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EARLY PREVENTION SERVICES TO AT RISK FAMILIES

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EARLY PREVENTION SERVICES WITH AT RISK FAMILIES

4.1 Intended audience for this section

The intent of Section 4, Early Prevention with At Risk Families, is to provide supervisors and social workers involved in early prevention with strategies for engaging families during an initial outreach contact, empowering families in decision-making, maintaining family engagement and partnership after a family has agreed to accept services and supporting self-sufficiency. This section provides the following information:

- Principles of practice for strength based, trauma informed practice and supervision in early prevention;
- Guidelines for early prevention family assessments;
- Early prevention oriented service planning;
- Guidelines for trauma informed case management;
- Tools to use for assessment and outcome measurements;
- Definitions of case types for prevention to increase consistency of the current data; and,
- Guidelines for foster care diversion services.

4.2 Definition of Early Prevention Services to At Risk Families

Early Prevention services are an integral part of the continuum of all child welfare services. These services include, but are not limited to, providing information and services intended to: strengthen families and improve child well-being, minimize harm to children, maximize the abilities of families to protect and care for their own children and prevent abuse, neglect, and the need for out of home care across the continuum of services within local departments of social services.

Early Prevention services are the first step on the prevention continuum (Appendix E in Section 1). They are defined as services provided to families before, or in the absence of, a current, valid child protective services referral. These services include the following:

- Primary Prevention: Public education and awareness activities directed to the general public;

- Secondary Prevention: Services to groups of parents or children who are considered to be at high risk; and, services to families who have no current, valid CPS referral, but may be at risk of maltreatment or out of home care, as well as those who may have been the subject of a CPS referral that was determined to be invalid or families assessed at low risk or moderate through child protective services.

Tertiary Prevention services are those services provided to families after a current, valid child protective services referral through ongoing CPS, foster care and/or adoption. These services prevent the reoccurrence of maltreatment and family disruption in foster care and adoption. They also provide an element of secondary prevention by preventing maltreatment in foster care and adoption. These services are not addressed in Chapter B.

Section 4 of Chapter B is focused on Early Prevention Services to At Risk Families. Guiding principles for Early Prevention to At Risk Families

Early 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 volunteer services are essential to achieving desired outcomes.

Experience shows that individuals and organizations can make a profound and positive difference in the lives of children and families if they embrace a common set of values and believe that people can and do change. General principles for all prevention are identified in Section 1 The following principles guide prevention work with at risk families and should be embraced by all staff that provide direct services, supervision, and administration at the local level.

- All families have strengths.

- 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 and increasing resiliency before problems develop and/or reducing risk factors that may be present.

- Children are best served when services are provided in the context of safe and stable support of their mother, father, extended family and other adults who are connected to the family.

- Family strengthening and child abuse/neglect prevention can have the most dramatic impact in pregnancy and during the first five (5) years of a child's life.

- Outcomes for families improve when a comprehensive, mutual assessment of children and families' strengths and protective and risk factors is conducted with the family. When families are respectfully included in the decision-making process in a timely manner, they are capable of identifying and participating in addressing their needs and making decisions about their children. As a result, outcomes improve.

4.3 Referral sources

Knowing the referral sources most frequently identified in each locality can provide direction for targeting education and information about prevention services and how to identify protective and risk factors at intake in any community based organization/agency. These organizations could also benefit from information about what will and will not happen when an appropriate referral of a family is made for prevention services when there is no current, valid, CPS referral, and how to approach families from strength based perspective, and how to engage them in decision making.

In the 2011 Prevention Survey, LDSS identified all sources of referrals for early prevention services. Noteworthy are the large percentage of self-referrals (80%) and referrals from eligibility staff (83%).

Tables 65 and 66

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

4.4.1 Child well being

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.

The Administration for Children, Youth and Families emphasizes the importance understanding the impact of trauma on children and providing services that address the trauma symptoms as a primary vehicle for ensuring child well-being. ACYF has adapted a framework by Lou, Anthony, Stone, Vu, & Austin (2008). The framework 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.

4.4.2 Family well being

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.

4.5 Engaging the family in voluntary services

Over the last decade, child welfare systems, including Virginia's system, have been making a philosophical shift in practice toward strengths-based, family focused collaborative work with families, and away from the interventionist, expert approach. The Early Prevention Chapter reflects this shift in practice.

Engaging the family begins with the response the family is given when they first contact the agency, and the first contact with the social worker is critical to achieving positive outcomes with families. Family centered intervention is the most effective model for early 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.

Michigan's Child Welfare Practice Model defines family engagement as follows:

"A series of intentional interventions that work together in an integrated way to promote safety, stability, well-being and permanency for children, youth and families. The family actively participates as a partner in solution- and outcome-focused planning that is needs-driven and strengths-based. Interactions are open, honest, transparent, and non-judgmental and relationships are viewed as partnerships."

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

- Stabilize their situation when they are in crisis;
- Determine what their family needs to be strengthened and supported;

- Make well-informed decisions about their child's safety and well-being, what resources they need; and,

- 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; and,

- Being sensitive and responsive to cultural differences

4.5.1 Cultural competence

Cultural competence is essential in a program that works 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 someone's life circumstances and culture, and be open to learning from the family about their cultural and spiritual norms and expectations.

- Explore cultural and spiritual values that impact their views about children, parental and gender roles, education and 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 that some people cannot read even in their first language.

- 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 truly 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 skills in families that will help them solve the next problem or challenge on their own, without assistance from the agency.

4.5.2 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, fathers who are not living with their children full time and/or are incarcerated.

Evidence 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, have higher academic achievement; and,

- Children in single-parent households are twice as likely to experience physical, emotional and educational neglect.

Higher father involvement:

- Promotes healthy child development;
- Creates more informal supports in the family systems;
- Facilitates concurrent planning; and,
- Enhances outcomes re: family involvement evaluated by Child and Family Service Reviews

The following strategies help 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; ask, instead, "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 and understand what it is like to be a man and a father;

*Source: National Fatherhood Initiative's Father Facts

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

4.5.3 Resources for involving fathers

Appendix B has an agency assessment on father-inclusive practices that includes an assessment of organizational philosophy that promotes the importance of father inclusion, an environment that gives the message "fathers are welcome here". This includes implementing policies and procedures that respect fathers, hiring staff who communicate that fathers are important and capable, developing programs and services geared to fathers, and reaching out to fathers in the community. (See Appendix B)

The Nurturing Father's Program is an evidence – based, 13-week training course designed to teach parenting and nurturing skills to men. Each 2 ½ hour class provides skills for healthy family relationships and child development. (See The Nurturing Father's Program)

Identifying and exploring the family's natural support network (those adults who are connected to the family) can be helpful in supporting both the parents and the child. Families may need help in identifying these potential resources which include extended family members (grandparents, aunts, uncles, cousins, etc.), friends of the parents, and parents of good friends of the child, teachers, co-workers, and others. Again, parents may need help in approaching these individuals about assisting the family and establishing positive relationships with individuals who can be a long term support to the family.

The National Fatherhood Initiative has a wide range of resources available.

4.5.4 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 early prevention services.

Research has demonstrated that marriage education can strengthen the relationships of married couples, yielding improved relationship quality and stability (Carroll and Doherty 2003).The Community Healthy Marriage Initiative (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. Two concepts underlie the CHMI strategy. One is that community coalitions can be an effective vehicle for developing a range of healthy marriage and healthy family activities. These can include classes that build marriage skills, partnerships with clergy and others, celebration days, and media messages about the value of marriage and healthy families. The second is that communities with a critical mass of such activities can lead to positive outcomes for families, individuals and couples as a direct result of their participation in classes and other services and indirectly through their interactions with friends, family, and others in the community who were themselves influenced by a local marriage-related activity sponsored by the local coalition.

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 low income neighborhoods;
- 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 (Gibson et al., 2003);
- Utilizing experienced married couple facilitators and mothers and fathers who have been able to develop and maintain healthy, engaged relationships with each other and their children; and,
- Providing assistance to families to help them better understand and manage crisis situations such a loss of job, death in the family, unplanned pregnancy, divorce, etc. and to accept the realities of these life changing experiences in their families.

What children need most is to be with people who will love and take care of them no matter what they do or what they say. Marriage/relationship education can be a vehicle for positive change when both parents put the child first and are invested in having a healthy and satisfying relationship. For more information, see the National Healthy Marriage Resource Center.

4.6 Intake/Short Term Assessment

4.6.1 Intake: Initial contact

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

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

Intake services should provide a timely, coordinated transition for the family to needed services and sufficient information or services to enable a family to utilize personal or community resources. The target population of intake services is anyone seeking services of the local agency. Families who believe they need help to care for their children should be encouraged to contact the agency and should be served to the extent that funds and staff are available.

4.6.2 Consideration of risk factors at intake

Research has indicated that there are certain demographic characteristics that are not predictive of abuse, neglect or the risk of out of home care but do tend to correlate with these risks. Childhood history of abuse or neglect is the most powerful risk factor for abusing or neglecting one's own children (2011 Statewide Evaluation Report to the General Assembly of Healthy Families Virginia.) Other characteristics include the following:

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

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 (Barth et al., 2007; Administration for Children and Families, 2007):

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

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/neglect/out of home care. At intake, however, if the family reveals several of these factors, the family should be referred for services and a short-term assessment should be conducted. For a detailed list of parent, child, family and environmental risk factors, see 4.8.2.1.2 of this section.

4.6.3 Information and referral only

In some cases, a family's needs can be met with information and referral only. Information and Referral is defined as follows:

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

If a family refuses services even when there appears to be a need, the social worker should consider a follow up phone call or sending a follow-up letter with a brochure and additional information about how agency services can help the family.

Until OASIS can change to add I & R as a case type, localities should collect this information locally in order to develop a family history of services provided.

4.6.4 Short-term assessment/crisis intervention

Definition of Short-term Assessment/Crisis Intervention:

- Short-term services (within 45 days) to families to stabilize the crisis and/or
- Brief assessment to determine the families need for services and clarify the support they need. This assessment should be completed within 45 days.
- May be opened to services in OASIS under the current short-term assessment or crisis intervention case type.

Short-term assessment and crisis intervention should be solution focused. It begins with the presentation of a problem or concern either expressed by the family or a referral source. Strength based, family focused assessment requires that, once the problem or concern is clarified and agreed upon by the worker and the family, an assessment of the strengths of the family is conducted. The five protective factors outlined in Section 6.4 provide the framework for assessing family strengths and building competency and self-sufficiency of families. The family and worker's mutual identification of the family's strengths and concrete needs and resources can then be utilized to address the problem or concern.

Before the first meeting:

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

Consistent with the principles of family engagement, the assessment begins with the family telling their story and continues with the worker explaining their role and the services their agency has to offer. Suggested questions for the assessment are provided in Appendix A.

Purpose of short-term assessment/crisis intervention:

- Join with the family and establish a relationship with the family that will set the stage for future, positive interactions;
- Assist the family in managing a current crisis, if one is presented and meeting their basic needs;
- Help them navigate the complicated systems with which they are involved and assist them in accessing resources in their community;
- Empower the family to seek solutions to the problem or concern they present;
- Begin the assessment of strengths and how they will be used to reduce the risks and/or solve the problem presented;
- Help the family identify and prioritize their immediate needs;
- Help the family navigate the complicated systems in which they may be involved, including service delivery systems, courts, mental health, education and others;
- Help the family identify and assess their natural community and family based support networks;
- Identify if any trauma has been experienced by the child or within the family; and,
- Assist the family in determining whether the agency will provide services and/or refer the family to another community resource.

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

If the LDSS opens a case for a Short-term Assessment during this 45 day period, it should be currently coded in OASIS as Short term Assessment or Crisis Intervention. If the decision is made to initiate or continue services and the family makes application for services, the case type should be changed to one of the prevention case types or other appropriate case type. (See Case Types, Section 4.9.2)

4.6.5 Screening for trauma

Current research demonstrates the relationships between trauma, child traumatic stress and the risk of abuse and/or neglect. At intake, if there is any indication that

any of the traumatic events listed below are present, the family should be referred for a comprehensive assessment:

- Sexual abuse or assault;
- Physical abuse or assault;
- Emotional abuse/psychological maltreatment;
- Chronic neglect;
- Serious accident or illness;
- Hospitalization;
- Witness to domestic violence;
- Victim/witness to community violence;
- Victim/witness to school violence;
- Natural or manmade disasters;
- Forced displacement/homelessness;
- War/terrorism/political violence;
- Traumatic grief/separation;
- System induced trauma (removal, change in placements, etc.)

4.6.6 Workers' and parents' role

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

- Helping the family identify the impact of their life experiences on their family; and,
- Recognizing the competencies that family members demonstrate and how to use their strengths to build parental resilience, encourage social connections, provide resources for concrete support, increase parents' knowledge of parenting and the impact of trauma on child development, and to build the social and emotional competence of children through helping families provide a nurturing and structured environment and developing strong and healthy attachments

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

The workers tasks are as follows:

- To demonstrate respect and a sincere interest in partnering with the family;
- To maintain a non-judgmental supportive tone and body language;
- To explain the purpose of the short term assessment and the worker's role, and to explore expectations of the parent or other family members;
- To help the family clarify the problem or challenge that brought them to the agency;
- To reinforce the strengths evident in parenting revealed throughout the assessment and provide behavior specific feedback to parents about what they have done well;
- To educate them about the agency's services and community resources;
- To be transparent about the legal obligations of the agency and what will happen if safety is a concern and how the worker will help them through the process;
- To communicate a sincere and genuine desire for family to succeed;
- To raise questions that help them explore solutions and options to their challenges;
- To listen to cues from the family that indicate if trauma has occurred and how the family has responded (e.g. death in the family and one child who has become aggressive; family is homeless and father depressed; child who has witnessed family violence and is quiet and sullen or fearful, etc.) More information about trauma symptoms is in Section 4.10.2.3.2.
- To find out what they want and expect from the agency and worker;
- To help them identify familial and other supports, community and agency resources that might be available to them; and,
- To gather information to help them and the worker assess together how the family can best be served and by whom.

Parents' initial role in this process is:

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

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

4.6.7 Decisions made at the completion of the short term assessment

- Is this family an appropriate candidate for prevention services?
- What are the family's strengths that they can build on to solve the current problem?
- What type and level of service is needed to increase parental resilience, competency of the parents, and other protective factors?
- What trauma symptoms are present and how can they best be addressed? (See Section 4.10.2.3.2)
- What are the family's most immediate needs?
- Does the agency have the resources to respond to the needs identified?
- Is the parent ready to move forward? Are they open to change and willing to try new behaviors or do something different to change the situation?
- Will a case be opened?
- If not, what resources in the community could serve this person?

