, ultimately, of out-of-home care, including foster care.
Safety Services	*Formal or informal services provided to or arranged for the family with the explicit goal of ensuring the child's safety. These services must be immediately available and accessible and may be provided by professionals, family members, or other willing parties as long as each involved individual understands their role and responsibility. The safety services must be clearly documented (i.e., safety plan, service plan, court order, Structured Decision Making (SDM) plan, etc.) for the involved parties and in the case record.*
Secondary Prevention Services	Selective prevention strategies that identify groups or individual families at risk of abuse/neglect or out-of-home care and direct activities to these at-risk groups or families with the goal of preventing child maltreatment and out-of-home care.
Service Worker	The worker primarily responsible for case management or service coordination for a prevention case.
Human Trafficking	Refers to both sex and labor trafficking
Strength-Based Practice	A social work practice theory that emphasizes families' self-determination and strengths. Strength-based practice is client

Term	Definition
	led, with a focus on future outcomes and strengths that the family brings bring to a problem or crisis.
Strength-Based Supervision	An approach to supervision that emphasizes staff's strengths, encourages them to use those strengths to improve their practice, engages them in decision-making and focuses on outcomes.
Strengthening Family Initiative	Focuses on a holistic approach that looks beyond clients as individuals and focuses on strengthening the family unit as a whole, reflects a fundamental shift regarding how systems work with families. Through the alignment of resources, policies, and processes and the implementation of specific strategies, the well-being of the families is positively impacted by strengthening them at every point of client contact.
Tertiary Prevention Services	Selective prevention strategies that direct activities to parents and children who have experienced maltreatment with the goal of preventing the recurrence of abuse or neglect and preventing out-of-home care.
Trauma	An event or situation that causes short-term and long-term distress or family disruption and can create substantial damage to a child's physical, emotional, and psychological well-being.
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).
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

Term	Definition
	mental or behavioral health needs, or needs a referral for a comprehensive trauma-informed mental health assessment.

1.9 Context for prevention in Virginia

The research and the data on maltreatment suggest that "child abuse prevention efforts have grown considerably over the past 30 years. Some of this expansion reflects new public policies and expanded formal services such as parent education classes, support groups, home visitation programs, and safety education for children. In other cases, individuals working on their own and in partnerships with others have found ways to strengthen local institutions and create a climate in which parents support each other."[1] Virginia continues to contribute to these efforts through initiatives at both the state and local levels.

Public agencies across the state have recognized the benefits to families of providing prevention services and their cost effectiveness. Yet, many localities still do not have a formal prevention program. Intake is the common ground for prevention services provided before a valid child abuse or neglect referral is received. Many agencies across the state, specifically smaller and more rural agencies, often are unable to respond beyond that level; other agencies in Virginia are using a range of funding sources, flexible staffing, and community-based teams and organizations to meet the needs of families before crises occur.

Statewide dialogue has continued within the VDSS and with community partners about how to more effectively collaborate to strengthen families. A Prevention Advisory Committee comprised of VDSS staff, LDSS staff, and community partners have worked to develop a vision and plan for:

- Creating a prevention presence in LDSS.
- Promoting prevention as a core program within the VDSS Division of Family Services.

[1] Child Information Gateway. (2017). Child Maltreatment Prevention: Past, Present and Future. Retrieved from https://www.childwelfare.gov/pubPDFs/cm_prevention.pdf.

- Strengthening the infrastructure that supports local prevention efforts and creates prevention partnerships.

This guidance is an outgrowth of that dialogue and the expressed need from LDSS to develop protocols and best practices to support prevention and to enhance public-private collaboration at the local level.

VDSS supports several prevention services through public-private partnerships, using federal, state and local funding. VDSS administers the Virginia Family Violence Prevention Program (VFVPP) Child Abuse and Neglect Prevention grants that offer local communities an opportunity to tailor projects to meet prevention community needs. VDSS distributes VFVPP grants through request for proposals (RFPs) with appropriated state funds and federal Community Based Child Abuse Prevention (CBCAP) funds. VDSS is also responsible for funds appropriated by the General Assembly for the Healthy Families program. In addition, VDSS administers Promoting Safe and Stable Families (PSSF) funds, the Head Start State Collaboration Grant, and the Child Care and Development Fund.

VDSS also collaborates with numerous partners including the Virginia Family and Children's Trust Fund of Virginia (FACT), the Virginia Partnership for People with Disabilities, the Department of Behavioral Health and Developmental Services, the Department of Health, the Department of Criminal Justice Services, the Department of Juvenile Justice, the Department of Education, Families Forward Virginia (formerly known as Prevent Child Abuse Virginia (PCAV)) as well as other state, local, public, and private non-profit agencies and organizations. In conjunction with the collaborative network of child abuse and neglect prevention programs, VDSS utilizes prevention initiatives to improve the commonwealth's system of child abuse and neglect prevention and the delivery of family resource and support services. This work reinforces linkages among prevention initiatives that will improve services for children and families.

Several other statewide initiatives that have contributed to the success of current prevention efforts are delineated in Appendix C: Virginia's prevention initiatives.

1.10 Vision for the future of prevention

Prevention services in Virginia are provided across the prevention continuum, which includes primary, secondary, and tertiary activities. Both LDSS and VDSS provide services across the continuum. VDSS has historically provided tertiary prevention services through CPS Ongoing services; however, with the passing of the Family First Prevention Services Act (Family First), VDSS will enhance prevention services and

programs to support LDSS in providing prevention services for children and families, particularly those at risk of entering foster care. VDSS will continue to collaborate with other public and private partners to provide primary and secondary prevention services.

In Virginia's locally administered child welfare system, LDSS have the flexibility to design services to meet a wide range of individual needs and circumstances for children and families based on needs, local demographics, and available resources. LDSS are expected to coordinate services with local public, private, and community organizations engaged in activities relevant to the unique needs of children and families in each locality. By doing so, several localities in Virginia have maximized local funding opportunities, along with the Office of Children's Services (OCS), to provide prevention services for children and families.

Moving forward, the Prevention Services program will play an integral role in targeting resources and services that prevent foster care placements and help children remain safely in their homes or with relatives, when appropriate. This In-Home services work is achieved through engagement of the family, their support system, and other service providers. Children and families will benefit from LDSS receiving additional guidance, training, and resources to support quality and uniform practice in the prevention of foster care. In-Home services that work with children at high or very high risk require a focus on family engagement, identifying individualized needs, creating and monitoring service plans and progress with families, and continually assessing safety, risk, and protective factors. Attention to In-Home case practice at both the supervisor level and worker level is needed to create consistency in practice. This framework reflects the key priorities in child welfare and VDSS broader strategic efforts such as the Child and Family Services Plan (CFSP), Child and Family Services Review (CFSR)/Program Improvement Plan (PIP), and the Family First.

Programmatic efforts will continue to focus on the following: developing the prevention services workflow, including prevention services planning, case management process, and practice guidance and training; improving ease of access to prevention services; and ensuring quality of programs and services through implementation of a quality assurance and continuous quality improvement process. This approach aligns with the concept that prevention services are an integral part of the continuum of all child welfare services. The Prevention Services program will continue to collaborate with the Prevention Advisory Committee and other program areas within the Division of Family Services to develop a prevention strategies and best practice guidelines that can be used by LDSS in their delivery of prevention services.

1.11 Benefits of providing prevention services to at-risk families

Benefits of providing prevention services to families in a strength-based, trauma-informed system that promotes protective factors include the following:

- Families who identify their problems and seek help through prevention are more likely to benefit quickly from services and their children are less likely to be at risk of abuse and neglect and out-of-home care.
- Early involvement with the family reduces the likelihood of abuse and neglect occurring, maintains permanency for the child in their family, and preserves sibling groups.
- Strength-based family engagement approaches empower family members and increase their opportunity to be self-sufficient.
- Training and education in the areas of parents' understanding of child development, behavior management, stress management, attachment, and nurturing reduces negative behavior problems and family conflict and improves family relationships.

1.12 Focus of prevention on best practice models

1.12.1 Family driven services

This chapter reflects a family focused and family driven approach to prevention services. Although the concerns presented to the LDSS, either by families or by the community, are initially centered on the child, prevention requires a more holistic approach to services that is focused on the family system. Assessment, service planning, service delivery, and evaluation of services are all directed by the family in the provision of prevention services.

1.12.2 Engaging families and a shift to family based decision-making

Engagement is essential to supporting families seeking prevention services. Support is dependent on a relationship with the service worker that engages the family in the process. The voluntary nature of prevention services also necessitates that the family is the primary decision maker. FPMs can be a helpful tool to engage the family and assist in decision-making. For more guidance regarding family partnership meetings, please refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.

1.12.3 Use of strengthening families perspective for prevention

A strengthening families perspective requires an empowerment and strengths-based approach and supports an emphasis on the whole family throughout the process. Characteristics of this approach include:

- Positive and proactive work with the family.
- Engaging mothers, fathers, extended family, and other key individuals in the process.
- Dialogue with the family focused on family strengths rather than limitations.
- Emphasizing and reinforcing positive functioning of the parents.
- Building the capacity of the family to be independent.
- Providing concrete supports to the family.
- Increasing social supports to the family.
- Teaching competency in parenting and child development.
- Promoting positive mental health and healthy parent – child interaction.
- Empowering families to find their own solutions requires realistic expectations of families in the context of their own values, beliefs, and system of support.

1.12.4 Emphasis on trauma-informed practice

Research has demonstrated that traumatic childhood experiences, including maltreatment, removal, and placement disruptions, have a profound impact on many areas of children's biological, physical, and mental functioning. The Adverse Childhood Experiences Study (ACE Study) conducted by the Centers for Disease Control and Prevention and Kaiser Permanente, examined the effect of ten categories of negative experiences in childhood. 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 use disorder, depression, and suicide attempts.

Other studies reveal that both preschoolers and school age children in contact with the child welfare system show a variety of increased developmental risks. These children show higher levels of behavior problems and depression, impaired social and life skills, cognitive and neurological development, and academic achievement than children their age in normative samples. In addition, placement instability is relatively common for those children placed outside the home, later mental health needs are associated with unstable placements and high levels of children's mental health needs go unmet.

In short these experiences present a major health issue, result in loss of individual and collective productivity of these children as adults and are a major cost to their communities.

Cost-benefit analyses demonstrate the stronger return on investments that result from strengthening families, supporting development, and preventing maltreatment during childhood and adolescence rather than funding treatment programs later in life.[2]

A report released by the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC) in 2018 estimates the total lifetime costs associated with just one year of confirmed cases of child maltreatment (physical abuse, sexual abuse, psychological abuse, and neglect) are approximately $428 billion.

A comprehensive summary of the research and the costs to children, families and communities can be found in Appendix B: What the research reflects about the impact of maltreatment and removal and the costs to children, families and communities.

[2] Child Welfare Information Gateway. (2017). Supporting Brain Development in Traumatized Children and Youth. Retrieved from https://www.childwelfare.gov/pubPDFs/braindevtrauma.pdf.

1.12.4.1 Characteristics of a trauma-informed child welfare system

The National Child Traumatic Stress Network (NCTSN) describes a service system with a trauma-informed perspective as one in which programs, agencies, and service providers:

- Routinely screen for trauma exposure and related symptoms.
- Use culturally appropriate evidence-based assessment and treatment for traumatic stress.
- Make resources available to children, families, and providers on trauma exposure.
- Engage in efforts to strengthen the resilience and protective factors of child and families.
- Address parent and caregiver trauma and its impact on the family system.
- Emphasize continuity of care and collaboration across child – service systems.
- Maintain an environment of care for staff that reduces secondary traumatic stress.

In addition, SAMHSA and *Virginia HEALS* introduce a concept of trauma and offers a framework for becoming a trauma-informed organization, system, or service sector.

1.12.5 Use of the framework of protective and risk factors

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 whatever problems they are 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.

Risk factors are conditions that occur within families that research has demonstrated increase the likelihood of child maltreatment (e.g., parent abused as a child, substance use disorder, etc.).

1.12.5.1 Protective Factors

Emerging research indicates that a wide range of prevention strategies has demonstrated an ability to reduce child abuse and neglect reports and foster care placement.

Six protective factors provide the foundation of the strengthening families approach and are promoted by the FRIENDS: National Center for Community-Based Child Abuse Prevention (CBCAP) and the National Alliance of Children's Trust and Prevention Funds (Alliance):

- **Parental resilience**: the ability to cope and bounce back from all types of challenges.
- **Social connections**: friends, family members, and other members of the community who provide emotional support and concrete assistance to parents.
- **Knowledge of parenting and child development**: accurate information about raising young children and appropriate expectations for their behavior.
- **Concrete support in times of need**: financial security to cover day-to-day expenses and unexpected costs that come up from time to time, access to formal supports like Temporary Assistance for Needy Families (TANF), and informal support from social networks.
- **Children's social and emotional competence**: a child's ability to interact positively with others and communicate his or her emotions effectively.
- **Nurturing and attachment**: parents who consistently meet children's physical, emotional and educational needs, and who provide a nurturing environment through the sharing of physical affection and engaging in positive interactions with their children.

A more comprehensive description of protective factors can be found in Appendix D: Protective Factors and the Child Welfare Information Gateway.

The Alliance has also 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.

1.12.5.2 Risk Factors

Research has indicated that there are certain demographic and family 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 was identified as the most powerful risk factor for abusing or neglecting one's own children in the 2011 Statewide Evaluation Report to the General Assembly of Healthy Families Virginia.[3] Other demographic risk factors include the following:

- Parents with a history of family violence, abuse, and neglect as perpetrators.
- Substance use disorder or psychiatric care.
- Parents with low income, lack of education, and/or language barriers.
- Single parents.
- Children under four (4) years of age.

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.[4]

[3] Prevent Child Abuse Virginia. (2011). Healthy Families Virginia – State Evaluation Executive Report (FY 2007 – 2011). Retrieved from https://www.dss.virginia.gov/files/about/reports/children/annual_progress_services/apsr2011.pdf.

[4] 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.

- Biomedical risk conditions in a child (such as low birth weight, physical deformities, or chronic heart or respiratory problems).
- Child maltreatment, particularly before three (3) years of age.
- Parental substance use or mental health disorder.
- Single or teenage parent.
- Low educational attainment of parent.
- Four or more children in the home.
- Family poverty or domestic violence (DV).
- Involvement with the child welfare system.

All of these characteristics should be considered in the context of the current family system, current family functioning and in conjunction with formal assessment tools and processes when assessing risk of abuse, neglect, or out-of-home care. They can, however, be cues to explore with families whether they would be interested in or can benefit from prevention services. Appendix E: Risk Factors is a list of risk factors associated with maltreatment from the literature for children, parents, the family, and their environment.

1.12.6 Using a solution focused approach with families

In strength-based, trauma-informed practice, the primary role of the service worker includes the following:

- Helping the family identify the impact of their life experiences on the family.
- Recognizing the competencies that family members demonstrate and how service workers can assist families in enhancing their protective factors.
- Shifting the approach from problem focused to solution focused.

The chart in Appendix F: Moving from problem focused to solution focused in strength-based practice reflects this shift throughout the casework process.

1.12.7 Collaboration as a critical component

Collaboration is a central component in prevention. The challenges of developing a common framework among different organizations, competition for funding, etc. often impacts the level of collaboration within communities. An integrated service approach is critical so that each community is able to provide the range of services needed by families from birth through adulthood, before and after problems arise, and regardless of whether CPS is involved.

Types of organizations that have a presence statewide and who partner with LDSS include public and private mental or behavioral health providers, community services boards (CSB), DV programs, prevention providers, child advocacy centers (CAC), respite care providers, Head Start, home visiting providers, post-legal adoption networks, foster parent support groups, substance use disorder prevention providers, sexual assault centers, statewide non-profit agencies such as Families Forward Virginia, food banks, faith-based organizations, schools, shelters, etc.

There is also a need for outreach to mandated reporters; specifically, schools, law enforcement, child care providers, and other connected community organizations to (1) educate them about the early warnings and risks before abuse or neglect occurs, and the resources that may be available to families; and, (2) explore how their organization can be more responsive to families' needs before a child's safety is jeopardized.

1.13 Engaging the family in prevention

Family engagement begins with the response the family is given when they first contact the agency and is critical to achieving positive outcomes with families. Family centered intervention is the most effective model for prevention services, because it focuses on the whole family system. It addresses family functioning, problem-solving communication, role performance and behavior management and is delivered in the context of parental involvement and recognizing and supporting family strengths.

Family engagement is one of the cornerstones of the Virginia Children's Services System Transformation. No longer are Virginia's social service agencies the sole decision makers for Virginia's children and families. Family engagement requires a shift from the belief that agencies alone know what is best for children and families to one that allows the family to fully participate in decision-making.

Family engagement is the process of partnering with the family to help them:

- Stabilize their situation when they are in crisis.
- Determine what needs to be strengthened and supported.
- Make well-informed decisions about their child's safety and well-being and what resources they need.
- Identify how available family and community supports can be used to keep the family together and the child safe.

Effective family engagement is based on establishing trust through open communication, mutual respect and honesty throughout the process. It includes the following:

- Ongoing dialogue with the family focused on the family's strengths as a way to manage their challenges, using the protective factors as a guide.
- Helping families develop and sustain skills that they can apply throughout their life to keep their children safe and their family stable.
- Asking permission from the family to move forward with each step from intake through assessment, planning and service delivery to closure, and before information is shared with others.
- Respecting family structure, roles and relationships.
- Empowering families to take responsibility for themselves and to become self-sufficient.
- Being sensitive and responsive to cultural differences.

For more guidance regarding family partnership meetings, please refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.

1.13.1 The concepts of family and child well-being and their use in prevention

Child well-being can be conceptualized as the social and emotional functioning of a child that promotes healthy development, resiliency, competency in developing and maintaining relationships, and protective factors. All of the work in child welfare is directed, in some way, towards ensuring the well-being of children.

A family well-being approach respects individual differences in families, strengthens and empowers families, minimizes intervention in family life, and promotes self-sufficiency and personal accountability, while ensuring children's safety and well-being and the stability of the family. It also incorporates an understanding of the impact of trauma on the whole family and addresses the symptoms of trauma in service provision.

The Administration on Children, Youth and Families (ACYF), an Office of the Administration for Children and Families (ACF), emphasizes the importance of understanding the impact of trauma on children and providing services that address the trauma symptoms as a primary vehicle for ensuring child well-being. The ACYF has adapted a framework that identifies four basic domains of well-being: (a) cognitive functioning, (b) physical health and development, (c) behavioral/emotional functioning, and (d) social functioning. The framework also takes into account environmental supports, such as family income and community organization, as well as personal characteristics, such as temperament, identity development, and genetic and neurobiological influences. Within each domain, the characteristics of healthy functioning relate directly to how children and youth navigate their daily lives: how they engage in relationships, cope with challenges, and handle responsibilities. For example, self-esteem, emotional management and expression, motivation, and social competence are important aspects of well-being that are directly related to how young people move through the world and participate in society.

1.13.2 Cultural competence

Cultural competence is essential in practice and engagement with families from diverse backgrounds. This diversity encompasses race, ethnicity, language, socio-economic status, family composition, immigration status, religious background, family culture, community culture and other characteristics specific to each family. The following are suggestions that will demonstrate to families that they are respected and will acknowledge their diverse backgrounds:

- Be honest about lack of knowledge of other's life circumstances and culture, and be open to learning about their cultural and spiritual norms and expectations.

- Explore cultural and spiritual values that impact their views about children, parental and gender roles

- Explore attitudes and perceptions about education, school attendance, and discipline.
- Use a certified interpreter whenever possible for families for whom English is not their first language. Avoid using children for interpretation during visits.
- Provide written information in the parents' first language, when possible, but understand potential limitations regarding comprehension and interpretation.
- Be aware of local resources in the community that serve culturally specific groups, as well as gaps in the community for culturally specific needs; be open with families about these missing resources.
- Using a strength-based, family engagement approach not only helps families manage their current situation more effectively but is more likely to result in building strengths and developing greater problem solving skills.

1.13.3 Cultural humility

Cultural humility refers to "the attitude and practice of working with clients at the micro, mezzo, and macro levels with a presence of humility while learning, communicating, offering help, and making decisions in professional practice and settings."[5] *The concept of cultural humility is at the center of cultural competence. When working cross-culturally, service workers cannot be effective without the presence of cultural humility. In child welfare, cultural humility challenges service workers to learn from the people with whom they serve, reserve judgment, and bridge the cultural divide between perspectives, in order to promote child well-being, safety, and permanency.*

1.13.4 Connecting and reconnecting fathers through engagement

There is a growing recognition of the need to support fathers' (and other male caregivers) involvement in their children's lives. This includes fathers who are living with their children but would like to be more engaged with them and fathers who are not living with their children full time or are incarcerated.

[5] National Association of Social Workers. (2016). *Standards and indicators for cultural competence in social work practice*. Washington, DC.

