# Virginia's Annual Report on the Five Year Child Welfare Plan

# 2012

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# Commonwealth of Virginia

## Department of Social Services

## Division of Family Services

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**Training Plan**
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# Frequent Abbreviations

| | |
|---|---|
| APSR | Annual Progress Services Report |
| BHDS | Virginia Department of Behavioral Health and Developmental Services |
| CAPTA | Child Abuse Prevention and Treatment Act |
| CFCIP | Chafee Foster Care Independence Program |
| CFSP | Child and Family Service Plan |
| CFSR | Child and Family Services Review |
| CPMT | Community Policy and Management Teams |
| CPS | Child Protective Services |
| CRAFFT | Community Resource, Adoptive and Foster Family Training |
| CSA | Comprehensive Services Act for At Risk Youth and Families |
| CSB | Community services boards |
| CQI | Continuous Quality Improvement Unit |
| DFS | Division of Family Services |
| DJJ | Virginia Department of Juvenile Justice |
| DMAS | Virginia Department of Medical Assistance Services |
| DOE | Virginia Department of Education |
| EPSDT | Early Periodic Screening, Diagnosis and Treatment |
| ETV | Education and Training Vouchers |
| FACES | Virginia's Foster, Adoptive, and Kinship Parent Association |
| FAPT | Family Assessment and Planning Teams |
| FFY | Federal fiscal year |
| ILP | Independent Living Program |
| LDSS | Local departments of social services |
| NYTD | National Youth in Transition Database |
| OBRA | Outcome Based Reporting and Analysis Unit |
| OCS | Office of Comprehensive Services for At Risk Youth and Families |
| PCAV | Prevent Child Abuse Virginia |
| PSSF | Promoting Safe and Stable Families |
| QSR | Quality Services Review |
| SEC | State Executive Council |
| SFY | State fiscal year |
| SLAT | State and Local Advisory Team |
| VDH | Virginia Department of Health |
| VDSS | Virginia Department of Social Services |
| VYAC | Virginia's Youth Advisory Council |

## Format of the Report

### I. Description of Continuum of Child and Family Services

This section describes the continuum of child and family services in Virginia. It includes child safety services, permanency services, child well-being services, and DFS' quality assurance and data management systems.

### II. Primary Strategies, Goals and Action Steps

Virginia is pursuing six primary strategies to improve safety, permanency and well-being outcomes for children and families. These strategies are fundamental for transforming and strengthening Virginia's service system. They strive to create a more comprehensive, family-focused, integrated and effective service of care for children and families.

This section delineates the six primary strategies, goals and action steps for the five years of this plan. This represents an evolving process that will be enhanced as Virginia continues to learn. For each strategy, the applicable Children's Services System Transformation outcomes, CFSR outcomes and Systemic Factors, and CFSR items that Virginia is striving to achieve are listed. This section contains progress made on Program Improvement Plan (PIP) strategies in addition to other divisional activities.

### III. Additional Reporting Information

This section details monthly case worker visits, timely home studies, inter-country adoptions, licensing waivers, juvenile justice transfers, collaborations with tribes, and continuations of operations.

### IV. Outcomes, Goals and Measures

Virginia has integrated the outcomes, goals and measures of two important initiatives into Virginia's Five Year State Plan for Children and Family Services:

- Virginia's Children's Services System Transformation; and
- The Federal Child and Family Services Review *(CFSR).*

### V. Attachments

Attachments include the Virginia Child Welfare Staff and Provider Training, the CAPTA plan, Budget and Finance plans, and reports from the Citizen Review Panels.

# I. Description of Continuum of Child and Family Services

## A. Child Safety Services

VDSS' child safety efforts involve prevention services, prevention collaborations and the Child Protective Services Program. Each area is described below:

### 1. Child Safety Prevention Services

Prevention services include activities that promote certain behaviors as well as stop actions or behaviors from occurring. Child abuse and neglect prevention activities in Virginia include the following recognized approaches:

- Public awareness activities such as public service announcements, information kits and brochures that promote healthy parenting practices and child safety;
- Skills-based curricula for children that help them learn about and develop safety and protection skills;
- Parent education programs and parent support groups that help caregivers develop positive discipline techniques, learn age appropriate child development skills and gain access to needed services and support;
- Home visitation programs that provide support and parenting skill development;
- Respite crisis care programs that provide a break for caregivers in stressful situations; and
- Family resource centers that provide formal and informal support and information.

**Healthy Families:** The Virginia General Assembly appropriates funding for the Healthy Families program. These funds are currently awarded to 33 local Healthy Families sites serving 81 communities in Virginia to provide home visiting services to new parents who are at-risk of child maltreatment. Funding for Healthy Families Programs has been reduced since 2010. The projected amount for 2013 is $3,235,501 which is an additional decrease of 5.5% in funding from 2012. It is unknown at this time how many sites will be able to continue to operate. New contracts are being negotiated for the new state fiscal year. The Healthy Families' goals include: improving pregnancy outcomes and child health; promoting positive parenting practices; promoting child development; and preventing child abuse and neglect. The statewide organization, Prevent Child Abuse Virginia (PCAV), also receives funding through the Healthy Families Initiative to provide technical assistance, quality assurance, training and evaluation for the Healthy Families sites.

**Child Abuse and Neglect Prevention Sub-Grants:** In January 2010, a RFP was issued and 27 programs received funding including three mini grants for special initiatives around parent involvement and fatherhood. The other projects provide direct services to parents and children at risk of abuse and neglect, regional and statewide training, public education, outreach and technical assistance. Special populations served include pregnant and parenting teens, Hispanic families, homeless families, incarcerated parents, high risk fathers, elementary and middle school children, parents with disabilities and children with disabilities. Services provided include family assessments, home visiting, bilingual parent education and support groups, resource awareness, service coordination, family events, playgroups and the use of a parent education van equipped with education materials and other resources that travels to neighborhoods reaching out to parents. These grants were renewed for SYF2011-2012 and will be renewed for one final year. On June 30, 2011, a new RFP was issued for the contract period of October 1, 2011 through September 30, 2012 and 18 projects were funded from federal Community-Based Child Abuse Prevention

(CBCAP) program funds. A total of $2,135 is available from CBCAP and from the Virginia Family Violence Prevention Program.

## Child Safety Prevention Collaborations

**Governor's Advisory Board on Child Abuse and Neglect:** VDSS has utilized the Governor's Advisory Board on Child Abuse and Neglect to provide guidance and support for developing a continuum of child abuse prevention and treatment programs in the past. Effective July 1, 2012, the Governor's Advisory Board is being merged with the Family and Children's Trust Fund (FACT). FACT also provides grant funding to the state and local programs that provide prevention and family support services in the Commonwealth. FACT's mission focuses on intergenerational violence including child abuse, domestic violence and elder abuse. While transition planning is still taking place, it is likely that a standing committee of the FACT Board will serve as a Citizen Review Panel. FACT has been and will continue to be a partner with VDSS and others such as Prevent Child Abuse Virginia (PCAV) on child abuse prevention initiatives.

**Child Abuse Prevention Play:** VDSS annually contracts with Theatre IV for the production and delivery of performances of the child sexual abuse prevention play "Hugs and Kisses" in elementary schools across Virginia. Theatre IV subcontracts with Prevent Child Abuse Virginia *(PCAV)* and Virginia Commonwealth University for continued evaluation. VDSS and PCAV staff provides training on child sexual abuse to each touring cast.

**State Child Fatality Review Team:** The State Child Fatality Review Team is an interdisciplinary team that reviews and analyzes sudden, violent or unnatural deaths of children so that strategies can be recommended to reduce the number of preventable child deaths in Virginia. The Team is currently reviewing all child deaths that are related to unsafe sleep practices. The Child Protective Services Program Manager serves as a permanent member of the Team. The Team also serves as one of the Citizen Review Panels.

**Home Visiting Consortium:** The Virginia Home Visiting Consortium operates as part of Virginia's Early Childhood Initiative to increase local and state collaborative efforts and to increase the efficiency and effectiveness of home visiting services. The Consortium is chaired by the Virginia Department of Health (VDH). The Consortium has identified 38 high risk communities and proposals have been solicited from those communities. The Consortium is in the process of developing the Updated State Plan for Virginia and will be administering the funding. VDSS has an MOU with VDH and provides funding through CAPTA to support the work of the Consortium. Other members of the Consortium include Departments of Medical Assistance Services; Behavioral Health and Developmental Services; Education and two non-profit partners.

**The Virginia Statewide Parent Education Coalition** *(VSPEC)* was convened as part of the Virginia Early Childhood Comprehensive Systems initiative sponsored through the VDH as a result of a Maternal and Child Health Bureau grant. The work of this group is linked to the Virginia Early Childhood Initiative and also links with the work of the Child Abuse Prevention Committee. VSPEC consists of state and community stakeholders and service providers working together to identify gaps in parent education and to strengthen existing services. VSPEC sponsors an annual parent education conference and is working to improve the availability and quality of parent education programs.

**Children's Justice Act/Court Appointed Special Advocate (CJA/CASA) Advisory Committee**: The CJA/CASA Advisory Committee oversees the CJA and CASA programs and makes recommendations to the Criminal Justice Services Board. The Committee is composed of 15 members appointed by the Board

and is focused on improving the investigation and prosecution of child abuse and neglect. The CJA/CASA Advisory Committee serves as one of the Citizen Review Panels.

**Child Abuse Prevention Month:** Shaka and Maya Smart served as the Honorary Chairs for Child Abuse Prevention Month. Shaka Smart is the Head Men's Basketball Coach at Virginia Commonwealth University and he and his wife are new parents. A Child Abuse Prevention Conference was held on April 2, 2012 with the theme of "Every Child Counts – Know Them, Nurture Them, Protect Them". Over 400 people participated in this very successful event. The Child Abuse Prevention Month packet is developed collaboratively with PCAV. Approximately 2,000 packets are printed and distributed annually. The packet is posted on the VDSS public web site at: http://www.dss.virginia.gov/family/cps/prevention_month.cgi and on the PCAV web site at: http://www.preventchildabuseva.org for wider distribution.