4.6.8 Outcomes expected

- The family will leave feeling they have been heard and that their concerns were addressed.
- The family will be able to identify some of the strengths they have successfully used in the past to manage problems.
- Both the worker and the family will have a clear understanding of what will happen next.

- The stage has been set for establishing a positive relationship, empowering the family, building resilience and teaching new skills.

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

4.7 Opening a case

4.7.1 Application for services

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 Act to see public and personal information in the custody of any public agency. FOIA provides procedures for requesting records and responding to those requests. It also provides exceptions to providing certain information to individuals who make requests pursuant to the Code of Virginia.

Both the Code of Virginia and federal law require that information be maintained in the state-approved Child Welfare Information System, OASIS. This includes early prevention cases. Application for Services

Early Prevention services are universal access services.

4.7.2 OASIS case type

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

Until OASIS is changed, workers should use the current case types as defined.

Below are OASIS case types for Early Prevention services provided *prior to* a current, valid CPS referral:

4.7.2.1 Early Prev./Fam Supp: no court

(Currently Prev/Support: Stabilization/Support)

Definition: A birth or adoptive family (after the final order), or other caregiver of a child or a pregnant woman or an incarcerated parent is receiving services to support and strengthen the family under the following conditions:

- No current, valid CPS referral has been received. The family may or may not have had a previous valid CPS referral, and the family is not currently open to services in CPS AND
- Services are being provided to strengthen and support the family circumstance. A child's safety is not currently in jeopardy, although there may be minimal or low risk of abuse/neglect or out of home care AND
- No court order is in place AND
- Family has agreed to services.
- This case type includes courtesy supervision of a child in the custody of another Virginia local agency, monitoring a family with whom the child may be placed after the child was removed from his birth family. This case type should be used only when there is no current valid CPS referral on the family with whom the child was placed.

4.7.2.2 Early Prev/Fam Supp: Court Order

(Currently Prev.Sup: Home Study/Court Order)

Definition: Services to support and strengthen the family under the following conditions:

- No current, valid CPS referral has been received. The family may have a previous valid CPS referral but the family is not currently open to services in CPS AND
- LDSS has received a court order from a Virginia court to provide services or a home study either of a birth parent or a caretaker identified as a potential placement, excluding adoption or foster care home studies. This case type could include a child in need of services disposition, court ordered custody study, mediation, services ordered on behalf of a child committed to the department of corrections, or other services ordered by the court AND
- A child's safety is not currently in jeopardy, although there may be minimal or low risk of abuse/neglect or out of home care.

4.7.2.3 Early Prev/Fam Preserv

(Currently Prevention/support: Prevention of Abuse/Neglect)

Definition: Services to a family under the following conditions:

- No current, valid CPS referral has been received. The family may have a previous valid CPS referral but the family is not open to services in CPS AND
- LDSS has determined that the child may be at risk of abuse/neglect/out of home care and **possible** foster care but not imminent within six months. Services are being provided. Informal short term out of home care may be considered by the family as part of the service plan and supported by the agency but the child's safety is not jeopardized at this point AND
- There is no court order in place AND
- Family has agreed to services.
- This can include supervision or monitoring of a birth family whose child has been returned to them from foster care or from a diversion situation.

4.7.2.4 Early Prev/Int. Fam Preserv: high risk of foster care

(Currently Placement Prevention)

- No current, valid CPS referral has been received. The family may have a previous valid CPS referral but the family is not open to services in CPS AND
- Without intensive prevention services, the child is at risk of entering foster care because the child's safety is jeopardized due to the high risk of abuse or neglect or other critical circumstance that would require a change in caretakers OR
- Without an alternative living arrangement, the child is at risk of entering foster care because the child's safety is jeopardized due to the high risk of abuse or neglect or other critical circumstance AND
- Family has agreed to services.
- This case type meets the criteria for eligibility for reasonable candidacy. Until OASIS is changed, agencies should continue to complete the Reasonable Candidacy Documentation Form

Below are OASIS case types for Prevention services provided to families <u>after</u> receipt of a current, valid CPS referral.

4.7.2.5 Prevention/Low or moderate risk: after CPS

Currently the case type is either CPS ongoing or Prevention/Support: Prevention of abuse/Neglect

<u>Definition: Services to families under the following conditions:</u>

- LDSS has received a current, valid CPS referral AND
- LDSS has conducted a family assessment (LDSS may or may not have also conducted an investigation) AND
- The family has been assessed at low OR MODERATE risk of abuse/neglect but could benefit from voluntary services AND WILL NOT BE RECEIVING ONGOING CPS SERVICES AND
- Family has agreed to services.

Foster Care Diversion provided through ongoing CPS services should be captured using the Ongoing CPS Services Case Type. Foster care diversion in CPS is defined as follows:

- A current, valid CPS referral has been received on the family AND
- Family is or has received an investigation, family assessment or other ongoing CPS service AND
- Without an alternative living arrangement, the child is at risk of entering foster care because the child's safety is jeopardized due to the high risk of abuse or neglect or other critical circumstance. In this instance, these children are a target service population in need of foster care prevention services and eligible for funding (§ 2.2-5211 B and § 63.2-900.) AND
- Family either is pursuing an alternative living arrangement for their child or is requesting assistance from the agency in doing so.
- This case type meets the criteria for eligibility for reasonable candidacy. Until OASIS is changed, agencies should continue to complete the Reasonable Candidacy Documentation Form.

4.8 Comprehensive assessment of the family's needs

Once the family and the agency have made the decision to open a case, the next step is to conduct a Comprehensive Family Assessment with the family. This decision could be made at any time and begin once the short term assessment is initiated. This assessment provides the foundation for continued engagement with the family, service planning, and delivery and is more comprehensive and in-depth than the Short Term Assessment.

Protective Factors should be considered in all aspects of work with families at each point in child welfare, including Early Prevention. Strength based, family focused assessments can help caseworkers and families identify the Protective Factors that reduce risks that are evident or solve the problem that is presented. Practice models and tools should be structured around both mitigating Risk Factors and finding and bolstering Protective Factors.

4.8.1 Step 1: Engaging the family in the process

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

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

As information surfaces that the worker is concerned about, transparency is critical. The worker should share the concerns immediately with the family to explore whether or not the worker's perception is accurate, to find out the family's perception of the information, and, if the worker still has concerns, to figure out, with the family, how the concerns can be addressed.

4.8.2 Step 2: Conducting the comprehensive family assessment

Below are the components of a comprehensive family assessment.

4.8.2.1 Protective and risk factors as the framework for assessment

Using the protective factors framework in working with families can more effectively strengthen families and sustain the practice approaches such as those suggested in this chapter. Protective Factors can be thought of as "family characteristics" that are framed in a positive manner. These characteristics (factors) have been identified as those needed by families to provide a buffer against abuse and neglect. The degree to which Protective Factors are present or absent is determined by an assessment

of the family. Protective factors that are present in a family represent strengths that can be utilized by the family to help them overcome 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.

These identified needs should be used in conjunction with the Risk Factors (defined below) and Protective Factor strengths when creating an assessment and service plan. Integrating these protective factors into agency 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 agency by training workers to recognize risk factors during an interview and know the resources to which families can be referred for services, within the agency and/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. Online Training Course

4.8.2.1.1 Protective Factors

Parental Resilience

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

Specific examples of parental resilience 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;
- Maintain a positive attitude; and,

- Listen to each other.

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. Examples 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;
- Parents who spend time with friends who are supportive; and,
- Neighbors who help each other with food, hand me down clothing, etc.

Concrete Support in Times of Need

Providing concrete/tangible 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. Specific examples include the following:

- Knowledge of community resources and available supports where to go for help;
- Adequate and stable housing;
- Access to health care and social services;

- Parental employment and financial solvency;
- Opportunities for education and employment and,
- 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

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 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 development age;
- Parent engages in positive interactions with child;
- Parent uses praise; and,
- Parent disciplines their child in a safe way and consistent supervision.

Social and Emotional Competence of Children

Behavior and expression of emotion vary widely based on a child's developmental stage and temperament. Helping children become more capable of handling life's challenges as they grow is critical for their social, emotional and intellectual development. Challenging behaviors or delayed development creates extra stress for families, so early identification and assistance is necessary for both. Specific examples of social and emotional competence of children included the following:

- Ability to communicate clearly;
- Ability to recognize and regulate their emotions;

- Ability to establish and maintain relationships with both peers and adults; and,
- 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;
- Demonstrate empathy towards the child and understand and 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 our parent when upset;
- Nurtures the child and is affectionate;
- Positive, strong, stable and caring parent child relationships; and,
- Open communication.

All of these have a positive impact on their relationships with their family, other adults, and peers.

4.8.2.1.2 Risk factors

Research has indicated that there are certain demographic characteristics that are not predictive of abuse, neglect or the risk of out of home care but do tend to correlate with these risks. Childhood history of abuse or neglect is the most powerful risk factor for abusing or neglecting one's own children (2011 Statewide Evaluation Report to the General Assembly of Healthy

Families Virginia.) Other parent, family, child and environmental risk factors include the following:

Parent related

- Parental history of child abuse/neglect in family of origin;
- Parental history of receiving domestic violence services and/or involvement of the police due to domestic violence;
- Self-reported incident or exposure to domestic violence;
- Parent substance abuse or history of substance abuse;
- History of child abuse/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 domestic violence is present;
- Single parents;

- Nonbiological, transient caregivers in the home; and,
- Language barriers.

Child related

- Child younger than 4 years of age;
- Child exposure to domestic violence;
- Child's behavior and temperament;
- Child with disabilities or other special needs that may increase caregiver burden; and,
- 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, no phone;
- Marital or family problems;
- Single-parent family; and,
- 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-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; and,

- Community disorganization/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/neglect/out of home care.

4.8.2.2 Questions to raise to assess protective factors as strengths and/or needs

The questions below are generic questions to explore information with the family to achieve the following outcomes:

- To help the worker and the family assess each protective factor;

- To determine which protective factors are strengths and which protective factors are needs that may need to be strengthened to increase the child's and family's safety and stability; and

- To identify how the strengths that are present can reduce the concerns and meet the needs.

The questions are based on the protective and risk factors survey with additions from other models and approaches used by social workers across the state. They are neither negative nor positive, but are intended to be neutral.

4.8.2.2.1 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 are they able to stay in control when problems arise or child misbehaves? What are the pervasive feelings of the parents (contented, happy, depressed, angry, hopeful, etc.)? What are the parents' views of themselves as parents (their feelings of competence in parenting roles.)? What is the relationship between the child's parents? What, if any, problems within the relationship impact child safety, well-being and stability? What if, any special needs do the parents have that impact safety, stability or well-being (substance abuse, family violence, physical and/or mental health

issues, language barriers, managing their own behavior, history of psychiatric care)? To what extent have the parents been able to identify problems, solve them, connect with resources and learn from their experiences? What other caregivers are in the home, how and what parental role do they play? What other strengths do they bring to parenting?

- Social connections: Who has provided support to the family in the past or is available to provide emotional support and concrete assistance to parents in times of need or crisis (friends, family members and other members of the community)? Does the family know where to go for help?

- Knowledge of parenting and child development: What information does the family know and demonstrate about raising young children and how they develop? To what extent are their expectations realistic of their child? How able are they to identify their child's physical and emotional needs? What did they learn from their parents that they want to repeat? That they want to do differently? When does the parent use praise with the child for compliance and success? What techniques do the parents use to discipline their children?

- Concrete support in times of need: How is the family able to maintain financial security to cover day-to-day expenses and unexpected costs that come up from time to time? What access to formal supports (TANF, early infant and child services, day care, mental health resources, education resources, after school programs, parent support groups, child development information, etc.) and informal support from social networks does the family have? Does the family have adequate and stable housing and child care? Do they have access to health care and social services? Are they aware of the local resources they can utilize? What opportunities are there for education and employment? What access to services does the family have, including transportation? What risk factors exist within the community (drugs, violence, teen pregnancy, isolation, etc.) that impact this child's safety, well-being and stability?

- Child and Parents' relationship: What is the parents' view of this child? What words do they use to describe the child? What is the relationship between the child and parents? Do the parents enjoy being with the child? How do parents soothe the child when the child is upset? How much time do they spend with the child in play? To what extent are both parents involved? What roles do they each play? What barriers exist to involving the absent or other parent? How have they managed those barriers? What behaviors challenge the parents the most and how do they manage those behaviors? How does the parent express empathy towards the child and is attuned to the child's needs? 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 and/or pull together in times of stress?

- Children's social and emotional development: What prenatal care was provided to the child? What is the child's ability to interact positively with others and communicate his or her emotions effectively? What is the child's social and emotional competence? What is the child's ability to protect themselves should the need arise? To what extent does the child express pleasure in being with the parents? How resilient is the child? What is the child's temperament? What provocative behaviors does the child exhibit? What other special needs does the child have that may increase caregiver burden?

- Past history of success: What are the things that happen in your family that cause you to feel like you are a good parent? How have you been able to solve problems in the past? In spite of the problem or concerns you now have, what is currently working well or good enough?

- Spiritual/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?

Beyond protective factors, other strengths that ameliorate the concerns and support family stability, well-being and safety or risks should be explored.

4.8.2.3 Preliminary assessment of trauma

For purposes of this chapter, assessing for trauma refers to a brief, focused inquiry to determine whether an individual has experienced specific traumatic events and what symptoms of that trauma may be present. It is distinct from a comprehensive clinical trauma based assessment which is usually completed by a mental health professional and explores, in-depth, the nature, severity and intensity of the traumatic events, and symptoms of child traumatic stress and includes recommendations for treatment.

The outcome of this initial assessment is to determine how the present trauma symptoms can be addressed within the family and if a comprehensive clinical trauma based assessment needs to occur. A comprehensive resource for trauma screening and initial assessment is the Child Welfare Trauma Referral Tool which can be found in the Child Welfare Trauma Training Toolkit (2008).

4.8.2.3.1 Types of trauma

There are three broad types of trauma: (1) Acute trauma refers to ; (2) Chronic trauma refers to multiple and/or chronic events, such as neglect; and, (3) Complex trauma refers to multiple, chronic and prolonged, developmentally adverse events which most frequently involve the child's caregiver. Most of the children seen in 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; and,
- 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. and impact 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

4.8.2.3.2 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 feelings towards others than prior to the trauma, problems sleeping and or with eating, difficulty concentrating, outbursts of anger, etc.;
- Attachment challenges-getting close to caregivers and others or inappropriate boundaries with others, lack of eye contact, etc.;
- Child presents as fearful, anxious, depressed;
- Child has difficulty regulating emotions-gravitates towards extremes of emotion an/or difficulties expressing feelings;
- Child has physical complaints with no apparent physical basis; and,
- Child has feelings of detachment, numbness or spaced out;
- Avoiding places or people associated with the trauma;
- Child is hypervigilent, has difficulties concentrating, difficulties with sleeping, irritability and anger outbursts;
- Child is anxious, clingy, over-compliant and/or depressed; and,
- Child engages in provocative or high risk behaviors such as oppositional behaviors, substance abuse, self-harm or suicide attempts.