The National Fatherhood Initiative's - Father Facts demonstrates the numerous long-term benefits this has for children:

- Fathers provide support related to the safety, permanency, and well-being of their children.
- Fathers who provide consistent child support and interaction with their children give benefits to the whole family.
- Fathers provide additional leadership and guidance.
- They provide mentoring and role modeling.
- They provide other supports which contribute to their children becoming healthy successful adults.
- Their children display enhanced social skills, develop and demonstrate greater problem-solving skills, demonstrate increased cognitive and verbal abilities, and have higher academic achievement.

Higher father involvement:

- Promotes healthy child development.
- Creates more informal supports in the family systems.
- Facilitates concurrent planning.
- Enhances outcomes.

The following strategies promote help-seeking behavior in men:

- Start with the assumption that fathers want to be involved.
- Suspend judgments and listen to all sides.
- Make room for appropriate expressions of anger.
- Avoid asking men how they feel; instead, ask, "What do you think" or "What is it like for you?"

- Connect problem-solving to concrete action and allow fathers to separate the problem from themselves and gain a sense of objectivity.
- Use approaches that focus on logic and behavior.
- Involve men in leadership roles who can share their experiences as fathers.

Mothers and fathers may need help in managing conflict and improving communication between each other and with the child to navigate co-parenting. Both parents need to be educated about the important role a father plays in a child's life and they need to make a lifetime commitment to their child and to maintaining a healthy relationship with each other.

For more information and resources on father involvement, see The National Fatherhood Initiative, Nurturing Father's Program, Appendix G: Father Friendly Environmental Assessment Tool, VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement, and Virginia Birth Father Registry.

1.13.5 Strengthening marital and parental relationships

Strengthening families and preventing maltreatment and out-of-home care requires education and support for both marital relationships and parental relationships. When parents share a strong commitment to their children, it is more likely they can come to a common understanding of what is in their child's best interest. When parents share a strong commitment to their relationship, it is more likely they will positively impact their child's well-being. Promoting family and child well-being by supporting healthy marriage and family relationships and encouraging emotional and financial support of children can play an important role in prevention services.

Research has demonstrated that marriage education can strengthen the relationships of married couples, yielding improved relationship quality and stability.[6] Community Healthy Marriage Initiatives (CHMI) is a key component of the healthy marriage demonstration strategy of the Administration for Children and Families (ACF) to determine how public policies can best support healthy marriages and child well-being.

[6] Carroll, J. S. and Doherty, W. J. (2003). Evaluating the Effectiveness of Premarital Prevention Programs: A Meta-Analytic Review of Outcome Research. Family Relations, 52: 105–118.

Some of the components of services that support healthy marriage and family relationships include, but are not limited to, the following:

- Training that emphasizes relationship skills, communication and other attributes of successful couples and families.
- Teaching skills, attitudes and behaviors to help individuals and couples achieve long lasting, successful marriages and intimate partner relationships.
- Utilizing partnerships that are a trusted part of the community to recruit both mothers and fathers into new programs.
- Providing parent and relationship workshops and support groups in both English and Spanish.
- Including access to employment services on site for parents who participate in groups and workshops.
- Involvement with the child support system to encourage both emotional and financial support of children.
- Targeting underserved communities.
- Providing information on what the literature identifies as two of the most common obstacles to marriage in unmarried parents who initially plan to marry but do not: financial concerns and relationship problems[7].
- Utilizing experienced married couple facilitators, mothers and fathers, who have been able to develop and maintain healthy, engaged relationships with each other and their children.
- Providing assistance to families to help them better understand and manage crisis situations, such as loss of a job, death in the family, unplanned

[7] Gibson et al. (2005). High Hopes But Even Higher Expectations: The Retreat From Marriage Among Low-Income Couples. Retrieved from https://www.opressrc.org/content/high-hopes-even-higher-expectations-retreat-marriage-among-low-income-couples.

pregnancy, divorce, etc.; and, to accept the realities of these life changing experiences in their families.

Marriage and relationship education can be an agent for positive change when both parents put the child first and are invested in having a healthy and satisfying relationship. For more information on marriage and relationship education, see the National Resource Center for Healthy Marriage and Families.

Family engagement begins with the response the family is given when they first contact the agency and is critical to achieving positive outcomes with families. Family centered intervention is the most effective model for prevention services, because it focuses on the whole family system. It addresses family functioning, problem-solving communication, role performance and behavior management and is delivered in the context of parental involvement and recognizing and supporting family strengths.

Family engagement is one of the cornerstones of the Virginia Children's Services System Transformation. No longer are Virginia's social service agencies the sole decision makers for Virginia's children and families. Family engagement requires a shift from the belief that agencies alone know what is best for children and families to one that allows the family to fully participate in decision-making.

Family engagement is the process of partnering with the family to help them:

- Stabilize their situation when they are in crisis.
- Determine what needs to be strengthened and supported.
- Make well-informed decisions about their child's safety and well-being and what resources they need.
- Identify how available family and community supports can be used to keep the family together and the child safe.

Effective family engagement is based on establishing trust through open communication, mutual respect, and honesty throughout the process. It includes the following:

- Ongoing dialogue with the family focused on the family's strengths as a way to manage their challenges, using the protective factors as a guide.

- Helping families develop and sustain skills that they can apply throughout their life to keep their children safe and their family stable.
- Asking permission from the family to move forward with each step from intake through assessment, planning and service delivery to closure, and before information is shared with others.
- Respecting family structure, roles, and relationships.
- Empowering families to take responsibility for themselves and to become self-sufficient.
- Being sensitive and responsive to cultural differences.

For more guidance regarding family partnership meetings, please refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.

1.14 Levels of prevention services

Professionals working to prevent child abuse and neglect have incorporated ideas and information from other disciplines, including public health, education, and mental health, to influence and guide practice. The prevention framework consists of three levels of services:

- *Primary prevention programs,*
- *Secondary prevention programs,*
- *Tertiary prevention programs.*

Prevention services are recognized as occurring along a continuum. A comprehensive system of care for improving outcomes for children and families need to include strategies that coordinate resources across the entire continuum, from primary to secondary to tertiary. What distinguishes the services on the continuum is the following:

- *Target population.*
- *Degree of trauma experienced by the child and family.*

- *Level of intervention by LDSS or prevention services provider.*

1.14.1 Primary prevention

Primary prevention activities are directed at the general population and attempt to address maltreatment before it occurs. All members of the community have access to and may benefit from these services. Primary prevention activities with a universal focus seek to raise the awareness of the general public, service providers, and decision-makers about the scope and problems associated with child maltreatment.

Universal approaches to primary prevention may include:

- *Public service announcements that encourage positive parenting.*
- *Parent education programs and support groups that focus on child development, age-appropriate expectations, and the roles and responsibilities of parenting.*
- *Family support and family strengthening programs that enhance the ability of families to access existing services, and resources to support positive interactions among family members.*
- *Public awareness campaigns that provide information on how and where to report suspected child abuse and neglect.*

1.14.2 Secondary prevention

Secondary prevention activities are offered to populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance use disorder, young parental age, parental mental health concerns, and parental or child disabilities. Programs may target services for communities that have a high incidence of any or all of these risk factors.

Approaches to prevention programs that focus on at-risk populations may include:

- *Parent education programs located in high schools, focusing on teen parents, or those within substance use disorder treatment programs for parents with young children.*
- *Parent support groups that help parents deal with their everyday stresses and meet the challenges and responsibilities of parenting.*

- *Home visiting programs that provide support and assistance to expectant mothers and new parents in their homes*
- *Respite care for families that have children with special needs.*
- *Family resource centers that offer information and referral services to families living in underserved communities.*

1.14.3 Tertiary prevention

Tertiary prevention activities focus on families where maltreatment has occurred and seeks to reduce the negative consequences of the maltreatment and to prevent its recurrence.

Programs in tertiary prevention may include services such as:

- *Intensive family preservation services with trained mental or behavioral health providers.*
- *Parent mentor programs with stable, non-abusive families functioning as "role models" and providing support to families in crisis.*
- *Parent support groups that help parents transform harmful practices and beliefs into positive parenting behaviors and attitudes.*
- *Mental health services for children and families affected by maltreatment to improve family communication and functioning.*

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

The Pathway to the Prevention of Child Abuse and Neglect, a 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 Families Forward Virginia. Among others. Examples of public education and awareness activities include the following:

- *Family Fun Days conducted in various communities.*
- *community forums on substance use disorder.*
- *Presentations at faith-based activities and other community groups on topics of interest to all parents.*
- *Parenting tips and other parenting information on a local web page.*
- *Distributing brochures and other parenting information at health fairs, local festivals, community centers, libraries, and places of worship.*
- *Publishing electronic or print articles on topics of interest to all parents during Child Abuse Prevention month and other child welfare advocacy months.*
- *Playing 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 use disorder 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*.

1.15.1 Child Abuse and Neglect Prevention Month

Since the early 1980's, Virginia has recognized April as Child Abuse Prevention Month. This observance has prompted concerted efforts to disrupt the cycles of child abuse and neglect in Virginia and across the country. 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, Child Abuse 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 communities 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.*
- *Families Forward Virginia.*
- *Child Welfare Information Gateway – Spread The Word.*
- *Children's Bureau.*
- *Virginia Cooperative Extension – local offices.*
- *Early Impact Virginia (EIV).*

1.16 Secondary prevention: Prevention services with at-risk families

1.16.1 Characteristics of at-risk families

In this section, at-risk families are populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance use disorder, young parental age, parental mental health concerns, and parental or child disabilities. Programs may target services for communities that have a high incidence of any or all of these risk factors.

1.16.2 Outreach to at-risk families

1.16.2.1 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 the messages to communicate are essential first steps. Answering the following questions can be helpful in determining the audience that 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 E: Risk Factors) 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 use, low income families, etc.)?*
- *Which of the protective factors (Appendix D: Protective Factors) 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 prevention services or have frequent contact with the target population (e.g., schools, hospitals, neighborhood resource centers, etc.). These natural points of contact, often referred to as "touch points," can be used by the LDSS to communicate necessary information to the target population.

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 prevention services, how to approach families from a strength-based, trauma-informed perspective, and how to engage families in planning and decision-making.

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

Some LDSS have initiated 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 wish to be 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 pediatrician 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 and include dates, time, duration, incentives provided, and contact information for registration.

1.17 Tertiary prevention: In-Home services and foster care prevention

The primary goal of In-Home services is to support families to safely maintain children, in their own homes or with relative/ fictive kin caregivers in their own communities, by addressing identified safety and risk concerns and reducing the reoccurrence of child maltreatment. This is achieved through engagement of the family, their support system, and other service providers. For more information on tertiary prevention and In-Home services, see Section 2.3, Tertiary prevention: In-Home services and foster care prevention.

1.18 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.

1.18.1.1 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. Families Forward Virginia can also provide information about parent support groups.

1.18.1.2 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 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 use disorder, incarcerated parents, teen parents, co-parenting, etc.); and, if court ordered clients are served, identifying 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 program be completed in full 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 improved 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 can be found in Evidence-Based Practice in CBCAP and Title IV- E Prevention Services Clearinghouse.

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.

1.18.1.3 Parent leadership and involvement

Parent leadership is promoted on a meaningful level when parents are given the opportunity for personal growth, the opportunity to gain the knowledge and skills to function in leadership roles, and opportunity to help shape the direction of their families, programs, and communities. Parent leadership is achieved when parents and service workers build effective partnerships based upon mutual respect and shared responsibility, their expertise and leadership is valued 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 allow parents to bond with other parents. This confidence and connection to other moves parents towards more meaningful roles in programs which gives parents 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 FRIENDS – Parent Leadership.

1.18.1.4 Educational/support groups for youth

Educational or support groups for at-risk youth 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 D: Protective Factors) increase children's resilience, enhance parent child relationships, and contribute to reducing the risk of maltreatment. 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 can be provided to at-risk youth include, but are not limited to the following:

- *Teen parenting 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.*
- *Lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or allied (LGBTQIA) 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 children and 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®, URSTRONG 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 use disorder and Mental Health Service Administration (SAMHSA).

1.19 Practice and administrative standards for effective prevention programs

It has been difficult to identify characteristics common to effective prevention programs because there are few interventions related to child welfare that have been rigorously

evaluated. However, there are characteristics that have been observed most frequently through evaluations of effective programs that exhibited a significant reduction in either child abuse and neglect or out-of-home placements. Washington State Institute for Public Policy identified five (5) broad characteristics shared among the majority of effective programs, including Healthy Families America, Nurse Family Partnership, Structured Decision Making in the State of Michigan, Triple-P Positive Parenting Program in the State of South Carolina, and at least ten (10) other evidence-based programs. These program characteristics are as follows:

- Targeted populations: successful programs tend to be targeted toward a specific group of people who might be expected to benefit the most from prevention services.

- Intensive services: programs with strong impacts on child welfare outcomes tend to provide intensive services (a high number of service hours and a requirement for a high level of engagement from participants).

- A focus on behavior: effective programs are likely to take a behavioral approach (vs. an instructional approach) to educating parents, such as parent coaching.

- Inclusion of both parents and children: successful programs take an approach that acknowledges the central role of the parent-child relationship in child outcomes.

- Program fidelity: programs that demonstrate the importance of maintaining adherence to the program model utilized demonstrate the most success.

Research has demonstrated that early intervention, specifically early childhood education programs designed to promote children's development by building protective factors in both children and their families, can help to protect vulnerable children from the consequences associated with the early experience of multiple risk factors.[8] This body of research, along with the extensive literature review that supports the impact of the strengthening families' protective factors, articulates a strong justification for the incorporation of a family-centered developmental approach into child welfare practice with young children and families.

[8] Center for the Study of Social Policy. (2010). Allied for Better Outcomes:

Child Welfare and Early Childhood. Retrieved from https://childcareta.acf.hhs.gov/systemsbuilding/allied-better-outcomes-child-welfare-and-early-childhood.

The State of Arizona's Child Abuse and Neglect Prevention System conducted an extensive literature review about effective prevention programs and recommended a set of standards adapted from the State of New Jersey Task Force on Child Abuse and Neglect's standards. Virginia has added some standards based on the emergence of information on the importance of trauma-informed practice.

PRACTICE WITH FAMILIES	PRACTICE WITH COMMUNITIES	ADMINISTRATIVE STANDARDS
1. Family-focused. 2. Strength-based, goal setting in partnerships with family. 3. Flexible and responsive. 4. Accessible and incentivized. 5. Voluntary and non-stigmatizing. 6. Comprehensive and integrated. 7. Developmentally informed. 8. Long-term and adequate intensity. 9. Cultural responsiveness/ reciprocity. 10. Trauma competence.	1. Participatory development planning. 2. Community integration. 3. Early intervention at all developmental stages. 4. Sensitivity, awareness and use of knowledge of trauma into the organizational culture and service array. 5. Strength-based approach.	1. Long-range and ongoing planning. 2. Supervision, organization management, and professional development. 3. Parent and community leadership. 4. Fidelity to an established, appropriate model. 5. Highly qualified, competent and caring staff. 6. Data collection and documentation. 7. Measures outcomes and conducts evaluation. 8. Adequate funding and long-term commitment to

11. Youth and family empowerment, choice, and control.		sustainability of the program. 9. Policies and procedures that support strength-based, trauma-informed approach and use of protective factors.

These standards are consistent with the literature on family support programs that emphasize families:

- Helping themselves.
- Preventing problems rather than correcting them.
- Increasing the stability of families.
- Increasing parents' confidence and competence in their parenting abilities.
- Building on formal and informal resources.
- Responding to the impact of trauma on children and families.
- Promoting the flow of external resources and supports to families.

1.20 Administrative supports needed for effective prevention services

The VDSS Practice Model and the Children's Services Practice Model both emphasize "how we do our work is as important as the work we do." Furthermore, the ACYF makes the following statement: "An understanding of the impact maltreatment has had on children when they come to the attention of the child welfare system allows providers to be more proactive, knowing what to look for and anticipating the services that may be needed. This capacity is necessary at the service worker level, but also at the level of administrators who are making decisions about the array of services needed internally or through contracts."

1.20.1 Key tasks for administrators and supervisors

The Center for the Study of Social Policy (CSSP) suggests five (5) approaches for changing systems to more effectively strengthen families and to sustain the practice approaches such as those suggested in this guidance manual.

Family-strengthening and trauma-informed child welfare practice across the continuum of services extending from public education to prevention with intact families, supporting foster families and kinship caregivers, preparing families for reunification and post adoption or post reunification supports:

- Infrastructure changes, including integration of a protective factors and trauma-informed approach into regulations and procedures that govern practice.
- Professional development that integrates the protective factors and trauma-informed approach into ongoing education and training for all who work with children and families.
- Parent partnerships at all levels of the child welfare system with parents engaged in decision making.
- Early childhood systems integration across diverse early childhood initiatives and systems in order to reach families sooner.

In addition to these system changes, administrative and supervisory staff at the local level plays a critical role in insuring positive outcomes for families and support of prevention.

Key tasks for administrators and supervisors to facilitate a strengthening families, trauma focused system for prevention that incorporates the protective factors include the following:

- Recognize and acknowledge the many ways in which staff is providing prevention services across the child welfare continuum.
- Ensure that staff have the resources they need to do the best job they can.
- Provide staff with the training and information they need.
- Create a positive working environment and an organizational climate and culture that supports change.

- Assess the LDSS and staff's readiness for change.
- Engage staff in program decision making and administrative decisions that will impact them and the families they serve.
- Model a strength-based approach with staff, emphasizing what they do well and using their knowledge and skills to achieve change when change is needed.
- Establish written policies and procedures that reflect strength-based, trauma-informed practice and the use of protective factors.
- Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.
- Be transparent about the expectations of staff.
- Provide opportunities for both peer and individual supervision.
- Encourage staff to collaborate with individuals and organizations that embrace strength-based, trauma-informed practice.
- Utilize case staffing to insure that all staff are operating out of the same value and practice base so that clients get consistent messages no matter what program or individual serves them.
- Provide concrete support for service workers in the field and in crisis.
- Evaluate program effectiveness by utilizing input from the field about what is working and what is not working well and making needed changes based on the information gathered.
- Partner with parents for child safety and permanency at various levels beyond case specific activities such as a FPM, including providing peer support to each other, sharing their successes and suggestions with other parents, assisting with LDSS special events, soliciting their ideas and suggestions about policy and practices within the LDSS, and serving on LDSS committees and the local board.

- Work with the community to establish a positive image of the LDSS that reduces their fear of either contacting the LDSS for help or opening their door to LDSS staff before a crisis arises.

1.20.2 Realigning resources

1.20.2.1 Staffing

LDSS have to be both creative and flexible in the use of staff in the delivery of prevention services. Staff utilized to provide prevention services include service workers and supervisors in all program areas, as well as local directors, family support workers, child care workers, case or parent aids, school-based workers, intake workers in all program areas, interns, generic workers, training staff, FPM facilitators, and volunteers.

In order to use existing staff for prevention services, it is critical to develop mechanisms to carry out the following activities:

- Identify the needs of families in each community through a community needs assessment or other strategy that solicits input both internally and externally.
- Monitor caseloads and job responsibilities as needs shift.
- Utilize data collection and documentation to monitor outcomes in programs to determine if needs are being met.
- Consider a variety of positions, including benefit programs, supervisors, and others to either provide prevention services or to recognize the need for such services and refer the family to the appropriate prevention resource.
- Develop partnerships with local community-based agencies at both the administrative and service level who can work collaboratively with the LDSS to provided needed services.
- Include competency in practice approaches known to be effective in prevention in job descriptions and performance evaluations.

1.20.2.2 Funding

Diversity and creativity are reflected in the range and types of funding utilized to provide prevention services. As the programmatic structure of many localities varies, localities often combine diverse funding sources to use for families at different points in the child welfare continuum. Examples of federal and state funds, grant opportunities, and local funds used by localities to provide prevention services are included in Appendix H: Funding Sources for Prevention.

1.20.3 Measuring program outcomes

VDSS recognizes that a robust Continuous Quality Improvement (CQI) system is vital to improve services and supports for children and families, ensure effective use of resources, and achieve targets and desired outcomes. An effective system integrates quantitative and qualitative measures toward an integrated system that thoroughly captures data processes to properly inform policy and service provision at all levels. This is inclusive of building out a comprehensive data plan allowing examination of the many data sources, while also identifying opportunities to incorporate the different quantitative and qualitative aspects of the case review system. This approach is both data-driven and practice-informed.

A system that uses data for decision-making requires two things: access to data and processes for making decisions. CQI should provide the necessary information to make good decisions. This requires quantitative indicators of progress, qualitative case reviews, comparisons over time, cross-system data, and adequate reporting. Short and long-term reporting supplements mandatory federal requirements tied to funding, including titles IV-B, IV-E, the CFSP, the CFSR, and the PIP. The five-year period of Virginia's CFSP covers the timeframe during which an integrated system of accountability will be developed. Given the structure of child welfare services in Virginia, data capacity and structures of accountability need to be developed at all three levels of operations: state, regional, and local.