**Virginia Child Protection Newsletter *(VCPN):*** An agreement is renewed annually with James Madison University for the publication of VCPN. The circulation of the newsletter is approximately 13,000 people. The topics for the three newsletters for 2012 are: Strengthening Families; Worker Safety; and Partnering with Business and Faith-Based Organizations. VCPN is also on the web at: http://psychweb.cisat.jmu.edu/graysojh.

## 2. Child Protective Services *(CPS)* Program

**Children Served.** The number of CPS complaints has remained relatively stable over the past 10 years with approximately 32,000 to 36,000 reports annually involving approximately 47,000 to 51,000 children. In 2011, there were 33,963 completed reports of suspected child abuse and neglect involving 49,619 children. Of those, 6, 116 were founded and 34, 876 reports were placed in the Family Assessment Track. In SFY 2010 -2011, 31 children died as a result of abuse and neglect.

**Child Protective Services *(CPS)*:** CPS is a program operated by VDSS focused on protecting children by preventing abuse and neglect and by intervening in families where abuse or neglect may be occurring. Services are designed to:

- Protect a child and his/her siblings;
- Prevent further abuse or neglect;
- Preserve family life, where possible, by enhancing parental capacity of adequate child care;
- Provide substitute care when the family of origin cannot be preserved.

CPS in Virginia is a specialized service designed to assist those families who are unable to safely provide for the care of their children. CPS, by definition, is child-centered, family-focused, and limited to caretaker situations. The delivery of CPS is based upon the belief that the primary responsibility for the care of children rests with their parents. Parents are presumed to be competent to raise, protect, advocate, and obtain services for their children, until or unless they have demonstrated otherwise.

Activities for child protection take place on the state and local levels. At the state level, the CPS Unit is divided into central and regional offices. Roles of the central office include:

- Developing regulations, policies, procedures and guidelines;
- Implementing statewide public awareness programs;
- Explaining programs and policies to mandated reporters and the general public;
- Coordinating and delivering training;
- Funding special grant programs; and
- Maintaining and disseminating data obtained from an automated information system.

In addition to its administrative responsibilities, the CPS Unit offers two direct services: operating a statewide 24-hour Child Abuse and Neglect Hotline; and maintaining a Central Registry of victims and caretakers involved in child abuse and neglect.

Regional office staff provides technical assistance, case consultation, training, and monitoring to the 120 LDSS. LDSS staff is responsible for responding to reports of suspected child abuse and neglect and for providing services in coordination with community agencies in an effort to provide for the safety of children within their own homes. Services can be provided through either an Investigation or a Family Assessment Response. The Investigation focuses on the situation that led to a valid abuse or neglect complaint involving a serious safety issue for the child. A disposition of founded or unfounded is made, and, if the disposition is founded, the name(s) of the caretaker(s) responsible for the founded abuse or neglect is entered in the state's Central Registry. The Investigation will also identify services that are to be provided to the family.

The Family Assessment Response is for valid CPS reports when there is no immediate concern for child safety and no legal requirement to investigate. LDSS work with the family to conduct an assessment of service needs and offer services to families, when needed, to reduce the risk of abuse or neglect. No disposition is made and no names are entered into the Central Registry.

Under Virginia law, an abused or neglected child is one under the age of 18 whose parents or other person responsible for his care cause or threaten to cause a non-accidental physical or mental injury, create a high risk of death, disfigurement or impairment of bodily or mental functions, fail to provide the care, guidance and protection the child requires for healthy growth and development, abandon the child, or commit or allow to be committed any act of sexual exploitation or any sexual act on a child.

Services include, but are not limited to: individual and/or family counseling; crisis intervention; case management; parenting skills training; homemaker services; respite day care; and/or family supervision provided through home visits by the CPS worker. The nature and extent of services provided to families depends upon the needs of the family and the availability of services within the community.

## B. Permanency Services

VDSS' permanency efforts are implemented through the Promoting Safe and Stable Families Program, Permanency Program including Foster Care and Adoptions, Independent Living, Interstate Compact on the Placement of Children, and Resource Family Development. Each area is described below:

### 1. Promoting Safe and Stable Families *(PSSF)*

PSSF services reflect the Virginia Children's Services Transformation Practice Model concept that "Children are best served when we provide their families with the supports necessary to safely raise them. Services to preserve the family unit and prevent family disruption are family focused, child centered, and community based."

PSSF services may be provided through local public or private agencies, or individuals, or any combination of resources. The funding for the program is used for direct and purchased services to preserve and strengthen families, avoid unnecessary out-of-home or out-of-community placements, reunify children and their families, or to find and achieve new permanent families for those children who cannot return home. The program funding is flexible and a local planning body determines what community services on behalf of the children and families in their respective communities will be funded or reimbursed for services.

The PSSF Program provides services to children who are at risk of out-of-home placement or who are in Foster Care. Services include:

- ***Family preservation*:** These services are designed to help families alleviate crises that might lead to out-of-home placements for children because of abuse, neglect, or parental inability to care for them. They help maintain the safety of children in their own homes, support families preparing to reunify or adopt, and assist families in obtaining other services to meet multiple needs.
- ***Family support*:** These services are voluntary, preventive activities to help families nurture their children. They are often provided by community-based organizations. These services are designed to alleviate stress and help parents care for their children's well-being before a crisis occurs. They connect families with available community resources and supportive networks which assist parents with child rearing. Family support activities include respite care for parents and caregivers, early development screening of children to identify their needs, tutoring health education for youth, and a range of center-based activities.
- ***Time-limited family reunification*:** These services and activities are provided to children who have been removed from home and placed in a foster home or a child care institution and to their parents or primary caregivers. The goal is to facilitate reunifications safely and appropriately within a timely fashion, but only during the 15-month period that begins on the date that children entered foster care. Services may include: individual, group, and family counseling; inpatient, residential, or outpatient substance abuse treatment services; behavioral health services; assistance to address domestic violence; temporary child care and therapeutic services for families, including crisis nurseries; and transportation to or from any of the services.
- ***Adoption promotion and support*:** These services and activities are designed to encourage adoptions from the foster care system that promote the best interests of children. Activities may include pre- and post-adoptive services and activities designed to expedite the adoption process and support adoptive families.

The following services are offered under each of the program service types depending on the needs of the family:

**Table 1: Promoting Safe & Stable Families Program Service Array**

| Service Code | Service Array | Service Code | Service Array |
|---|---|---|---|
| 010 | Adoption Promotion/Support Services | 160 | Juvenile Delinquency/Violence Prevention Services |
| 020 | Assessment | 170 | Leadership and Social Skills Training |
| 030 | Case Management | 180 | Mentoring |
| 040 | Community Education and Information | 190 | Nutrition Related Services |
| 050 | Counseling and treatment: Individual | 200 | Other (identify) |
| 051 | Counseling: Therapy Groups | 210 | Parent-Family Resource Center |
| 060 | Day Care Assistance | 211 | Parenting Education |
| 061 | Developmental/Child Enrichment Day Care | 212 | Programs for Fathers (Fatherhood) |
| 070 | Domestic Violence Prevention | 213 | Parenting Skills Training |
| 080 | Early Intervention (Developmental Assessments and/or Interventions) | 220 | Respite Care |
| 090 | Educational/ School Related Services | 230 | Self Help Groups (Anger Control, SA, DV) |
| 110 | Financial Management Services | 235 | Substance Abuse Services |
| 120 | Health Related Education & Awareness | 240 | Socialization and Recreation |

| Table 1: Promoting Safe & Stable Families Program Service Array | | | |
|---|---|---|---|
| **Service Code** | **Service Array** | **Service Code** | **Service Array** |
| 130 | Housing or Other Material Assistance | 250 | Teen Pregnancy Prevention |
| 140 | Information and Referral | 260 | Transportation |
| 150 | Intensive In-Home Services | | |

***Children and Families Served.*** The following table shows the number of children and families that received services by service type in 2012:

| *Children and Families Served by Service Type 92 Agencies reporting* | | |
|---|---|---|
| ***Service Type*** | ***Total Children*** | ***Total Families*** |
| ***Preservation*** | *5845* | *3718* |
| ***Support*** | *9553* | *6294* |
| ***Reunification*** | *1073* | *699* |
| ***Adoption (1)*** | *18* | *15* |
| ***Other PSSF Services (2)*** | *54,380* | *52,002* |
| ***Total*** | *70,869* | *62,728* |

*(1) $2M PSSF funds were allocated for adoption initiatives at the home office level, therefore, localities were not required to spend 20% on adoption promotion. This number includes localities that provided local adoption services.*

*(2) Some localities provided services that do not lend themselves to identifying data, as they are not targeted toward specific individuals or families (e.g., community fairs, brochures, information and referral, newsletters, library resource centers, websites, etc.)*

Many children and families receiving PSSF funds are assessed by the CSA FAPT Teams. These teams provide for family participation, assess the strengths and needs of children and their families, and develop individual family services plans.

***Funding process:*** Title IV-B Subpart 2 funds for this program are allocated to communities for control and expenditure. The CSA CPMTs are designated as the local planning bodies for PSSF funds. This role is consistent with their statutory responsibilities to manage community collaborative efforts for at-risk youth and families, conduct community-wide service planning, and maximize the use of state and community resources.

**Local receipt of funding is based on VDSS approval of individual community plans developed from comprehensive community-based needs assessments.** Localities are required to spend at a minimum: 20% funding on family preservation; 20% on family support; 20% on family reunification; and 20% on adoption promotion and support. Localities may be eligible for a waiver for these percentages with adequate justification. All localities are given a waiver for adoption promotion and support since the state applies 25% of Title IV-B Subpart 2 to adoption service contracts approved by the state.

Communities are required, under their community assessment and planning process, to establish and document linkages among services, programs, agencies, organizations, parents and advocacy groups in order to identify and prioritize service needs. Of the 120 localities (LDSS) 109 had approved plans for SFY 2012. Some plans cover more than one local jurisdiction. Also, it is not uncommon for the localities to combine their plans and then split based on dictates of local governing bodies during the plan cycle.