Conclude the trauma screening with a discussion of its implications for service planning and help the parents begin to connect trauma concerns with the any other problems and change goals that have been identified by the family.

If any of the trauma related symptoms surface during the worker's assessment, the child and/or family should be referred for a comprehensive clinical trauma based assessment. For questions to raise to assess the

appropriateness or fit of a mental health provider for a family, see Appendix C: Questions to ask mental health providers

4.8.3 Step 3: Analyzing the information gathered

Throughout the assessment process, as the information is being gathered, the worker's role is to explore with the family how the information impacts the child's safety and stability. There is a great deal of information that may have no impact in these areas. Some information may reveal strengths in each family member that have been used or are underutilized to solve problems and reduce risks. Some information may raise additional concerns.

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

4.8.3.1 Mutual agreement on the issues or concerns

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

4.8.3.2 Prioritizing the issues

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

4.8.3.3 Managing concerns the worker identifies

If there are concerns that the family does not identify as needs, the worker should talk with the family respectfully and honestly to help them see possible consequences of not addressing the concern.

4.8.3.3.1 Transparency

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

- Clarifying the family's and worker's role in a mutual assessment process and the purpose of gathering information;
- Letting the family know why the worker is asking questions;
- Being open to challenge;
- Listening for the meaning the family assigns the information rather than making assumptions about the information;
- Being honest and open in sharing information and raising concerns; and,
- Assuming the best.

4.8.3.3.2 Exploring needs

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

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

If the family does not raise concerns that the worker perceives, ask if they had thought about whatever is concerning the worker, what they think about the situation raised by the worker, and how critical they feel this concern is. Unless the concern is safety related, the starting point should be the family's concerns.

4.8.3.3.3 Assessing the family's perception of the problem and willingness to change

It is helpful for both family members and the worker to have a starting point in terms of the family's perception of the seriousness of the problem and their willingness to do something different to meet the need. Likert scales are describes as a method of ascribing quantitative value to qualitative data.

These types of scales can be helpful to clarify the families perception of the problem and can provide a baseline a for pre and post service measure of

change. Appendix D presents a set of Likert scales that can be used with families to prior to and after service implementation.

4.9 Tools and strategies that could be utilized in the assessment process

It is important to understand that any tool is just an instrument to facilitate the family and the worker's understanding of their circumstances. No tool should be used without an in depth discussion and clarity when it is needed.

4.9.1 Genograms

Genograms diagram family heritage, relationships, changes in relationships and family dynamics (births, adoption, foster care placement, deaths, marriages, divorces, etc.), traumatic events and child movement. Through the discussion it generates and the questions raised the genogram goes beyond a family tree to assist the worker and the family in exploring relationships, identifying supports and figuring out how those relationships impact safety and stability in the family. They can be completed on flip charts, on paper or electronically. There are several genogram software applications available on line.

4.9.2 Eco-maps

An eco-map is a tool for identifying the family members' current relationships with both people and systems and for mapping out the strength of those relationships and the level of stress created by those relationships. It is a graphical representation that shows all of the systems at play in an individual's or family's life. It is built on the concept of systems theory which links the family to their social environment. It can be particularly helpful in prevention work to identify possible family supports, and to assist families in managing stressful relationships and negotiating systems. The eco-map can be completed on flip charts, on paper or electronically. There are several eco-map software applications available on line and samples to review.

4.9.3 Family Partnership Meetings (FPM)

A Family Partnership Meeting (FPM) is a team approach for partnering with family members and others in decision making throughout the family's involvement with the child welfare system. FPM could be a helpful mechanism to assist the family in making the many decisions they need to make in Early Prevention, including the consideration of a diversion family, determining whether or not a diversion family needs to be a permanent option for a child and, if so, what supports need to be in place, the roles and responsibilities of each family, etc.

Current Family Engagement Guidelines require an FPM when a child is at risk of foster care or out of home care. Families at risk of either could be served through Early Prevention and would be part of the mandated population to convene a FPM.

FPMs can also be helpful at the short term assessment/crisis intervention stage to bring together potential community resources, extended family members that do or could provide support and other community members that the family could utilize to either stabilize the crisis or support the family

4.9.4 Child and Adolescent Needs and Strengths (CANS) Assessment

The CANS is a tool developed by John S. Lyons, Ph.D. to assist in the management and planning of services to children and adolescents and their families. The CANS is a standardized assessment instrument that incorporates a quantitative rating system within an individualized assessment process. It provides a structured assessment of children's strengths and needs that can be used for service planning and decision making. The CANS became the mandatory uniform assessment instrument required for children and youth served through the Comprehensive Services Act in July, 2009. All children and youth receiving CSA funded services must have a CANS administered on at least an annual basis.

The Virginia CANS is composed of six domains;

- Life Functioning (measures dimensions such as Family, Living Situation, Sleep, Legal, Independent living, etc.)-may reflect needs or strengths
- Child Strengths (dimensions such as Optimism, Family, Interpersonal, Talents/Interests, Spiritual/Religious, Child Involvement in Care, etc.)
- School (School Behavior, Attendance and Achievement-may reflect needs or strengths)
- Planned Permanent Caregiver Strengths and Needs (dimensions such as Supervision, Involvement with Care, Knowledge of the Child, Organization, Social Resources, Residential Stability, Substance Abuse, Employment, Transportation, Safety, etc.)
- Child Behavioral/Emotional Needs (dimensions such as Psychosis, Impulsivity/Hyperactivity, Oppositional, Adjustment to Trauma, Anger Control, Substance use, etc.)
- Child Risk Behaviors (dimensions such as Suicide Risk, Self-Mutilation, Sexual Aggression, Runaway, Delinquent Behavior, Fire Setting, Sexually Reactive Behavior, Bullying, etc.)

There is also a Trauma dimension that can be used. The majority of items on the CANS are rated for the past thirty days in an effort to keep the assessment focused on current needs and strengths, although some historical data is noted.

The CSA website offers online training and certification in the use of CANS at no cost to localities Confidential data collected from the assessment is entered into the online CANVaS database accessed on the same website.

4.10 Valid and reliable instruments

Below are some instruments often used with families receiving prevention services. The list is not intended to be all inclusive but will provide links to potentially helpful resources.

4.10.1 Protective Factors Survey

The Protective Factors Survey (PFS) was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention (www.friendsnrc.org) in partnership with the University of Kansas Institute for Educational Research & Public Service Center through funding provided by the US Department of Health and Human Services. The PFS is designed for use with caregivers receiving child abuse prevention services. The instrument measures protective factors in five areas: family functioning/resiliency, social emotional support, concrete support, nurturing and attachment, and knowledge of parenting/child development. Workers can administer the survey before, during, or after services.

The primary purpose of the Protective Factors Survey 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; and,

• Areas where 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.

4.10.2 Kempe Family Stress Checklist

This checklist 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. See Family Stress Checklist under Social Connections To complete an assessment using this 10 item checklist, a family assessment worker would meet face to face with the family, either prenatally or within two weeks of the birth of their baby. The ten items collect information about the following:

- Childhood;

- Substance abuse, mental health, history of arrests;
- Previous or current CPS involvement;
- Self-esteem, available support, depression, coping skills;
- Stressors;
- Potential for violence;
- Expectations of baby's behavior;
- Discipline of children;
- How parent describe their baby; and,
- Bonding/attachment.

4.10.3 Adult Adolescent Parenting Inventory (AAPI-2)

The AAPI-2 is an inventory designed to assess the parenting and child rearing attitudes of adolescents (ages 13-19) 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 specific parenting and child rearing behaviors:

Construct A Inappropriate Expectations of Children

Construct B Parental Lack of Empathy towards Children's Needs

Construct C Strong Parental Belief in the Use of Corporal Punishment

Construct D Reversing Parent-Child Family Roles

Construct E Oppressing Children's Power and Independence

4.10.4 A Measure of Family Well Being

The University of Georgia College of 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 My Family's Well-Being" which parents compete. They rate a range of items that reflect their perception of well-being both before and after receiving services.

4.10.5 Social Skills Rating System

The Social Skills Rating system (SSRS) is used to assess children who have problems with behavior and interpersonal skills. It is backed by research and was standardized on a national sample of over 4,000 children. It assists in identifying the underlying causes of behaviors that can interfere with the development of positive social skills such as shyness, trouble initiating conversation and difficulty making friends. It is also a tool for identifying the behaviors that need to be addressed in intervention. The SSRS measures cooperation, empathy, assertion, self-control and responsibility. It provides separate norms for boy and girls ages 3-18 and for elementary students with and without disabilities.

4.10.6 Nurturing Parenting Programs®

The Nurturing Parenting Programs are evidenced based programs that have proven effectiveness in treating and preventing the recurrence of child abuse and neglect. The Programs are designed to be family based with a highly structured series of sequenced lessons. To maximize the potential in achieving the results of years of research with the Nurturing Program, fidelity to the program content, sequence of lessons, program length and manner of implementation should be followed rigorously. The Nurturing Programs work best with families identified as abusive and/or neglecting.

- The strength of the Nurturing Programs is that skills and competencies are taught to all families in a predetermined sequenced manner. The Nurturing Programs are recognized for their effectiveness in preventing the recurrence of child abuse and neglect.

The Nurturing Skills Parenting Programs allow professionals the flexibility of meeting the assessed parenting needs of families while maintaining the fidelity of the philosophy and model of the Nurturing Parenting Program. Lessons are presented in the Lesson Guide for Parents and in the Lesson Guide for Children. The goal underlying Nurturing Skills Programs is to tailor specific parenting programs designed to meet the needs of individual families. Parents and the Parent Educators work together in creating the programs.

4.10.7 North Carolina Family Assessment Scale (NCFAS)

The NCFASN (DSS-5229-ia) 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.

4.10.8 Trauma Screening Referral Tool

This measure is designed to help child welfare 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 child welfare 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).

4.10.9 Child Welfare Trauma Toolkit

The 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 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 National Child Traumatic Stress Network, 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)

4.11 Service planning

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

- Active involvement of the family helps family members think through the best course of action to achieve the goals they've selected and the steps to be taken to achieve the goals;
- There is increased likelihood that the services, activities and objectives will be successfully completed;
- Service plans and decisions will be more individualized and relevant to the family;
- The likelihood of implementation and of creating more opportunity for lasting change is greater; and,

- When family members and other individuals who have significant relationships with the child and family are able to provide resources and support for the family and are included in the service plan, sustaining change over the long-term is more likely to occur and resources for temporary out of home care if/when it is needed are identified.

4.11.1 Stages of change

Change occurs in stages on a continuum:

- Stage 1: Resistance-the parent or child may initially be unwilling to do anything differently and may see the problem behavior as having more advantages than disadvantages;

- Stage 2: Reexamination-the parent or child begins to see the problem differently and seeks to understand their role in resolving it;

- Stage 3: Preparation-the parent or child is ready to take steps to make the change happen and is primed for suggestions and ready for coaching;

- Stage 4: Action-the parent or child begins to make the changes and is open to feedback from the coaching experience;

- Stage 5: Backsliding-the parent or child may struggle from time to time with the new behavior and revert to old behaviors; and,

- Stage 6-Sustained change-the parent or child has been able to sustain the change and views the problem as resolved

Throughout the change process, the worker's role of consultant/coach is critical to achievement of the family's outcomes. Backsliding once behaviors have begun to change is normal and shouldn't be viewed as a failure but as an opportunity to discuss what's getting in the way of change and exploring ways to remove the stumbling blocks.

An important part of the planning process is taking a look at the objectives and expectations and talking with the family about how the change will occur and when there will be opportunities to practice the change. To the extent possible, each contact with the family after a plan is in place should explore what's been successful and what the challenges still are. The 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 reach goals.

4.11.2 Components of an effective service plan

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

Below are the components of an effective service plan:

4.11.2.1 Clear statement of needs

The needs identified should reflect the protective factors assessed that surfaced as needs, other needs the family and worker identified and the identification of any risk factors and/or trauma related needs.

A need is behavior driven and is distinct from the service to be provided. Examples of needs related to protective factors might include the following:

- Parents need to increase their knowledge about how children develop at each stage in their lives and adjust their expectations based on this knowledge;
- Parents need to recover from the difficult experiences they have had and develop a problem solving style that can be used when other problems surface;
- Parent and child need to develop a closer relationship;
- Parents need to increase their empathy and understanding of their children's needs and behaviors;
- Child's trauma symptoms need to be addressed and reduced;
- Family needs to be connected to services and individuals that can provide ongoing support to them;
- Family needs housing and income;
- Parents need to help the child manage his or her emotions so that their feelings don't get in the way of their behavior as much.

4.11.2.2 Identification of the change goals

A goal is a broad statement of the overall purpose of involvement with the family-the qualitative results from activities and services. *What difference will*

the service make for the child, family or community? The goals should be related to child well being, family well being, safety, or permanency. They should be limited to one or two which reflect the priorities that the family and the worker have agreed on and may be related to protective factors that need to be strengthened.

Example: Parents will increase their knowledge of child development and learn safe ways to manage their children's behavior

4.11.2.3 Clear objectives

Objectives are measurable outcomes that reflect the change in the lives of individuals and families as a result of receiving services. Each objective should be stated in language that the parent can understand and be as behavior specific as possible. Being behavior specific will also facilitate identifying the best resource for a particular service that will most likely meet the family's need. The Initial Service Plan should keep the objectives to a minimum-no more than 3 are recommended. All objectives should be realistic, manageable, attainable and prioritized based on the family's assessment of the most critical need for change.

Family members will have more motivation to make changes if they, themselves, have identified the changes needed. The worker's job is to lead the way through raising questions to guide their response. It's important in this process to acknowledge how hard it is to make changes and to offer support for the change. Once the goals have been identified and prioritized, the next question to the family is:

- What will it look like when this problem is solved?

The worker's role is to help the family be as specific as possible. Follow up questions could include the following:

- How will it feel to you, your spouse or partner, the child, others in the house?

- What will you each be doing differently when this problem is solved?

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

4.11.2.4 Strengths used to achieve goals

It is important to both acknowledge and identify the strengths families bring that will contribute to achieving goals and objectives and acknowledge those in the

context of the discussion of the service plan. This should include the protective factors and other strengths identified in the assessment process.

Example: Parent learns from reading and doing. Parent enjoys spending time with their children when not correcting behavior.

4.11.2.5 Barriers to achieving goals and objectives

The barriers to achieving the goals and objectives should be identified and ways to minimize those barriers should be listed. (e.g., transportation, no services that match the families' need, worker's time, financial resources, etc.)

Example: No parenting class available that teaches what the parent needs to know or gives them an opportunity to practice what they learn.