1.20.4 Professional development

Having a skilled, knowledgeable, and caring workforce is essential to achieving program outcomes. The key to individual change in families is the ability to build an effective working relationship with clients and to know how to simultaneously support and empower families. They need to believe that families can and do change and those families have the inherent capacity to know themselves better than any service worker can and to be a good parent. Insuring that the messages all staff convey to the

community and families, including administrative support, intake, information system staff and all program staff, can greatly impact the effectiveness of all services.

The Division of Family Services training system offers competency-based training for both supervisors and service workers. Competency-based training is supported by a definable list of core competencies that are a statement of knowledge and skill required for service workers to complete a job task effectively and represent fundamental and essential best practice.

Minimum competencies in prevention include the following:

- Engaging and motivating families for change.
- Understanding the impact of trauma on children and families and how to implement trauma-informed practice.
- Cultural competence.
- Understanding DV and its impact on children.
- Interviewing skills using a strength-based approach.
- Family assessment and service planning using risk and protective factors in voluntary services.
- Working with at-risk groups.
- Engaging fathers.

The Virginia Administrative Code (VAC) mandates uniform training requirements for all In-Home services workers and supervisors. The uniform training requirements establish minimum standards for all service workers and supervisors in Virginia, including In-Home services workers. Any course designated with a CWSE indicates an e-learning course and is available online in the Virginia Learning Center (VLC).

1.20.4.1 First three (3) weeks training requirements

The following online courses will be required to be completed within the first three (3) weeks of employment.

- *CWSE1002: Exploring Child Welfare.*

- *CWSE5692: Recognizing and Reporting Child Abuse and Neglect – Mandated Reporter Training.*
- *CWSE1510: Structured Decision Making in Virginia.*
- *Children's Services Act (CSA) for New LDSS Employees (Five (5) modules numbered CSA011 – CSA015).*

1.20.4.2 First three (3) months training requirements

The following instructor-led or online courses will be required to be completed within the first three (3) months of employment.

- *CWS1000 In-Home Services New Worker Guidance Training with OASIS – 2 days.*
- *CWS4020 Engaging Families and Building Trust-Based Relationships.*
- *CWS5307 Assessing Safety, Risk, and Protective Capacities in Child Welfare – 2 days.*
- *CWS2010 In-Home Services Skills – 2 days.*
- *CWS4080 Kinship Care in Virginia – 2 days.*
- *CSA CANS Certification.*
- *CWSE4060 Family Search and Engagement.*
- *CWSE5501 Substance use disorder.*
- *CWSE1006 Reasonable Candidacy.*
- *CWSE2090 Injury Identification in Child Welfare.*
- *CWSE4000 Identifying Sex Trafficking in Child Welfare.*
- *CWS5011 Case Documentation – 1 day.*
- *CWS1061 Family Centered Assessment in Child Welfare – 2 days.*
- *CWS1071 Family Centered Case Planning – 2 days.*

- *CWSE7000 Family First in Virginia – e-Learning series.*
    - *Module 1: Overview of Family First.*
    - *Module 2: Opening an In-Home Services Case: First 30 Days.*
    - *Module 3: Service Planning for In-Home Services.*
    - *Module 4: Monitoring the Delivery of In-Home Services.*
    - *Module 5: Module 5: Goal Achievement and Case Closure or Case Transfer for In-Home Services.*

1.20.4.3 First six (6) months training requirements

The following online and instructor-led courses will be required to be completed within the first six (6) months of employment.

- *CWS1305 The Helping Interview: Engaging Adults for Assessment and Problem-Solving – 2 days.*
- *CWS5305 Advanced Interviewing: Motivating Families for Change – 2 days.*
- *CWSE4015 Trauma-Informed Child Welfare Practice.*
- *CWS4015 Trauma-Informed Child Welfare Practice – 2 days.*
- *DVS1001 Understanding Domestic Violence – 2 days.*
- *DVS1031 Domestic Violence and Its Impact on Children – 1 day.*

1.20.4.4 First 12 months training requirements

The following instructor-led courses will be required to be completed within the first 12 months of employment.

- *CWS1021 The Effects of Abuse and Neglect on Child and Adolescent Development – 2 days.*
- *CWS1305 The Helping Interview: Engaging Adults for Assessment and Problem-Solving – 2 days.*

- *CWS5305 Advanced Interviewing: Motivating Families for Change – 2 days.*
- *CWS3071 Concurrent Permanency Planning – 1 Day.*
- *CWSE6010 Working with Families of Substance Exposed Infants (two modules).*

1.20.4.5 First 24 months training requirements

The following instructor-led courses will be required to be completed within the first 24 months of employment.

- *CWSE4050 Psychotropic Medications in the Child Welfare System.*
- *CWSE5000 Preventing Premature Case Closure in In-Home Services.*
- *CWSE5010 Advocating for Child and Adolescent Mental Health Services.*
- *CWSE2020 On-Call for Non-CPS Workers (On-call workers Only).*
- *CWS2020: On-Call for Non-CPS Workers – 1 day (On-call workers Only).*

1.20.4.6 Additional training requirements for In-Home services supervisors

In addition to the courses listed above, all In-Home services supervisors are required to attend the Family Services CORE Supervisor Training Series. These courses are to be completed within the first two (2) years of employment as a supervisor.

- *SUP5701 Principles of Leadership.*
- *SUP5702 Management of Communication, Conflict, and Change.*
- *SUP5703 Enhancing Staff Performance & Growing a Team.*
- *SUP5704 Critical issues in Family Services Supervision.*
- *SUP5705 Trauma-Informed Leadership and Developing Organizational Resilience Culture.*

1.20.4.7 Annual training requirements

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

Continuing education/training activities to be credited toward the 24 hours should be pre-approved by the LDSS supervisor or person managing the In-Home services program. Continuing education/training activities may include, but are not limited to: online and classroom training offered by VDSS, organized learning activities from accredited university or college academic courses; continuing education programs; workshops; seminars; and conferences.

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

1.20.4.8 LDSS must ensure worker compliance

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

A training job aid is located on the VDSS Division of Family Services Training website.

1.20.4.9 Additional training resources

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.

A comprehensive resource for trauma screening and initial assessment is the Child Welfare Trauma Referral Tool (CWT), which can be found in the *Child Welfare Trauma Training Toolkit*.

Early Impact of Virginia offers online courses on many topics including child development; screening for substance use, intimate partner violence, mental health and perinatal depression; engaging fathers; and personal safety.

For additional information on Division of Family Services (DFS) training visit the DFS Training website on *FUSION*.

1.20.5 Parent Partnerships

FRIENDS: National Center for Community-Based Child Abuse Prevention (CBCAP) promotes and encourages parent partnerships and parent leadership as a critical component of prevention services. The following activities can all positively impact a family-strengthening prevention approach across the child welfare continuum:

- Engaging parents at each step of their involvement with agency.
- Involving parents in decision making, not just about their family but about the policies and procedures that affect them.
- Providing opportunities for parents to support the LDSS as volunteers.
- Facilitating the process for parents to serve as role models for other families

1.20.6 Community and systems integration

The Children's Bureau Office on Child Abuse and Neglect states the following:

“The responsibility for addressing child maltreatment is shared among community professionals and citizens. No single agency, individual, or discipline has all the necessary knowledge, skills, or resources to provide the assistance needed by abused and neglected children and their families.”

Prevention services have been embraced by community-based organizations who have often taken the lead in their communities. It is clear that the development of functional partnerships to address the complex needs of all families should occur in order to optimize the effectiveness of a multi-disciplinary response to strengthening and supporting families and reducing the risk of child maltreatment and out-of-home care.

An integrated service approach to strengthening families begins at the administrative level, with directors and other administrative staff reaching out to other organizations to inform them of the work and role of the LDSS, to seek out ways to fill the gaps in

services to families, and to provide leadership for a community-based approach to prevention.

A list of online resources for prevention information, best practice models, and funding is in Appendix J: Online resources for information and funding.

1.21 Benefits of embracing a prevention perspective across child welfare

The literature, research, and Virginia's data reflect the need for a continuum of prevention services. Investments made in families and children become assets in the development of strong citizens and communities. Prevention services with a strength-based, trauma-informed approach which integrates the protective factors as described in this manual can accomplish the following:

- Reduce costs associated with CPS, foster care, and adoption.
- Reduce the number of families requiring intervention as a result of abuse and neglect and the resulting costs to the agency, the family, and the community.
- Increase opportunities for self-sufficiency and personal accountability.
- Increase safety and stability of children and families.
- Improve Child and Family Services Review (CFSR) well-being, safety, and permanency outcomes.
- Normalize all families' need and desire to learn how to be effective caregivers.
- Connect families to resources throughout the life-span of their children.
- Increase community awareness of prevention efforts and cultivate an integrated service approach.
- Change the way the community views LDSS so that the local department is seen as helpful and proactive, rather than punitive and reactive.
- Increase opportunities to collaborate with other groups and organizations within the community.

- Provide valuable opportunities for interaction and engagement, which is key to setting the stage for collaborative work through the co-location of prevention of child abuse and neglect programs and state systems.
- Other states that have used the protective factors and the strengthening families' framework identify these approaches as an effective method of grounding their work and engaging others in prevention work.

1.22 Appendix A: Resources used in developing guidance

The following activities were conducted in the development of this guidance:

- A review of the literature on best practices in prevention.
- Technical assistance from FRIENDS (Family Resource Information, Education and Network Development Services), which provides the technical assistance for the federally funded Community Based Child Abuse Prevention Program (CBCAP).
- Review of what other states provide prevention services.
- Implementation of a statewide Prevention Advisory Committee comprised of VDSS staff, LDSS staff, and community partners who provided direction, feedback, and support for the development of the manual.
- Participation in regional, local, and community-based prevention meetings to provide information and solicit input on the development of the manual.

Other resources used include the following:

Administration for Children and Families, Office of Planning, Research and Evaluation: Abuse, Neglect, Adoption and Foster Care Research: National Survey of Child Abuse and Adolescent Well-Being (1997 – 2014 and 2015 – 2022).

Best Available Research Evidence: A Guide to the Continuum of Evidence and Effectiveness. Atlanta, GA: Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention (2020). *Child Maltreatment: Risk and protective factors*. Atlanta, GA: Centers for Disease Control and Prevention.

Center for the Study of Social Policy. *Research in Brief: Resilience in Childhood*. Washington, DC: Center for the Study of Social Policy.

Community-Based Care Technical Assistance Project & University of South Florida; College of Behavioral and Community Sciences National Center of Child Abuse and Neglect (2010). *A National Review of State Legislative, Policy and Implementation Approaches to Fostering Connections Options Guardian Assistance Program and Extended Foster Care to Age 21*.

Congressional Coalition on Adoption Institute's 2015 Foster Youth Internship Report.

Early Head Start National Research Center.

Felitte, V. J. & Anda, R. F. *Arizona Child Abuse and Neglect Prevention System: Characteristics of Effective Programs and Recommendations for Prevention Child Abuse and Neglect in Arizona Adverse Childhood Experiences Study*. Centers for Disease Control and Prevention.

FRIENDS: The National Resource Center for Community-Based Child Abuse Prevention.

Healthy Families Virginia: *Statewide Evaluation Report FY 2014-2018*.

Initial Views*: Parenting with Parents for Child Safety and Permanency: Results of a Baseline Survey Conducted with Child Safety and Permanency Division Staff of the Minnesota Department of Human Services* (2010).

National Center for Children in Poverty: Young Child Risk Calculator.

National Survey for Child and Adolescent Well-Being.

North Carolina Department of Health and Human Services Online Manual (2003). *Family Support America: Standards for Prevention Programs: Building Success through Family Support, New Jersey Task Force on Child Abuse and Neglect*.

Office of Adolescent Health, Evaluation Technical Assistance Brief for Office of Adolescent Health (OAH) and Administration of Children, Youth and Families (ACYF) Teenage Pregnancy Prevention Grantees.

Puddy, R. W. & Wilkins, N. (2011). Understanding Evidence Part 1: *Best Available Research Evidence. A Guide to the Continuum of Evidence of Effectiveness*. Atlanta, GA: Centers for Disease Control and Prevention.

U.S. Department of Health and Human Services (2011). *Abuse, Neglect, Adoption & Foster Care Research: National survey for child and adolescent well-being*. Washington, DC: Administration for Children and Families.

U.S. Department of Health and Human Services & U.S. Department of Education (2011). *State issues and innovations in creating integrated early learning and development systems: A follow-up to early childhood 2010: Innovations for the next generation* (HHS Publication No. SMA 11-4661). Rockville, MD: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services Administration for Children and Families. *Systems of Care Policy Action Guide*.

U.S. Department of Health and Human Services Administration for Children and Families: Children's Bureau: Child Information Gateway.

U.S. Department of Health and Human Services Administration for Children and Families: Children's Bureau: Child Information Gateway: My Child Welfare Librarian. *Supporting Brain Development in Traumatized Children and Youth*.

Strengthening Families Initiative: Strengthening Organizations to Support Families and Communities.

The Early Head Start National Resource Center.

Van der Kolt, B. A. (2000). *Developmental Trauma Disorder. Psychiatric Annals*.

Virginia Child Protection Newsletter (2010). *35 Years of Progress in Prevention and Intervention Executive Summary*.

Virginia Child Protection Newsletter (2011). *Parent Leadership and Family Engagement in Child Protective Services and Foster Care*.

Violence at Home: Family and Children's Trust Fund (FACT) of Virginia – FACT Report.

1.23 Appendix B: What the research reflects about the impact of maltreatment and removal and the costs to children, families and communities

Research has demonstrated that traumatic childhood experiences, including maltreatment, removal, and placement disruptions have a profound impact on many areas of their biological, physical and mental functioning. The following information reflects a brief review of the literature that identifies both the short-term and long-term financial, physiological, and emotional costs of maltreatment, family instability and trauma on children, families and communities.

1.23.1 The impact of maltreatment and trauma on child well-being

The Adverse Childhood Experiences Study (ACE Study) conducted by the Centers for Disease Control and Prevention and Kaiser Permanente from 1995 to 1997, examined more than 17,000 participants. Although no further participants will be enrolled, the medical status of the baseline participants continues to be tracked. The ACE study examined the effect of ten categories of negative experiences in childhood, including 5 types of maltreatment and 5 types of family dysfunction, and found a strong link between these experiences and the following:

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

Dr. Bessel A. Van der Kolk, past President of the International Society for Traumatic Stress Studies, Professor of Psychiatry at Boston University Medical School, and Medical Director of the Trauma Center at JRI in Brookline, Massachusetts reviewed the ACE study and found that it "confirmed … a highly significant relationship between adverse childhood experience and depression, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity and sexually transmitted diseases."

The ACE Study concluded that what are conventionally viewed as public health problems are often personal solutions to long-concealed adverse childhood experience. Adverse childhood experiences are the most basic and long-lasting determinants of health risk behaviors, mental illness, social malfunction, disease, disability, death, and healthcare costs. Because adverse childhood experiences are common but typically unrecognized and their link to major problems later in life is

strong, proportionate and logical, they are the nation's most basic public health problems. Primary prevention is presently the only feasible population approach.

Scientists whose focus is neurobiology compared the results of their research with the results of the ACE Study research and found that "early experiences can have profound long-term effects on the biological systems that govern responses to stress".

According to an article in the Journal of General Internal Medicine, long-term healthcare costs are 16% higher for women who have experienced child sexual abuse and 36% higher if they experience both sexual and physical abuse. According to the National Cancer Institute, child sexual abuse is 75 times more common than pediatric cancer.

The National Survey of Child and Adolescent Well-Being (NSCAW), 1997-2010, surveyed 6,200 children from birth to age 14, and confirmed that mental health problems resulting from abuse and neglect carry into the grade schools years and likely into adulthood. Forty eight percent (48%) of children found to be abused and neglected as a result of an investigation carried mental health issues into early adulthood.

At the federal level, the physical, social and emotional gains that children and families experience when their needs are addressed sooner rather than later are implicit in the key principles guiding child protection delineated in the Child Abuse Prevention and Treatment Act and the Adoption and Safe Families Act. They are:

- Safety as the paramount concern that should guide prevention efforts.
- Permanency, emphasizing a sense of continuity and connectedness as being central to a child's healthy development.
- Child and family well-being, encouraging nurturing environments where a child's physical, emotional, educational and social needs are met.

The survey also emphasized the importance of accountability of service delivery systems in achieving positive outcomes for child related to each of these goals.

1.23.2 The impact of maltreatment and trauma on permanency

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 of someone critically important to the child (such as a parent or sibling). Chronic trauma refers to the

experience of multiple and varied traumatic events-experiences a death in the family, becomes physically ill and then becomes a victim of community violence or longstanding trauma such as physical abuse or war. One prevalent form of chronic trauma is child neglect, defined as the failure to provide for a child's basic physical, medical, educational, and emotional needs. Neglect can have serious and lifelong consequences-particularly for very young children who are completely dependent on caregivers for sustenance. Chronic trauma would also include multiple moves in foster care.

The short and long-term impact of traumatic events is determined in part by the nature of the events, and in part by the child's subjective response to them. Every distressing event does not result in traumatic stress and something that is traumatic for one child may not be traumatic for another. The ultimate impact of a potentially traumatic event depends on several factors, including:

- The child's age and developmental stage.
- The child's perception of the danger faced.
- Whether the child was the victim or a witness.
- The child's relationship to the victim or perpetrator.
- The child's past experience with trauma.
- The adversities the child faces in the aftermath of the trauma.
- The presence/availability of adults who can offer help and protection.

When trauma is associated with the failure of those who should be protecting and nurturing a child, it has profound, multifaceted, and far-reaching effects on nearly every aspect of the child's development and functioning, including their ability to achieve the national goals for children of well-being, safety, and permanency.

The NSCAW data indicate that both preschoolers and school age children in contact with the child welfare system show a variety of developmental risks. These children show higher levels of behavior problems and depression and also poorer social and life skills, cognitive and neurological development, and academic achievement than children their age in normative samples. Preschoolers appear to be particularly at risk cognitively and neurologically, while school age children show greater difficulties in their social skills and behavior. Other findings from NSCAW revealed the following:

- Placement instability is relatively common for those children placed outside the home.
- Among children who began the study without mental health problems, later mental health needs were associated with unstable placements.
- Young children appear particularly vulnerable to behavioral and developmental problems.
- Although slightly less than half of children reported to CPS show signs of an emotional or behaviors problems, these problems are especially high among those placed outside the home.
- High levels of children's mental health needs go unmet.

The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact. A child exposed to a series of traumas may become more overwhelmed by each subsequent event and more convinced that the world is not a safe place. Over time, a child who has felt overwhelmed over and over again may become more sensitive and less able to tolerate ordinary everyday stress.

As a result of these traumatic experiences, significant numbers of children known to the child welfare system are likely to be suffering from chronic traumatic stress. Under most conditions, parents are able to help their distressed children restore a sense of safety and control but when children are moved from one caretaker to another, the security of the attachment process is disrupted and mitigates against trauma-induced terror. Children are likely to become intolerably distressed and unlikely to experience a sense that their external environment is able to provide safety and relief.

According to Dr. Van der Kolk, exposure to complex trauma most often occurs within the child's care giving system and includes all types of maltreatment and multiple care giving experiences (removal, frequent moves in foster care, etc.).

What this means is that chronic trauma has a pervasive effect on the development of the mind and brain, resulting in long-term cognitive, language, and academic abilities (Child Welfare Information Gateway, 2008). In presenting findings from the ACE study, Dr. Vincent J. Felitti confirmed that these experiences result in:

- Disrupted neurodevelopment.

- Social, cognitive, and emotional impairment.
- Adoption of health risk behaviors, including drug and alcohol addiction, teen pregnancy and paternity.
- Disease, disability, and social problems.
- Early death.

The Child Welfare Trauma Training Toolkit presents a summary of the research on the impact of trauma:

- Maltreated children are more likely than non-maltreated children to have depressive symptomatology, school behavior problems, difficulties with peer relationships resulting in more peer rejection and victimization, as well as difficulties with mood regulation. Chronic maltreatment is associated with greater emotional and behavioral difficulties (Ether et al., 2004).
- A study of the prevalence of mental health diagnoses in three groups of abused children found that posttraumatic stress disorder (PTSD) generally co-occurs with other disorders including depression, anxiety, or oppositional defiant disorder (Ackerman et al., 1998).
- A study of children in foster care revealed that PTSD was diagnosed in 60% of the sexually abused children and in 42% of the physically abused children (Dubner & Motta, 1999). They also found that 18% of the foster children who had not experienced either type of abuse had PTSD, possibly as a result of exposure to domestic or community violence (Marsenich, 2002).

Simply stated, the brains of children who experience trauma are wired differently. Their ability to think before they act, their academic performance, their ability to regulate emotions, the integration of their senses, their self-defeating aggression, additive behaviors, hyperarousal, and their capacity for logical thinking are all impacted.