***Program Monitoring & Outcome Measures:*** The PSSF state office staff conducts limited training to assure local program staff knowledge in the following key areas: service planning and delivery; outcome measurement; data management; and budget development. Ongoing monitoring through review of quarterly reports and targeted on-site technical assistance as necessary is conducted to ensure the appropriate use of funds.

Regular reports are required of each locality to determine how well the localities meet the objectives. The reports include numbers of:

- Families receiving prevention services, and how many of their children enter foster care;
- Families whose children are in foster care 15 months or less who receive reunification services;
- Children who are placed with relatives other than the natural parents;
- Children for whom a new abuse complaint was made; and
- Families served by ethnicity.

## Populations at risk for Maltreatment

In Virginia, PSSF funds (Title IV-B) align with CAPTA funds. CAPTA state grant funds were used, alone or in combination with Title IV-B, in three major areas: Safe Children and Stable Families; Family, Child and Youth Driven Practice, and Strengthening Community Services and Supports. [See excerpt below from the Virginia State Plan for Child Abuse Prevention and Treatment Act (CAPTA)]

Last year, the Department of Social Services (VDSS) concentrated efforts in improving local department staffs' abilities to assess initial safety and risk, revised the CPS policy/guidance manual to include tools on how to more accurately and consistently assess initial child safety and risk including factors such as domestic violence, mental health issues, and substance abuse, and assessed local staffs' ability to improve response times to CPS reports. State CPS staff developed and implemented statewide training for CPS supervisors and workers on screening, assessment, decision making and referral for investigating suspected child abuse and neglect using new intake, safety and risk assessment tools. Fifty, two-day sessions were held across the state using the Structured Decision Making (SDM) model in May through July 2011. State CPS staff and local supervisory staff were paired to conduct this training. An additional 15 one-day sessions designed for those staff performing on-call functions took place in August through September 2011. In addition, two, one-day sessions for all State Hotline staff on the screening intake functions was held on June 22 and 23, 2011. Over 1,500 CPS supervisors and workers participated in the training sessions.

State staff is continuing to work with localities to support and sustain the practice change around intake, safety and risk assessments. Focus groups have been held to assess continued needs, field guides have been developed and are currently being piloted in 10 localities, support groups for supervisors are being held bi-monthly for supervisors to review the case monitoring tools and discuss outstanding issues. New reports have been generated by locality from Safe Measures to assist the State in evaluating the current use of the intake, safety and risk assessment tools as well as to evaluate local agency response times to reports of suspected child abuse and neglect. A new report has been developed in Safe Measures to assess how well local CPS workers are adhering to the new policy on timeframes for face to face contact

with victims. Regional CPS consultants are working with individual localities to help them improve in all of these identified areas.

In terms of improving local department staffs' abilities to conduct service needs, risk re-assessments and develop relevant service plans, State CPS staff have reviewed the SDM family strengths and needs assessment tools to ensure consistency with Virginia policies and regulation, and have completed a case review of approximately 50 cases to assess the quantity and quality of services being provided. This work is being done in conjunction with the National Resource Center for In-Home Services. CPS Policy directs staff to open cases based on the risk assessment. The Structured Decision Making model guides staff to open cases based on risk, very high, high or some moderate risk cases; it does not support serving families determined to be low risk.

## 2. Permanency Program – Foster Care Services and Adoptions

**Children served.** A total of 7,795 children received foster care services throughout FFY 2011. However, this number reflects children who were in care at any point in time during the year and is an aggregate number of children served. On September 30, 2011, there were 4,800 children in foster care.

Reductions in children in care from prior year totals reflect continued efforts to "clean up" OASIS data, providing financial incentives to place children in community-based settings, reductions in the number of children in congregate care, increased reliance on foster family homes, greater push to discharge children to permanency, implementing real-time access to permanency data for state and local staff (SafeMeasures), cross-system data sharing and state-supported implementation of selected best practices (e.g., family partnering).

**Permanency Unit - Foster Care Services:** The objective of Foster Care Services is to provide the programmatic and fiscal guidance and technical assistance to LDSS to enable them to provide safe, appropriate, 24-hour, substitute care for children who are under their jurisdiction and to increase their ability to find family homes and develop or maintain positive adult connections for all children in care. Foster care in Virginia is required by state law to provide a "full range of casework, treatment and community based services for a planned period of time to a child who is abused, neglected, or in need of services." All children in foster care are placed through a judicial commitment or a voluntary placement agreement to a LDSS or a licensed child-placing agency. Foster care services are provided to each child and family to either prevent foster care placement or, once placed in foster care, to facilitate a timely return to a permanent home. The LDSS have either legal or physical custody of children in foster care and are responsible for providing direct services to all children and their families.

VDSS continues to implement best practices to support local efforts to improve services to children and families involved in the foster care system. VDSS provides program training and technical support to each of its 120 LDSS through its regional support network of five permanency consultants. These consultants provide LDSS quality reviews, conduct technical assistance on foster care and adoption policy and procedures, and are available for on-site technical assistance as required. In this past year, the consultants also began holding "permanency roundtables" to assist the LDSS in staffing cases (particularly those of older youth) where achieving permanency has been a difficult issue. VDSS home office staff also provides program support for the implementation of Independent Living Services and family support, stabilization and preservation services through regional training efforts and technical assistance to all localities.

There has been work around developing guidance, procedures and tools to improve adoption assistance to facilitate adoption of children in foster care. Permanency, Resource Family, and CRAFFT regional

consultants have been involved in developing dissemination and training strategy for implementation. The division finalized the development of one Child and Family Services Manual (Introduction, Prevention, CPS, Resource Family, Foster Care and Adoption) that shares a consistent format, incorporates the practice model into substantive policy and practice changes, and integrates programmatic aspects across foster care and adoption. The Foster Care Chapter has been reorganized to reflect new philosophy, to be based on the needs of children and families, to be consistent with the work flow of best practice for the service worker, to consolidate information on topics in one place, and to simplify the user's ability to find information. In an effort to remove "silos" between foster care and adoption, parts of the adoption manual have been moved into the foster care manual to better integrate the processes. The adoption manual has been under revisions for the last year, resulting in a total rewrite that is currently in the final stages of review before making it available to the field.

VDSS has developed and is poised to post a second set of joint guidance and tools with the Virginia Department of Education (DOE) to ensure educational stability and improve educational outcomes for school aged children and youth. The guidance and tools were developed by a cross systems work group of VDSS, DOE, legal advocacy, and local stakeholders. Statewide training events continue to be convened by DOE and DSS (separately and together) to disseminate and train local education and social services staff. VDSS is working with DOE to obtain educational outcome data on children in foster care who receive adoption assistance payments (and custody assistance payments when that program is implemented). A major accomplishment has been the ability to get the Student Testing Identification Number statewide on all school aged children in foster care. VDSS has identified a list of outcome data that DOE routinely collects on all students that apply to children in foster care with the goal of producing aggregated reports by LDSS and by school division that shows educational outcomes for children in foster care. Aggregated data for LDSS or schools with less than ten children will not be reported to prevent any potential identification of individual children. VDSS is asking for assistance from the Legal Center for Foster Care and Education on developing an MOU to facilitate data sharing between the two agencies.

## Foster Care Collaborations

Foster care services cut across other programs and child-serving agencies, including foster care prevention, Adoption, OCS, BHDS, DJJ, DOE and VDH. Virginia is actively working with other internal Divisions and State agencies to improve service delivery to children and families involved in foster care as one component of the Children's Services System Transformation. Other collaborations include:

**FACES:** This non-profit is a membership organization for foster, adoptive and kinship families and others who support the benefit of children, youth and families across Virginia. FACES stands for Family Advocacy, Collaboration, Empowerment and Support.

FACES has formed an alliance with Voices of Virginia's Children and the Virginia Poverty Law Center to host a second housing and child welfare summit.

FACES developed a Lean on Me program to alert communities about needs of families in their area. This collaboration involves families, businesses, and others in individually and collectively responding to the unmet needs of foster, adoptive, and kinship families. In its first few months of operation the program served 56 families distributed over $10,000 in merchandise.

FACES partnered with Project LIFE, VA One Church One Child, and CRAFFT to provide family training across Virginia. These workshops were established based on assessed training needs of families. Training topics across the state included: Trauma and Loss: Impacts on Child Development; Nutrition and Behavior; Educational Advocacy; Permanency planning; and "Internet Safety". These workshops are also being developed into webinars hosted on the FACES website.

FACES provides the following log of outputs for the provision of services to families this past year:

- 1062 families through electronic alerts and newsletters
- 268 families served through the Warm-Line
- 89 youth served through subscriptions to V-street and training workshops
- 257 parents served through the annual training institute
- FACES receives an average of 300 hits per day on its website.

**Permanency Advisory Committee *(PAC):*** The PAC began regular meetings in 2009 and has grown in size through broader representation of stakeholders from around the Commonwealth. PAC established a clear purpose and charge, reflecting its advisory nature to the state's foster care and adoption programs, on policy and procedural changes needed to improve guidance to LDSS in both programs. With the changes affecting children's services in Virginia through the Systems Transformation, the PAC provides a venue within which guidance and best-practice is matched against the Virginia state practice model. In FFY 2012, PAC actively provided input on the new adoption guidance manual and has been involved in setting policy for the new credit check requirements for older youth in foster care and revisions to the assessment and service plan screens in OASIS.

**Court Improvement Program *(CIP):*** VDSS continues to work in partnership with the CIP in Virginia. The Division Director and the Manager of the Outcomes Based Reporting and Analysis Unit have met with CIP leadership to finalize a system for sharing data across both agencies for the purpose of better tracking of court hearings for children in foster care. CIP staff continues to be involved in the on-going efforts of the VDSS Child Welfare Advisory Committee, which served as an advisory group for the development and implementation of the CFSR Program Improvement Plan. In the last year, CIP staff also worked with VDSS to provide training to judges on adoption assistance, custody assistance (i.e., subsidized guardianship) and family engagement and family partnerships meetings. VDSS and CAP also partnered to provide training to local attorneys on similar topics.