4.11.2.6 Steps to achieve desired outcomes

The plan should identify clearly the specific incremental activities that will be undertaken to achieve the goals. Tasks should include the following:

- What each person involved will do, step by step, and by when;
- The behaviors that need to be strengthened and supported;
- The strategies that extended family, the social worker and others will use to support the goals;
- How the barriers will be minimized;
- The plan for ongoing review of the plan to determine if it's working and, if not, what needs to change, including the frequency of contacts; and,
- How the family will know they are succeeding-What will it look like if the goals and objectives have been met?

Example: Worker and parent will develop a plan to provide parent with knowledge needed by [date]. Parents will read the info provided and meet with worker to talk about the child's development, ask questions and figure out whether each child is on target, ahead or behind developmentally by [date]. . Parent and worker will identify expectations for children's behaviors that reflect their level of development [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]. Volunteer will meet with the parent to discuss progress, barriers that arose and any changes needed by [date].

4.11.3 Funding the service plan

Agencies use a range of funding sources to help meet family's needs. A vital part of service planning is exploring with the family the plan for funding the services. Public assistance funds, CSA funding for prevention, PSSF funds and SSBG funds, government and foundation grants and local businesses are all possible funding sources, along with IVE funding for administrative costs generated by reasonable candidacy random moment sampling results. Appendix H of Section 1 identifies a range of funding sources utilized by local departments.

4.12 Service delivery

As described in Section 1 an increasing body of evidence indicates maltreatment can alter brain functioning and consequently affect mental, emotional, and behavioral development. When social workers provide early prevention services, they have a unique opportunity to identify potential concerns and help families receive the support they need to reduce any long-term effects. This should occur in the context of Trauma Informed Practice. See Appendix C of Section 1

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

4.12.2 Definition of strength based practice

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

4.12.3 Role of the worker

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

- Initial intake;
- Information and referral:
- Assessment;
- Case management;
- Supporting, but not leading, the case management function, if another organization is providing that leadership;
- Crisis intervention;
- Advocacy, both internally and externally on behalf of the family;
- Foster care diversion; and/or,
- Clinical work with the family

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

4.12.4 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 caseworkers and providers to be more proactive, knowing what to look for and anticipating the services that may be needed. This capacity is necessary at the caseworker-level, but also at the level of administrators who are making decisions about the array of services needed internally or through contracts. It is critical to preventing the chronic and severe problems that can result from the trauma children and their families have experienced and to ensuring child well being and permanency.

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 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; and,
- Periodically reviewing the service plan to evaluate progress with the family and explore the barriers to progress.

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; and,
- Manage professional and personal stress.

There are several additional areas that case managers can address in the context of effective, trauma informed case management. The material below was adapted from information provided on the Child Welfare Information Gateway.

1. Provide prenatal development and post natal parent support

Efforts to support optimal brain development should start as early as pregnancy, when mother and child form their first attachments. Because babies begin to develop all five senses before birth, even experiences in the womb can affect their development (Klein, Gilkerson, & Davis, 2008). Case managers can help parents focus on their child's development before birth by teaching the mother to be aware of baby's movements and to embrace a positive lifestyle by avoiding alcohol, drugs, or cigarettes, eating nutritious meals, and practicing good hygiene. After birth, it is equally important for parents to continue to receive help as needed. Linking families to services such as Healthy Families, other home visiting programs, Early Head Start programs designed for at-risk expectant families, and parent education programs can help strengthen families early, promote healthy brain development and reduce the risk of problems. Prevention Programs-Child Welfare Information Gateway

Any program to which the family is referred should have staff knowledgeable about the impact of trauma on children and families and the symptoms that indicate ongoing problems and should include services designed to reduce trauma symptoms (See Appendix C: Questions to Ask Mental Health Providers). Provider programs and services should also enhance all of the protective factors: nurturing and attachment, knowledge of parenting and of child and youth development, parental resilience, social connections, concrete supports for parents and social and emotional competence of children

Parents can also support their baby's brain development by understanding and practicing the strategies to promote healthy brain development described below.

2. Provide support and guidance to the child's parents and caregivers

Children experience their world in the context of family relationships. Parents, kin, and other caregivers are the full-time and long-term supports for their children, and they will typically be involved in the child's life longer than will the child welfare or mental health professional. In many cases, the family system is experiencing traumatic stress along with the child. Promoting resilience and improving coping skills among family members helps them deal with traumatic events and also prepares them for future challenges.

3. Support and promote positive and stable relationships in the life of the child

Children form and maintain relationships to important figures in their lives through bonding and attachment, particularly the parent or caregiver. Child welfare workers

can play a major role in encouraging and promoting both the parent child relationship and other positive relationships in a child's life. They can also minimize the extent to which these relationships are disrupted by constant changes in placement. Promoting these positive relationships is a well-respected child welfare best practice and is also critical to a child's sense of safety and well-being, particularly during a stressful time.

As case managers are talking with parents they can help the parent or caregiver recognize cues when the child wants to eat, sleep, play, or engage in other activities. Over time, the caregiver's awareness of and response to the child's needs will lead to easier interactions between the two and, ultimately, a stronger relationship.

Whether a child is at home or is living with a relative caregiver, focusing on ensuring the child has a secure relationship with at least one important person in his or her life is one of most helpful prevention strategies a case manager can use. The connections babies and young children form with their caregivers and the experiences they share are essential to promoting healthy brain development. Essential to early prevention is preparing caregivers to support child development and provide appropriate learning opportunities by teaching the stages of child development and the timeline for milestones they can expect their children to achieve.

4. Help families establish nurturing routines

The predictability of a daily routine helps children understand the world is a safe place where they can learn and grow without fear. This structure helps to establish and maintain an attachment between the child and caregiver. Case managers can help caregivers understand the importance of routines and create a plan that meets the child's needs.

Children need to feel that their caregiver is in charge. Children in stressful or unpredictable circumstances need help in transitions, including changes in the routine and they need age-appropriate opportunities to make decisions about daily activities. Routines can also help the caregiver establish clear and logical limits for inappropriate behavior and develop disciplinary strategies that take the child's past experiences into consideration.

5. Support teenage brain development

Trauma and its effects are not limited to young children. Although the first few years of life are critical to supporting brain development, it is important to remember that the brain continues to grow into young adulthood. Right before puberty, the adolescent brain experiences a growth spurt in the areas that affect planning, reasoning, impulse control, and emotions.

Children who are experiencing stress or who have experienced trauma often have difficulty in these areas. Case managers can help caregivers and other important adults in a teen's life understand how the teenage brain develops and equip them with strategies to optimize that development. Teens benefit from quality time with their caregivers and adult mentors who help them:

- Organize tasks and set priorities;
- Practice making decisions;
- Master new skills;
- Seek healthy adventures and take positive risks;
- Minimize stress; and,
- Adopt healthy lifestyles and allow time for plenty of sleep.

6. Utilize a comprehensive, multi-dimensional assessment of families' needs

A thorough assessment identifies how trauma is impacting children and potential risk behaviors and can help determine interventions that will ultimately reduce risk. Assessment also tells us why a child may be reacting in a particular way and the behavior's connection to his/her experiences of trauma. A multi-dimensional assessment includes, at a minimum, the following:

- An extensive history of life experiences and traumatic events before, during and after involvement with child welfare;
- The neurological, sensory impact of trauma on children;
- Children's adaptive behavior and coping styles;
- The match or mismatch in temperament of children and parents;
- Parents' history of trauma; and,
- Parent child interaction.

A thorough assessment provides input for the development of goals with measurable objectives designed to reduce the negative effects of trauma.

7. Address the effects of trauma

Traumatic events can affect many aspects of the child's life beyond the initial trauma response and may create new or secondary problems. These effects may be adaptive in the short-term but can, in the long-term, become counterproductive and

interfere with a child's sense of safety and well being. These effects can include difficulties in school and relationships or health-related problems (e.g., weight gain and substance abuse. Other consequences of trauma—or secondary adversities—can also include changes in the family system precipitated by a traumatic event. It may be important to address these issues along with, or before, trauma focused treatment.

Focusing child welfare on improving social and emotional well-being requires careful consideration of how services are structured and delivered throughout the system. For example, a child welfare system with a focus on social and emotional well-being might be characterized by the following:

- Assessment tools used with children receiving child welfare services are reviewed to ensure that they are valid, reliable, and sensitive enough to distinguish trauma and mental health symptoms;
- Children are screened for trauma when their cases are opened;
- In-home caregivers receive services that have been demonstrated to improve parenting capacities and children's social-emotional functioning;
- Child welfare staff, respite providers, diversion families and other caregivers receive ongoing training on issues related to trauma and mental health challenges that are common among the children and youth being served by the system; and,
- Assessments take place at regular or scheduled intervals to determine whether services being delivered to children and youth are improving social and emotional functioning.

8. Help children and families make sense of their life experiences.

No two children are affected by trauma in the same way, depending on the age at which a child experienced a traumatic event or ongoing trauma, the personality style of the child, their physiological makeup (temperament, intellectual developmental, special needs) and their family circumstances. Their initial response may range from hyperarousal (fight or flight) to dissociation (freeze and surrender), or a combination of the two (Dr. Bruce Perry, 2002). Children need to process their feelings after a stressful or traumatic event. As Dr. Perry states "what's shareable is bearable." Case managers can discuss with parents how to help their children talk about the trauma. Parents themselves may also need help to process their feelings after a stressful or traumatic event. According to Dr. Perry, common emotional responses include:

- Making sense of the event;

- Creating memories;
- Re-experiencing the trauma;
- Avoiding reminders of the event;
- Experiencing anxiety or sleep problems; and,
- Acting impulsively;

Children who continue to experience heightened emotional responses for longer than 1 month may be experiencing posttraumatic stress disorder (PTSD) (Perry, 2002).

9. Support Health and Nutrition

Helping a family gain access to quality, affordable health care and make healthy decisions regarding diet and nutrition are important for supporting a child's brain development both before and after birth. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program provides comprehensive health services for individuals under age 21 enrolled in Medicaid.

10. Support the Mental Health of Children and families

When children are affected by a traumatic event, they may experience a variety of emotions or display behavioral problems that indicate the attention of a mental health professional is needed. The nature of the event, the age or sex of the child, and the child's previous experiences can all affect how he or she responds to trauma. When working with both older youth and parents who could benefit from mental health services, case managers should adhere to the following guidelines:

- Involve youth in decisions about their mental health care whenever possible;
- Leave the door open for youth and parents to request mental health services because they may be resistant initially but change their mind later;
- Help reduce any stigma attached to mental health services by giving family members a larger context in which to understand the need for mental health services and their benefits;
- Help them develop a "cover story" (not a cover up story) to share with those they choose about the issues and the services they are receiving. The story should be truthful but limited to what the family member is comfortable sharing; and,

- Respect and protect the privacy of family members who may or may not choose mental health services.

11. Help families manage behavior from a relationship perspective

There are some simple rules of thumb about behavior management which case managers can share:

- Most children want to do what's expected of them in order to keep their caretakers close to them. Children who have experienced stress or trauma that has been caregiver induced in some way get mixed messages. They want to do what is expected but if their caregiver is the source of stress, they may be afraid to get too close. Children need to feel safe and expectations need to be clear;

- Some behavior problems are really relationship problems. Parents may need help exploring their relationship with their child to determine if it is the relationship that needs to be strengthened first before the behavior can change; and,

- All children can benefit from having choices that are age appropriate. Making choices helps children feel in control. Types of choices can include anything from which color shoes to wear, where they will sit at the table, which class they will take and whether they will go to bed at 8 or 8:30. It's important for parents to understand that they should only give choices about things they are willing to let their child make a choice about. Also limiting the number of things to choose from is helpful.

12. Educate schools about the impact of trauma on children and families

The physical and emotional distress that traumatized children experience may lead to behavioral problems in school and poor academic performance. Potential developmental delays may worsen the situation as children fall behind their peers academically and have difficulty making social connections. Helping parents reach out to educators is an important function of the case manager to inform them of each child's unique needs and support. The status of the child's emotional or physical health may require the school to develop an Individualized Education Program (IEP) in collaboration with the child's family and other professionals involved in the child's life.

13. Provide concrete/tangible support

Concrete support to the family could include providing transportation, assistance with cleaning and moving, locating food, clothing, etc. when needed, training the family to assume these responsibilities, assistance with learning to communicate assertively with landlords to obtain needed home repairs, helping families navigate

the school system, teaching budgeting skills, identifying financial resources available to assist with needs, and banking information.

14. Utilize community based services and coordinate services among multiple providers

Children and their families are often involved with multiple service systems, including law enforcement, child welfare, the courts, schools, primary care, and mental health. Service providers working with traumatized children should strive to develop common protocols and frameworks for documenting trauma history, exchanging information, coordinating assessments, and planning and delivering care. In contrast to a fragmented approach, cross-system coordination views the child as a whole person. When different systems have many different and potentially competing priorities, there is risk that children and their families will receive mixed or confusing messages—or simply fall through the cracks.

In addition, no single system can address all the issues a child and family may experience. Case managers need to form collaborative relationships with other service providers to improve access to and coordination of services. Some of the key services for children affected by trauma and their families are listed below:

- Early intervention programs, such as Healthy Families, can serve as a source of support to help families address their children's development and, when necessary, provide services to minimize or eliminate developmental delays, including parent training, home visitation, or respite care;

- Early care and education (ECE) settings provide rich learning environments for children and work to strengthen families which can reduce the effects of a stressful or unstable home environment;

- Respite care can be a helpful resource in early prevention to reduce immediate stress by giving families short-term relief from caring for children. It can be an important strategy to reduce the risk of out of home care and can lead to increased stability of the family. Respite care can be provided formally with an approved provider or informally with a family member or friend of the family. It should be time limited, not extending beyond a total of 60 days. Frequent contact with family members during this time is essential to provide reassurance to the child and to allow the parents to continue to make decisions about their child while in respite; and,

- Clinical, multidimensional, trauma based assessment may needed when the worker's assessment reflects the presence of symptoms of complex trauma (see 4.8.2.3 of this section). This type of assessment should include the following:

- Comprehensive bio/psycho/social history of the child, including:
  - trauma history, including placement history prior to and since removal
  - trauma symptoms present
  - losses
  - attachment relationships
  - evidence of child's resilience
  - educational, medical and mental health history, including hospitalizations, prior evaluations and diagnoses, information from social workers and therapists
  - child's adaptive developmental stage, include how the child functions in multiple settings (i.e., home, school, peers, etc)
  - child's health
  - Child's strengths, coping mechanisms, interests, supports, understanding of the family's current situation, perception of the trauma and their role, who the child is closest to in the family, pervasive feelings, what they would like to be different in the family
  - Sensory integration child

- Family history (for both birth family and foster family), including:
  - Risk factors present in family history
  - Relationship of parents
  - Parent's view of child and themselves as parents
  - Strengths of parents, including parental resilience, knowledge of child development and parenting, social and family supports, concrete supports available, how their spiritual beliefs guide parenting
  - Parent-child relationship, including attachment (both birth and foster parents)
  - Parental stressors (birth birth and foster parents)
  - Current level of Family functioning, including any community or environmental factors that influence family functioning (both birth and foster parents)

- Method of gathering information
  - Interview with birth and foster parents
  - Child interview
  - Observation of parent child interaction (both birth and foster parents)

- Valid and reliable instruments to screen for sensory integration, adaptive development level of child, parent stress and to structure parent child observation)
- Interviews with social worker and therapists involved
- Pediatric examination

o Evaluation and recommendations, including:

- Assessment of protective factors present in the family (both birth and foster parents) that are either strengths or that need to be enhanced:
- Parental resilience
- Knowledge of child development and parenting
- Social connections and supports
- Concrete supports
- Nurturing and Attachment

- Other home visiting and intensive in-home services, crisis intervention, mental health counseling, training and support services, school based services, mentoring, subsidized child care, support groups and other community based services may be the most appropriate resource for a family.