Recognition and response to the understanding that many of their behaviors are a result of the sort and long-term impact of trauma on children and not an intentional desire to disobey has far reaching implications for the child welfare system. This understanding should be reflected in (1) the knowledge, skills, abilities and supportive services needed by birth parents whose children return home and, (2) by substitute

parents to help these children heal. Both need cash assistance programs and long-term access to services throughout each developmental stage of the child.

Research reflected in the 2010 report of the Strengthening Families Allied for Better Outcomes (LINK) also indicates that the long-term impacts of trauma on young children are numerous and entrance into the child welfare system is greater:

- Prenatal and Perinatal Health: Eighty percent (80%) of children under the age of six who enter child welfare are at risk for developmental issues stemming from maternal substance use , and 40% are born premature or with low birth weight (Committee on Early Childhood, Adoption, and Dependent Care, 2000).

- Physical Health: Traumatized children demonstrate biologically based challenges, including problems with movement and sensation, hypersensitivity to physical contact, insensitivity to pain, coordination and balances problems and unexplained physical symptoms and increased medical problems. As many as 90% of these children have serious or chronic conditions, and concurrent conditions are common (Dicker, Gordon, & Knitzer, 2001).

- Attachment: Traumatized children feel that the world is uncertain and unpredictable. Their relationships are often marked by distrust and suspiciousness. Young children involved with the child welfare system exhibit elevated rates of attachment disorders (Morton & Browne, 1998), which increase risk for poor peer relationships, behavior problems, and mental health issues throughout childhood.

- Cognition. Children exposed to trauma can have problems focusing on and completing tasks in school as well as difficulty planning for and anticipating future events and challenges with cause and effect thinking. These children experience developmental delay at four (4) to five (5) times the rate of the general population (Dicker, Gordon, & Knitzer, 2001).

- Education: Children with child welfare involvement have substantially lower grades and test scores, as well as more absences and grade repetitions (Eckenrode, et al., 1995). These children also have an increased risk of special educational needs (Emerson & Lovitt, 2003).

- Safety: Traumatic stress can adversely impact the child's ability to protect themselves from abuse, or for the LDSS to do so, in numerous ways (Child Welfare Trauma Training Toolkit: Comprehensive Guide—2nd Edition 11

March 2008). The child's altered world view may lead to behaviors that are self-destructive or dangerous, including premature sexual activities

- Regulation of moods and behavior: The extreme emotions and resulting behaviors may overwhelm or anger caregivers to the point of increased risk of abuse or re-victimization. Traumatic reactions may dull the child's emotions in ways that make some investigators skeptical of the veracity of the child's statements. The child's inability to regulate his or her moods and behavior may lead to behaviors that endanger or threaten stable placements, reunification, or adoptive placement.

- Behavior Control: Because of their inability to regulate their emotions, traumatized children can demonstrate poor impulse control, self-destructive behaviors and aggression towards others. Sleep and eating problems can also surface.

- Trust: The child's lack of trust may lead to the child's providing investigators or the courts with incomplete or inaccurate information about abuse experienced or witnessed.

- Permanency: The child's reaction to traumatic stress can adversely impact the child's stability in placements. For example, the child's lack of trust in the motivations of caregivers may lead to rejection of possible caring adults or, conversely, lead to superficial attachments. The child's early experiences and attachment problems may reduce the child's natural empathy for others, including foster or adoptive family members. A new foster parent or adoptive parent, unaware of the child's trauma history or of which trauma reminders are linked to strong emotional reactions, may inadvertently trigger strong reminders of trauma.

- Well-being: Traumatic stress may have both short- and long-term consequences for the child's mental health, physical health, and life trajectory, including:

    - The child's traumatic exposure may have produced cognitive effects or deficits that interfere with the child's ability to learn, progress in school, and succeed in the classroom and the community (and later in the workplace).

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

- 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 that impairs his or her ability and motivation to succeed in social and educational settings.

- A child's traumatic experiences may alter his or her worldview so that the child now sees the world as untrustworthy and isolates themselves from family, peers, and social and emotional support.

Despite children's vulnerabilities, the vast majority of them are not receiving mental health or special educational services. At most, half of the children showing developmental risk are receiving any given service; typically, the figures are far lower. Preschoolers are particularly unlikely to receive services; only about 1 in 10 children from birth to age 5 who are developmentally at-risk receives special educational services.

These findings imply that many children involved with the child welfare system, both in their homes and once removed, are not receiving needed services that will enhance their future development. Moreover, the findings suggest that child welfare LDSS staff need better tools for assessing children's developmental needs. Once needs are identified, it is critical that LDSS staff have access to needed services, provided by professionals trained in trauma and attachment. The high level of need found among children in the NSCAW sample highlights the importance of efforts to improve assessments, to establish strong linkages with other child service systems, and to provide timely access to needed services.

Children involved with the child welfare system are likely to have experienced both acute and chronic trauma, in environments characterized by adversity and deprivation, and often without the mitigating influence of consistent and supportive caregivers. It is important for child welfare service workers to recognize the complexity of a child's lifetime trauma history and to not focus solely on the single event that might have precipitated a report. In general, children who have been exposed to repeated stressful events within an environment of abuse and neglect are more vulnerable to experiencing traumatic stress.

1.23.3 The impact of poverty on families

The family is, historically, the cornerstone of American culture. As the culture has changed, so have families. Increased mobility of families often means less access to intergenerational support in child rearing. As poverty, homelessness, unemployment, divorce and violence in communities increase, the stress families experience also increases. Access to community-based services used to supplement family support in

times of stress is impacted by limited resources, diminished funding, and the lack of availability of widespread public transportation.

The American Academy of Pediatrics researchers compared the unemployment statistics from 1990 to 2008 to data from the National Child Abuse and Neglect Data system. Each one percent increase in unemployment was associated with at least .50 per 1000 increase in confirmed cases of child maltreatment. Unemployment has risen considerably since then, making children even more vulnerable to neglect and abuse and increasing the instability of families.

As a result, significant numbers of children are likely to be suffering from child traumatic stress and are at risk of child abuse and neglect and out-of-home care.

1.23.3.1 The costs to children, families and communities when prevention services are not provided

Research overwhelmingly points to the benefits of supporting children and families at an early age to prevent maltreatment and its negative effects on brain development before they occur. In addition, cost-benefit analyses demonstrate a stronger return on investments that result from strengthening families, supporting development, and preventing maltreatment during childhood and adolescence rather than funding treatment programs later in life (Center on the Developing Child at Harvard University, 2007, Child Welfare Information Gateway).

The Journal of Child Abuse and Neglect published the results of a study which used the best available secondary data to develop cost per case estimates. Results indicated the following:

"The estimated average lifetime cost per victim of nonfatal child maltreatment is $210,012 in 2010 dollars, including $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs. The estimated average lifetime cost per death is $1,272,900, including $14,100 in medical costs and $1,258,800 in productivity losses. The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States in 2008 is approximately $124 billion. In sensitivity analysis, the total burden is estimated to be as large as $585 billion." (Fang, X, Brown, D.S., Florence, C.S., & Mercy, J.A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect (36) 156–165).

Child maltreatment is a serious issue with both financial and emotional costs to families and the community. The costs of providing medical, mental health and social services, legal investigation and prosecution, educational remediation, foster care and adoption far outweigh the cost of strengthening families before problems arise and preventing child maltreatment and the need for out-of-home care before they occur.

A conservative estimate of the annual cost of child maltreatment based on 2007 data (including short-term costs of hospitalization, mental health care, child welfare services, law enforcement, special education juvenile delinquency and other long-term costs, such as criminal justice costs, the loss of productivity in the workforce and long-term health and mental health care) was $103.8 billion (Wang and Holton, 2001 & Holton 2007).

“Researchers calculated an average lifetime cost per child maltreatment case and applied it to confirmed cases of child maltreatment in 2008. They estimated a total lifetime economic burden from fatal and nonfatal child maltreatment in the United States in 2008 of $124 billion. This includes an average $210,012 (in 2010 dollars) per victim for the effects of nonfatal child maltreatment and close to $1.3 million dollars per fatal case of child maltreatment, which includes estimated lifetime productivity. (Fang, X, Brown, D.S., Florence, C.S., & Mercy, J.A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect (36) 156–165).

Children involved with the child welfare system or at risk of involvement are more likely to experience chronic stress and trauma that has both short and long-term consequences. Brain research conducted over the past few years has revealed that, when trauma is associated with the failure of those who should be protecting and nurturing a child, it has profound, multifaceted, and far-reaching effects on nearly every aspect of the child’s development and functioning, including their ability to achieve the national goals for children of well-being, safety, and permanency. These children suffer impairment in many of the following areas: brain development, biology, mood regulation, attachment, dissociation, behavioral control, ability to protect themselves as young adults, developmental delays, cognition and other learning difficulties, and low self-esteem. (Office of the Administration for Children & Families (ACF) – Office of Planning, Research & Evaluation (OPRE): National Survey of Child and Adolescent Well-Being (NSCAW), 1997-2014 and 2015-2022).

Prevention services reduce trauma to children and help avoid the physiological, psychological, and emotional costs associated with separation of the child from the family and the provision of child protective services, foster care, and adoption services. It is also the most cost effective approach to strengthening families and ensuring the well-being, safety, and permanency of children.

1.24 Appendix C: Virginia's prevention initiatives

VDSS continues to take the lead in coordinating statewide initiatives to support prevention at the local and state levels. Activities undertaken, in addition to those described in Section 1.9 of the guidance, include the following:

- VDSS continues to actively participate in Virginia's ongoing efforts to create interdisciplinary, collaborative, community-based public-private partnerships for prevention of child abuse and neglect.

- Prevention staff serves on state level inter- and intra-agency workgroups tasked with coordinating service and program initiatives to strengthen families and promote child health, well-being, and safety.

- Other statewide organizations such as the Early Impact Virginia (EIV) (formerly Virginia Home Visiting Consortium), Virginia Statewide Parent Education Coalition (VSPEC), Virginia Coalition for Child Abuse Prevention, and Families Forward Virginia all play a vital role in prevention.

- VDSS uses resources available through the Child Welfare Information Gateway and the FRIENDS: the National Center for Community-Based Child Abuse Prevention (CBCAP) as appropriate to provide training and technical assistance to grantees, supports the dissemination of information, and provides a forum for information-sharing related to positive family functioning and healthy child development.

- Since 1983, VDSS has provided leadership in the commonwealth's annual observance of Child Abuse Prevention Month. In partnership with Prevent Child Abuse Virginia, VDSS continues to spearhead a coalition of agencies and organizations charged with planning and promoting Child Abuse Prevention Month activities. Each year, the Coalition requests the Governor to proclaim April as Child Abuse Prevention Month. VDSS also participates with Prevent Child Abuse Virginia and others to sponsor an annual April Child Abuse Prevention Month conference for both public and private prevention partners.

- In Virginia, Child Abuse Prevention and Treatment Act (CAPTA) funding aligns and supports the overall goals for the delivery and improvement of child welfare services, title IV-B, and the Community-Based Child Abuse Prevention (CBCAP) program. CAPTA State grant funds were used, alone or in combination with title IV-B, CBCAP, TANF, Victims of Crime Act (VOCA), State General Funds, and

other child welfare programs in three major areas: Safe Children and Stable Families; Family, Child and Youth Driven Practice, and Strengthening Community Services and Supports. The plan identifies areas of work that have been completed, items being currently worked on, as well as ongoing activities.

- Promoting Safe and Stable Families (PSSF) planning and funding initiative has also played a key role in creating resources for prevention at the local level. PSSF is authorized under Title IV-B, Subpart II of the Social Security Act, as amended and is codified at SEC.430 through 435 [42 U.S. C. 629a through 629e]. The PSSF program was initially created in 1993 as the Family Preservation and Support Services Program, geared toward community-based family preservation and support. In 1997, the program was reauthorized under the Adoption and Safe Families Act (ASFA) and renamed the PSSF Program.

- Since 1986, the Family and Children's Trust Fund (FACT) of Virginia has worked 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.

- Virginia Family & Fatherhood Initiative (VFFI) is dedicated to the mission of "empowering fathers and mothers to improve the well-being of their children by aligning activities, mobilizing resources, advancing public policy and measuring impact." VFFI encompasses five (5) integrated services to promote whole family thriving: fatherhood support groups, motherhood support groups, co-parenting navigation, case management for teen and young adult parents and their families, and youth development programs.

- Healthy Families Virginia (HFV) has been supported by VDSS and has provided home-visiting service to Virginia's most over-burdened families for nearly two decades. What began as a state-funded demonstration project has grown into a statewide initiative defined by four major goals:

    - Improving pregnancy outcome and child health.
    - Promoting positive parenting practices.
    - Promoting child development.
    - Preventing child abuse and neglect.

- *Three Branch Model has been utilized to support VDSS collaborative implementation efforts. This model is based on the National Governor's Association, National Conference of State Legislatures, and Casey Family Programs' Three Branch Institute, which began in 2009. Virginia has been a participant in three previous Three Branch Institutes, with significant success in improving the child welfare system. The Three Branch model is a collaborative team composed of not only representatives from state, legislative, and court leadership, but also several state- and community-based agencies that respond to the needs of children and families, redefining the responsibility of child welfare to all agencies that serve children and families. The Three Branch model serves as a successful leadership group to enact legislative, financial, and policy changes to improve the child welfare system.*

  VDSS' goals for the Three Branch model include using data to improve decision-making and ensure services provided are informed by outcomes; promoting reliable, accurate, transparent and timely two-way communication among stakeholders throughout the implementation of Family First; acknowledging that true transformation will take time, and implementation will continually be monitored and updated to meet emerging needs; and collaborating and partnering with systems across the state as the key to successful implementation of Family First.

- *Family First Prevention Services Act (Family First). Family First is a key priority for Virginia. As an early adopter, in February 2018, VDSS assembled a dedicated project team to implement the Three Branch model in support of the implementation. This new law is quite broad and provides the opportunity for the Commonwealth to redesign the child welfare delivery system to one which focuses on preventing abuse and neglect, while ensuring foster care is used when necessary. Over the next five (5) years, VDSS will focus on developing a comprehensive prevention program guided by the Family First legislation. The Prevention Services program will play an integral role in targeting resources and services that prevent foster care placements and help children remain safely in their homes or with relatives, when possible.*

1.25 Appendix D: Protective Factors

Six protective factors provide the foundation of the strengthening families approach and are promoted by the FRIENDS: National Center for Community-Based Child Abuse Prevention (CBCAP) and the National Alliance of Children's Trust and Prevention Funds (Alliance).

The Alliance has also developed an online training course: Strengthening Families™ Protective Factors Framework, an excellent basic overview of how the protective factors can be incorporated into prevention work.

1.25.1 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. It 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 be able to identify and use the resources available. Specific examples include the following:

- Able to stay in control when child misbehaves-uses non abusive disciplinary techniques and consequences.
- Feelings of competence in parenting roles.
- Pulling together in times of stress.
- Listen to each other.

1.25.2 Social connections

Social connections are the antidote to social isolation, a primary risk factor for child abuse and neglect. Families can have many different types of social connections that provide different types of support. For example, friends, extended family members, other parents with children the same age, 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. An example includes the following:

- Have others to talk to when there is a problem or crisis.

1.25.3 Concrete support in times of need

Providing concrete help to families at times when they need it most can help fortify families, minimize the stress they are experiencing and help them take care of their children despite the circumstances they face. Meeting basic economic needs like food, shelter, clothing and health care is essential for families to thrive. Meeting basic emotional needs is equally important. All families can benefit from concrete support in times of need and when crises arise. When this happens, both social connections and adequate services and supports need to be in place to provide stability, treatment and help for family members to get through the crisis. Specific examples include the following:

- Knowledge of community resources and available supports where to go for help.
- Supportive family environment and social connections and supports.
- Adequate and stable housing.
- Access to health care and social services.
- Parental employment and financial solvency.
- Opportunities for education and employment.

1.25.4 Knowledge of parenting and child development

One of the primary factors in family disruption is unmatched expectations of the parents. 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 as well as parent education classes and surfing the internet. Studies show 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 extra help to change the parenting patterns they learned as children. Specific examples include the following:

- Effective parenting knowledge.
- Understanding of child development.
- Realistic expectations of child.
- Uses praise.

1.25.5 Social and emotional competence of children

All of these have a positive impact on their relationships with their family, other adults, and peers. Challenging behaviors or delayed development creates extra stress for families, so early identification and assistance is necessary for both.

1.25.6 Nurturing and attachment

Parents, who are nurturing, provide structure and consistently meet children's emotional and physical needs and 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.

- Demonstrate empathy towards the child and understand and attuned to the child's needs.
- Enjoys being with child.
- Able to soothe child when they are upset.
- Spend time with the child doing what the child likes to do.
- Provides nurturing and affection.
- Positive, strong, stable, and caring parent child relationships.
- Open communication and problem-solving.

1.26 Appendix E: Risk Factors

Research has uncovered a number of risk factors or attributes commonly associated with maltreatment. Children in families and environments where these factors exist have a higher probability of experiencing maltreatment.

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 must 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.

Common factors associated with increased risk of child maltreatment are often categorized as follows:

1.26.1 Parent related

- Parent substance use disorder or history of substance use disorder.
- Parental history of child abuse or neglect in family of origin.
- Parental history of receiving domestic violence (DV) services or involvement of law enforcement due to DV.
- Self-reported incident of or exposure to DV.
- 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 adoption sought or attempted for a particular child.
- History of psychiatric care.
- Education under 12 years.
- Low maternal self-esteem.
- Low parental IQ.
- Parents' negative view of the child in families where DV is present.
- Single parents.
- Non-biological, transient caregivers in the home.
- Language barriers.

1.26.2 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.

1.26.3 Family related

- Abnormal or nonexistent attachment and bonding.
- Family economic factors.
- Unemployment, inadequate income, unstable housing, and no phone.
- Family management problems and family conflict.

- History of family violence of any kind.
- Marital or family problems.
- Single-parent family.
- Inadequate emergency contacts-excludes immediate family.

1.26.4 Community/environmental related

- Lack of social supports.
- Isolation.
- Few housing opportunities.
- High unemployment.
- High incidence of teen pregnancy.
- Lack of resources: lack of access to early infant and child services, day care, mental health resources, educational resources, after-school programs, parent support groups, child development information.
- Availability of drugs in the community.
- Community violence.
- Community disorganization/low neighborhood attachment.

For more information on risk factors, see the Child Welfare Information Gateway.

1.27 Appendix F: Moving from problem focused to solution focused in strength-based practice

	Problem Based	Solution Based
FOCUS	What's wrong?	What's right? What can be more right? What's happened to you?
VIEW OF PARENT	"Bad" parent	Parent struggling with a challenge
PURPOSE	Service worker seeking answers to questions; Interrogation	Service worker and family raise questions and together explore answers; Consensus building
ASSESSMENT	Service worker assesses family	Mutual assessment; Both service worker and family have a wealth of knowledge to share
PLANNING	Service worker driven plan; Individual focused	Family driven plan and owned; Both individual and family focused
ROLE OF THE SERVICE WORKER	Monitor progress; Often adversarial; Interpret lack of progress as resistance	Coach the family; Acknowledge learning and change; Expect backsliding; Explore with the family what's getting in the way
OUTCOME	Compliance of the individual; Service worker owns outcome	Family members gain new knowledge and learn new skills; Family owns outcome
EMOTIONAL RESPONSE	Parent and service worker anxious about outcomes and often feel guilty or bad	Parent and service worker manage feelings and feel good about what the family has accomplished

1.28 Appendix G: Father Friendly Environmental Assessment Tool

100% Self-Monitoring Tool -

To be completed by the Fatherhood Representative

Fatherhood Representative Name _____ Date of Review _____

Directions: Walk through your center and complete the following audit. If you are a female, imagine you are male or take a trusted man with you.

Scoring: *2 points for each area of full compliance*

1 point for each area of partial compliance

0 points for noncompliance

A. *First Impression* _____

The initial reception area is free of signs or posters that would be possibly intimidating for men (e.g., domestic violence posters that target men as batterers). Staff members are warm, friendly and comfortable with men and fathers coming for services.

B. *Landscape* _____

All visual materials include men and fathers of varied racial and ethnic backgrounds in positive roles; posters have positive, non-stereotypical messages. Magazines and brochures are relevant to men and women.

C. *Role Models* _____

There are visuals (posters, pictures, toys) present within the center; including male staff working with parents and children in roles other than that of bus driver, cook, janitor or accountant. Examples: a poster with a male nurse, pictures of male teachers, books with male bakers, magazines with male restaurant waiters etc.

D. *Linguistic Pollution* _____

Verbal and nonverbal language and cues avoid stereotyped generalizations about men; there is no joking or humorous conversation where men/fathers are the butt of the joke; there are no informal negative conversations about men to be overhear.