**Office of Comprehensive Services for At Risk Youth and Families *(OCS):*** Areas of collaboration include: Clarifying CSA and Foster Care Code interpretations regarding custody assistance (i.e., subsidized guardianship); clarifying guidance related to what CSA funds can be used for when Title IV-E funds are not allowable; involvement in regional family engagement roundtables with the regional Foster Care/Adoption Consultants, the CPS Consultants, the Resource Family Unit Consultants, the CRAFFT regional consultants and the IL Consultants.

**Department of Education; Department of Medical Assistance Services:** The Foster Care Program staff continued strengthening previously non-existent relationships with these agencies through workgroups to assess and develop improved policies and practices for children in care. The Educational workgroup's work plan includes a strategy to develop and document a process for on-going collaboration between the two state agencies that can also serve as a model for how local educational associations and LDSS' should work together on an on-going basis. The Department of Medical Assistance Services (DMAS) is actively working with the VDSS to implement managed care for all children in foster care and adopted children. The move to managed care was accomplished for a pilot LDSS and a statewide workgroup has been formed and is meeting to address implementation strategies for the central and eastern regions by April 2013. This initiative with DMAS is a two year project, during which other aspects of the health care needs of children in foster care are being addressed (See Health Care advisory committee report).

**National Resource Center *(NRC):***
<u>Kinship Care</u>

Virginia requested and was approved for technical assistance on assessment in kinship care. The reason for this request was to support the implementation of the foster care permanency option of Placement with Relative with transfer of custody to the relative with custody assistance as described in the Fostering Connections Act. Gary Mallon, consultant National Resource Center on Permanency and Family Connections (NRCPFC) came to Virginia on April 23, 2012 to facilitate a site assessment. Participants included state and local staff with experience in working with foster, adoptive and kinship (resource) families. A work plan has been developed to address several needs in the area of kinship that are identified below:

1) Select or develop a tool or instrument for use in conducting kinship family assessments which will address domestic violence, substance abuse and mental health issues and make it available to child welfare staff conducting kinship home studies.
2) Select or develop a training curriculum for child welfare staff to facilitate their skills for working effectively with kinship families and evaluating the appropriateness of family members to meet the needs of children in foster care as the child's permanent family and develop an implementation plan
3) Develop a script/strategy to assist child welfare workers in explaining to relatives the various ways that they can be involved in a child in foster care's life including custody transfer, adoption and custody assistance and make it available to child welfare workers.

Independent Living

Virginia requested and received approval for training and technical assistance (T/TA) from the National Resource Center on Permanency and Family Connections (NRCPFC) on youth permanency. Due to a new law, the LDSS can no longer assign the goal of Independent Living (IL) to youth; however, the law did not affect IL services. Eliminating the goal of IL (effective 7-1-11) is a major change for many of the LDSS and they are in need of T/TA in achieving permanency and lifelong connections for youth. NRCPFC will assist the state in developing and implementing an integrated approach to permanency and preparation for adulthood. Gary Mallon, consultant with NRCPFC, met with representatives from VDSS and LDSS on May 9, 2012 and collaboratively a work plan was developed to address permanency for older youth. NRCPFC will provide detailed information and T/TA to inform three action groups focusing on; Family Finding; Integration of youth voice in Family Partnership meetings, and Permanency Roundtables.

Adoption

Virginia has also requested assistance from the NRC for Adoption to provide capacity building around negotiating for adoption assistance. With the advent of the new adoption manual slated to be issued by fall 2012, LDSS have expressed a need for training on the skill set involved in negotiating adoption assistance agreements. The first teleconference with the federal training liaison for such NRC requests was held on May 23, 2012.

**Permanency - Adoption Services:**

Virginia's Adoption Program is state supervised and locally administered. LDSS provide direct adoption services to children in their custody with the permanency goal of adoption. The VDSS Permanency Unit Adoption Services is responsible for developing adoption policy and managing the Adoption Resource Exchange, developing and managing special initiatives, managing adoptions records, and maintaining access to adoption records. Virginia's special adoption initiatives are designed and implemented in order to assist LDSS to ensure that children achieve permanency through adoption. The special initiatives provide adoption services and funding by VDSS to local departments of social services and private adoption agencies to achieve adoptions.

The following chart shows Virginia's adoption initiatives and the funding for these initiatives in SFY 2012.

| Adoption Initiatives SFY 2012 | Funding Source | Allocation & Services |
|---|---|---|
| Adoption Support | Title IV-B, Subpart 2 Adoption | $1,125,000 Post Legal System<br>$173,650 Ainsworth Clinic<br>$531,271 34 LDSS array of adoption services |
| One Church, One Child | SSBG State General Funds | $193,209 recruitment |
| Adoption Services | SSBG State General Funds | $1,079,931 9 private agencies<br>Full array of adoption services |
| Adoption Assistance | Title IV-E State General Funds | June 2012<br>$43,500,000 Title IV-E<br>$46, 200,000 State |

Virginia was found to not be in substantial conformity with the adoption outcomes in the 2009 CFSR. Two key findings on adoption from the Review are:

- Delays in completing or approving home studies
- Delays due to a general lack of effort to finalize an adoption.

Data showing the decrease in placements of eligible children in adoptive homes and increase in the numbers of children waiting for such placements suggests that, without focused and intensive strategies to find, approve and place children into safe and permanent adoptive homes, Virginia's waiting children will increase.

Consequently, the adoption services contracts beginning July 1, 2011 to June 30, 2012 were redesigned based on data specific to the number of children in the custody of each LDSS with the goal of adoption, with parental rights terminated but not in an adoptive placement. Virginia contracted with Michaeline (Mickey) Groomes, Consultant, Data Driven Performance Based Management to frame and to guide the contract process.

Virginia awarded approximately $1.8 million in funding through Title XX/SSBG (Social Services Block Grant), Title IV-B Subpart 2 (CFDA 93.556) and State General Funds for adoption services contracts. Thirteen contracts were awarded to private non-profit licensed child placing agencies (LCPA) licensed in Virginia and Virginia local departments of social services (LDSS). Under the title, "Adoption Through Collaborative Partnerships" (ATCP), two types of contracts were awarded as specified:

- LCPAs (Offeror/Lead Agency) in partnership with a minimum of two (2) local Department of Social Services (total team of at least 3); and
- LDSSs (Offeror/Lead Agency) in partnership with other local Department of Social Services, other child serving agencies, or service providers (total team of at least 3)

The primary outcome expected by VDSS from the use of collaborative partnerships to achieve adoptions is to *finalize* adoptions for a minimum of 356 children and youth in foster care. Grant funds awarded are to be used to expedite the adoption of three particular subsets of children in the custody of local departments of social services (LDSS).

<u>Target Group</u>

**Category 1:**Children and youth with a goal of adoption, with termination of parental rights (TPR), not in a pre-adoptive home, who have the potential to be adopted prior to twenty-four months (i.e., children in foster care less than 16 months). The target number for final adoptions in this group is a minimum of 32.

**Category 2:** Children and youth who have a goal of adoption, with termination of parental rights (TPR), not in a pre-adoptive home, and are not likely to be adopted within 24 months of their entry into foster care (i.e., children in foster care 16 months or more). These youth are at high risk of aging out of foster care due to an excessive length of stay in the foster care system. The target number for final adoptions in this group is a minimum of 149; and

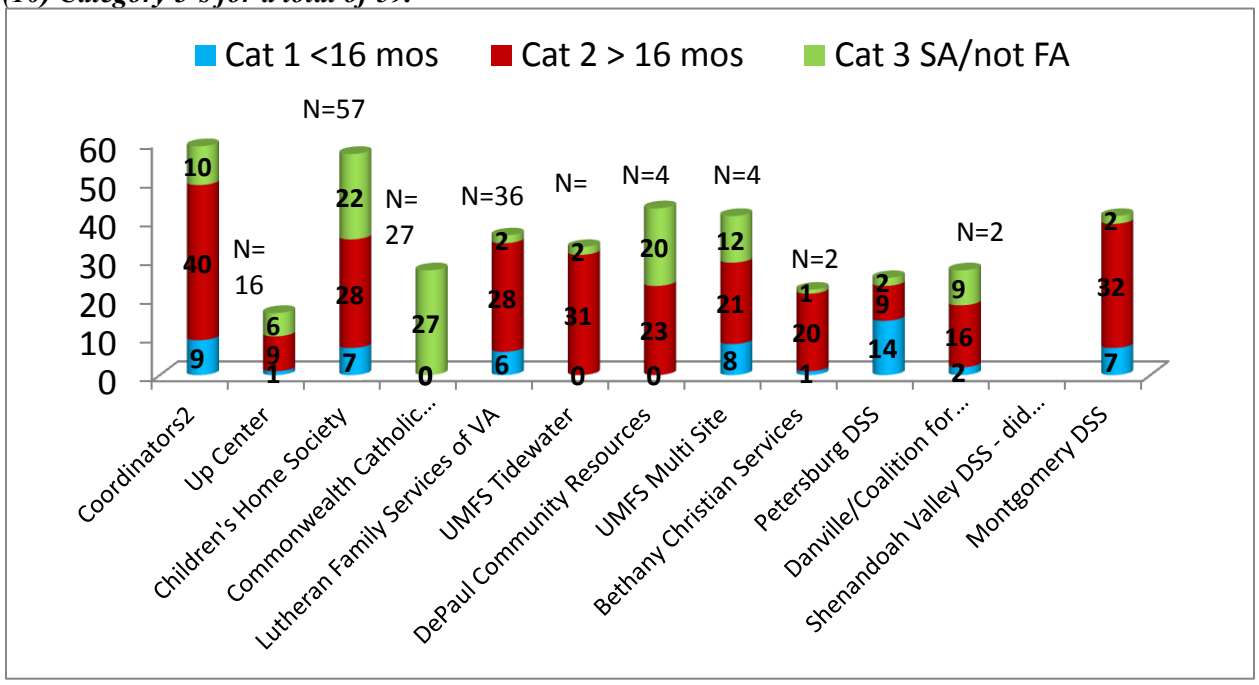
**Category 3:** Children and youth in foster homes, with the goal of adoption, with termination of parental rights (TPR), and an adoptive placement agreement has been signed, but the adoption is not finalized. The target number for final adoptions in this group is a minimum of 175.