The key to the right fit for a family is based on a mutual understanding of the behaviors that need to be changed and what the provider offers to help change those behaviors.

For more information on trauma informed practice go to: Child Welfare Trauma Training Toolkit (2008)

4.12.5 Intensive In-home services

Intensive in-home services may be provided by the LDSS or by other service providers. Intensive in-home is indicated when there are multiple problems in the family and/or when a child is at risk of out of home care due to the possibility of abuse and/or neglect. Several factors distinguish intensive in-home services from other services to families:

- Services are provided in the family's home or in the community where the problems are occurring and, ultimately, where they need to be resolved;

- Workers are available to families 24 hours a day, 7 days a week to diffuse the potential for violence or family disruption;

- Families are seen at times when it is convenient for them, including evenings and weekends;

- Families receive education and support in areas more commonly associated with counseling, such as child development, parenting skills, anger management, other mood management skills, communications, and assertiveness; and,

- In-home staff utilizes a range of research-based interventions, including crisis intervention, motivational interviewing, parent education, skill building, and cognitive/behavioral therapy.

In addition, in-home providers may also provide the following services:

- Teach individualized problem-solving skills that can be used by family members to respond to and manage crisis and problem situations;

- Teach families basic skills such as using public transportation systems, budgeting, and where necessary, dealing with the social services system; and,

- Develop strategies that will be used to facilitate families' successful use of non-home based community resources following termination.

4.12.6 Use of short term respite

Respite care is the provision of temporary care for children on an emergency or planned basis for the purposes of providing family stability, supporting the achievement of timely permanency, and promoting connections to relatives or other important people in the child and family's life. In early prevention, the use of respite should be a decision made by the family. Respite could be voluntary or could be funded by the agency when resources are available. Respite in early prevention is distinct from respite used in foster care so different restrictions of funding sources may apply.

Respite for a child of a family receiving early prevention services can reduce stress levels, improve family well-being and stability, enhance marriages, sibling and other family relationships and can delay or eliminate the need for foster care. The length of time for respite depends on the needs of the child and family. It is important that the respite provider support the child's family, respect and honor their role as decision makers and be consistent with behavioral expectations and behavior management.

4.12.7 Frequency of contacts

Although there is not required number of contacts, at least one face-to-face or telephone contact with an active member of the case should be made weekly in the beginning phase of service provision so that the worker can determine if the plan is working and how much help the family needs to be successful with the plan. Ideally, monthly a face-to-face contact should be made with the family to explore what the worker, parents, youth and others involved have accomplished, what has been successful, what challenges have surfaced, how to manage those challenges and how the service plan may need to change. The worker should also talk with service providers monthly to assess the progress of the family and determine how they can be helpful in reinforcing the changes the family is making through these service providers.

4.12.8 Foster care diversion in early prevention

Definition of foster care diversion: A strategy to prevent or eliminate the need for foster care placement by engaging caregivers in a process to identify relatives and/or nonrelatives who can provide short term or long term care for their children outside the foster care system and to support the move through services provided to both families and the child. Foster care diversion also occurs within child protective services. Although the best practice guidelines presented in this chapter refer to diversion at the early prevention stage, they can also serve as a best practice guide in child protective services. The difference is that in child protective services the LDSS has authority to act without families' permission in certain circumstances that are not present in Early Prevention.

4.12.8.1 When to explore alternate living arrangements with families

The purpose of foster care diversion services is to prevent or eliminate the need for foster care placement. Foster care diversion activities usually occur after either early prevention services or intensive ongoing child protective services have been provided to maintain children in their families and those efforts have been unsuccessful, and/or the caretaker is unable to provide safe, adequate care.

It is also possible that families may present themselves for services requesting assistance with out of home care for various reasons prior to, or in the absence of, a current, valid CPS referral. Examples include mental or physical illness of a parent who feels he or she cannot currently care for a child, a parent who feels out of control and is concerned about the safety of his child, a parent with a terminal illness seeking permanent placement of the child outside the foster care system, domestic violence situations where the victim parent can no longer care for the child, parent or caregiver feels unable to manage the child’s behaviors, etc. This section refers only to foster care diversion services provided through Early Prevention.

4.12.8.2 Authority of LDSS

Voluntary Nature of Early Prevention Services: Services provided in Early Prevention (prior to, or in the absence of, a current, valid CPS referral) or services provided to a family that has been assessed at low risk by child protective services are voluntary. Unless the LDSS identifies information that would jeopardize a child's safety to the extent that the child is in imminent danger, the authority and decision-making for placement of a child in an informal, alternate living arrangement lies with the parent or caretaker. Code Definition of Legal Custody

Exceptions to Voluntary Services:

If at any time in providing early prevention services, the LDSS determines that the family's circumstances meet the definition of a valid CPS referral and/or the child is in imminent danger, the LDSS should follow CPS guidance to determine if an investigation and/or family assessment is needed and if the child should be removed.

Once the LDSS determines that without intensive family preservation services or an alternative living arrangement, a child is at imminent risk of foster care placement (within 6 months) due to the high risk of abuse or neglect or other critical circumstance, the LDSS is mandated to offer services. (CSA manual). If the family refuses services in this circumstance, the LDSS should document the family's response and determine if the circumstances meet the definition of a valid, CPS referral and/or if a petition for a protective order is appropriate. (CPS guidance)

4.12.8.3 Role of the agency when a diversion family is used

The primary role of the agency in early prevention diversion situations is to facilitate the decision making of the parents in identifying a safe family with whom they will place their child. The LDSS serves in the role of consultant, raising questions for the family to consider, sharing information about risk factors that could impact a child's safety, educating the diversion family about the needs of the child and the issues that need to be addressed, supporting the child's move to a particular family and helping both families plan for permanency of their shared child. The length of time services should be provided to the diversion family and the original family and the child will vary according to the families' needs and the service goals and objectives. According to the 2011 Prevention Survey, 95% of LDSS assist families in finding alternative living arrangement; 88% of LDSS provide services after the child is placed by their family; 30% provide services for 3 to 4 months; and, 41% provide services for 5 to 6 months.

4.12.8.4 Service objectives for early prevention diversion situations

- To assist the family in identifying either a temporary or permanent, alternative living arrangement for their child that can include the family or original caretakers placing the child with relatives, fictive kin or other caretakers or to provide services to families who have already placed their child with other caretakers and need assistance in managing those relationships;

- To assure permanency for the child and a safe, lifelong connection to extended family, siblings and others and provide continuity with racial and ethnic heritage, culture and language; and,

- To explore other resources that can be utilized by all caretakers in a diversion situation, including benefit programs, custody options, etc.

4.12.8.5 Special considerations in diversion situations

There are some unique considerations with both related and non-related caretakers who may provide temporary or permanent care as diversion families. The worker's role is to facilitate the discussion, mediate differences of opinion and help the two families achieve enough consensus to be able to move forward with the placement and insure the child's safety. The following issues should be discussed and explored with the original caretakers and the diversion family:

- Relationship of the diversion family to the birth family and child-kin vs. non-kin;

- What Protective factors and strengths are present with the diversion family that reduce possible risk to the child;

- Role/boundary redefinitions with child and birth parent and the diversion family;

- Financial/housing responsibilities;

- School placement issues;

- Court involvement;

- Maintaining attachment with birth family and siblings and developing attachment with diversion family;

- Training/information needs of diversion family;

- Short term vs. long term plans for the child to remain with the diversion family;

- What services will continue to be provided to the original caregivers and what services will be provided to the diversion family and how they will be funded (e.g. child care, Medicaid for the child, etc.); and,

- Unique challenges based on family circumstances and child's needs

4.12.8.6 Assisting the family with finding a diversion family

Families who need help with caretaking may or may not be able to identify or locate family members or friends who can provide temporary caretaking for their child. The family finding model developed by Kevin Campbell and colleagues at Catholic Community Services in Tacoma, Washington, identifies six stages or steps to be completed when searching for family members to achieve permanency for children in foster care. Although helping families find a diversion family is a different context for family finding, the process is similar and can be adapted as follows:

Step 1: *Discovering as many family members and other important people* in the child and family's life as possible, through conversation with parents and children and by exploring their connections and relationships with them. Helping families locate these individuals through community resources, the Virginia State Library, which houses records used for genealogy searches, and the use of ACURINT when needed. Because of the confidential nature of all the information in ACURINT, the worker should not share the detailed information found in ACURINT but may let the family know if a relative has been located. Both parties must give permission in order for you to share identifying information. Once located, the worker should make the first contact with the family and explore the parents' or caregivers' desire to consider this relative as a placement option for their child. Once both parties agree, the worker can facilitate a connection between the two families to explore the feasibility of placement.

Step 2: *Helping the family engage as many of these adults as possible.* It is important to remember that the family is making the decisions in early prevention diversion situations, so engagement could either occur with the family alone or, at their request, with your involvement. These identified or located adults could provide a range of support, including assisting in planning, providing respite care, helping with specific tasks, such as transportation or babysitting, as well as becoming a placement resource for the family.

Step 3: *Helping the family plan for diversion* and meeting with identified individuals.

Step 4: *Helping the family make decisions* about if and how they want to proceed and with whom and for how long.

Step 5: *Helping the family evaluate the plans* made and manage these new relationships.

Step 6: *Providing follow-up support* to both families as needed and requested.

4.12.8.7 Other types of services provided in diversion situtations

Once the family decides that out of home placement is the best alternative for their child, to either avoid foster care or for other legitimate reasons, the LDSS may provide services to the original caretakers, to the child, and to the "diversion" family.

The LDSS may support the placement by helping the original caretakers:

- Identify the circumstances under which a child may need to live with another family;
- Determine whether a temporary or permanent move is currently needed;
- Identify resources the family needs to get the child back home as soon as possible, if that's the plan;
- Acknowledge and respond to trauma the child and family experience when a move occurs and help the family know what to do to help the child heal from that trauma;
- Assess and identify child's needs when he moves to another family and share that information with the diversion family;
- Explore the family's placement options with both their relatives and non relatives and the family's relationship to all possible families, including to whom the child is connected and to whom the parents are connected;
- Identify the potential risks to the child's safety if placed with a particular family and assist the family in deciding whether or not that family can meet the child's needs;
- Help the family to make a plan for a safe and smooth transition of the child to the new family, and to decide what the child will be told, how it will occur and who will be involved;
- Facilitating relationship building and attachment with the new family and maintaining relationships and attachments with the original caregiver;

- Helping the family determine the plan for the child continuing in school, whether or not he has to change schools, provide any needed documentation the school requires due to a change in placement and determine how transportation will be provided for school;

- Assisting the family in executing consent for the child's medical treatment to the diversion family;

- Assisting in developing a plan with the diversion family for family to family interaction, visitation of the child with his original caretakers, how decisions about the child will be made and how and when the original caretakers will be involved in those decisions, problem solving, etc., once the child moves;

- Helping resolve conflict between the two families;

- Providing information and education about the unique issues in out-of-home care;

- Helping the family determine how they will know when the child should return home or if the placement will be permanent;

- Facilitating a discussion with the family about who else needs to be informed about the situation and the child's needs and develop a plan to share that information;

- Providing other situation management services as requested by the family

- Helping the family develop a plan for when LDSS services will end and what other community and family resources can be utilized after the situation is closed; and,

- Facilitating a Family Partnership Meeting to assist in decision making

The LDSS may also provide services to help the new or "diversion" family to:

- Understand the trauma the child and family experience when a move occurs, how to recognize trauma related symptoms and how to help the child and family heal from that trauma;

- Understand the child's needs and assist in identifying helpful resources to meet the needs;

- Assess their needs and assist the family in connecting to needed resources (e.g. Respite, day care, benefit programs, support groups, etc.)

and determine what resources the original family has that can transfer to the diversion family, such as child care, Medicaid, child only TANF, etc.

- Facilitate a safe and smooth transition of the child to the new family, and to decide what the child will be told, how it will occur and who will be involved;

- Identify the financial and emotional impact of the move on their family and explore what resources are available to the family through LDSS and other actions the family can take to minimize these impacts;

- Prepare the family for the "honeymoon" period and provide information and suggestions about how to manage the relationship once the honeymoon is over;

- Participate in the plan for the child continuing in school, whether or not he has to change schools, and how transportation will be provided for school;

- Develop a plan for family to family interaction with the original caretakers, visitation of the child with his original caretakers, how decisions about the child will be made and how and when the original caretakers will be involved in those decisions, problem solving, etc., once the child moves. This should be a written agreement signed by both families and may facilitate getting needed services from providers and schools and making sure both families are involved in decision making and provide a mechanism to resolve conflict between the two families;

- Provide information and education about the unique issues in out of home care (See Section 4.14.6.10)

- Facilitate a discussion with the original caretakers about the circumstances under which the child will return home;

- Explore whether they can provide permanency for the child if the child isn't returning home and whether they are willing to do this;

- Engage in a discussion with the family about who else needs to be informed about the situation and the child's needs and develop a plan to share that information;

- Understand the constraints on the agency in supporting transfer of custody or foster home approval when there is a criminal record or CPS record;

- Provide other situation management services as requested; and,

- Assist in the development of the plan for when LDSS services will end and what, if any, community and family resources can be utilized after the situation is closed

The LDSS may also provide a range of services to the child to meet any special needs of the child.