E. *Communication and Roles* _____

Men in the program (staff or fathers) are listened to with open minds; their ideas are considered thoughtfully. Differences in male/female communication styles are understood and respected; men are not expected to communicate exactly like women. Men are appreciated in both traditional and nontraditional roles. They are not asked to do all of the heavy labor tasks, but are appreciated if they volunteer to do some heavy tasks. Their ability to be effective and appropriate in their interactions with young children is recognized. Examples would include: respecting that males talk more about information or to report. Men talk more about things (business, sports, food) than about people. Men convey facts, not details. Men are goal oriented. Women talk to gain information and to connect, and are relationship oriented.

F. *Materials/Activities for Parents* _____

Equipment, resources and types of parenting activities are diverse and relevant for both fathers and mothers. Specific brochures/publications are provided for fathers. Referral lists include services for fathers as well as mothers.

G. *Interaction with Parents* _____

Mothers and fathers get equal respect and attention from staff. Staff members encourage and expect fathers to be involved, welcome them warmly, recognize and respect differences in male and female parenting styles, and avoid "correcting" fathers as they interact with their children. Examples: Records show interactions with fathers during Home Visits and staff/parent conferences, fathers input in child's goal setting and observations.

Total Score Rating _____

0-5	Just beginning
6-10	In Process
11-14	Almost There
14	CONGRATULATIONS!

ACTION PLAN

Based on the Father-Friendly Environmental assessment, what do you recommend to make the environment more welcoming to men/fathers?

Action Steps	Persons Responsible	By When
1._____	_____	_____
_____		
_____		
2. _____	_____	_____
_____		
_____		
3. _____	_____	_____

_____

Agency Name: _____

(Adapted from the Male-Friendliness Environment Audit developed by Pamela Wilson under contract with the Head Start Bureau, 2001.)

1.29 Appendix H: Funding sources for prevention

1.29.1 Federal and state funds used by localities to provide prevention services

1.29.1.1 Promoting Safe and Stable Families (PSSF)

Promoting Safe and Stable Families (PSSF) is designed to assist children and families resolve crises, connect with necessary and appropriate services, and remain safely together in their own homes whenever possible. Services are provided to meet the following objectives:

- Prevent or eliminate the need for out-of-home placements of children.
- Promote family strength and stability.
- Enhance parental functioning.
- Protect children.
- Assess and make changes in state and local service delivery systems.

The services provided through the program, are child-centered, family-focused, and community-based. The citizens of Virginia communities receiving funding determine how best to utilize those funds on behalf of the children and families in their respective communities. Receipt of the funding is based upon approval by the state of individual community plans that have been developed from comprehensive community-based needs assessments. Funds in each community are managed by the Community Policy and Management Team (CPMT).

1.29.1.2 Children's Services Act (CSA) state pool funds

The need for services funded by the Children's Services Act (CSA) is determined by local Family Assessment and Planning Teams (FAPT) on a case-by-case basis. The purpose of the funds is to avoid out-of-home or out-of-community placements of at-risk children. The funding varies by locality and type of service.

> (§ 2.2-5212). In order to be eligible for funding for services through the state pool of funds, a youth, or family with a child, shall meet one or more of the criteria specified in subdivisions 1 through 4 and shall be determined through the use of a uniform

assessment instrument and process and by policies of the community policy and management team to have access to these funds.

1. The child or youth has emotional or behavior problems that:

a. Have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;

b. Are significantly disabling and are present in several community settings, such as at home, in school or with peers; and

c. Require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies.

2. The child or youth has emotional or behavior problems, or both, and currently is in, or is at imminent risk of entering, purchased residential care. In addition, the child or youth requires services or resources that are beyond normal agency services or routine collaborative processes across agencies, and requires coordinated services by at least two agencies.

3. The child or youth requires placement for purposes of special education in approved private school educational programs.

4. The child or youth requires foster care services as defined in § 63.2-905.

B. For purposes of determining eligibility for the state pool of funds, "child" or "youth" means (i) a person younger than 18 years of age or (ii) any individual through 21 years of age who is otherwise eligible for mandated services of the participating state agencies including special education and foster care services.

According to the 2011 Prevention Survey of LDSS, 90% of LDSS brought prevention cases to FAPT for funding. The primary reason children were brought to FAPT was for a child at risk of foster care resulting from suspected, initial, or recurring maltreatment or a Child In Need of Services (CHINS). Other prevention cases are brought to FAPT as a result of a court order, delinquency, truancy, educational issues, and homelessness.

Access to CSA funds is governed by state and local policies which require multiagency planning, uniform assessment, utilization review, and authorization of funds. Service workers should become familiar and comply with policies established by their local CPMT and FAPT for access to CSA funding.

For more information on CSA state pool funds, see the CSA User Guide and Policy Manual.

1.29.1.3 Family Preservation and Support Program (FPSP)

Federal Social Services Block Grant (SSBG) funds are provided to enable each state to furnish social services best suited to meet the needs of the individuals residing within the state. Virginia's portion of SSBG funds is administered through the Family Preservation & Support Program (FPSP).

FPSP funds are allocated to each LDSS based on a budget submission. The purpose of the FPSP is to strengthen the family unit or to prevent or remedy neglect or abuse of children who may be at-risk of entering foster care.

FPSP goods or services include interventions to maintain and strengthen the family unit while ensuring the safety of the child. The goods or services provided through FPSP are child-centered, family-focused, and community-based. The primary purpose of the FPSP is to help children and families that are in crisis who need short-term support to become self-sustaining.

FPSP funds must be used for two broad types of funding and eligible populations:

- Family Support Services (FSS): This service type is used to assist vulnerable families where there is no immediate risk of the children entering foster care. Services that families may receive include community-based preventive activities designed to promote the safety and well-being of children and families; promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children; enable families to use other resources and opportunities available in the community; create supportive networks to enhance child-rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families; and strengthen parental relationships and promote healthy marriages. This definition also includes mentoring programs.

- Family Preservation Services (FPS): This service type is used to assist families whose children have been identified as being at risk of out-of-home placement 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 multiple needs in a culturally sensitive manner.

1.29.1.4 Other federal or state funding sources

In addition to the above funding sources, LDSS may help families access Temporary Assistance for Needy Families (TANF), Virginia Initiative for Employment Not Welfare (VIEW), Medicaid, General Relief (GR), Supplemental Nutrition Assistance Program (SNAP), and adoption assistance to prevent maltreatment and support stable foster and adoptive families.

1.29.2 Grant programs used for prevention

Availability of grant funds varies from year to year. LDSS staff should explore the logical connections between local program needs and community resources to build the assets of the LDSS for prevention. Many localities have been creative in finding a good “fit” with funding sources that may not have been obvious. The examples below are not intended to be all inclusive but to be used as impetus for brainstorming ideas about possible funding sources.

Some of the types of state grant funding used by localities have included Community-Based Child Abuse Prevention (CBCAP) funds, Family and Children's Trust Fund (FACT), Substance use disorder Prevention and Treatment Block Grant (SABG), Maternal Infant Early Childhood Home Visiting (MIECHV) funding, Office of Juvenile Justice and Delinquency Prevention (OJJDP) grants, Virginia Foundation for Healthy Youth (VFHY) grants, and United States Department of Housing and Urban Development (HUD) Emergency Shelter Grants (ESG). Localities have also identified foundation, corporation, and community-based organization funding sources.

1.29.3 Local funding sources

Local agencies can dial 2-1-1 to find out about resources in their community. Other local resources can include local only government funds; community block grants; United Way; local churches and faith-based organizations; local businesses; funds from local advocacy teams or coalitions; civic, social and fraternal organizations (i.e. Kiwanis, General Federation of Women’s Clubs, etc.); Girl Scouts and Boy Scouts

councils, and local banks. Some local agencies also conduct fund raising events and solicit donations from the public.

1.30 Appendix I: Online 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.

1.30.1 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 knowledge, talents and resources.

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

1.30.2 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 well-being, safety, and permanency 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.

1.30.3 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.

Families Forward Virginia: 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.

Champions For Children: Prevent Child Abuse Hampton Roads: A 501 (c) 3 organization that has served the Hampton Roads region since 1983 in the quest to

prevent child abuse and neglect. Champions For Children focuses its efforts and resources on public awareness, education, and advocacy for the prevention of all forms of 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.

1.30.4 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.

1.30.5 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.

1.30.6 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.

1.30.7 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 - State Agency Planning & Performance Measures: Shows how Virginia is doing in areas that effect quality of life for people and their families.

1.30.8 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 use disorder 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.

Title IV- E Prevention Services Clearinghouse: Developed in accordance with the Family First Prevention Services Act (FFPSA) as codified in Title IV-E of the Social Security Act, rates programs and services as well-supported, supported, promising, or does not currently meet criteria.

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.

1.30.9 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.

1.30.10 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 use disorder, 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.

1.30.11 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.

1.30.12 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.

1.30.13 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 use disorder 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 use disorder 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 use disorder 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 use disorder 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.

1.30.14 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.

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.

1.30.15 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.

1.30.16 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.

1.30.17 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.

1.30.18 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.

Virginia HEALS: A model of service delivery that that has been developed to assist service providers in better linking systems of care and providing support and care to children, youth, and families impacted by trauma and/or victimization. This model, and the toolkit which supports it, is intended to be adopted and implemented at the community level by child, youth, and family serving organizations and service providers from child welfare, advocacy, education, juvenile justice, behavioral health, and public health.

2

PREVENTION AND IN-HOME SERVICES TO FAMILIES

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2

PREVENTION AND IN-HOME SERVICES TO FAMILIES

2.1 Intended audience for Section 2

The intent of Section 2, Prevention and In-Home Services to Families, is as follows:

- To provide program managers, supervisors, and service workers involved in In-Home services with best practice strategies for engaging families during an initial outreach contact, empowering families in decision-making, and maintaining family engagement and partnership.

Section 2 includes the following information:

- Guidelines for standardized assessments to create and inform individualized service plans
- Definitions of case types for prevention to facilitate consistent data collection.
- Principles of practice for strength-based, trauma-informed family engagement practice and supervision in prevention, using the protective factors as a framework.
- Guidelines for trauma-informed case management.
- Supporting case decision-making through consistent use of available tools.

2.2 Definition of prevention services to families

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) levels of prevention services as families move across the continuum:

- **Primary prevention**: Activities with a universal focus that seeks to raise the awareness of the general public, service providers, and decision makers about the scope and problems associated with child maltreatment. *For more information on primary prevention, see Section 1.16, Primary prevention: Public education and awareness activities for all families.*

- **Secondary prevention**: Activities with a focus on populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance use disorder, young parental age, parental mental health concerns, and parental or child disabilities. Programs may target services for communities that have a high incidence of any or all of these risk factors. For more information on secondary prevention, see *Section 1.17, Secondary prevention: Prevention services with at-risk families.*

- **Tertiary prevention**: *Activities with a focus on families where maltreatment has occurred and seeks to reduce the negative consequences of the maltreatment and to prevent its recurrence.*

2.3 Tertiary prevention: In-Home services and foster care prevention

The primary goal of In-Home services is to support families to safely maintain children in their own homes or with relative/fictive kin caregivers in their own communities, by addressing identified safety and risk concerns and reducing the reoccurrence of child maltreatment. This is achieved through engagement of the family, support systems, and other service providers.

2.3.1 Principles of In-Home services

In-Home services provide interventions and services to families that are based on the following principles:

- *Address child safety and risk factors.*
- *Preserve families by maintaining children safely in their own homes or with relative/fictive kin caregivers in their own communities.*
- *Prevent further abuse or neglect by strengthening the family's capacity to protect and nurture their children.*
- *Interventions and services are provided in a manner to reduce or eliminate re-traumatization to children and families.*
- *Deliver interventions and services within the context of the family's own community culture and the child's current living arrangement.*
- *Engage children, youth, and families in the planning process while producing better outcomes of safety, permanence, and well-being.*

2.3.2 In-Home services population

In-Home services may serve the following population:

- *Families self-referred due to significant crisis.*
- *Families who may have had a substantiation of abuse or neglect.*
- *Children or youth who, in the absence of preventive services, would be at imminent risk of out-of-home care or placement into foster care.*
- *Court involved children or youth that have not been removed from the home.*
- *A child who is receiving family reunification support after foster care placement.*
- *A pregnant or parenting youth in foster care.*

- *A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.*

2.4 Opening a case

2.4.1 Application for services

The Code of Virginia and federal law require that child welfare information be maintained in the statewide child welfare information system. *When safety factors or risk factors have been identified, the opening of an In-Home services case should occur without delay. The case must be opened electronically in the child welfare information system and opened through the case connect function within the family assessment or investigation, when applicable. The case must have a primary worker assigned within* ***three (3) business days*** *of case opening.*

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.

When services are identified that will address identified safety and risk concerns and will reduce the reoccurrence of child maltreatment, a Service Application or a Family Service Agreement can be utilized to 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 following instructions on FUSION.

See Section 2.10.10.1 for additional guidance if a family refuses services.

2.4.2 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 ongoing 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., parent education or home visiting services 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 additional information about how LDSS services can assist the family.

2.4.3 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 must have a face-to-face visit with the child(ren) and family **at least one (1) time per month**. Face-to-face visits with an active member of the case must be made consistently so the service worker and the family can assess ongoing safety, risk, level of functioning, and the status of the service plan objectives. 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.

2.4.4 Opening case narrative

An opening case narrative should be documented in the In-Home services case within the child welfare information system. This summary should include a brief explanation about how the family became known to the LDSS and any needs or concerns relating to safety, risk, court involvement, and current status of the family's situation.

2.4.5 Case type

Below are definitions of case types for *Family Support, In-Home*, and *Dual In-Home and Foster Care*. For each case type, there is a reference to the case type to use in the child welfare information system 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 the case type may change.

2.4.5.1 Family Support

**These cases appear in OASIS as Family Support (Early Prev/Family Preserv).*

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

- *The family has been identified to benefit from voluntary services and is not in need of In-Home services or a formal service plan.*
- *LDSS has determined that services provided are intended to help families alleviate crises and promote family well-being.*
- *This case type may include services ordered by the court related to a petition for relief of care and custody or court ordered custody, visitation, or mediation.*
- *Family has agreed to services.*

2.4.5.2 In-Home (CPS: Ongoing Services)

**These cases appear in OASIS as In-Home (CPS: Ongoing Services)*

Services to a family under the following conditions:

- *A case that is associated with a concern of child maltreatment and as a result of a family assessment, investigation, or a high or very high risk assessment.*
- *An adoption or guardianship arrangement that is at risk of a disruption or dissolution that would result in a foster care placement.*
- *Absent effective preventive services, the child may be at imminent risk of out-of-home care or placement into foster care.*
- *The child or youth may meet eligibility for a reasonable candidate or candidate for foster care. LDSS must complete the Candidacy Determination Documentation Form in the child welfare information system. Additional information regarding candidacy determinations can*

be found in Section 2.6.6.5 or the online course available in the Virginia Learning Center (VLC).

- *Family has agreed to services or services are court ordered.*

2.4.5.3 Dual In-Home & Foster Care (Dual: CPS & Foster Care)

Services to a family under the following conditions:

- *When a child is in the custody of the LDSS and is in foster care **and** there are other children remaining in the home who are not in the custody of the LDSS.*

- *Family has agreed to services or services are court ordered.*

2.4.6 Transfer case within LDSS

*When another service worker in the LDSS is assigned the case, the LDSS must ensure a quick and smooth transition of the case to continue safety monitoring, commence the Child and Adolescent Needs and Strengths (CANS) assessment and begin service planning with the family. If the case is transferred to another worker, the first contact or attempted contact must occur **within five (5) business days** of assignment. The first contact must be a face-to-face worker visit with the parents, custodians or legal guardians, relative/fictive kin caregivers, the child, the initial service worker and the service worker. This seamless transition helps to ensure a thorough assessment of strengths and needs of the child and family and that the service plan will be completed **within 30 calendar days** of opening the case.*

If a case is being transferred to another worker in the LDSS, a case transfer staffing should be held. The meeting should address:

- *The safety and risk factors identified.*

- *The existing safety plan with the family.*

- *Any pending legal matters and who is responsible for any upcoming court hearings.*

- *When a joint initial visit with the family will occur.*
- *The family's view of the concerns and needs that require In-Home services.*
- *Recommendations from the Family Partnership Meeting (FPM), if held.*
- *The "stage of change" of the family. (See "Motivational Strategies and Stages Handout").*

The service worker should receive the entire electronic and hard copy record for the family. The need for the entire record should not delay the transfer of enough information to begin essential services to prevent abuse or neglect.

2.5 Child safety scenarios in an In-Home services case

In-Home services aim to support families to safely maintain children or youth in their own home or with relative/fictive kin caregivers by eliminating identified safety and threat concerns and reducing risk of future child maltreatment. This is achieved through engagement of the family, their support system, and other service providers. During the delivery of In-Home services, LDSS must provide, arrange for, and coordinate interventions and services for children and families in the following safety scenarios:

- ***Child or youth residing with parent(s) or relative/fictive kin caregiver(s).***
- ***Child or youth temporarily residing with relative/fictive kin caregiver(s) and will return to the parent(s) or caretaker/guardian(s) within six (6) months.***
- ***Child or youth permanently residing with relative/fictive kin caregivers(s).***

In-Home services involves the provision of accessible, equitable, individualized services to reduce the reoccurrence of child maltreatment or out of home placement. In-Home services in all of the identified safety scenarios include, but are not limited to:

- *Routine and uniform assessment **every 90 days**, to include:*
  - *Safety assessment.*
  - *Risk Assessment and Risk Reassessment.*

- *Child and Adolescent Needs and Strengths (CANS).*
- *Candidacy Determination.*
- *For more information on initial contact and assessment to include safety and risk, see Section 2.6. For more information on the comprehensive assessment of the family's needs and strengths, see Section 2.7.*

- *Well-planned, focused, and meaningful face-to-face worker visits with the child and family **at least one (1) time per month.***
- *Teaming to engage children, youth, and the family as partners in shared decision-making, to include:*
  - *Family Partnership Meetings (FPM) which must be held at critical decision points and prior to the development of the service plan.*
  - *Child and Family Team Meetings (CFTM) which must be held **every 90 days** and should be held **every 30 days** to help inform the service plan.*
- *Monitoring, expanding, and updating the service plan **every 90 days**. For more information on service planning and review, see Section 2.8 and Section 2.11 respectively.*
- *Referral and monitoring of services and connection to available formal supports (e.g., TANF, Relative Maintenance Support, early infant and child services, child care, mental health resources, education resources, after school programs, parent support groups, child development information, etc.). For more information on service delivery, see Section 2.10.*
- *Documentation of In-Home services activities in the child welfare information system.*
- *Case staffing between the assigned service worker and supervisor that provides coaching and support.*

2.5.1 Child or youth residing with parent(s) or relative/fictive kin caregiver(s)

In-Home services to children and families in this safety scenario includes, but are not limited to:

- *Safety assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*
    - *The initial safety decision and safety plan are documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed. In the absence of an initial safety assessment, the initial safety decision and safety plan must be documented in a new Safety Assessment Tool in an In-Home services case in the child welfare information system **within three (3) business days**.*
    - *The safety assessment must cover all children and youth in the home. The focus of the assessment is on conditions that exist at the time of the assessment.*
    - *For more information on assessing safety, see Section 2.6.5.2.*
- *Risk assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*
    - *In the absence of an initial risk assessment, the risk assessment must be conducted **within 30 calendar days** of opening an In-Home services case.*
    - *This risk assessment is completed on the household that includes all persons who have significant in-home contact with the child or youth, including those who have a familial or intimate relationship with any person in the home. The primary caretaker is the adult living in the household where the allegation occurs who assumes the most responsibility for the child or youth's care. When two adult caretakers are present and the service worker is in doubt as to which one assumes the most responsibility for the child or youth's care, the adult with legal responsibility for the child or youth should be identified as the primary caretaker.*

      When both parents are in the household, equally sharing caretaking responsibilities, and both have been identified as perpetrators or alleged

perpetrators, the parent demonstrating the more severe behavior is identified as the primary caretaker.

The secondary caretaker is defined as an adult living in the household who has routine responsibility for the child or youth's care, but less responsibility than the primary caretaker. A partner may be a secondary caretaker even though they may have minimal responsibility for care of the child or youth.