Focus Areas

- Locate and place children/youth in safe, permanent adoptive homes;
- Increase timely adoptions for children/youth who can be adopted within 24 months of entry into care;
- Increase the number of children/youth adopted over age 6; and
- Increase of children whose foster parents have expressed an interest in adopting the child/youth, but have not yet signed adoptive placement agreements, is a particular area of concern to VDSS.

**Based on the reporting (12) ATCP Providers, the "number" breakdown for Category 1, 2 and 3 populations currently being worked* Total n=427 (Cat 1 = 55 + Cat 2= 257 + Cat 3 = 115)**

***How to read this chart – i.e., Coordinators2 is working with (9) Category's 1, (40) Category 2's, and (10) Category 3's for a total of 59.***




The thirteen contractors are partnering with sixty-two local departments of social services. Milestone Performance Measures for the ATCP contractors are as follows:

1. *Home Study Completed/Updated and Approved*

2. *AREVA Family Registration Completed*
3. *ATCP Contract Team Agrees to Match*
4. *Adoption Placement Agreement Signed*
5. *Six (6) Month Supervision Completed, if required*

Based on self-report 3rd Quarter Reports from the thirteen contractors the following are the outcomes:

| ***Children Served through 3rd Quarter*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***Measures*** | *Final Order* | *Age 9<* | *Age 10>* | *Matches* | *Agreement Signed* | *Disruptions* | *Dissolutions* |
| ***Total*** | *209* | *111* | *98* | *198* | *170* | *13* | *0* |

| ***Families Served through 3rd Quarter*** | | | | |
|---|---|---|---|---|
| ***Measures*** | *Home Study Completed/Updated* | *AREVA Registration* | *Match Approved by LDSS* | *Matched and Placement Agreement Signed* |
| ***Total*** | *151* | *45* | *81* | *70* |

Below are a few notes provided by the ATCP contractors for youth who did not achieve a finalize adoption or who are in a "holding pattern" unpacking the no's:

- Youth not interested in adoption, plans to pursue Independent Living.
- Relative identified, exploring placement option.
- Run away status
- Closed, aged out
- Grandmother identified; looking at custody

The ATCP contractors provide recruitment through various means such as Wednesday's Child, flyers, the Heart Galleries, churches, parent magazines, etc. Preparation of the children for adoption includes creation of life books, family partnership meetings, etc. Preparation of families includes training using the PRIDE curriculum and specialized training on topics such as CPR, Crisis intervention, Communication in Crisis, Love and Logic Parenting and Foster Parent College.

**Adoption Assistance Program:** Virginia's adoption assistance program provides a money payment or services to adoptive parents on behalf of a child with special needs who are either eligible for Title IV-E or state supported assistance. Virginia also provides non-recurring expenses and may provide special service payments for children who meet the state's definition of special needs.

Number of Children Served during SFY 2011 (last complete year data is available):

- A total of 6,409 children per month received Adoption Assistance.
- 4,948 children received Title IV-E Adoption Assistance.
- Total allocation for Title IV-E Adoption Assistance was $43,500,000
- 1,461 children received State Adoption Assistance.
- Total allocation for State Adoption Assistance was $46,3000,000
- The local departments of social services provided for a total of 753 adoptions in federal fiscal year 2011.

**Adoption Evaluations and Assessments**: VDSS contracts with the Mary D. Ainsworth Child- Parent Attachment Clinic (MDA) to provide pre and post-adoption mental health assessments for children and

families interested in adopting or who have adopted children. The Mary D. Ainsworth Child-Parent Attachment Clinic provides assessments and evaluations to families statewide in need of mental health assessment after post adoption. During SFY 2012, MDA provided assessments to 20 children and their families. They also provided training for up to 60 families on managing children with attachment disorders. The training was a new aspect of services from Mary D. Ainsworth and involved 12 sessions of training per family.

**Adoption Family Preservation Services:** Virginia utilized Title IV-B, Subpart 2 funding to create an Adoptive Family Preservation Services *(AFP*) system. United Methodist Family Services manages and provides for the statewide services delivery AFP network. The AFP project serves families who have adopted domestically and may also serve families that have adopted internationally. The AFP program design uses a multi-site, multi-level system of services to offer families an array of options that they may need to support and strengthen functioning, and preserve adoptive families.

The post-adoption services model is implemented in Virginia by a network of a total of four private agencies employing adoption professionals, clinicians, and adoptive parents hired and trained to provide services as Adoptive Parent Liaisons (APLs). These agencies are: UMFS Northern VA, UMFS Tidewater, UMFS Charlottesville, UMFS Lynchburg, UMFS South Central, Center for Adoption Support and Education (C.A.S.E.), Coordinators 2, and DePaul Community Resources in Roanoke/Abingdon. Multiple program sites each operate a somewhat different blend of services tailored to the diverse rural and urban communities served.

For Fiscal Year 2012 **(**July 2011 - March 2012**),** a total of 315 families were served across these sites. There were 1181 hours of counseling offered to 159 families and 1431 hours of support groups offered to 143 families. UMFS is reporting 4341 hours of case management activities with 311 families and 254 hours of educational case management was offered to 60 families. There were 363 hours of information and referral activities completed for 423 inquiries. 377 hours of therapeutic counseling was offered to 35 families and 41 hours of crisis intervention was offered to 19 families. There were 72 hours of parent training activities with 21 families and 65 families accessed the client fund.

**Adoption Resource Exchange of Virginia *(AREVA).*** VDSS administers AREVA, providing statewide recruitment efforts for children in foster care who are legally free for adoption. AREVA staff maintains Internet websites featuring photographs and narrative descriptions of waiting children at http://www.dss.virginia.gov/family/ap/children_for_adoption.cgi and (http://www.adoptuskids.org/states/va/index.aspx). AREVA staff supports efforts of AdoptUsKids on a national level and works with local agencies to have Heart Galleries in each of the five regions of the Commonwealth on a continuing basis. The most recent Heart Gallery for Central Virginia created in March, 2011 was displayed at the Children's Museum of Richmond, and is currently on display in Charlottesville, Virginia with plans of future displays in Williamsburg, VA. Another Heart Gallery opened in Portsmouth in November 2011 at the Portsmouth Children's Museum featuring twenty-three waiting children. The Northern Virginia Region is planning to open a Gallery in Winchester on November 9, 2012 with 14 new children who are awaiting permanent placements. Heart Galleries have been very effective in recruiting families for waiting children. More than 270 children have been featured and 52% of those children are either in a finalized adoptive placement or some phase of the adoption process. More information about the Heart Galleries is available at: (www.heartgalleryva.org).

In December 2004 there were waiting children for adoption in the Colorado foster care system. It was known that there were over 3,000 churches in Colorado with members 'called' to adopt children. The result was Project 1.27 as the answer to the question of how do we assist in connecting the children waiting for a 'forever Christian family' with church members wanting to adopt? This philosophy is similar to the One Church, One Child minority movement that began in Illinois in the '80's and was

created in Virginia in 1985. Using this blue print as the guide, VDSS, Virginia One Church, One Child and several faith-based Child Placing Agencies collaborated with organizers of the "Change Who Wait" (Project 1.27) movement. In May 2012, this collaboration produced two large rallies (in Central and Eastern VA) with over 5oo persons in attendance. The purpose of the rallies was to engage families to become foster parents, adoptive parents or mentors for the waiting children in VA. Prospective families heard from seasoned foster and adoptive parents about the joys and trials that come from engaging in this quest. They also were given "words of advice" through several short videos, including one produced locally by United Methodist Family Services. There are plans to extend this recruit methodology into other region of the state. The goal is to have families waiting for children rather than children waiting for families.

AREVA works collaboratively with local agencies and child placing agencies that are devoted to working with children from the foster care system during November of each year to promote Adoption Day Celebrations on the third Saturday and other adoption celebratory events throughout the month. In 2011, there were 23 events throughout the month with 13 events on National Adoption Day. Virginia General Assembly passed House Joint Resolution 41 which recognized November 2008, and each succeeding year thereafter, as Adoption Awareness Month. The Governor signs a proclamation annually declaring November Adoption Awareness Month.

***Number of People Served.*** As of May, 2012, 707 children and 262 families were registered with AREVA.

**Adoption Incentive Funds:** In October 2011, VDSS received notice of a $53,647 Adoption Incentive Award based on adoptive placements of children from foster care during FFY 2010. In past years, the adoption incentive funds received were allocated to the LDSS. Due to the low amount of incentive funds awarded, no such allocation took place this year. VDSS used these funds to support two faith-based adoptive parent recruitment events and to assist in funding adoption contracts.

**Other Services:** In addition to adoption services for children in foster care, VDSS is the central records keeper of closed adoption records. The Department maintains over 250,000 closed adoption records dating back to 1942. During FFY 2011, VDSS added 2,379 more adoption records to the archives. Information from closed adoption records may be released to adopted individuals over the age of 18 under specific circumstances and to adopted parents and birth family members for adoptions finalized after July 1, 1994, all governed by law. VDSS also provides adoption services for children who are not in the custody of LDSS, as well as other court ordered services such as custody investigations and visitation.

**Adoption Collaborations**

**AdoptUsKids**: Virginia collaborates with the national adoption network to provide national photo listing of waiting children in Virginia.

**Adoption Development Outreach Planning Team *(ADOPT).*** ADOPT is a voluntary child-advocacy group of individuals from public and private child welfare agencies, adoptive parents, therapists, attorneys and other interested in promoting its purpose. ADOPT is committed to promoting and assuring the rights of children in Virginia to permanent homes through advocacy, education, legislative activities, and examination of practice issues.