4.12.8.8 Assisting families with a written agreement

Both families and the child could benefit from a written agreement, spelling out some of the issues identified above. The worker may explore with the families the possibility of having the form notarized. The agreement could include the following:

- Contact information, including, but not limited to, both caretakers, extended family, school staff, medical personnel, agency staff, and others with a vested interest;
- Clarity about with whom the child can have contact, including specific names and contact information;
- Frequency and circumstances of visitation with original caretakers;
- Information regarding any special needs of the child, medications used, allergies, immunizations, current medical treatment, the child's doctors' names and contact information;
- Educational information including provisions for getting the child to school and, if applicable, the plan for enrolling the child in a new school;
- How the original caretakers will be involved in decisions about the child (re: school, health, haircuts, etc.);
- How the agency will be involved with the families and the child; and,
- Any concerns related to confidentiality

4.12.8.9 What requires the family's consent

Criminal and CPS background checks: The LDSS may request a Virginia Criminal Records and/or CPS Background check with the consent of each diversion family considered by the parent or original caretaker. Each parent can also request these checks for themselves and receive their results. If the LDSS has requested the checks, the diversion family needs to give their consent to the LDSS to share this information with the original caretakers, or share the

information themselves, to facilitate decision making. SP-167 Criminal History Record Name Search Request

Note: Office of Background Investigation does not screen background check results for diversion families. The request should be sent to the Virginia State Police.

Medical care: The diversion family needs written permission from the original family to provide medical care for a child.

Exchange of information with service providers, other family members, etc.: The original family must sign consent to release information in order for the exchange of any information about their family to occur.

Permission to perform tasks related to a child's school: The school will require written permission from the legal parent to allow the diversion family to perform certain functions at school either with the legal parent or in lieu of the legal parent.

4.12.8.10 Considerations when making the decision to support an identified diversion family placement

When considering whether or not to support a family's decision to place their child with another caretaker, it is critical that the assessment be made *with* the family not *for* the family. It is important to remember that the family, not the agency, is making this placement; therefore, the standards for foster home approval do not apply. Basically, the agency wants to assist the family in making sure this is a home where the child is likely to be safe and feel safe, have their physical needs met, and be comfortable with the caregiver(s); the diversion caregiver is clear in understanding the expectations; and, the diversion caregiver conveys a commitment to the child, to keeping the child safe and to maintaining contact and involvement with the child's family.

The following factors should be considered:

- Child's safety

The minimum criteria for safety should include an understanding that the child's basic physical and financial needs will be met; age appropriate supervision will be provided; no evidence of current domestic violence, substance abuse or child abuse.

- Permanency

The relationship between the two families does not have to be close, but, they do need to feel comfortable with each other and with the plan to be able to

negotiate differences and not put the child in the middle. The diversion family should understand that the child may not want to move and/or may resist the efforts of the family to reach out and connect with the child. The diversion family needs to be willing to provide care at least through the initial time identified.

- Child's well-being

Both families need to understand the stress associated with an out of home placement and the move itself can have both short and long-term consequences for the child's mental and physical health. Both families should be willing to learn about trauma related symptoms and how to help children heal.

Use of criminal and CPS checks: Once a possible diversion family has been identified (either through caretaker or child connections or agency resources) criminal and CPS check may be conducted with consent. If the LDSS receives the results of the Criminal History Record Name Search, the LDSS may share the results only with the person(s) who authorized and consented to the search. The LDSS may facilitate a discussion between the two families on this issue, if the diversion family has agreed and is willing to share this information with the original family directly.

- If the original caretakers decide to proceed with a placement with a family who has committed a barrier crime or who has a founded CPS disposition, the agency should explain they are unable to support the placement and explore other placement options with the family.

- If there are no other options among the family's kin or fictive kin, the agency should explore respite care options through the LDSS or collaborate with foster care to determine if there are foster or other families who may be willing to serve in this capacity.

- If the child's safety is in jeopardy if the child remains with the original caretakers and no other resources for placement are available to the family, then the LDSS should collaborate with child protective services and/or foster care to explore other options with the family. This could include making a CPS referral and/or the possibility of a voluntary placement of the child in foster care.

If the child and/or original caretakers have a relationship with the diversion family selected, the original caretakers are comfortable with this family, the diversion family is willing to accept the child and the child will be safe there, the LDSS may support the move in order to reduce the amount of trauma to the child caused by the change.

4.12.8.11 What to do when the family has placed a child in an informal arrangement before they are known to LDSS

In reality, many out of home placements are arranged by families informally without the involvement of the agency. Sometimes these families request or are referred for assistance when problems arise. These situations should be considered Early Prevention Family Support situations not Foster Care Diversion situations since the agency was not involved prior to the child's move. The same kinds of services suggested for diversion families may be appropriate for these families as well, particularly renegotiating relationships, clarifying responsibilities and expectations, mediating conflicts and assisting in short and long term planning for permanency.

4.12.8.12 Helping the family determine if the diversion family they chose can be a permanent placement for their child

If the original family feels they will be unable to take care of their child on a permanent basis, the logical option is consideration of the diversion family as a permanent caretaker. In making this decision, the original family may need some assistance in identifying the factors they should consider:

- Has the relationship between the child and the diversion family been a positive experience?
- What are the child's feelings about this option?
- Is the family willing to consider a permanent arrangement?
- What are the benefits and challenges of continued contact with the original family?
- To what extent can the diversion family meet the long term safety needs of the child?
- What long term supports need to be in place to support a permanent plan with the diversion family?

Family Partnership Meetings can be helpful in exploring these issues and helping the family make some of these decisions.

Custody options and benefit programs available:

Families can be referred to an attorney or to the court intake unit for specific information about custody options, which could include, but are not limited to:

- Original family could file a petition for relief of custody;

- The diversion family could file a petition to the court requesting custody of the child;

- When terminally or seriously ill, a parent can appoint a standby guardian either by filing a petition in the Juvenile and Domestic Relations District Court or by completing a written designation to be filed by the guardian when the time comes;

- Parental placement adoption could be pursued by the original family with the diversion family; or,

- The original family could sign a permanent entrustment agreement and the diversion family could be approved as a foster care provider with the intent to move towards a permanency plan.

- Families can be referred to Legal Aid for assistance with pursuing custody options by calling **1-866-534-5243** or there may be local legal aid organizations available such as Lipman Family Law.

Considerations when custody transfer or foster care is being considered with the diversion family

- Use of the authority of the LDSS to remove a child and place the child in foster care should be considered under the following circumstances:

    - The safety of the child is at high risk and the child is in imminent danger; and/or

    - Intensive services have been provided to the family to reduce the risk but the child's safety is still in jeopardy; and/or

    - No relatives or fictive kin are available or accessible to provide care or the LDSS is unable to support the diversion family identified by the original caretakers.

- If the family has a barrier crime on their criminal record, they cannot be approved as a foster family and the court may not be willing to transfer custody to them.

- If the family is in the Central Registry with a founded disposition, they cannot be approved as a foster family. If transfer of custody is being sought by the family, the court will make the final decision.

Financial Assistance Available:

Diversion families should be referred to Benefit Programs to determine eligibility for General Relief, TANF, SNAP, FAMIS or other benefits that may be availability through LDSS.

4.12.9 Parent helpline

1-800-CHILDREN (800-244-5373) is a toll-free, statewide helpline that can be a resource for families served through early prevention both during and after services have been provided. Calls are answered by trained experienced professionals Monday through Saturday from 8:00 AM – 9:00 PM. The service is designed to respond to a variety of callers: parents, other caregivers, relatives, concerned citizens, professionals and children. They can discuss a problem, concern, frustration, or crisis related to parenting, child development/behavior, the safety of a child, family issues, etc. Callers receive guidance related to possible solutions, emotional support to reduce isolation and frustration, personalized information from the Prevent Child Abuse Virginia Family Resource Center, referrals to local services or to report suspected abuse/neglect, and follow up if needed. Callers do not have to identify themselves.

The Helpline is not a substitute for the Child Abuse Hotline; staff is required to report any suspected abuse or neglect to the hotline at 1-800-552-7096.

4.13 Appeals and fair hearings

Dissatisfied families applying for and/or receiving early prevention services can request a local conference to discuss their concerns about services or payments and request a change in action. During the conference the local department should examine reasons for their actions or recommendations and consider additional information presented by the family to determine if the agency's services or payment decisions should be changed.

4.14 Reassessment and service plan adjustment

Periodic reassessment of the family's situation and their movement towards change and independence is essential and should, at a minimum, occur monthly through a face to face meeting with family members, service providers, diversion families, if relevant, and others providing support. The meeting should be focused initially on the successes that everyone has identified since the last meeting and the degree to which the goals and objectives have been met. The service plan serves as a contract with the family and needs to be renegotiated when new information or new challenges have surfaced or as needs change. The worker and the family should discuss the need to revise the service plan and make a mutual decision about how it needs to be adjusted.

Face to face meetings with family members, service providers, diversion families, if relevant, and others providing support should occur monthly. Periodic review of the service plan should occur every 90 days until the goals are achieved and/or the case is

closed. The service plan serves as a contract with the family and needs to be renegotiated when new information or new challenges have surfaced or as needs change. The worker and family should discuss the need to revise the service plan and make a mutual decision about if and how it needs to be adjusted.

At a minimum the review should include the caseworker, the family and, where relevant, the diversion family. Ideally, service provides should also be included in the review as well. If they are not present for the review, their input should be solicited prior to the review meeting with the family.

The review should include the following:

- Identification of what has been accomplished/what success the family has achieved since the last review;
- Reassessment of the family's situation and situation at this point in time;
- Evaluation of the extent to which the goals and objectives have been met;
- Identification of what else needs to happen for the family to be independent; and,
- Revision of the service plan as needed.

4.14.1 Tools to assess progress and/or change in families

4.14.1.1 VDSS On-Line Parent Survey

The purpose of the VDSS On-Line Parent Survey is to measure parents' level of satisfaction with a range of prevention services provided by subgrantees receiving funding from the Child Abuse and Neglect Prevention Program. It is designed for parents whose children may be at risk of abuse or neglect and who are currently receiving home visiting, parent education, training and support and group services. It is to be administered at the completion of a service. It is generic enough that it could also be used with LDSS parents receiving early prevention services.

For those interested in using the on-line survey, contact C. Lynne Edwards at lynne.edwards@dss.virginia.gov. A sample copy of the survey is provided In Appendix F The VDSS on-line Parent Survey should not be used or copied from the Appendix. The LDSS should receive a copy to use for parents with the appropriate barcode.

4.14.1.2 Other Instruments

Both the Protective Factors Survey and the Measure of Family Well-Being Survey can be used pre and post service delivery to measure change. Links to

both of these can be found in 4.12 on this section. Several evidence based programs also have instruments to measure progress and change, depending on the model of service delivery utilized. Appendix J: Evidence Based Clearinghouses found in Section 1: Overview of Prevention provides resources to explore some of these programs.

4.15 Goal achievement and case closure

If the goals, objectives and tasks are clear, behavioral outcomes have been established and embraced by the family, and ongoing evaluation of the service plan is occurring, case closure will be indicated when the family has achieved the outcomes. When the family is within a month of case closure, the worker should meet with the family and facilitate a discussion about whether the family feels ready for closure and if not, what else needs to happen. During this discussion, the worker could ask the following questions:

What are you doing differently now than before we began our work together?

How is your family different?

What have you learned that you can use when the next problem arises?

What supports do you have in place to help you with problems?

On a scale of 1 to 10, how ready do you feel to mange on your own without help? (10 is I feel confident I have learned what to do differently and I don't need help anymore; 1 is I don't know how to proceed and I need help)

What would it take to get you to the next step?

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

4.15.1 Reasons for closure

In order to close a case, a service plan must have been completed. The following reasons for closure are appropriate:

- Family stabilized and connected to community resources (used when case opened for short-term assessment only and no other services were provided) OR
- Services completed, goals met, no reasonable risk OR
- Services completed, risk reduced, goals partially achieved OR
- Services no longer available OR

- Risk increased, referral made to CPS OR
- Family no longer participating in services OR
- Family moved out of the area OR

For families receiving foster care prevention services only:

- Intensive services prevented foster care placement OR
- Diversion family used by original family which prevented removal and foster care placement OR
- Child entered foster care

4.16 Record retention and purging the case record

Records shall be maintained in accordance with the Library of Virginia's record retention schedules. Records shall be destroyed only when there are no litigations, audits, or investigation of Freedom of Information Act requests.

Destruction of service records shall be done by shredding, pulping, or burning. "Deletion" of confidential or privacy protected information in computer files or other electronic storage media is not acceptable. Electronic records shall be overwritten, "wiped" clean, or the storage media physically destroyed.

Records shall be destroyed in a timely manner, defined as no later than the end of the fiscal year in which the retention period expired. Any records containing Social Security numbers shall be destroyed within six months of the expiration of the records retention period, which for prevention cases is three years from the date of closure. A certificate of records destruction shall be completed and approved by the LDSS' designated records officer. After a record is destroyed, the LDSS shall forward the original certificate of records destruction to the Library of Virginia (§ 42.1 -86.1). Click on Records Management

4.17 Guidelines for supervision in early prevention

The National Child Traumatic Stress Network identifies the following characteristics of a service delivery system with a trauma informed perspective that promotes the protective factors:

Programs, agencies, and service providers:

(1) Routinely screen for trauma exposure and related symptoms;

(2) Use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms;

(3) Make resources available to children, families, and providers on trauma exposure, its impact, and treatment;

(4) Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and/or vulnerable to trauma;

(5) Address parent and caregiver trauma and its impact on the family system;

(6) Emphasize continuity of care and collaboration across child-service systems; and,

(7) Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.

Below are supervisory practices that can promote the practice guidelines outlined in this chapter.

4.17.1 Modeling strength based practice in the supervisory relationship

Strength based supervision is 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. Just as staff should model and teach a strength based approach with families so that parents can support and encourage their children's competencies and resilience, supervisor should model that approach with their staff to promote staff competence and resilience. Transparency, honesty, respect and professionalism are critical to sound practice. Specific strategies in modeling strength based practice include the following:

4.17.1.1 Giving and receiving feedback

Giving and receiving feedback is an important task in supervision that can support the behaviors and attitudes desired and help to change those that are less desired. However, timing is critical. The following tasks and activities are recommended:

- Identify staff interactions and practice strategies that reflect strength based, trauma informed practice and the use of protective factors and communicate behavior specific feedback to staff about these strengths *as soon after observance of them as possible*;

- Identify staff interactions and practice strategies that need to be enhanced or changed to more effectively reflect strength based, trauma informed practice and the use of protective factors and communicate behavior

specific feedback to staff about what could be changes *just before staff is engaging in these activities again;* and,

- Ask staff for feedback about the supervisory relationship and how the supervisor demonstrates a strength based, trauma informed approach and the use of protective factors and supports that approach with staff.

4.17.1.2 Evaluating staff performance

Staff evaluations are not just an event but process that reflects the following components:

- Clear expectations for performance, job descriptions, activities and tasks that reflect the attitudes and behaviors that promote a strength based, trauma informed practice and the use of protective factors;
- Ongoing feedback about work performance, given in an appropriate and timely fashion as indicated above;
- The opportunity for the staff member to provide their assessment of their strengths and needs first;
- Strengths and needs expressed by the supervisor within a strength based context and as behavior specific as possible; and,
- The expectation that there should be no surprises at evaluation time.