- *For more information on assessing risk, see Section 2.6.6.*

- *Risk Reassessment must be completed **every 90 days** until the case is closed. It must be completed before renewing or ending a service plan in the child welfare information system.*
  - *The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently to allow an In-Home services case to be closed, or whether the risk level remains high and services should continue. This is accomplished through evaluating whether behaviors and actions of the family have changed as a result of the service plan.*
  - *Service workers should explain to the family the structure and process for conducting the reassessment, and should link the reassessment process to the developed service plan.*
  - *For more information on risk reassessment, see Section 2.11.1.*
- *Child and Adolescent Needs and Strengths (CANS) must be completed and documented for all children and their caregivers in the CANVaS online application **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*
  - *The CANS identifies and prioritizes the strengths and needs of the child and family and assists in the planning and provision of services. In addition to service planning, the CANS can be used to measure progress over time at both the child and family levels.*
  - *For more information on CANS, see Section 2.7.1.*
- *Service Plan must be developed **within 30 calendar days** of opening the case. It must be re-evaluated **every 90 days thereafter** or sooner if safety, risk, or*

family circumstances change. The service plan must be documented in the child welfare information system. For more information on service planning and review, see Section 2.8 and Section 2.11 respectively.

- *Candidacy Determination must be documented in the child welfare information system **within the first 30 days of case opening** and **every 90 days thereafter** in conjunction with developing and renewing the service plan. LDSS must use the Candidacy Determination Documentation Form in the child welfare information system to document the child or youth's candidacy determination.*
    - *For more information on Candidacy Determination, see Section 2.6.6.5.*
- *Decision-making and case management*
    - *Within six (6) months, the service worker must assess progress toward reaching goals and objectives as outlined in the service plan. If the case is to remain open for 12 months or longer, that justification must be documented in the child welfare information system.*
    - Service workers must give proper consideration to both static and dynamic factors on the risk reassessment when determining whether the case should remain open or close.
    - Service workers should use formal and informal family engagement strategies during monthly worker visits to gather information about change over time, which should be documented in the child welfare information system.

      Family Partnership Meetings (FPM) must be held at critical decision points and prior to the development of the service plan.

      *Child and Family Team Meetings (CFTM) must be held **every 90 days** and should be held **every 30 days** to help inform the service plan.*

      This collective information can then form the basis for risk reassessment. The use of formal engagement strategies, such as FPMs to conduct the formal reassessment, develop an updated service plan, or engage in planning for case closure, is highly recommended.
    - *For more information regarding case closure, see Section 2.12.*

2.5.2 Child or youth temporarily residing with relative/fictive kin caregiver(s) and will return to the parent(s) or caretaker/guardian(s) within six (6) months

In-Home services to children and families in this safety scenario includes, but are not limited to:

- *Safety assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*
    - *The initial safety decision and safety plan are documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed. In the absence of an initial safety assessment, the following circumstances must be documented in a new Safety Assessment Tool in an In-Home services case in the child welfare information system **within three (3) business days**.*
    - *The safety assessment must cover all children in the home of the relative/fictive kin caregiver and all others present. The focus of the assessment is on conditions that exist at the time of the assessment.*
    - *For more information on assessing safety, see Section 2.6.5.2.*
- *Risk assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*
    - *In the absence of an initial risk assessment, the risk assessment must be conducted **within 30 calendar days** of opening an In-Home services case.*
    - *This risk assessment is completed on the previous primary caretaker, with whom the child or youth will most likely return with services. If two adult caretakers were present and the service worker is in doubt as to which one assumes the most responsibility for the child or youth's care, the adult with legal responsibility for the child or youth should be identified as the primary caretaker.*

      If both parents were in the household, equally sharing caretaking responsibilities, and both were identified as perpetrators or alleged perpetrators, the parent demonstrating the more severe behavior is identified as the primary caretaker.

The secondary caretaker is defined as an adult living in the household who had routine responsibility for the child or youth's care, but less responsibility than the primary caretaker. A partner may be a secondary caretaker even though they may have minimal responsibility for care of the child or youth.

- *The risk assessment is not completed on the relative/fictive kin caregiver(s).*
- *For more information on assessing risk, see Section 2.6.6.*

- *Risk Reassessment must be completed **every 90 days** until the case is closed. It must be completed before renewing or ending a service plan in the child welfare information system.*
  - *The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently for the child or youth to return home safely with services. This is accomplished through evaluating whether behaviors and actions of the family have changed as a result of the service plan.*
  - *Service workers should explain to the family the structure and process for conducting the reassessment, and should link the reassessment process to the developed service plan.*
  - *The risk assessment is not completed on the relative/fictive kin caregiver(s).*
  - *For more information on risk reassessment, see Section 2.11.1.*
- *Child and Adolescent Needs and Strengths (CANS) must be completed and documented for all children, caretaker/guardian(s), and relative/fictive kin caregivers in the CANVaS online application **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*
  - *The CANS identifies and prioritizes the strengths and needs of the child and family and assists in the planning and provision of services. In addition to service planning, the CANS can be used to measure progress over time at both the child and family levels.*
  - *For more information on CANS, see Section 2.7.1.*

- *Service Plan must be developed **within 30 calendar days** of opening the case. It must be re-evaluated **every 90 days thereafter** or sooner if safety, risk, or family circumstances change. The service plan must be documented in the child welfare information system. For more information on service planning and review, see Section 2.8 and Section 2.11 respectively.*

- *Candidacy Determination must be documented in the child welfare information system **within the first 30 days of case opening** and **every 90 days thereafter** in conjunction with developing and renewing the service plan. LDSS must use the Candidacy Determination Documentation Form in the child welfare information system to document the child or youth's candidacy determination.*

    - *For more information on Candidacy Determination, see Section 2.6.6.5.*

- *Decision-making and case management*

    - *A Family Partnership Meeting (FPM) must be conducted when it is assessed that the child is not safe to reside with the primary caretaker. The purpose of the meeting is for the family and the agency to facilitate planning to identify a relative or kin caregiver with whom the child can temporarily reside. The FPM should identify the services and supports needed to sufficiently mitigate further safety and risk concerns for the child or youth to return home safely. The FPM should also address visitation needs for the child or youth with the previous primary caretaker. The FPM must be documented in the child welfare information system. For guidance on conducting the FPM, refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.*

    - *Within six (6) months of case opening, the service worker must assess progress toward reaching goals and objectives as outlined in the service plan. If the case is to remain open for 12 months or longer, that justification must be documented in the child welfare information system.*

    - *Service workers must give proper consideration to both static and dynamic factors on the risk reassessment when determining whether the child can return home safely with services.*

- Service workers should use formal and informal family engagement strategies during monthly worker visits to gather information about change over time, which should be documented in the child welfare information system.

  Family Partnership Meetings (FPM) must be held at critical decision points and prior to the development of the service plan.

  *Child and Family Team Meetings (CFTM) must be held **every 90 days** and should be held **every 30 days** to help inform the service plan.*

  This collective information can then form the basis for risk reassessment. The use of formal engagement strategies, such as FPMs to conduct the formal reassessment, develop an updated service plan, or engage in planning for case closure, is highly recommended.

- *A FPM must be held prior to the child or youth returning to the parent(s) or caretaker/guardian(s) of origin and prior to the decision of case closure. The FPM may result in the decision for the child or youth to remain permanently with the relative/fictive kin caregiver. For more information on this safety scenario, see Section 2.5.3.*

- *For more information regarding case closure, see Section 2.12.*

2.5.3 Child or youth permanently residing with relative/fictive kin caregivers(s)

In-Home services to children and families in this safety scenario includes, but are not limited to:

- *Safety assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*

  - *The initial safety decision and safety plan are documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed. In the absence of an initial safety assessment, the following circumstances must be documented in a new Safety Assessment Tool in an In-Home services case in the child welfare information system **within three (3) business days**.*

- *The safety assessment must cover all children in the home of the relative/fictive kin caregiver and all others present. The focus of the assessment is on conditions that exist at the time of the assessment.*

- *For more information on assessing safety, see Section 2.6.5.2.*

- *Risk assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*

  - *In the absence of an initial risk assessment, the risk assessment must be conducted **within 30 calendar days** of opening an In-Home services case.*

  - *This risk assessment is completed on the previous primary caretaker living in the household where the allegation occurred. If two adult caretakers were present and the service worker is in doubt as to which one assumes the most responsibility for the child or youth's care, the adult with legal responsibility for the child or youth should be identified as the primary caretaker.*

    If both parents were in the household, equally sharing caretaking responsibilities, and both were identified as perpetrators or alleged perpetrators, the parent demonstrating the more severe behavior is identified as the primary caretaker.

    The secondary caretaker is defined as an adult living in the household who had routine responsibility for the child or youth's care, but less responsibility than the primary caretaker. A partner may be a secondary caretaker even though they may have minimal responsibility for care of the child or youth.

  - *The risk assessment is not completed on the relative/fictive kin caregiver(s).*

  - *For more information on assessing risk, see Section 2.6.6.*

- *Risk Reassessment must be completed **every 90 days** until the case is closed. It must be completed before renewing or ending a service plan in the child welfare information system.*

  - *The purpose of the risk reassessment is to help assess whether risk has been reduced sufficiently to allow an In-Home services case to be closed, or whether the risk level remains high and services should continue. This is accomplished through evaluating whether behaviors and actions of the caretaker/guardian(s)*

has changed as a result of the service plan and to assess visitation needs. For more information on risk reassessment considerations and decisions that guide case closure, see Section 2.11.1.1 and Section 2.11.1.2 respectively.

- *Service workers should explain to the family the structure and process for conducting the reassessment, and should link the reassessment process to the developed service plan.*
- *The risk assessment is not completed on the relative/fictive kin caregiver(s).*
- *For more information on risk reassessment, see Section 2.11.1.*

- *Child and Adolescent Needs and Strengths (CANS) must be completed and documented for all children and the relative/fictive kin caregiver in the CANVaS online application **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed.*
  - *The CANS identifies and prioritizes the strengths and needs of the child and family and assists in the planning and provision of services. In addition to service planning, the CANS can be used to measure progress over time at both the child and family levels.*
  - *For more information on CANS, see Section 2.7.1.*
- *Service Plan must be developed **within 30 calendar days** of opening the case. It must be re-evaluated **every 90 days thereafter** or sooner if safety, risk, or family circumstances change. The service plan must be documented in the child welfare information system. For more information on service planning and review, see Section 2.8 and Section 2.11 respectively.*
- *Candidacy Determination must be documented in the child welfare information system **within the first 30 days of case opening** and **every 90 days thereafter** in conjunction with developing and renewing the service plan. LDSS must use the Candidacy Determination Documentation Form in the child welfare information system to document the child or youth's candidacy determination.*
  - *For more information on Candidacy Determination, see Section 2.6.6.5.*

- *A FPM must be held prior to the child or youth returning to the parent(s) or caretaker/guardian(s) of origin and prior to the decision of case closure. The FPM may result in the decision for the child or youth to remain permanently with the relative/fictive kin caregiver. For more information on this safety scenario, see Section 2.5.3.*

- *Decision-making and case management*

  - *A Family Partnership Meeting (FPM) must be conducted when it is assessed that the child is not safe to reside with the primary caretaker. The purpose of the meeting is for the family and the agency to facilitate planning to identify a relative or kin caregiver with whom the child can temporarily reside. The FPM should identify the services and supports needed to sufficiently mitigate further safety and risk concerns for the child or youth to return home safely. The FPM should also address visitation needs for the child or youth with the previous primary caretaker. The FPM must be documented in the child welfare information system. For guidance on conducting the FPM, refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.*

  - *Within six (6) months, the service worker must assess progress toward reaching goals, objectives, and visitation needs as outlined in the service plan. If the case is to remain open for 12 months or longer, that justification must be documented in the child welfare information system.*

  - *Service workers must give proper consideration to both static and dynamic factors on the risk reassessment.*

  - Service workers should use formal and informal family engagement strategies during monthly worker visits to gather information about change over time, which should be documented in the child welfare information system.

    Family Partnership Meetings (FPM) must be held at critical decision points to include prior to custody hearings and prior to the development of the service plan.

    *Child and Family Team Meetings (CFTM) must be held **every 90 days** and should be held **every 30 days** to help inform the service plan.*

This collective information can then form the basis for risk reassessment. The use of formal engagement strategies, such as FPMs to conduct the formal reassessment, develop an updated service plan, or engage in planning for case closure, is highly recommended.

- *For more information regarding case closure, see Section 2.12.*

2.6 Initial contact and assessment in an In-Home services case

This section of guidance presents the framework for assessment, planning, service delivery, and evaluation that can increase positive outcomes for families.

2.6.1 Frequency of worker visits

*The frequency of worker visits with the child and family should be determined from the safety, risk, and needs that have been assessed. The minimum contact requirement is a face-to-face worker visit between the service worker and the child and family **at least one (1) time per month** and should occur in the home.*

2.6.2 Additional contacts defined

- *Collateral contacts: These are contacts with people who have information about the family and/or are providing interventions for the child/family. These include police, attorneys, teachers, neighbors, relatives, and treatment providers, among others. Collaterals do not include the principals in the case such as the child and parents.*
- *Designated contacts: The service worker/supervisor or service team may delegate and document additional face-to-face contacts to providers with a contractual relationship to the LDSS and/or other agency staff such as family services specialist aides or other service providers outlined in the service plan. The service worker must always maintain **at least one (1)** face-to-face worker visit with the parent/guardian and child per month.*

2.6.3 Parental permission to speak to a child

The service worker must gain consent from the parents or legal guardian to speak to a child outside their presence unless a court order specifies consent is not required.

This should be discussed with the family while developing the service plan and documented in the child welfare information system.

2.6.4 Contact information

The service worker must enter and update all case contacts, narratives, and data in the child welfare information system **within five (5) business days**.

2.6.4.1 Worker visit with the child or youth

The following information is collected, assessed, and documented in case contacts in the child welfare information system.

- *Identified safety concerns addressed.*
- *Child or youth's feelings/observations about the factors that led to LDSS involvement and the impact of trauma.*
- *Concerns pertaining to the child or youth's needs, services, and case goals.*
- *Education.*
- *Family interactions with parents, relative/fictive kin caregivers, or siblings.*
- *Extracurricular activities, hobby participation, or cultural traditions.*
- *Medical, dental, or mental health needs.*
- *Observation of the child's physical, emotional, and mental appearance.*

2.6.4.2 Worker visit with the parent/guardian/relative or kin caregiver

The following information is collected, assessed, and documented in case contacts in the child welfare information system.

- *Identified safety and risk concerns address.*

- *Progress toward reaching goals and objectives as outlined in the service plan.*
- *Medical/dental/mental health concerns, appointments, treatment, and follow up care for the child and/or themselves.*
- *Child behaviors: worker and parent concerns, developmental concerns, and any behavioral management plan, if applicable.*
- *Education: school status/performance, behaviors, and educational services being provided.*
- *Tasks required to meet child's needs.*
- *Inquiry about non-custodial parents.*
- *Any new CPS reports since last contact.*
- *Law enforcement or court system involvement since last contact.*
- *Needs or services not being provided.*
- *Observation of the home, including the sleep environment for any child less than one (1) year of age. For additional information related to safe sleep environments, see VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 4.5.6.7.1, Safe sleep environment and practices.*

2.6.4.3 Contact with collaterals or designated contacts

- *Information regarding the safety of the child and reduction of risk of future maltreatment.*
- *Information regarding their contact with the family.*
- *Medical/dental/mental health concerns, appointments, treatment and follow up care for the child and/or the parents/guardians.*

- *Education: school status/performance, behaviors, and educational services being provided.*

- *Status of any criminal or civil court matters.*

2.6.5 Consideration of safety at initial contact

2.6.5.1 Initial safety assessment in an In-Home services case

*An initial safety assessment must be conducted **within 30 calendar days** of opening the case and updated **every 90 days thereafter** if the case is to remain open, until the case is closed. The purpose of the initial safety assessment is to:*

- *Assess whether any children are currently in immediate danger of serious physical harm that may require a protection intervention.*

- *Determine what interventions should be maintained or initiated to provide appropriate protection.*

Safety Assessments differ from Risk Assessments in that the purpose is to assess a child's present or immediate danger and the interventions currently needed to protect the child. In contrast, Risk Assessments evaluate the likelihood of future maltreatment.

A safety and risk field guide is available on FUSION. This field guide may be used by the service worker in the field to help guide interviews as it provides the safety factors, protective capacities, and risk factors that should be identified in every assessment. This field guide must be used in conjunction with the definitions provided for the safety and risk assessment tools.

2.6.5.2 Assessing safety in an In-Home services case

Safety assessment is both a process and a document. The process of assessing child safety is ongoing throughout the life of an In-Home services case. The initial safety decision and safety plan are documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed.

In the absence of an initial safety assessment, the safety decision and safety plan must be documented in a new Safety Assessment Tool in an In-Home services case in the child welfare information system ***within three (3) business days*** *of case opening. The following circumstances must be considered when documenting the assessment:*

- *A change in family circumstances such that one (1) or more safety factors previously present are no longer present.*
- *A change in information known about the family in that one (1) or more safety factors not present before are present now.*
- *A change in availability of safety interventions to mitigate safety factors and require changes to the safety plan.*

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

Service workers must be familiar with the safety assessment process and tool. See VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 4, Family Assessment and Investigation, for guidance on completing the Safety Assessment Tool. Additional information about the safety assessment can be found in Module 2 of CWSE 1510: Structured Decision Making in Virginia located in the Virginia Learning Center. The final safety decision is one (1) of the following:

- ***SAFE****. There are no children likely to be in immediate danger of serious harm at this time. No safety plan is required.*
- ***CONDITIONALLY SAFE****. Protective safety interventions have been taken and have resolved the unsafe situation for the present time. A safety plan is required to document the interventions.*
- ***UNSAFE****. Approved removal and placement was the only possible intervention for the child. Without placement, the child will likely be in danger of immediate serious harm. A court order is required to document intervention.*

If a child is assessed as unsafe and court action is required, it is important for the LDSS to obtain legal counsel prior to petitioning for the removal of a child. Removal of a child should only occur after consideration of alternatives to an out-of-home placement. The court will need to establish that reasonable efforts have been made to prevent the removal and there are no alternatives less drastic than removal that could reasonably protect the child's life or health. The LDSS will need to determine whether to file for an Emergency Removal Order (ERO) or a Preliminary Removal Order (PRO). Refer to VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 8, Judicial Proceedings, for guidance on ERO and PRO. The main difference between an ERO and PRO is the urgency. An ERO may be issued ex-parte and the preliminary removal hearing must be held ***within 5 business days****. The PRO differs from the ERO in that a hearing must take place before PRO can be issued.*

If the safety decision is unsafe and the child is removed and placed into foster care and no other children remain in the home, the In-Home services case type must be changed to foster care in the child welfare information system.

If any child is placed into foster care and other siblings or children remain in the home, the In-Home services case type must be changed in the child welfare information system to reflect a dual case type (Dual In-Home & Foster Care).

2.6.5.3 Safety decision and FPM

The LDSS should schedule a FPM when the service worker assesses the child's safety to be in jeopardy or at risk of removal or out of home placement. Safety concerns are paramount and necessary action to address safety concerns must not be delayed. The FPM should be scheduled ***within 24 hours*** *after safety concerns have been identified and the agency is considering removal. The FPM must be documented in the child welfare information system. For guidance on conducting the FPM, refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.This meeting provides the opportunity for family and community participation in the decision-making process for the child. Engaging relatives and natural supports of the family will be crucial to facilitate planning to determine whether:*

- *The child can remain or return home safely with services.*

- *There will be voluntary placement of the child by the parent or caretaker with a relative/fictive kin caregiver with provision of services and a safety plan.*

- *The agency should file for custody and facilitate placement into foster care.*

The service worker and supervisor should discuss the convening and timing of a FPM at this critical decision point. Additional guidance for holding a FPM when there is DV can be found in Section 1.9 of the VDSS Child and Family Services Manual, Chapter H. Domestic Violence, Section 1.9, Family Partnership Meetings (FPM) and DV.

2.6.6 Determining risk level at initial contact

The initial risk level is documented in the child welfare information system by the CPS worker if an investigation or family assessment is completed. In the absence of an initial risk assessment, the risk assessment must be conducted ***within 30 calendar days*** *of opening the case and updated* ***every 90 days thereafter*** *if the case is to remain open, until the case is closed.*

The service worker must gather information in order to complete the Family Risk Assessment which includes assessing the following risk factors:

- ***Caretaker related***
  - *History of childhood maltreatment.*
  - *History of mental health concerns.*
  - *History of substance use disorder.*
  - *History of criminal activity (adult or juvenile).*
  - *DV incidents in past year.*
  - *History of prior CPS, In-home, or foster care services.*
  - *Developmental or physical disability.*

- *Medically fragile or failure to thrive.*
- *Substance exposed newborn.*
- *Delinquency.*
- *Mental health or behavioral problem.*
- *Prior injury as result of abuse or neglect.*

- ***Caretaker and child relationship***
  - *Blames child.*
  - *Justifies maltreatment.*
  - *Provides insufficient emotional or psychological support.*
  - *Uses excessive or inappropriate discipline.*
  - *Domineering.*
  - *Provides physical care inconsistent with child needs.*

- ***Other***
  - *Housing is unsafe.*
  - *Family is homeless.*

The service worker must determine the likelihood of any occurrence or recurrence of abuse or neglect by completing a Family Risk Assessment. The Family Risk Assessment does not predict recurrence but assesses whether a family is more or less likely to have an incident of abuse or neglect without intervention by the agency. The Family Risk Assessment is completed based on conditions that exist at the time the incident is reported and assessed as well as prior history of the family. Risk is calculated in the Family Risk Assessment tool completed in the child welfare information system. For accurate completion, it is critical to refer to the definitions. The Family Risk Assessment tool with definitions is located under CPS forms on the VDSS

public website. Selections made on the Family Risk Assessment tool must be based on supporting narrative in the child welfare information system.