**Adoption Exchange Association:** This national non-profit organization is committed to the adoption of waiting children. It is the lead agency in AdoptUsKids, a Federal grant through the Children's Bureau, to recruit adoptive families for children waiting in foster care across the United States. It is also the membership organization for Adoption Exchanges, of which VDSS is a member.

**American Academy of Adoption Attorneys:** This organization is a not-for-profit national association of attorneys, judges, and law professors who practice and have otherwise distinguished themselves in the field of adoption law. It has collaborated with the VDSS by participating on various committees regarding adoption and providing input for proposed legislation regarding adoption and custody issues.

**The Center for Adoption Support and Education *(C.A.S.E)*:** This private, non-profit is an adoptive family support center. Its programs focus on helping children from a variety of foster care and adoptive backgrounds to receive understanding and support which will enable them to grow into successful, productive adults. C.A.S.E. defines post-adoption services as ongoing, comprehensive support services that include education, counseling, family forums, and advocacy which address clearly identified developmental issues and social-emotional challenges frequently shared by adoptees and their families. Post-adoption involves preventive measures to ensure the preservation of adoptive families.

**FACES:** This non-profit is a membership organization for foster, adoptive and kinship families and others who support the benefit of children, youth and families across Virginia. FACES stands for Family Advocacy, Collaboration, Empowerment and Support.

**Virginia One Church, One Child (OCOC):** The Virginia Department of Social Services (VDSS) has a sole source contract with OCOC to recruit families for children in foster care with the goal of adoption. Virginia's OCOC program is the only organization that solely recruits within African-American churches. These churches make a commitment to find adoptive families within their congregations and throughout their communities. VDSS has contracted with OCOC since 1985. However, beginning in 1994 with the Multiethnic Placement Act (MEPA) and the 1997Adoption and Safe Families Act (ASFA), OCOC has more broadly focused its recruitment efforts to include support of the adoption services contractors in the areas of child specific recruitment for any waiting child and family training and support. These efforts are now including regional trainings in Best Practices for matching families and children; Best Practice in completing assessments of the children and Best Practice in post-placement services to families and children.

For SFY 2012 the following are outputs from OCOC recruitment, family training and support:

| | |
|---|---|
| Individuals Attending Church and Community Presentations | 2600 |
| Families Attending Orientations | 49 |
| Families Referred to Contract Agencies for Adoption Services | 20 |
| Families Attending Faith-Based Rallies | 400 |
| Parents Receiving In-Service Training (Family Academies) | 132 |
| Families Receiving Post Adoption Services | 28 |
| Workers Receiving Specialized Adoption Training (Regional Institutes) | 114 |
| **OCOC Unduplicated Count of Children** | |
| Children Served—Child Specific Recruitment | 67 |
| Children/Youth Receiving Post Adoption Services (Youth participating in Adoptive Family Retreats) | 55 |

**National Resource Center for Adoption**: This center provides assistance to states and other federally funded child welfare agencies in building their capacity to ensure the safety, well being, and permanency of abused and neglected children through adoption and post legal adoption services program planning, policy development and practice.

**Department of Medical Assistance Service *(DMAS):*** DMAS provides a system of cost effective health care services to qualified individuals and families. It provides medical services through Medicaid providers for adopted children with adoption assistance agreements that require medical or rehabilitative needs or who qualified for Title IV-E.

**Office of Comprehensives Services for At Risk Youth and Families *(OCS):*** OCS administers CSA which provides child-centered, family focused, cost effective, and community-based services to high-risk youth and their families. The VDSS collaborates with CSA to coordinate and provide services for children with adoption assistance agreements.

## 3. Independent Living Program

**Children served.** According to FFY 2011 data entered in OASIS by the local departments of social services (LDSS), more than 1,665 youth, (unduplicated number) ages 14 and over, received independent living (IL) services.

***Independent Living Program*** *(Services to Older Youth)*

Services to Older Youth (previously, the Independent Living Program) is a component of the state's foster care program. While the goals and services of the program apply to older youth in care, these services are integrated throughout the Foster Care Manual to reinforce the need for all children and youth to learn independent living skills as their age and capability permits. Independent Living (IL) services are not limited to youth with the goal of IL or youth living in an IL arrangement. These services must be provided to each youth, age 14 or over, in foster care regardless of the youth's permanency goal. While the provision of such services is mandated by law, assisting youth in developing the permanent connections and skills necessary for long-term success is the most important consideration in utilizing this funding.

State staff are responsible for developing policies, procedures and develop new programs as necessary to increase understanding of, and statewide services to older youth in accordance with the Chafee Foster Care Independence Program (CFCIP) and the Education and Training Vouchers (ETV) Program. VDSS has developed a chapter in the Foster Care Manual, entitled, *Serving Older Youth* which provides guidance to the local workers in working with youth in and transitioning out of care.

LDSS are primarily responsible for providing IL services to eligible youth ages 14-21. They continue to work closely with the local Comprehensive Services Act (CSA) teams which are responsible for overseeing the planning of, and approving state funds for, additional services for youth not covered by the CFCIP funds. Together, LDSS and CSA teams share the primary responsibility for ensuring that youth in foster care are provided with the services needed to enhance their transition into adulthood. Virginia Code indicates that youth are no longer in foster care when they reach the age of majority; however youth over the age of 18 who have been in foster care can voluntarily agree to receive IL services until age 21. This population continues to receive all services available to youth in foster care and continue to have Medicaid coverage as long as they meet eligibility requirements. In addition, funding and services are available for youth between ages 18 and 21 who discontinued receiving IL services and then requested the resumption of IL services within 60 days. In accordance with options in the Fostering Connections to Success and Increasing Adoptions Act of 2008, Virginia continues to develop or refine guidance addressing youth engagement, educational stability and attendance, health, transitioning planning for young adults aging out and how VDSS and LDSS will support youth who are adopted after attaining 16 years of age.

Due to a change in state law, the LDSS can no longer assign the goal of IL to youth. This law allows youth ages 16 and over with the goal prior to July 1, 2011 to retain this goal with no changes required; however LDSS must provide a program of care and services. IL services are not affected. In FY 2012, state staff developed and is in the process of implementing, in collaboration with key stakeholders including youth, a work plan that will provide technical support, resources, tools, policy and practice guidance on achieving permanency with a sense of urgency for all youth. Virginia requested and received approval for training and technical assistance (T/A) from the National Resource Center on Permanency and Family Connections (NRCPFC). Eliminating the goal of IL is a major change for the state and training and T/A are needed in assisting workers in achieving permanency and lifelong connections for youth. NRCPFC will assist the VDSS in developing and implementing an integrated approach to permanency and preparation for adulthood. Gary Mallon, consultant with NRCPFC, met with representatives from VDSS and LDSS on May 9, 2012 and collaboratively a work plan was developed to address permanency for older youth. For FY 2013, NRCPFC will provide detailed information and T/A to inform three action groups focusing on; Family Finding; integration of youth voice in Family Partnership meetings, and Permanency Roundtables.

*IL funds*

For FY 2012, VDSS allocated its CFCIP funds into three primary spending categories: basic allocations; private contractor; and Education and Training Vouchers (ETV). VDSS does not have a trust fund for foster care youth. Approximately 90% of Virginia's Chafee grant is spent on the following services to prepare youth for self-sufficiency: education; vocational training; daily living skills/aid; counseling; outreach services; and, other services and assistance related to building competencies that strengthen individual skills, promote leadership skills and foster successful independent living. The majority of the LDSS collaborate with community-based organizations and agencies to provide support and services to youth (i.e., local health departments, workforce investment boards [WIB] including one-stop centers and VA Cooperative Extension offices, etc.).

VDSS determines basic allocations to each LDSS based on their percentage of the statewide population of foster care youth, 13 years old and over, for the previous 12 month period. Currently, 111 of Virginia's 120 LDSS actively participate in providing services to older youth. The 9 LDSS not participating do not have age appropriate youth or they opt to use other funding sources to provide services to youth.
In July 2009, VDSS awarded a contract to United Methodist Family Services (UMFS) to provide IL services to youth in and transitioning out of foster care statewide. UMFS' program entitled "Project LIFE, Living Independently, Focusing on Empowerment", serves youth in the Commonwealth who are in or transitioning out of foster care. Five regional IL Consultants and two Best Practice Consultants are responsible for carrying out the vision, mission and goals of the Chafee Foster Care Independence Act, the principles of the Virginia Children's Services Practice Model and family engagement by collaborating with LDSS and private providers for adulthood by offering;

- Hands-on training
- Structured, uniform program of services
- Technical assistance
- Best practice development

For SFY 2012, Project LIFE offered the following training, technical assistance (TA), and services:

- Ansell Casey Life Skills Assessment (ACLSA)
- National Youth Transition in Database (NYTD)
- Independent Living Program (ILP); ETV; Transition Living Plan (TLP); Permanency for Youth
- Facilitation of IL skills group
- Development of youth advisory councils

- Regional youth conferences/events

Project LIFE provided the following activities/services with youth:

| **Topic/Activity** | **# of Activity** | **# of youth participants** |
|---|---|---|
| Transition Living Plan | 1 | 35 |
| IL Life Skills (i.e., health/wellness, IL workshops) | 3 | 82 |
| Permanency Events (i.e., Family Engagement/ Family Partnership Meetings, Family Academy) | 9 | 132 |
| Generosity activities (i.e., giving back, service learning projects, community service) | 8 | 51 |
| Youth Leadership Institute, Know Your Rights, Shout Out | 4 | 27 |

During this fiscal year, the Project LIFE team achieved the following:

- Coordinated two VYAC weekend conferences with at least 65 youth participants at each. Older youth co-facilitated some of the workshops and activities and served as mentors;
- Participated in state work groups and committees representing the needs of older youth including the National Youth and Transition Database (NYTD), Family Engagement, Fostering Connections to Success Education Workgroup, and the statewide Permanency Advisory Committee;
- The State council worked in partnership with The National Foster Youth Action Network to develop strategies for expanding regional council membership and providing leadership and advocacy training to improve the foster care system;
- Developed a Speaker's Bureau and conducted formal training for current and former youth in care. Youth and young adults from around the state learned how to effectively make presentations and give personal testimonies to community stakeholders, policy makers, social workers, foster parents and other foster care youth throughout Virginia;
- The Regional IL Consultants in collaboration with the regional Independent Living Committees planned and delivered one-day youth events; and
- Assisted with implementing Virginia's Family Partnering Model and participated in the roundtables which included meeting with the Foster Care/Adoption, CPS and Family Resource Consultants to jointly plan for their unique and collaborative roles in helping LDSS integrate this practice into all planning for children in care.