4.17.1.3 Offering concrete supports

Staff needs resources to do their job well. One of the responsibilities of supervision is to insure that these resources are available to them. This includes, but is not limited to the following:

- Adequate supplies, technology and access to administrative support;
- Reviewing policies and procedures from a strength based, trauma informed perspective and making needed changes to support that perspective;
- Training and coaching needed to develop the skills and abilities needed;
- Adequate funding for early prevention services;
- Sufficient staffing within the agency that reflects the needs of families and the organization;

- Encouraging the use of compensatory or flex time for staff to be accessible to families;
- Insuring that procedures are in place to keep staff safe;
- Monitoring workload and adjusting workload when needed;
- Modeling and monitoring cultural competence;
- Cultivating community resources to more effectively meet families' needs; and,
- Concrete reward to staff for jobs well done.

4.17.2 Supporting peer supervision and teamwork

Although quality supervision is critical, equally important is the access to advice, brainstorming and problem solving from other staff. Suggestions for fostering mutual supportive relationships among all staff members include the following:

- Reducing physical, psychological and attitudinal barriers between programs and units;
- Developing and fostering a common goal that all programs and staff can embrace;
- Encouraging the sharing of resources;
- Providing opportunities to build teams and to engage in team decision making; and,
- Providing less formal opportunities for relationship building and stress reduction.

4.17.3 Engaging staff in decision making

Research and practice wisdom have demonstrated that both productivity and job satisfaction increase when staff is involved in the thinking as well as the doing within an organization. All managers and supervisor should cultivate the habit of soliciting employee opinion on important decisions that affect employees' work and/or compensation or that significantly impact the organization. Modeling the principles of Family Partnership Meetings in agency decision making gives staff a voice and a choice in decisions that impact both them and the families they serve. It communicates respect for their knowledge and practice expertise and increases buy in of staff and an understanding of the rationale for decisions. Engaging staff in

decision making also enhances the decisions that are made and leads to more consistent practice and a stronger organization.

4.17.4 Reducing barriers within the system

Middle management has always played a critical role in LDSS. Line supervisors have a strong impact on customer satisfaction, employee satisfaction and the efficiency, productivity and development of the organization. Supervisors interpret and represent the established management policy and facilitate implementation of those policies. They are key persons in communicating and tracking different kinds of goals and in making information flow up and down. They are instrumental in coaching staff to achieve the knowledge and skills needed to do their jobs.

At the same time, supervisors are responsible for negotiating the internal and external systems that impact practice to reduce what barriers may exist, much in the same way that staff is assisting families in negotiating system barriers.

Line supervisors are critical to enabling the organization to benefit from change. Their perspective in developing policies and procedures as an integral part of a change initiative is critical to achieving the support, commitment, and optimal performance of staff. They have four critical tasks:

- To seek clarity from the top on the nature and dimension of change and the rationale for decisions made;
- To break down the communication in a manner that makes sense to the individual units they represent;
- To communicate the change in a clear, honest, and timely manner, including the relevant details, regardless of their anticipation of staff's response; and,
- To solicit feedback from staff on the change initiative and communicate that feedback to senior management.

4.17.5 Managing secondary trauma and burnout

Secondary trauma is defined as the stress from helping or wanting to help a traumatized or suffering person. Child welfare is a high-risk profession, and child welfare workers are confronted every day—both directly and indirectly—with danger and trauma. Threats may come in from violent or angry family members. On top of this, hearing about the victimization and abuse of children can be very disturbing for the empathic child welfare worker and can result in feelings of helplessness, anger, and hopelessness. Those who are parents themselves or who have their own histories of childhood trauma might be at particular risk for the negative effects of

secondary traumatic stress. Some professionals struggle with maintaining appropriate boundaries and with a sense of overwhelming personal responsibility.

These challenges can be intensified in resource-strapped agencies, where there is little professional or personal support available. It is critical to address professional or personal stress because, if left unaddressed, it can result in burnout and undermine work performance, to the detriment of the children and families served. Signs of burnout might include avoidance of certain clients, missed appointments, tardiness, and lack of motivation. Some of the symptoms of secondary trauma include the following:

- ***Emotional indicators*** such as anger, sadness, prolonged grief, anxiety, depression, feelings of hopelessness, emotional numbing.

- ***Physical indicators*** such as headaches, stomachaches, lethargy, hyper-arousal, increased fatigue or illness.

- ***Personal indicators*** such as self-isolation, cynicism, mood swings, irritability with spouse, family or friends, social withdrawal.

- ***Workplace indicators*** such as avoidance of certain clients, missed appointments, tardiness, lack of motivation, reduced productivity, job dissatisfaction, and increased job turnover

Supervisors can help workers with secondary trauma symptoms and improve productivity by engaging in the following activities:

- Model handling stress well while providing encouragement and emotional support to workers;

- Be aware of the extent to which workers have become separated from the original meaning and purpose of their work;

- Model good communication;

- Provide variety in the workload and autonomy in the workplace;

- Assist workers in establishing boundaries between themselves and their clients; and,

- Provide workers with an opportunity to "talk" about how they have been impacted by the trauma they encounter in their work lives.

4.18 Benefits of providing early prevention services to at risk families

Benefits to families of providing early prevention services 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/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 his family, and preserves sibling groups;

- Strength based family engagement approaches empower family members and increase their opportunity to be self-sufficient; and,

- 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.

4.19 Appendices

4.19.1 Appendix A: The Family's Story-The First Step in Engagement

An important step in engaging and empowering the family is giving them the opportunity to tell their story, regardless of the how they have come to the agency: Tell me what brings you here today? OR Tell me your understanding of why we are here talking today?

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

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

For example,

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

- Avoid challenging information at this point;
- Keep focused on strengths and successes that you can identify from the family's story and acknowledge those with the parent;
- Look for opportunities to communicate the following messages to parents:

  - You're a good parent
  - Your feelings and needs are as important as your child's needs
  - You know best about what you, your child and your family needs
  - I know how difficult/challenging this situation must be
  - Together we will find the answers that work best in your family;

- Once the family has told their story, identify what risk factors may be present and seek additional information. Suggested questions include the following:

- What other challenges are you experiencing (parent, child, family or community related)?
- What help or services have you received for these challenges?
- What was the outcome of those services?

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

4.19.2 Appendix B: Father Friendly Environmental Assessment Tool

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

Directions: Walk through your agency and complete the following assessment. If you are female, it might be useful to take a male with you.

Scoring: 2 points for having achieved this goal

1 point for some progress made

0 points for no progress made

	Score
A. First Impressions	_____

The initial reception area is free of signs or posters that would be possibly intimidating for men. The receptionist is warm, friendly and comfortable with men and fathers who are served by the agency.

B. Physical Landscape	_____
C. Role Models	_____
D. Linguistic Landscape	_____
E. Materials/Activities for Parents	_____
F. Communication and roles	_____
G. Interaction with Parents	_____
H. Waiting Room Environment	_____
TOTAL SCORE	_____

Rating: 0-5 Just Beginning 6-10 In process 11-14 Almost there 15-16 Congratulations!

4.19.3 Appendix C: Questions to Ask Mental Health Providers

(adapted from Child Welfare Trauma Training Toolkit: Questions for Mental Health Providers | March 2008, The National Child Traumatic Stress Network, www.NCTSN.org)

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

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

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

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

4. Does the individual/agency provide ongoing clinical supervision and consultation to its staff?

5. Which approach(es) does the clinician/agency use with children and families? Are they seen together or separately?

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

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

- Building a strong parent child relationship
- Affect expression and regulation skills
- Anxiety management
- Relaxation skills
- Cognitive processing/reframing
- Construction of a coherent trauma narrative
- Personal safety/empowerment activities
- Resiliency and closure

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

9. Is the clinician or agency willing to participate in either family partnership meetings (FPM) or multidisciplinary team (MDT) meetings, as appropriate?

4.19.4 Appendix D: Assessing Parent's Motivation for Change

Likert Scales can be helpful in assessing motivation, success, confidence, and readiness for independence. These types of questions are easy to use and versatile and can be particularly helpful with a non-verbal family member or a person who is uncomfortable or unable to express his or her feelings. They are often used in solution focused therapy. Lickert Scales use scaling questions to help family members identify where they are, where they want to be and what it will take to get there. Scaling questions related to the parents' perception of the seriousness of the concerns and their willingness to change were found to be the most significant variables in outcomes for post adoption services identified by research conducted by Norfolk State University in 1995. They can be used with both children and parents. These questions can also be used periodically throughout service provision to gauge change and assess the family member's continued investment.

The basic steps in using a scaling question include introducing the scale, and posing the question. Suggested questions are below:

- Imagine a scale of 1 to 10. 10 represents the situation you would like to see in your family. 1 represents the situation at its worst.
  - Where are you now on this scale?
  - Where would you like to be?
  - If the score is not at 1, how did you get from 1 to the current score?
  - What's the highest you have ever been on the scale?
  - What was different then?
  - What would have to be different now for your score to increase by 1 or 2 points? What would that look like?
- On a scale of 1 to 10 how serious are the problems you or we have identified? (10 is that the problems are so serious I'm really worried about what will happen to my family; 1 is I'm not really concerned at all)
  - What would have to be different now for your score to increase by 1 or 2 points? What would that look like?
  - What would have to be different now for your score to decrease by 1 or 2 points? What would that look like?
- On a scale of 1 to 10 how willing are you to do something different or change what you are doing in order to improve the situation? (10 is I am

willing to do whatever it takes to make things better; 1 is I've done everything I can and I'm not willing to try something new)

- What would have to be different now for your score to increase by 1 or 2 points? What would that look like?

- On a scale of 1 to 10, how hopeful do you feel that positive change can occur? (10 is I feel very hopeful that change can occur; 1 is I feel hopeless)

  - What would have to be different now for your score to increase by 1 or 2 points? What would that look like?

The answer begins to reveal the family members' expectations and what they think the change will look like. The answer can be used as a starting point for service plan and, later can be used for the family to gauge their own progress.

4.19.5 Appendix E: VDSS SAMPLE Parent Survey

Parent Survey

The purpose of this survey is to provide information on parent satisfaction. Please help us try to improve services to families by completing this survey. Your responses will be kept confidential.

Thinking about your experience with the program, please answer the following questions:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1) The services I received have helped my family.	☐	☐	☐	☐	☐
2) I have more confidence in being able to meet my child's needs.	☐	☐	☐	☐	☐
3) I have more confidence in knowing how to take care of my child.	☐	☐	☐	☐	☐
4) I feel closer to my child because I have a better understanding of my child.	☐	☐	☐	☐	☐
5) Staff members spent enough time with me.	☐	☐	☐	☐	☐
6) Program staff are polite and treat me with respect.	☐	☐	☐	☐	☐
7) Staff members respect me as the person who knows my child best.	☐	☐	☐	☐	☐
8) I received helpful information about child development.	☐	☐	☐	☐	☐

9) The written information is clear and easy to understand.	☐	☐	☐	☐	☐
10) Staff gave me information about other services for parents and families in my community.	☐	☐	☐	☐	☐
11) I would recommend this program to other parents.	☐	☐	☐	☐	☐

12) What do you like most about this program?

13) What can the program do to better assist and support families?

Demographic Information

1) How many children live in your household?

☐

2) Your gender:

☐ Male

☐ Female

3) I have participated in this program for:

☐ Less than one month

☐ Between 1 and 6 months

☐ Between 7 and 12 months

☐ More than 1 year but less than 2 years

☐ 2 years or more

4) Your relationship to the children in your household?

(check all that apply)

6) Your ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

7) Your race:

☐ White

☐ Black or African American

☐ American Indian or Alaskan Native

☐ Native Hawaiian or other Pacific Islander

☐ Asian

☐ Multi-racial

☐ Other ☐

8) Your marital status:

☐ Single

☐ Married

☐ Divorced/Separated

- ☐ Birth Parent
- ☐ Step parent
- ☐ Grandparent / Great Grandparent
- ☐ Foster Parent
- ☐ Adoptive Parent
- ☐ Other relative
- ☐ Non-relative

5) Your age:

- ☐ under 17 years
- ☐ 18 to 25 years
- ☐ 26 to 35 years
- ☐ 36 to 45 years
- ☐ 46 to 55 years
- ☐ 56 to 65 years
- ☐ over 65 years

- ☐ Widowed

9) Your family income (annual or yearly income):

- ☐ under $10,000
- ☐ $10,000 to $29,999
- ☐ $30,000 to $49,999
- ☐ $50,000 and over

Thank you for completing this survey!

4.19.1 Appendix F: On-Line Resources for Information and Funding

The resources below are listed alphabetically by content areas. Within each content area there is a mix of national and state resources and, in some cases, a site to identify local programs, such as Healthy Families. Content Areas include the following:

ATTACHMENT
CHILD ABUSE AND NEGLECT (NATIONAL)
CHILD ABUSE AND NEGLECT (STATE)
CHILD CARE
CHILDREN AND YOUTH
COURT SERVICES
DATA AND STATISTICAL
DOMESTIC VIOLENCE
EARLY CHILDHOOD
EDUCATION
EVIDENCE BASED PROGRAMS
EVIDENCE BASED TOOLS
EVIDENCE BASED CLEARINGHOUSES
FAMILY FINDING
FATHERHOOD
FUNDING
HEALTH
HOMELESSNESS
IN-HOME SERVICES
MENTAL HEALTH AND DEVELOPMENTAL DISABILITY SERVICES
PARENT EDUCATION AND SUPPORT
PROTECTIVE FACTORS
PUBLICATIONS
STRENGTHENING FAMILIES
SUBSTANCE ABUSE
TRAUMA

4.19.1.1 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-promotes parenting practices that create strong, healthy emotional bonds between children and their parents

4.19.1.2 Child abuse and neglect prevention (National)

American Humane Association-Children-protecting children from child abuse and neglect

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 Resource 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-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-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- national study of children who are at risk of abuse or neglect or are in the child welfare system

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

4.19.1.3 Child Abuse and Neglect (State)

Casey Family Programs – state child welfare policy database-resources, statistics, data

Children's Advocacy Centers of Virginia-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 of the Roanoke Valley-provides parent education to new or inexperienced parents, high risk parents experiencing homelessness and/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 of Virginia-worked to prevent and treat family violence in Virginia. Family violence includes child abuse and neglect, domestic violence, sexual assault, elder abuse and neglect, dating violence, and suicide

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

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

Prevent Child Abuse Virginia-statewide, nonprofit, non-partisan organization that works to prevent child abuse and neglect by valuing children, strengthening families and engaging communities

Rappahannock Area Council for Children and Parents-provides eight Circle of Parents mutual self-support groups in the Greater Fredericksburg Area (City of Fredericksburg, counties of King George, Stafford, Spotsylvania, Caroline and Orange).