Assessed risk will be:

- ***Low**. The assessment of risk related factors indicates that there is a low likelihood of future abuse or neglect and no further intervention is needed or*
- ***Moderate**. The assessment of risk related factors indicates that there is a moderate likelihood of future abuse or neglect and minimal intervention may be needed or*
- ***High**. The assessment of risk related factors indicates there is a high likelihood of future abuse or neglect without intervention or*
- ***Very High**. The assessment of risk-related factors indicates there is a very high likelihood of future abuse or neglect without intervention.*

Overrides, either by policy or discretionary, may increase risk one level and require supervisor approval. The initial In-Home services risk level may never be decreased.

2.6.6.1 Risk level guides in an In-Home servcice case

When risk is clearly defined and objectively quantified, resources are targeted to families at higher-risk because of the greater potential to reduce subsequent maltreatment. The risk level helps inform the decision whether or not to open a case as follows:

Low Risk	*Close case*
Moderate risk	*Remain open OR close case*
High Risk	*Open and Maintain to In-Home Services*
Very High Risk	*Open and Maintain to In-Home Services*

The service worker and service supervisor should assess the decision to open and maintain a case for services and document in the child welfare information

system the decision not to open a case. For more guidance on service planning in a case, refer to Section 2.8: Service planning of this manual.

2.6.6.2 Risk level determines need to convene FPM

A FPM should be scheduled by the LDSS when the worker assesses a child to be at "high" or "very high" risk of abuse or neglect or the child is at risk for out-of-home placement in those families who will be or are receiving services. This meeting is scheduled to develop the plan and services to prevent the out-of-home placement and identifies the circumstances under which a removal might be considered. The meeting should convene ***within 30 days*** *of initiating services and prior to the development of the service plan. The FPM must be documented in the child welfare information system. For guidance on conducting the FPM, refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.*

2.6.6.3 Domestic violence (DV) and substance use disorder as risk factors

Two (2) family concerns that can have a major impact on safety and risk are DV and drug or alcohol misuse 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 the VDSS Child and Family Services Manual, Chapter H. Domestic Violence, Section 1.4, Screening for DV. This chapter presents an overview of DV and the related statutory requirements impacting LDSS and local DV programs. Information specific to Prevention, CPS, and Foster Care is provided. Additional information about DV can be found on the VDSS public website.

LDSS may also request an evaluation for substance or drug misuse. 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.

2.6.6.4 Screen all children for human 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 human 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.

2.6.6.4.1 Signs of human trafficking

Signs that a child is a victim of human 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.
- Alcohol or drug misuse.
- Withdrawal or lack of interest in previous activities.
- Gang involvement.

2.6.6.4.2 When human trafficking is identified

If the LDSS identifies or receives information that a child has been a victim of human trafficking, they must notify local law enforcement **within 24 hours** of

identifying or receiving such information and document such notification in the child welfare information system.

The LDSS may contact the National Human Trafficking Resource Center (NHTRC) at 1-888-373-7888 if they suspect human trafficking of a minor. NHRTC operates a 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 I: 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 human 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.

2.6.6.5 Candidacy determination in an In-Home services case

A critical assessment that must be completed in all In-Home services cases is determining candidacy. In order to determine candidacy, the service worker must evaluate whether or not a child is at imminent risk of out-of-home placement. Imminent risk means a child and family's circumstances demand that a defined service plan is put into place ***within 30 days****. The service plan must identify interventions, services, or supports, and absent these interventions, services, or supports, foster care placement is the planned arrangement for the child.*

Possible determinations include:

- ***Reasonable candidate:*** *The service worker must determine if the child is a reasonable candidate when they assess that the child is at risk of foster care placement if services are not provided.*

- ***Candidate for foster care:*** *The service worker must determine if the child is a candidate for foster care when they assess that the child can remain safely in the child's home or in a kinship arrangement as long as an evidenced-based and trauma-informed prevention service(s) (e.g., mental*

health, substance use disorder, or in-home parent skill-based program services) is provided. The service(s) necessary to prevent the entry of the child into foster care must be identified in Virginia's approved federal Prevention Plan available on FUSION.

The specific eligibility requirements for 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 service plan was developed jointly with the child, and the parents or guardians.*
- *A description of the services offered or provided to prevent the removal of the child from the home.*
- *The In-Home services case is actively being managed to maintain the child in the home, or in a kinship arrangement, in order to 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.*

The service worker must document in the child welfare information system, in conjunction with developing and renewing the service plan, the child's candidacy determination ***within the first 30 days of case opening and every 90 days thereafter****. LDSS must use the Candidacy Determination Documentation Form in the child welfare information system to document the child's candidacy determination. Additional information regarding candidacy determination can be found in the online Candidacy Determination course found in the VLC.*

It is important to note that candidacy eligibility and documentation are related to the fiscal reimbursement for case management provided by the LDSS or the provision of evidenced-based and trauma-informed prevention service and does

not replace the requirement to determine the need for preventive services. 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.

2.6.6.6 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.

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 must be held:

- *Once a CPS investigation or family assessment has been completed and the family is identified as "high" or "very high" risk and the child is at risk of out-of-home care or placement.*
- *Prior to removing a child, whether emergency or planned.*
- *Prior to any change of placement for a child already in foster care, including a disruption in an adoptive placement.*
- Prior to *the development of a foster care plan for the foster care review and permanency planning hearings. The purpose is to discuss permanency options and concurrent planning, as well as the foster care goal.*
- *When a meeting is requested by the parent (birth, foster, adoptive or legal guardian), child, or service worker to address one of the four decision points above.*

The service worker and supervisor should discuss the convening and timing of a FPM at these critical decision points. The meeting should convene ***within 30 calendar days*** *of opening an In-Home services case and prior to the development of the service plan.*

See Section 2.10.5: Using teaming in child welfare practice for additional guidance that supports teaming as part of family engagement and best practice.

All FPMs must be documented in the child welfare information system. For more guidance regarding FPMs, please refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement. Additional guidance for holding a FPM when DV is present can be found in the VDSS Child and Family Services Manual, Chapter H. Domestic Violence, Section 1.9, Family Partnership Meetings (FPM) and DV.

2.6.6.7 Child and Family Team Meeting (CFTM)

Another practice strategy to ensure family engagement, voice, choice, and teaming are Child and Family Team Meetings (CFTM). A CFTM includes the child, parents, extended family and all service providers. A CFTM provides a mechanism by which regular review of services and progress is shared among all the individuals involved in the case and where the family's needs and preferences are routinely informing decision-making.

There is no fixed formula for CFTM size or composition.

- ***Formation** - CFTM members should include all available family members, service worker and supervisor, any contracted service providers, health care providers, educational partners, and child and parent advocates. When applicable, team members should also include mental health professionals, spiritual leaders, caretakers, Guardian ad Litems, CASA volunteers and others, as identified. Collaboration among team members from different agencies is essential. Team composition should be competent and have the right balance of personal interest in the family, knowledge of the family, technical skills, cultural awareness, authority to act, flexibility to respond to specific needs, and time necessary to fulfill the commitment to the family.*

- ***Functioning** - Most importantly the teaming process must develop and maintain unity of effort among all team members. CFTM members should develop a unified vision of what would have to happen for the case to*

close. The team must assess, plan, implement and prepare for safe case closure.

- ***Frequency*** *- The frequency of a CFTM will vary depending on the individual circumstances of each case. The CFTM should help inform the service plan and should be held prior to any service plan review.*

In the matrix provided in the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement, the FPM and CFTM are compared and contrasted. The opportunities for family engagement, incorporation of voice and choice and teaming are clear in both, but differences are also highlighted.

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

Children of Native American or Alaskan Eskimo or Aleut heritage of a federally recognized tribe are subject to the Indian Child Welfare Act (ICWA). Virginia currently has seven (7) federally recognized tribes. In January 2016, The United States Department of Interior granted federal recognition to the Virginia Pamunkey Indian Tribe. In January 2018, the following tribes were granted federal recognition: Chickahominy, Eastern Chickahominy, Monacan, Nansemond, Rappahannock, and Upper Mattaponi.

A child is covered by ICWA when the child meets the federal definition of an Indian child. Specifically, the child is an unmarried person under 18 years of age and is either:

- A member of a federally recognized Indian tribe.
- Eligible for membership in a federally recognized tribe and is the biological child of a member of a federally recognized Indian tribe (25 U.S.C. § 1903).

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

If there is any reason to believe a child is an Indian child and is at risk of entering foster care, the LDSS must treat that child as an Indian child, unless and until it is determined that the child is not a member or is not eligible for membership in an Indian tribe. Once it has been determined the child is either a member or eligible for membership in a federally recognized tribe, the LDSS must make active efforts to reunite the Indian child with their family or tribal community if already in foster care. Active efforts must begin from the time the possibility arises that a child may be removed from their parent, legal guardian or Indian custodian and placed outside of their custody.

Active efforts are more than reasonable efforts. Active efforts applies to providing remedial and rehabilitative services to the family prior to the removal of an Indian child from his or her parent or Indian custodian, and/or an intensive effort to reunify an Indian child with his/her parent or Indian custodian.

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

- Engaging the Indian child, their parents, guardians and extended family members.
- Taking necessary steps to keep siblings together.
- Identifying appropriate services and helping parents overcome barriers.
- Identifying, notifying and inviting representatives of the Indian child's tribe to participate in shared decision-making meetings.
- Involving and using available resources of the extended family, the child's Indian tribe, Indian social service agencies and individual caregivers.

An Indian child who is officially determined by the tribe to not be a member or eligible for membership in a federal tribe is not subject to the requirements of ICWA. In instances where ICWA does not apply, but the child is biologically an Indian child, part of a Virginia tribe that is not federally recognized or considered Indian by the Indian community, the LDSS should consider tribal culture and connections in the provision of services to the child.

Additional information is located in Child and Family Services Manual, Chapter C. Child Protective Services, Section 1, Appendix A: Indian Child Welfare Act (ICWA).

In the event an Indian child is in imminent danger and does not live on a reservation where the tribe exercises exclusive jurisdiction, CPS has the authority to exercise emergency removal of the child. Additional guidance regarding the removal of an Indian child can be found in Child and Family Services Manual, Chapter C. Child Protective Services, Section 4, Family Assessment and Investigation. If a child is removed and placed into foster care, see the Child and Family Services Manual, Chapter E. Foster Care, Section 3, Entering Foster Care and Child and Family Services Manual, Chapter C. Child Protective Services, Section 8, Judicial Proceedings, Appendix D, Guidelines for State Courts and Agencies in Indian Child Welfare Custody Proceedings.

2.6.7 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 initial contact, 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 2.7.3):

- 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.).

2.6.8 Reasonable diligence to locate family

The LDSS must use reasonable diligence to locate a missing child or family in an In-Home services case.

> *22 VAC 40-705-150 F. The local department must use reasonable diligence to locate any child for whom a founded disposition of abuse or neglect has been made and/or a child protective services case has been opened pursuant to § 63.2-1503 F of the Code of Virginia. The local department shall document its attempts to locate the child and family.*

2.6.8.1 What constitutes reasonable diligence

The CPS In-Home worker shall document all reasonable and prompt attempts to locate the child and family. The worker should check the following, where applicable:

- *Child welfare information system.*
- *Postal Service for last known or forwarding address.*
- *Neighbors, landlords, or known relatives/kin.*
- *School records.*

- *Department of Motor Vehicles.*
- *Department's Division of Support Enforcement.*
- *Department of Corrections or Probation and Parole.*
- *Law Enforcement.*
- *Telephone and utility companies.*
- *Employer.*
- *Person locator tools or SPIDeR searches.*
- *Internet searches including generic search engines such as Google, Yahoo, Bing, etc.*
- *Social networks such as Facebook, Instagram, or Twitter.*
- *Other appropriate contacts.*

A Reasonable Diligence Checklist is located on FUSION.

2.6.8.2 Conducting periodic checks for missing child/family

*If the victim child or family is not found, the service worker must conduct periodic checks. Periodic checks for the missing child/family must continue monthly for **at least 90 days**, until the LDSS is satisfied with the resolution of the case. The service worker must document the timetable in a case contact in the child welfare information system as well as the results of the periodic checks. The service worker must document the results of the monthly periodic checks in the child welfare information system.*

2.7 Comprehensive assessment of the family's needs and strengths

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 phase provides the foundation for continued engagement with the family and service planning and delivery.

It is critical that the assessment process with the family is mutual. 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.

Protective factors should be considered in all aspects of work with families along the child welfare continuum, including 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 Child and Adolescent Needs and Strengths (CANS) assessment

The Child and Adolescent Needs and Strengths (CANS) assessment must be completed in all In-Home services cases. The CANS must be documented in the CANVaS online application ***within 30 calendar days*** *of opening the case and updated* ***every 90 days thereafter*** *if the case is to remain open, until the case is closed. The CANS assessment must be completed by a certified CANS rater who has the primary or secondary case assignment.*

2.7.1.1 CANS

CANS is a comprehensive, multi-domain, standardized assessment instrument which helps plan and manage In-Home 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.

2.7.1.2 Who should be assessed with CANS

A CANS must be completed for all children and their caregivers in an In-Home services case.

2.7.1.3 Assessment areas

The CANS identifies and prioritizes 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 cases, the CANS includes the following areas:

- *An enhanced trauma module.*
- *A 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.*

2.7.1.4 CANS resources

The Children's Services Act (CSA) provides resource information on the CANS. Resources include:

- *CANS Overview.*
- *CANS Training and Certification Information.*
- *CANS User Manual and Score Sheets.*
- *CANVaS Online Application.*

2.7.2 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 challenges 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 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 use disorder, 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.

2.7.2.2 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 a significant risk factor for abusing or neglecting one's own children. 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 use disorder or history of substance use disorder.
- History of child abuse or neglect involving parents' child.
- Current or history of depression.

- Parent physical and mental health concerns.
- 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.
- 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 B: 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.

2.7.3 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) and *Virginia HEALS model of service delivery*.

2.7.3.1 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.

2.7.3.2 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 use disorder, 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 A: Questions to Ask Mental Health Providers.

2.8 Service planning

2.8.1 Definition of service plan

The service plan documents all services to prevent further child maltreatment, out-of-home care, or placement into foster care. The Virginia Administrative Code defines a service plan:

> *(22 VAC 40-705-10). "Service Plan" means a plan of action to address the service needs of a child or his family in order to protect a child and his siblings, to prevent future abuse and neglect, and to preserve the family life of the parents and children whenever possible.*

2.8.2 Timeframe to complete service plan

*The initial service plan must be developed **within 30 calendar days** of opening the case. It must be re-evaluated **every 90 days thereafter** or sooner if safety, risk, or family circumstances change. The service plan must be documented in the child welfare information system.*

2.8.3 Information needed to develop service plan

The service plan incorporates information about the parents, caretakers, legal guardians, and children. It is important for the service worker to review all relevant documents prior to developing the service plan with the family. The following information should be reviewed and considered in developing a service plan with the family:

- *The most recent safety assessment completed with the family, noting any safety factors that have been identified.*
- *The most recent Family Risk Assessment completed for the family, noting the identified risk factors.*
- *The CANS completed prior to developing or renewing the service plan.*
- *The most recent safety plan developed with the family.*
- *CPS family assessment or investigation that may have prompted the opening of the In-Home services case.*
- *Prior CPS history for the family, including any prior screened out reports, family assessments, investigations or service cases.*
- *A Candidacy Determination that may identify a child as a reasonable candidate or candidate for foster care, noting whether or not the child is at imminent risk of out-of-home placement.*
- *The Family Service Agreement completed in the family assessment or investigation.*

- *The recommendations from the FPM (if conducted).*
- *Reports received from collateral sources such as psychological evaluations, forensic evaluations, parenting capacities, home studies, court reports, etc.*
- *Any court orders.*

2.8.4 Develop the plan with the family

The child and family should have an active role and voice in identifying their strengths and needs, which guide the goals, objectives, and activities of the service plan. Engagement involves consistent use of strength-based, respectful, unbiased, non-judgmental, and empowering language in all communication. The service worker should engage the family to:

- *Identify their strengths.*
- *Recognize, explain and prioritize their needs, preferences, and challenges.*
- *Understand, accept, and work toward any non-negotiable conditions that are essential for child safety and well-being.*
- *Attend team meetings and shape key decisions about goals, intervention strategies, special services, and essential supports.*
- *Advocate for their needs, supports, and services.*
- *Follow through on interventions.*

2.8.5 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 they need 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:

2.8.5.1 Goals

Goals are broad statements that 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.

2.8.5.2 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 should be derived from the *CANS* 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 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.** In *In-Home services* cases, many goals reflect the elimination of harmful parenting behaviors. If the goal is to prevent removal of the child from their home or reunite the child residing voluntarily outside of the home, intervention will be directed towards helping parents alter their behaviors or lifestyles to resolve safety threats and reduce the likelihood of future harm. Objectives should clearly describe specific behavioral changes parents/caretakers need to adopt.

- **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.

2.8.5.3 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.

2.8.5.4 Barriers to achieving goals and objectives

Each contact with the family after a service plan is in place should explore what has 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.

2.8.5.5 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 2.10: Service delivery. *In addition, for more information on evidence-based and trauma-informed prevention services, see Section 2.10.7 or Office on Trafficking in Persons for services available to victims of human trafficking.*

2.8.5.6 Strategies

The service plan should also specify the necessary strategies 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.

Strategies 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?

Strategies 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 strategies 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 challenges 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.

The service worker should ensure that the family has the knowledge and ability to carry out assigned activities. If not, the strategies should be reformulated.

When formulating strategies to achieve objectives, the service worker should consider and maximize any family strength identified by the worker and family during the assessment process.

Examples of strategies:

- Father will enroll in and attend all seven (7) sessions of the parenting class held at the community hall starting on [date] and ending on [date].
- By [date] worker will develop a plan to provide the caretaker with information about child development. Caretakers will read the information provided and meet with worker to talk about the child’s development, ask

questions and assess whether each child is on target, ahead or behind developmentally by [date].

- Parent and worker will identify expectations for child's behaviors that reflect their level of development by [date]. Parent will identify what they will do to encourage expected behaviors and manage behavior when child does not do what is expected and practice those behaviors by [date]. Worker will meet with the parent to discuss progress, barriers that arose and any changes needed by [date].

2.8.6 Living arrangement

The child's living arrangement must be documented on the service plan in the child welfare information system. The child's living arrangement must be indicated as one of the following selections in the child welfare information system:

- *Child living in own home.*
- *Child living temporarily with alternate caregiver.*
- *Child living permanently with alternate caregiver.*

2.8.7 Share and document the service plan

The service worker must document the service plan in the child welfare information system and include how the family was involved with its development. All goals, objectives, *strategies*, and services must be documented in the child welfare information system.

The service plan is also utilized to document a candidacy determination. It is important to note that the documentation of reasonable candidate and candidate for foster care determinations are related to fiscal reimbursement for case management provided by the LDSS and provision of evidenced-based and trauma-informed prevention services respectively. Furthermore, failure to meet documentation requirements regarding candidacy determinations, redeterminations, and preventive services provided in the child welfare information system can result in the child being ineligible for federal funding for prevention services.

The completed service plan must include the signatures of all participating parties and a copy given to the family. The original service plan, with signatures, must be maintained in the hard copy file.

2.8.8 Supervisory review of the service plan

The service supervisor should review the service plan in the child welfare information system. The service plan should describe the complement of services and supports required to address ongoing well-being, safety, and permanency for the child. The plan should address the unique needs of the child and family and should build upon their strengths, resources, and natural supports, as identified through the comprehensive assessment process. Services should be for a planned period of time to meet specific needs.

2.8.9 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 services, PSSF funds and SSBG funds, health insurance, and government and foundation grants are all possible funding sources.

Access to CSA funds is governed by state and local policies which require multiagency planning, uniform assessment, utilization review, and authorization of funds. The service worker should become familiar and comply with policies established by their local Community and Policy Management Team (CPMT) for access to CSA funding. The LDSS must refer the child and family to the Family Assessment and Planning Team (FAPT) or approved multi-disciplinary team, consistent with CPMT policies.

In addition, Appendix *H*: Funding Sources for Prevention of Section 1 identifies a range of funding sources utilized by LDSS.