In order to increase the LDSS' capacity to meet the goals of establishing permanent connections for older youth and developing adult living skills, Project LIFE and VDSS are committed to assisting LDSS in providing necessary services to eligible youth on a statewide, regional and local basis. For FY 2013 Virginia is moving toward Performance-based Contracting with UMFS. VDSS will provide the leadership necessary for Project LIFE to accomplish the following goals:

- Strengthen the capacity of LDSS to more effectively support youth in conducting life skills assessments and transition plans in preparing youth to make successful transitions to adulthood,

- Promote youth's meaningful engagement in case planning and in advocating for themselves; and
- Increase the capacity of public and private service providers to engage in IL best practices with older youth in foster care.

Virginia is committed to having youth's voice and involvement in their own service planning, foster care policy, NYTD workgroup and other state committees.

In addition, VDSS is responsible for providing IL training, tools and technical assistance (TA) to local department of social services (LDSS) workers to strengthen their program of services to foster care youth. Most of the training and TA is provided by Project LIFE which is a public/private partnership between the VDSS and United Methodist Family Services (UMFS). During SFY 2012, Project LIFE staff (five regional IL consultants and two best practice consultants) provided the following:

- Ansell Casey Life Skills Assessment (ACLSA) trainings/TA
- National Youth in Transition Database (NYTD) trainings/TA
- Guidance and training on the Independent Living Program (ILP); Education and Training Vouchers Program (ETV); Transition Living Plan (TLP); and Permanency for Older Youth

| Topic | # of Trainings/TA | # of Adult Participants |
|---|---|---|
| ACLSA | 26 | 125 |
| NYTD | 14 | 134 |
| ETV | 10 | 61 |
| General( i.e., Transition Plans, Permanency) | 4 | 23 |

Also, VDSS provided training and technical assistance to LDSS on the SFY 2012 ILP/ETV Funding package including using up to 30% of their basic allocation for room and board for young people who left foster care at age 18 but have not turned 21, or who have moved directly from foster care to IL programs. In Virginia, room and board includes security deposits, apartment application fees, utilities and telephone connection fees, emergency shelter, and rent payments if youth are at risk of being evicted. Approximately 20% of Virginia's Chafee grant was spent on room and board for eligible youth. In Virginia, youth who are receiving IL services can continue to receive Medicaid coverage until the age of 21 as long as they continue to meet eligibility requirements.

For FY 2013, VDSS and Project LIFE will continue to collaborate to ensure older youth and LDSS staff are receiving the support, training and technical assistance needed for an integrated approach to youth permanency and preparation for adulthood.

For FY 2012, the VDSS used the federal government's outcomes for the purpose of evaluating efforts in preparing youth for self-sufficiency as they exit the foster care system. LDSS must develop and document in the Basic IL Services application the outcomes to be achieved by use of these funds. IL services are required to be part of a planned program of service to youth that meets their assessed needs for permanency and development of life skills. Formal service planning and review of the service plan by the juvenile and domestic relations court occurs at least annually. Service planning must involve multiple parties (i.e. mentors, foster parents, birth parents, relatives, and other individuals) as identified by the youth and as appropriate in the development of the service plan. During this fiscal year, VDSS

experienced an increased number of youth receiving IL and post-secondary educational services and increased its ability to reach more youth through partnering with Project LIFE.

For FY 2013, VDSS will continue to enhance and increase linkages, coordination and collaborations among the different local and state agencies, organizations, and private providers. Such linkages would clarify funding sources available for service provision and allow for effective and efficient planning around use of such funds; develop shared policies across child-serving agencies; and increase knowledge across systems regarding available services. Additional goals include:

- Increase youth involvement in service planning and developing transition living plan to promote permanency and self-sufficiency;
- Increase the full array of independent living services and resources through implementing strategies for successful transition to self-sufficiency; and
- Explore ways to utilize the federal ASSET (Assets, Saving, Support, Education and Training) Initiative in order to connect youth to asset building opportunities and to establish a foundation for economic success in adulthood.

## ***Education and Training Program***

The Education and Training Vouchers (ETV) Program provides federal and state funding to help youth receive post-secondary education, training, and services necessary to obtain employment by covering the expenses associated with college or vocational training programs. Vouchers are available of up to $5,000 (based on availability of funds) per year per eligible youth for post-secondary education and training. Although the ETV Program is integrated into the overall purpose and framework of the Chafee Foster Care Independence Program (CFCIP)/ILP, the program has a separate budget authorization and appropriation from the general program.

LDSS applying for ETV funds must agree to the following special requirements:

1. Reimbursements for expenses will not exceed the cost of the annual education or training program tuition and related expenses or $5,000 (whichever is less) per eligible youth per fiscal year;
2. Will track and report on use of ETV funds separately from the Basic ILP allocation.
3. Will use ETV funds to supplement and not supplant any other state or local funds previously expended for the same general purposes; and
4. Will administer these funds in any amount on the behalf of any eligible youth as long as it does not exceed $5,000 per youth per fiscal year, or the amount awarded to any student does not exceed the "cost of attendance" (whichever is less).

Youth who were adopted from foster care after the age of 16 are also eligible for ETV funds. Virginia administers its own ETV Program through Services to Older Youth staff. Due to the state's significant outreach efforts in partnership with LDSS, Project LIFE and public and private partners, there has been an increase in the number of eligible youth participating in the program.

All localities are eligible to participate in the ETV Program. However, some localities do not participate due to not having eligible foster care youth. Youth must have a high school diploma or GED. Youth are made aware of program services and eligibility guidelines through social workers, IL coordinators, life skills training and educational workshops, the V-YAC, Project LIFE, and marketing efforts of the VDSS Permanency Program staff. For SFY 2012, Virginia was allotted approximately $580,599 in ETV funds. From the FFY 2012 grant, over 573 students took advantage of ETV services and of that number 225 were new students.

Each year, the LDSS must complete an ETV Application and submit the number of eligible youth on the application to VDSS. Eligible youth are those who will be/are attending post-secondary education institutions or vocational training programs for the fiscal year. The number of eligible youth in Virginia is totaled and then divided into the available allocation, giving a basic amount per youth. Each LDSS' eligible youth will then be multiplied by the basic amount per youth. Youth in foster care with the guidance of their IL coordinators create a transition plan which is a program requirement. Youth are then able to access ETV funds based on the ETV student application, educational needs and availability of funding.

In addition to coordinating the states ETV program, the VDSS Education Specialist is involved in several educational initiatives such as supporting the Community College Tuition Grant for foster care youth and special needs adoptees, the Great Expectations Program, the Greater Richmond Aspirations Scholarship Program (GRASP), and the Fostering Connections to Success Education workgroup. Information learned from these initiatives suggests that youth in foster care should be introduced to college or vocational training prior to high school. Youth will better understand educational opportunities that are provided to them after turning 18. This will help youth to prepare for higher education earlier so they can succeed throughout their educational journey. Educational initiatives must be collaborative, strategic, multi-tiered, and above all youth oriented and family centered. These core initiatives help to strengthen the state's postsecondary education assistance program and promote academic achievement and educational stability. A collaborative strategy which includes VDSS, LDSS, the Department of Education, and local school divisions, families and children can help improve youth educational outcomes.

## Independent Living Collaborations

**Project LIFE**: Project LIFE is a partnership with the VDSS. The goal of Project LIFE is to support permanency for older youth in care through the coordination and enhancement of independent living services by collaborating with local departments of social service, private providers and community stakeholders. (www.vaprojectlife.org) Project LIFE has taken over the responsibility of managing the Virginia's Youth Advisory Council *(VYAC)* which is composed of youth ages 15-21 statewide.

**Community College Tuition Grant:** Tuition Grant pays for tuition and fees at the Virginia Community Colleges for foster care youth or special needs adoptees that have graduated from high school or obtained their GED and meet eligibility requirements.

**Great Expectations**: Great Expectations helps Virginia's foster youth complete high school, gain access to a community college education and transition successfully from the foster care system to living independently. The program helps ensure that young people have the personal connections and community support they need to live productive and fulfilling lives. (Website: http://greatexpectations.vccs.edu/) This initiative of the Virginia Foundation for Community College Education is in partnership with:

- VDSS and LDSS;
- Workforce Investment Boards; and
- One-stop centers, community colleges, alternative education providers, other public agencies, school to career partnerships, and employers.

The intent of Great Expectations includes:

- Help foster care youth ages 13 – 17 complete high school and move into higher education;
- Encourage youth transitioning from foster care to continue in an ILP;
- Offer a comprehensive program for foster care youth and alumni ages 18 -24 to help them gain access to a community college education; and

- Create an endowment that will provide long-term, consistent funding for the program when traditional sources are not available.

**National Resource Center for Youth Development (NRCYD)*:*** VDSS continues to collaborate with the NCWCYD for training and TA *(e.g. Ansell Casey Life Skills Assessment Training, Adult and Youth Partnership).*

**National Resource Center for Permanency and Family Connections (NRCPFC):** Virginia requested and received approval for training and technical assistance (TA) from NRCPFC on youth permanency. NRCPFC will assist the state in developing and implementing an integrated approach to permanency and preparation for adulthood.