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.

4.19.1.4 Child care

Virginia Child Care Resource and Referral Network-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.

4.19.1.5 Children and youth programs

Boys and Girls Clubs of America- Boys & Girls Clubs are a safe place to learn and grow – all while having fun

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

Find Youth Info – Map My Community-Use the interactive mapping tool on this page to locate federally supported youth programs in your community-search by using fell address or zip code

Incredible Years-research-based, proven effective programs for reducing children's aggression and behavior problems and increasing social competence at home and at school

STRYVE Youth Violence Prevention- national initiative lead by the CDC, which takes a public health approach to preventing youth violence before it starts

Virginia High School League-extracurricular activities, including sports teams

Virginia RULES-Designed especially for teens, provides information about the laws in Virginia with particular emphasis on how they apply to teens in their day-to-day lives

4.19.1.6 Court services

Virginia CASA-court appointed special advocate program. Child advocacy program that seeks to provide trained volunteers to speak for abused and neglected children who are the subjects of juvenile court proceedings

4.19.1.7 Data and other statistical information

Casey Family Programs – state child welfare policy database-resources, statistics, data

Child Abuse and Neglect Statistics-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 in Children's Defense Fund website-non-profit child advocacy organization

Family and Children's Trust Fund of Virginia: Violence at Home: The FACT Report

Father Facts- the latest statistics on families and fatherhood

Food service programs – Participation in Virginia

Kids Count VA data

National Data Archive on Child Abuse and Neglect-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

SNAP-Participation in Virginia

Virginia Performs-shows how Virginia is doing in areas that effect quality of life for people and their families

Virginia Welfare Report Card

http://www.childwelfare.com/states/Profiles/Virginia/Welfare/0welfare.htm

4.19.1.8 Domenstic violence

Futures Without Violence - works to prevent and end violence against women and children around the world.

Love is Respect - Teen dating violence resources and helpline 1-866-331-9474

Virginia Domestic Violence Programs

Virginia Family Violence and Sexual Assault Hotline-24-hour access to crisis intervention and technical assistance 1-800-838-8238

Virginia Sexual and Domestic Violence Action Alliance-is a recognized leader in Virginia's response to sexual and domestic violence

4.19.1.9 Early childhood

Early Head Start National Resource Center-federally funded community-based program for low-income families with infants and toddlers and pregnant women

Head Start and Early Intervention Resources

Head Start Program Directory-Virginia

Healthy Families America- nationally recognized evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment

Healthy Families America-Virginia Locations/Contact Information

Infant and Toddler Connection of Virginia- early intervention supports and services in the infant and toddler connection of Virginia

Smart Beginnings-network of locally operated coalitions that are working to improve the quality of care for children from birth until kindergarten.

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

Virginia Home Visiting Consortium- collaboration of statewide early childhood home visiting programs that serve families of children from pregnancy to age 5.

Virginia Infant and Toddler Specialist Network-strengthens practices in early care and education programs to enhance the healthy growth and development of infants and toddlers

Virginia Office of Early Childhood Development- committed to expanding opportunities for high-quality early childhood development for Virginia's children-emphasizes access, quality, and accountability

Zero to Three-national, nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers.

4.19.1.10 Education

Early Childhood Special Education-provide services for children in Virginia from birth to Kindergarten age who qualify according to state and federal law

The Family Engagement for High School Success Toolkit -designed to support at-risk high school students by engaging families, schools, and the community

Virginia Department of Education-mission is to increase student learning and academic achievement

4.19.1.11 Evidence based clearinghouses

Blueprints for Violence Prevention-seeks to identify truly outstanding violence and drug prevention programs that meet a high scientific standard of effectiveness

California Evidence-Based Clearinghouse for Child Welfare- provides child welfare professionals with easy access to vital information about selected child welfare related programs

Centers for Disease Control-The CDC Division of Violence Prevention's mission is to prevent injuries and deaths caused by violence. The site includes Effective and Promising Child Abuse Prevention Programs.

Community Prevention Services Task Force-summarizes what is known about the effectiveness, economic efficiency, and feasibility of interventions to promote community heath and prevent disease

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

National Registry of Evidence-Based Programs and Practices-supplies a searchable online registry of mental health and substance abuse interventions that have been assessed and rated by independent reviewers

Office of Juvenile Justice and Delinquency Prevention- collaborates with professionals from diverse disciplines to improve juvenile justice policies and practices

Promising Practices Network-summaries of programs and practices that are proven to improve outcomes for children, youth, and families.

4.19.1.12 Evidence based programs

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

Healthy Families America-Virginia Locations/Contact Information

Incredible Years-research-based, proven effective programs for reducing children's aggression and behavior problems and increasing social competence at home and at school

4.19.1.13 Evidence based tools

Adult Adolescent Parenting Inventory-inventory designed to assess the parenting and child rearing attitudes of adolescents.

Kempe Family Stress Checklist- checklist 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. See Family Stress Checklist under Social Connections

North Carolina Family Assessment Scale-comprehensive family functioning and outcome measurement developed by providers, policy makers and evaluators

Nurturing Parenting Programs-evidence based programs that have proven effectiveness in treating and preventing the recurrence of child abuse and neglect

Parents As Teachers (PAT)-an evidence based parent education program**.** CHIP of Virginia is the state office for PAT.

Protective Factors Survey-designed for use with caregivers receiving child abuse prevention services.

Social Skills Rating System-used to assess children who have problems with behavior and interpersonal skills.

4.19.1.14 Evidence based clearinghouses

Registries rate evidence-based practices according to their own criteria. Child Welfare Information Gateway and the Children's Bureau do not endorse individual registries or the programs they include; the links are provided only as a resource.

Blueprints for Violence Prevention-FRIENDS

The National Center for Child Abuse Prevention provides a range of resources, including information on evidence based programs.

CENTER FOR STUDY and PREVENTION OF VIOLENCE

Center for the Study and Prevention of Violence, University of Colorado at Boulder

Identifies effective violence prevention programs and provides training and technical assistance to replication sites. The 11 model programs identified have been effective in reducing adolescent violent crime, aggression, delinquency, and substance abuse. Another 18 programs have been identified as promising. The guide includes details about the program review process and selection criteria.

California Evidence-Based Clearinghouse for Child Welfare

Identifies and disseminates information on evidence-based child welfare practices. Provides guidance to statewide agencies, counties, public and private organizations, and individuals on evidence-based practice as a method of achieving improved outcomes of safety, permanency, and well-being for children and families.

Guide to Community Preventive Services

The Task Force on Community Preventive Services summarizes what is known about the effectiveness, economic efficiency, and feasibility of interventions to promote community health and prevent disease. Two topics, social environment and violence, specifically address issues related to child welfare. A methods section summarizes how the task force evaluated the effectiveness of recommended programs.

National Registry of Evidence-Based Programs and Practices

Substance Abuse and Mental Health Services Administration supplies a searchable online registry of mental health and substance abuse interventions that have been assessed and rated by independent reviewers. Aims to assist the public in identifying approaches to preventing and treating mental and substance use disorders that have been scientifically tested and that can be readily disseminated to the field.

OJJDP Model Programs Guide and Database

Office of Juvenile Justice and Delinquency Prevention covers the entire continuum of youth services from prevention through sanctions to reentry. Evidence ratings are based on evaluation literature and are used to classify programs into three categories: exemplary, effective, or promising.

Promising Practices Network

Features summaries of programs and practices that are proven to improve outcomes for children, youth, and families. All of the information on the site has been screened for scientific rigor, relevance, and clarity.

Strengthening America's Families: Effective Family Programs for Prevention of Delinquency

Office of Juvenile Justice and Delinquency Prevention & Substance Abuse and Mental Health Service's Center for Substance Abuse Prevention Provides results of the 1999 search for best practice family strengthening programs, which are in two-page summaries, as well as a program matrix. Programs are divided into categories based on the degree, quality, and outcomes of research.

4.19.1.15 Family finding

Library of Virginia-archived information to find and locate family members

National Resource Center for Permanency and Family Connections- at the Hunter College School of Social Work is a training, technical assistance, and information services organization dedicated to help strengthen the capacity of State, local, Tribal and other publicly administered or supported child welfare agencies to: institutionalize a safety-focused, family-centered, and community-based approach to meet the needs of children, youth and families.

4.19.1.16 Fatherhood

National Fatherhood Initiative-seeks to improve the well-being of children by increasing the proportion of children growing up with involved, responsible, and committed fathers

National Fatherhood Initiative: Deployed Fathers and Families Guide

National Fatherhood Initiative: Programs and Products

National Quality Improvement Center on Non-Residential Fathers and the Child Welfare System-seeks to determine, through a research design, the impact of non-resident father involvement on child welfare outcomes

Virginia Department of Social Services Strengthening Families and Fatherhood Initiative-provides a point of contact for individuals and organizations seeking information about fatherhood related programs and services

4.19.1.17 Funding

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

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

Virginia CBCAP (Community Based Child Abuse Prevention) (Download)-community-based child abuse prevention-state reports

Virginia Comprehensive Service Act-provided for the pooling of eight specific funding streams used to purchase services for high-risk youth

4.19.1.18 Health

Family Access to Medical Insurance Security (FAMIS) - Virginia program that helps families provide health insurance for their children

Office of Adolescent Health- coordinates adolescent health promotion and disease prevention programs and initiatives across the U.S. Department of Health and Human Services

Virginia Department of Health-Virginia resources for resources related to healthy living

4.19.1.19 Homeless

Project HOPE-Virginia-Virginia, the Virginia Education Program for Homeless Children and Youth, is a federally-funded grant authorized by the McKinney-Vento Homeless Education Assistance Program-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

4.19.1.20 In-home services

Healthy Families America- nationally recognized evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment

Healthy Families America-Virginia Locations/Contact Information

Virginia Home Visiting Consortium- collaboration of statewide early childhood home visiting programs that serve families of children from pregnancy to age 5.

4.19.1.21 Mental health and developmental disabilities

Co-Occurring Disorders-provides information on co-occurring disorders

Maternal and Child Health Bureau-a learning portal that links individuals to existing open-access training, organized in areas consistent with nationally endorsed public health and MCH leadership competencies.

Medical Home Plus-dedicated to empowering children with special needs and their families by strengthening their pillars of supports through education, prevention, resource coordination and advocacy-organization that employs parents successfully navigating the system of care for their children

Mental Health America-country's leading nonprofit dedicated to helping ALL people live mentally healthier lives

National Institute for Child Mental Health-provides information on a range of topics that influence child and adolescent mental health.

SAMHSA – Prevention of Substance Abuse and Mental Illness-Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families-suicide prevention, mental health, substance abuse resources

The ARC of Virginia-promotes and protects the rights of individuals with intellectual and developmental disabilities.

Virginia Association of Community Service Boards, Inc. - the premier mental health, intellectual disability and substance use disorder services management and delivery in Virginia's Communities

Virginia Department of Behavioral Health and Developmental Services-Child and Family Services-ensures high quality behavioral healthcare for children from birth to age 17

Virginia Department of Rehabilitation Services-provides services to help Virginians with disabilities become more independent and self-sufficient

4.19.1.22 Parent education and support

Circle of Parents-provides a friendly, supportive environment led by parents and other caregivers. A place where anyone in a parenting role can openly discuss the successes and challenges of raising children

FACES (Family Advocacy Collaboration Empowerment Support) of Virginia Families-seeks to provide a united voice for children, youth, and families involved in foster, adoptive, and kinship care so all children and youth are treated with dignity, respect, and equality

KidsPriorityOne-Resource Center where families, and those working with families, find local resources and valuable information related to raising healthy, happy kids

National Healthy Marriage Resource Center-clearinghouse for timely information and resources on healthy marriage

Nurturing Parenting Programs-Virginia- family-centered initiative designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices

Parent Educational Advocacy Training Center-builds positive futures for Virginia's children by working collaboratively with families, school and communities in order to improve opportunities to excellence in education and success in school and community life-they provide services and support for families and professionals, easy-to-understand, research-based information and training; and opportunities for strategic partnerships and advocacy for systemic improvement.

Parent Resource Centers of Virginia-list of centers that offer information, assistance, referrals, and workshops to parents and educators

Virginia Department for the Aging-fosters the independence and well-being of older Virginians and supports their caregivers through leadership, advocacy and oversight of state and community programs, and guides the Commonwealth in preparing for an aging population

Virginia Cooperative Extension- provides a range of parent education and support resources in each locality

Virginia Cooperative Extension-Offices

Virginia's Parent Information Resource Center-serves culturally, linguistically, educationally, economically and geographically diverse families and the schools, programs and communities

4.19.1.23 Protective Factors

The National Alliance of Children's Trust and Prevention Funds: online training to support implementation of the Strengthening Families Protective Factors Framework. This free curriculum includes new materials on partnering with parents and promising strategies for practitioners. For more information and to access the online training, go to:

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

2012 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

4.19.1.24 Publications

Center for the Study of Social Policy-Publications- 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: Supporting Brain Development in Traumatized Children and Youth

My Child Welfare Librarian

National Child Traumatic Stress Network-focused on raising the standard of care and improving access to services for traumatized children, their families and communities throughout the United States

Virginia Child Protection Newsletter-focused on one or more topics in child welfare

4.19.1.25 Strengthening families

Center for the Study of Social Policy-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

Strengthening Families-research-based, cost-effective strategy to increase family strengths, enhance child development and reduce child abuse and neglect

Virginia Strengthening Families Initiative- focuses on a holistic approach that looks beyond clients as individuals and focuses on strengthening the family unit as a whole

4.19.1.26 Substance abuse

Co-Occurring Disorders-provides information on co-occurring disorders

National Center for Substance Abuse and Child Welfare- mission is to develop and implement a comprehensive program of information gathering and

dissemination, to provide technical assistance and to develop knowledge and its application that promotes effective practice, organizational, and system changes at the local, state, and national levels.

SAMHSA – Prevention of Substance Abuse and Mental Illness-Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families-suicide prevention, mental health, substance abuse resources

Virginia Al-Anon-The Al-Anon Family Groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope, in order to solve their common problems-believe that alcohol is a family illness

4.19.1.27 Trauma

Center for the Study of Social Policy- Using data, extensive community experience and a focus on results, CSSP promotes public policies that strengthen families and protect and lift children from poverty, helps child welfare and other public human services systems improve their work and achieve race equity for children and families in their care and provides tools and resources.

Child Welfare Information Gateway: Supporting Brain Development in Traumatized Children and Youth

National Child Traumatic Stress Network-focused on raising the standard of care and improving access to services for traumatized children, their families and communities throughout the United States. Also developed the Child Welfare Trauma Training Toolkit.