2.8.10 When parents and caregivers are not engaged

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

A family-centered approach to engaging the family may increase their readiness and ability to change. By involving families in the processes of assessment, case planning, and service delivery, families are more likely to be receptive to service provision. When families are able to identify strengths and problems in family functioning, they may contribute more to their own growth and can make more productive changes.

For more guidance regarding family engagement, please refer to the VDSS Child and Family Services Manual, Chapter A. Practice Foundations, Section 2, Family Engagement.

2.9 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:

2.9.1 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.

2.9.2 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 considerations in a constructive way.
- Help support integration of the concept of comprehensive assessment as an ongoing process.
- Support effective presentation of families' challenges 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.

2.9.3 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 use disorder, 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 VLC. The course is available to service workers and supervisors across all child welfare program areas.

- CWS5305: Advanced Interviewing: Motivating Families for Change.

2.9.4 Valid and reliable instruments

The following instruments in *Appendix C: Valid and reliable 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.

2.10 Service delivery

As described in Section 1: Overview of Prevention for Practice and Administration, an increasing body of evidence indicates maltreatment can alter brain functioning and consequently affect mental, emotional, and behavioral development. When service workers provide 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: Emphasis on trauma-informed practice.

2.10.1 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.

2.10.2 Safety services

Child and family safety must be continuously assessed in every child welfare program area throughout the life of a case. Safety assessment is both a process and a product (i.e., when a SDM tool is used). A continuum of immediate protective interventions and safety services must be initiated throughout the life of an In-Home services case anytime safety concerns are identified.

- ***Safety services definition:*** *Formal or informal services provided to or arranged for the family with the explicit goal of ensuring the child's safety. These services must be immediately available and accessible and may be provided by professionals, family members, or other willing parties as long as each involved individual understands their role and responsibility. The safety services must be clearly documented (i.e., safety plan, service plan, court order, SDM plan, etc.) for the involved parties and in the case record.*

As with all aspects of service planning, the family should be engaged in providing input and joint decision-making throughout the process of identifying, implementing, and evaluating these interventions and safety services. Documentation in the child welfare information system must clearly demonstrate how the actions taken, provided the child with immediate protection from the safety issue and how each safety service contributes to addressing or eliminating the safety matters specific to the child.

2.10.3 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.

2.10.4 Role of the service worker

The responsibilities of the service worker include:

- **Managing child safety**

The service worker maintains a focus on child safety at all points of the case including reassessing child safety, developing plans to control threats to child safety, and ensuring safety plan participants understand and fulfill their roles.

- **Engaging the family**

Family engagement is a relationship focused approach that provides structure for decision-making and empowers the family in the decision-making process. Success in the provision of services depends on the quality and durability of relationships among agency workers, service providers, children and families. The service worker is involved in developing strategies to engage the family in case planning and goal achievement and to the extent possible, establishing a partnership with the family to assure child safety and facilitate change. Strategies for engaging families reflect the family's language; cultural background; and balance family-centered, strength-based practice principles with use of protective authority. The worker should:

  - Approach the family from a position of respect and cooperation.

- Engage the family around strengths and utilize those strengths to address concerns for the health, safety, education, and well-being of the child.
- Actively involve the child and family in the case planning process, including establishing goals and objectives in the case plan and the service plan review.
- Engage the child and family in decision-making about the choice of services and the reasons why a particular service might be effective.
- When appropriate and/or necessary, respectfully conclude the relationship when the case is closed or the case plan goals are achieved.

- **Managing permanency planning**

The service worker maintains an overall focus on the importance of safe, stable living arrangements for the child including taking steps to assure that the family and service providers understand the importance of permanence for the child, the timeframe for change and the consequences for lack of progress.

- **Managing the case plan**

The service worker engages the family in decision-making and the treatment process, formulates goals, identifies appropriate services and service providers, monitors service provision to assure it supports the case plan, communicates with all service providers, and evaluates family progress and service plan appropriateness.

- **Managing the court process**

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

- **Managing documentation**

The service worker ensures the case record in the child welfare information system is accurate and current, that all decisions and the basis for those decisions is well

documented, and maintains copies of all court documents and other vital reports in the hard case file.

2.10.5 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.

2.10.5.1 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.

2.10.5.2 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.

2.10.6 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.

2.10.7 Trauma focused treatment services

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.[1]

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.[2]

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).

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1 Excerpted 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 use disorder and Mental Health Services Administration (SAMHSA).

2 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.

- Trauma and Grief Component Therapy for Adolescents (TGC T-A).
- *Multisystemic Therapy (MST).*
- *Functional Family Therapy (FFT).*

Examples of other types of therapy used with trauma include:

- 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.

2.10.8 Evidenced-based programs

Evidenced-based programs refers to the quality of the program being offered. To be called evidence-based, a program has to meet a series of rigorous standards that

show it is effective. Research of the program must illustrate that it actually helps children and families meet their treatment goals.

Evidence-based refer to programs that:

- *Have a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer it.*
- *Have no first-hand basis suggesting risk of harm.*
    - *The risks to participants are reasonable in relation to the potential benefits to participants. The benefits of these services outweigh the possible risks.*
- *Have reliable and valid outcome measures.*
- *Are administered consistently and accurately across all those receiving the practice.*

2.10.9 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.
- Mental health counseling.
- Parent education and training.
- Substance use disorder treatement.
- 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 services that are most effective are those that address the individual needs of the family based on a comprehensive assessment. For a comprehensive list of evidence-based models, see SAMHSA's NREPP.

2.10.9.1 Caretaker services

Suggested services include but are not limited to:

- ***Substance use disorder**: evaluation and treatment; support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).*
- ***Emotional stability**: mental health evaluation and treatment; and/or individual or group counseling.*
- ***Sexual abuse**: individual or group counseling.*
- ***Resource management and basic needs**: concrete assistance with food, clothing, shelter/housing; transportation; and/or budgeting.*

- ***Parenting skills****: parental capacity evaluation; parent education; coaching; and/or parent support group.*
- ***Household relationships/DV****: individual or group counseling; DV Program/Shelter; DV Batterer Intervention; and/or marital counseling.*
- ***Caretaker abuse/neglect history****: individual or group counseling.*
- ***Social or community support system****: support groups; faith based support programs.*
- ***Physical health****: EPSDT; family planning; maternity services; medical services; nutritional counseling; occupational/physical/speech therapy; residential maternity services.*
- ***Communications skills****: individual counseling; coaching; and/or mentoring.*

2.10.9.2 Child services

Suggested services include but are not limited to:

- ***Emotional/behavioral****: mental health evaluation and treatment; and/or individual or group counseling.*
- ***Family relationships****: individual or family counseling.*
- ***Medical/physical****: medical services; nutritional counseling; dental care.*
- ***Child development****: developmental assessment; Part C Early Intervention referral; occupational therapy; and/or speech therapy.*
- ***Cultural/community identity****: community support groups; faith based support programs; and/or after school programs.*
- ***Substance use disorder****: evaluation and treatment; support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).*

- ***Education****: educational services; educational/vocational training; tutoring.*
- ***Peer/adult social relationships****: individual or family counseling.*
- ***Delinquent/CHINS behavior****: individual counseling; legal services; probation services.*

2.10.10 Authority of LDSS

Prevention or *In-Home* services provided to an individual or family are 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 or *In-Home* 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.

2.10.10.1 Family refuses services

The LDSS has no authority to enforce the provision of services when a family, or other individual, refuses to accept those services. When services are refused, the LDSS must consider whether alternative action is necessary. The decision to seek alternative action to compel the acceptance of services should be based on the risk of harm to the child and/or immediate safety factors.

> *(22 VAC 40-705-150 B). Families may decline services offered as a result of family assessment or an investigation. If the family declines services, the case shall be closed unless there is an existing court order or the local department determines that sufficient cause exists due to threat of harm or actual harm to the child to re-determine the case as one that needs to be investigated or brought to the attention of the court. In no instance shall these actions be taken solely because the family declines services.*

If a parent, or any individual, refuses to accept services, the service worker should consult with the county/city attorney to determine if court action is needed. The service worker may petition the court to order the necessary services.

The service worker may also petition the court to require, not only a child's parent(s), but also guardian, legal custodian, other person standing in loco parentis or other family or household member of the child to cooperate in the provision of reasonable services or programs designed to protect the child's life, health, or normal development pursuant to Code of Virginia § 16.1-253.

> *(Code of Virginia § 16.1-253.) A. Upon the motion of any person or upon the court's own motion, the court may issue a preliminary protective order, after a hearing, if necessary to protect a child's life, health, safety or normal development pending the final determination of any matter before the court. The order may require a child's parents, guardian, legal custodian, other person standing in loco parentis or other family or household member of the child to observe reasonable conditions of behavior for a specified length of time. These conditions shall include any one or more of the following:*
>
> *1. To abstain from offensive conduct against the child, a family or household member of the child or any person to whom custody of the child is awarded;*
>
> *2. To cooperate in the provision of reasonable services or programs designed to protect the child's life, health or normal development;*
>
> *3. To allow persons named by the court to come into the child's home at reasonable times designated by the court to visit the child or inspect the fitness of the home and to determine the physical or emotional health of the child;*
>
> *4. To allow visitation with the child by persons entitled thereto, as determined by the court;*
>
> *5. To refrain from acts of commission or omission which tend to endanger the child's life, health or normal development; or*
>
> *6. To refrain from such contact with the child or family or household members of the child, as the court may deem appropriate, including removal of such person from the residence of the child. However, prior to the issuance by the court of an order removing such person from the residence of the child, the petitioner must prove by a preponderance of the evidence that such person's probable future conduct would*

> *constitute a danger to the life or health of such child, and that there are no less drastic alternatives which could reasonably and adequately protect the child's life or health pending a final determination on the petition.*

For more information on Protection Orders, see VDSS Child and Family Services Manual, Chapter C. Child Protective Services, Section 8, Judicial Proceedings.

When services are determined to be necessary to prevent abuse or neglect, but services are refused, both the offering and refusal must be fully documented in the child welfare information system.

2.10.10.2 Court refuses request for assistance

If the court does not issue an order compelling the family to accept services and the parents, other guardian, legal custodian, other person standing in loco parentis or other family or household member of the child continue to refuse critical services, the service worker should consult legal counsel to determine if any other alternatives are available in working with the court. If no other legal recourse is available, the worker should close the In-Home services case and document the reason for closure in the closing case summary in the child welfare information system.

2.11 Service plan review and reassessments

*The service worker must review the service plan with the family **every 90 days** or more often if the safety or risk changes. The purposes of a service plan review are to:*

- *Assess and manage child safety.*
- *Assess objectives to ensure they are helping attain goals.*
- *Assess family progress toward establishing and maintaining a safe environment.*
- *Keep all parties involved with the case plan informed and focused on common goals.*
- *Review performance and appropriateness of services and service providers.*

- *Determine the need to revise the case plan.*
- *Determine whether case closure is appropriate.*
- *Consider challenges and conerns related to permanency and well-being as applicable.*

Changes to the service plan must be based on the family progress toward attaining the goals and specific objectives in the service plan and reduction of risk of future maltreatment. A CFTM should be held when the service plan is reviewed.

2.11.1 Risk reassessment

The first step in reviewing the service plan is to reassess the risk of future maltreatment. The Risk Reassessment Tool informs whether the future likelihood of maltreatment has been reduced, increased, or remained the same following the provision of services or changing circumstances within the family. Reassessing risk in an In-Home services case measures the progress of the family towards meeting the goals and objectives of the service plan. Reassessing risk guides decisions about case closure. The risk reassessment must be completed ***every 90 days*** *until the case is closed. It must be completed before renewing or ending a service plan in the child welfare information system.*

2.11.1.1 Risk reassessment considerations

The service worker must use the Risk Reassessment Tool which is located in the child welfare information system, and on the forms page on the VDSS public website. There are two (2) main sections of the tool. The first section, R1 through R4, captures information that should be previously known and documented by the service worker. The second section, R5 though R9, assesses information obtained during the period since the last Family Risk Assessment done during the investigation or family assessment or the last Risk Reassessment, otherwise known as the period under review. The Risk Reassessment Tool assesses the following:

- *Prior history of child abuse or neglect.*
- *Prior history of child welfare services.*

- *History of caretaker childhood abuse or neglect.*
- *Characteristics of the child.*
- *New reports of abuse or neglect received.*
- *Concerns related to substance use.*
- *Concerns relating to adult relationships/DV.*
- *Providing care to the child consistent to their needs.*
- *Progress with the service plan.*

Each of these is clearly defined in the Risk Assessment Tool. The use of definitions with all SDM tools is critical.

2.11.1.2 Risk reassessment decision

The decision to keep a case open or close a case is based on the following suggestions.

Low Risk	*Close case*
Moderate risk	*Remain open OR close case*
High Risk	*Remain open*
Very High Risk	*Remain open*

The decision to close the In-Home services case must be approved by the service supervisor.

2.11.2 Update the CANS

After the decision is made that the case will remain open, the next step in reviewing the service plan is to update the CANS. Critical needs are likely to change as families engage in achieving the objectives in the service plan. For In-Home services cases

that have been assessed at moderate risk, the CANS should guide the decision regarding case closing. The CANS must be updated in CANVaS ***every 90 days****, in conjunction with the renewal of the service plan.*

2.11.3 Update service plan

After the Risk Reassessment Tool, and CANS reassessment are updated, the service plan must be revised.

If the decision is to close the case, all services must be ended in the service plan in the child welfare information system.

If the decision is to keep the case open, the service plan must be renewed and completed in the child welfare information system. The updated service plan must be shared with the family. The updated service plan should include the signatures of all participating parties and a copy be given to the family.

2.11.4 Update candidacy determination

Candidacy determination, must be updated ***every 90 days*** *or sooner if circumstances change and documented in the child welfare information system.*

2.12 Closing an In-Home services case

2.12.1 Update safety assessment

A new Safety Assessment Tool must be completed any time new safety threats are identified and must be completed prior to closing an In-Home services case. The final safety assessment must be completed ***within 30 days of case closure****. The safety assessment should be safe in order to close a case. The safety assessment must be documented in the In-Home services case in the child welfare information system.*

There may be occasions when the final closing safety assessment is still conditionally safe and a safety plan is developed with the family with the understanding that once the case is closed the plan will no longer be monitored by the LDSS. For more information on the process of assessing child safety throughout the life of an In-Home services case, refer to Section 2.7.6.2: Assessing safety in an In-Home services case.

2.12.2 Update risk reassessment

*A final Risk Reassessment Tool must be completed **within 30 days of case closure**. The risk reassessment should be low or moderate in order to close a case. The risk reassessment must be documented in the In-Home services case in the child welfare information system. There may be occasions when the final closing risk reassessment is still high or very high and justification for case closure must be documented in the child welfare information system.*

2.12.3 Closing the CANS

The CANS should guide the decision regarding case closing or the end of service provision. After the decision is made that the case will close, the CANS must be closed in CANVaS.

2.12.4 Closing notification/summary

The service worker should document a closing case summary in the child welfare information system. This closing case summary details the rationale for closing the case and should include:

- *The reason the case was opened.*
- *The services provided to the child and family.*
- *The results of any assessments completed to include but not limited to: Risk Reassessment, Safety Assessment, CANS, Candidacy Determination, etc.*
- *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 must be informed that the case is closed both orally and in writing. This notification must be documented in the child welfare information system.

2.12.5 Supervisory approval

The case closure must be approved by the service supervisor in the child welfare information system. The service worker and supervisor should discuss the decision to close a case for services, the summation of services in place at closure, child and family adjustment, and overall case progress.

2.13 Transferring an In-Home services case outside the LDSS

2.13.1 Transfer open *In-Home services* case to another LDSS in Virginia

When a family moves, the In-Home services case must be transferred to the LDSS in the locality where the family will reside.

> *22 VAC 40-705-150 H. When an abused or neglected child and persons who are the subject of an open child abuse services case have relocated out of the jurisdiction of the local department, the local department shall notify the child protective services agency in the jurisdiction to which such persons have relocated, whether inside or outside of the Commonwealth of Virginia, and forward to such agency relevant portions of the case records pursuant to § 63.2-1503 G of the Code of Virginia.*

2.13.1.1 LDSS to initiate transfer immediately

The LDSS must contact the receiving agency immediately to notify the agency that the family is moving to that locality and will need In-Home services. This notification should be done verbally.

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

- *Child welfare information system Case Number.*
- *Summary of the sending agency's involvement with the family, including the services currently being provided to the child or family.*

2.13.1.2 All contacts must be current

When transferring an In-Home services case to another LDSS, the sending agency should ensure that all contacts are current. The CANS, Risk

Reassessment Tool, Candidacy Determination and service plan must be current and documented in the child welfare information system. Client demographics such as date of birth, address, and phone numbers should also be updated.

2.13.1.3 LDSS must send entire record to receiving LDSS

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

2.13.1.4 Receiving LDSS must provide services

> *(22 VAC 40-705-150 H). The receiving local department shall arrange necessary protective and rehabilitative services pursuant to § 63.2-1503 G of the Code of Virginia.*

The receiving LDSS must complete or attempt the first contact ***within five (5) business days*** *of assignment. The first contact should be a face-to-face worker visit with the parents, custodians or legal guardians, the children, and the sending LDSS worker (if possible.)*

2.13.2 Transfer open In-Home services case to another state

If a family in an open In-Home services case moves to another state and services are still needed to prevent abuse and neglect, the LDSS must contact the receiving state for information and instructions. A complete listing of contact information for each state can be located on the Child Information Gateway website.

2.13.3 Transfer In-Home services case out of state; child in the custody of an LDSS

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

- *The LDSS must contact the Interstate Compact for the Placement of Children (ICPC) Unit at VDSS for assistance to transfer to another state an In-Home services case with at least one child in the home and at least one (1) child in the custody of an LDSS. (Dual In-Home & Foster Care case type).*

- *The LDSS must contact the ICPC unit at VDSS for assistance to transfer to another state an In-Home services case where there is a Virginia court which has an open child abuse/neglect or dependency case that established court jurisdiction to supervise, remove and/or place the child in another state.*

2.14 Appeals and fair hearings

Dissatisfied families applying for or receiving 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 *In-Home services* case records are to be destroyed in accordance with laws governing public records in the Commonwealth - Library of Virginia's Records Retention and Disposition Schedule. These rules allow for *In-Home services* case records to be destroyed or purged three (3) years from the date the case was closed if an audit has been performed. If no audit has been performed, the record may be destroyed five (5) years from the date the case was closed.

2.16 Appendix A: 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 considerations 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.)

2.17 Appendix B: Questions to raise to assess protective factors as strengths or needs

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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)?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• Does the family know where to go for help?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• 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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
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,SNAP early infant and child services, day care, mental health resources, education resources, after school programs, parent support groups, child development information, etc.) and

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• 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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• What risk factors exist within the community (drugs, violence, teen pregnancy, isolation, etc.) that impact this child's safety, well-being and stability?
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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• 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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• 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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• 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 Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	•

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• 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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	• 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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
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?

Protective Factors	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 use disorder, domestic or family violence, physical or mental health concerns, 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?
	•

2.18 Appendix C: 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.

2.18.1 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.

2.18.2 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 use disorder history.
- Childhood history of care.
- Emotional functioning.
- Attitudes towards and perception of child.
- Discipline of child.
- Level of stress in the parent's life.

2.18.3 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.

2.18.4 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.

2.18.5 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.

2.18.6 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.

2.18.7 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.

2.18.8 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).

2.18.9 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.

2.18.10 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 use disorder, 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.

2.19 Appendix D: Online 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.

2.19.1 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.

2.19.2 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.

2.19.3 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.

Families Forward Virginia: 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.

Champions For Children: Prevent Child Abuse Hampton Roads: A 501 (c) 3 organization that has served the Hampton Roads region since 1983 in the quest to prevent child abuse and neglect. Champions For Children focuses its efforts and resources on public awareness, education, and advocacy for the prevention of all forms of 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.

2.19.4 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.

2.19.5 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.

2.19.6 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.

2.19.7 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 - State Agency Planning & Performance Measures: Shows how Virginia is doing in areas that effect quality of life for people and their families.

2.19.8 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 use disorder 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.

Title IV- E Prevention Services Clearinghouse: Developed in accordance with the Family First Prevention Services Act (FFPSA) as codified in Title IV-E of the Social Security Act, rates programs and services as well-supported, supported, promising, or does not currently meet criteria.

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.

2.19.9 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.

2.19.10 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 use disorder, 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.

2.19.11 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.

2.19.12 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.

2.19.13 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 use disorder 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 use disorder 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 use disorder 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 use disorder 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.

2.19.14 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.

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: 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.

2.19.15 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.

2.19.16 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.

2.19.17 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.

2.19.18 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.

Virginia HEALS: A model of service delivery that that has been developed to assist service providers in better linking systems of care and providing support and care to children, youth, and families impacted by trauma and/or victimization. This model, and the toolkit which supports it, is intended to be adopted and implemented at the community level by child, youth, and family serving organizations and service providers from child welfare, advocacy, education, juvenile justice, behavioral health, and public health.