**Virginia Workforce Investment Act Youth Services Programs:** Local programs and career centers provide "transitional services to employment" for Virginia's neediest youth.

**Virginia's Intercommunity Transition Council (*VITC):*** VITC is an interagency initiative that ensures effective coordination of transition services for youth and young adults with disabilities in an effort to increase the accessibility, availability and quality of transition for these young people. Among other activities, VITC encourages a seamless movement from school to post-secondary services for all youth regardless of the nature of the disability**.** VITC members include: DOE, Virginia Department of Rehabilitative Services, Virginia Department of Behavioral Health and Development, Virginia Community College System, Virginia Department of Correctional Education, State Council of Higher Education for Virginia, VDSS, Virginia Department for Blind and Vision Impaired, Virginia Department of Juvenile Justice, Centers for Independent Living, Social Security Administration, Virginia Board for People with Disabilities, Virginia Department of Health, Woodrow Wilson Rehabilitation Center, and Workforce Development Centers.

**Foster Care Alumni of America (FCAA):** The mission of FCAA is to connect the alumni community of youth who are in foster care and to transform policy and practice, ensuring opportunity for people in and from foster care. Virginia's chapter had a successful "family reunion" for alumni, families and friends. The Chapter is involved in outreach and recruitment efforts.

### 4. Virginia's Interstate Compact on the Placement of Children *(ICPC)*

Children placed out of the state need to be assured of the same protections and services that would be provided if they had remained in their home state. They must also be assured of a return to their original jurisdictions should placements prove not to be in their best interests or should the need for out-of-state services cease.

Both the great variety of circumstances which makes interstate placements of children necessary and the types of protections needed offer compelling reasons for a mechanism which regulates those placements. An interstate compact *(a compact among the states that enact it)* is one such mechanism. Under a compact, the jurisdictional, administrative, and human rights obligations of all the parties in an interstate placement can be protected. Virginia has codified the compact and abides by the associated regulations.

**Children Served.** As of May 31, 2012, Virginia has 2,350 open ICPC cases and 3,770 open Interstate Compact on Adoption and Medical Assistance (ICAMA) cases.

**Types of Placements Covered.** The Compact applies to four types of situations in which children may be sent to other states:

- Placement preliminary to an adoption;
- Placements into foster care, including foster homes, group homes, residential treatment facilities, and institutions;
- Placement with parents and relatives when a parent or relative is not making the placement; and
- Placement of adjudicated delinquents in institutions in other states.

The compact does not include placements made in medical and mental facilities, in boarding schools, or in "any institution primarily educational in character." It also does not include placements made by a parent, stepparent, grandparent, adult brother or sister, adult uncle or aunt, or the child's non-agency guardian when leaving the child with any such relative in the receiving state.

**Safeguards Offered by the Compact.** In order to safeguard both the child and the parties involved in the child's placement, the Interstate Compact:

- Provides the sending agency the opportunity to obtain home studies, licensing verification, or an evaluation of the proposed placement.
- Allows the prospective receiving state to obtain information sufficient to ensure that the placement is not "contrary to the interests of the child" and that its applicable laws and policies have been followed before it approves the placement.
- Guarantees the child legal and financial protection by fixing these responsibilities with the sending agency or individual.
- Ensures that the sending agency or individual does not lose jurisdiction over the child once the child moves to the receiving state.
- Provides the sending agency the opportunity to obtain supervision and regular reports on the child's adjustment and progress in placement.

These basic safeguards are routinely available when the child, the person, or responsible agency and the placement are in a single state or jurisdiction. When the placement involves two states or jurisdictions, however, these safeguards are available only through the Compact.

**The Sending Agency's Responsibilities:** While the child remains in the out-of-state placement, the sending agency must retain legal and financial responsibility for the child. This means that the sending agency has both the authority and the responsibility to determine all matters in relation to the custody, supervision, care, treatment, and disposition of the child, just as the sending agency would have if the child had remained in the home state.

The sending agency's responsibilities for the child must continue until the interstate placement is legally terminated. Legal termination of an interstate placement may only occur when the child is returned to the home state, the child is legally adopted, the child reaches the age of majority or becomes self-supporting, or for other reasons with the prior concurrency of the receiving state Compact Administrator.

The sending agency must notify the receiving state's Compact Administrator of any change in the child's status. Changes of status may include a termination of the interstate placement, a change in the placement of the child in the receiving state, or the completion of an approved transfer of legal custody.

**Virginia/Tennessee Border Agreement – Non-custodial Children**

The Virginia/Tennessee workgroup continues to meet on a quarterly basis to assess the program, make identified process changes as needed and discuss challenges that may have developed related to individual cases. This process and meeting has been extremely useful and has expedited the placement of children across state lines with their relatives. There have been approximately 30 boarder Agreement cases as of March 2010.

**Virginia/Tennessee Border Agreement –Custodial Children**

Discussion will continue on the viability of a custodial children's Agreement. We will assess the challenges that have been identified and decide if this is a viable option. The Virginia Program Manager for Resource Development will review the ICPC Regulation 7 and give feedback on whether or not we can adapt Virginia's policy to expedite the placement of children in custody cross state lines.

## 5. Resource Family Development

In 2008, VDSS created the Resource Family Unit *(RFU)* that is responsible for recruitment, development and support activities for foster, adoptive and kinship caregivers, referred to as "resource families" in the Commonwealth. One program manager and five regional consultants comprise this unit. The overarching goal is to increase the quantity and quality of resource parents to be viable placement options for children in the system of care. In late 2009, regulations were passed mandating pre- and in-service training as well as implementing dual approval for family assessments (home studies). To ensure that agencies have the tools, knowledge and technical assistance needed to fully realize a system of recruitment and retention for resource families, the RFU implemented a series of structured meetings and information based on Annie E. Casey's Breakthrough Collaborative methodology, called "Regional Peer Collaboratives" (RPC) which were offered through December 2011.

The RPC process for the upcoming year will be structured in each region to meet the needs of that region. Many agencies expressed concern regarding the time commitment required for the RPC as previously designed and requested assistance with targeted recruitment needs and support. In addition, agencies that participated requested to continue meeting at least quarterly because of the benefits of information sharing and peer to peer networking. The Resource Consultants are also reviewing monthly data reports that provide agency information regarding family-based placements and kinship placements. The Consultants will develop targeted strategies to assist the agencies that are below the national practice standards.

Within recruitment, there are two key themes: using a data-driven approach to target what kinds of families are needed based on the needs of the children in foster care, and using accurate messaging about foster care as a family support service for birth families. Regarding adoption, recruitment efforts include a sharp focus on older youth, children with special needs, and sibling sets. In all cases, the emphasis is on maintaining children's family and community connections in order to:

- Increase the likelihood that children are kept within their communities, without having to change schools or leave their faith community;
- Make better matches between children and their caregivers, so as to preserve their significant relationships, cultural and racial heritage, and family traditions;
- Decrease separation and loss issues inherent in foster care by focusing on those individuals already known to the child/family rather than defaulting to "stranger" foster care;
- Strengthen the communities from which our children are most often removed by investing in building strong resource families there—particularly important in more urban areas where the intersection of race, poverty and middle class bias contribute to the disproportionate removal of African-American children from their birth families; and
- Promote longer-term stability and safety for children by ensuring that their supports, services, care providers, and other important adults can be maintained both during placement and after reunification.

Through consultation from the Annie E. Casey Foundation, the Resource Family Consultants received training in this area of family search and engagement. In an effort to increase the number of kinship

providers, the Resource Family Consultants offered two trainings per region to local agencies during 2010. During 2011 and 2012, training continued with a minimum of two sessions offered per region open to both local departments and private providers. In additional to the family search and engagement training, the Consultants will provide technical assistance to local agencies regarding the use of Accurint, the internet search system used to locate relatives and permanent connections for youth.

The Resource Family unit is continuing to work closely with the CRAFFT Coordinators to ensure the resource family training needs within the region are met.

Finally, in June and July 2012, the Resource Family Consultants will be providing training to LDSS staff on the implementation of Custody Assistance which goes into effect July 1, 2012. In FY 2013, the Resource Family Consultants will provide technical assistance and support to LDSS to promote quality assessment and support of kinship families who may become the permanency plan for youth in foster care.

### Resource Family Collaborations

**Community Resource, Adoptive and Foster Family Training *(CRAFFT).*** CRAFFT has been addressing development and support issues for resource families for nearly six years. It is a collaborative venture between VDSS and Norfolk State University, Virginia Commonwealth University and Radford University. Two Coordinators are housed by each university. CRAFFT Coordinators provide direct pre-service training to families *(conducted in coordination with LDSS)*, as well as provide some support to agencies to build their own training and support capacity. Similarly, CRAFFT Coordinators provide a wide range of in-service training to families on topics responsive to local needs and issues.

## 6. Prevention Unit

The Division of Family services established the Prevention Unit in 2009 to accomplish the following:

a. Give clarity to the definition of prevention that provides the framework for a common language to use across the continuum of child welfare services;
b. Promote prevention services as a "core" program within the VDSS system;
c. Develop the capacity of our local departments to recognize, promote, and support prevention services;
d. Build a repertoire of prevention strategies and best practice guidelines that can be used by localities in their delivery of prevention services;
e. Create a presence for prevention in the DSS database so that services can be recorded and outcomes measured;
f. Coordinate and collaborate with our community partners to maximize our prevention efforts.

In order to obtain a picture of Prevention Services in Virginia, the Prevention Unit conducted a survey of local departments during the summer of 2011. Ninety six percent of local departments responded to the survey, providing a wealth of information related to what prevention services are being provided, how the services are funded, who provides the services, and how collaboration with community partners is occurring. The Prevention Survey results are informing guidance creation and identifying localities in the state where Prevention Services are well-established as well as those localities without defined Prevention programs.

The focus of the Prevention Unit's efforts is on Early Prevention, defined as those prevention services provided prior to, or in the absence of, a current valid child protective services (CPS) referral. Results of the 2011 Prevention Survey indicated that 94% of responding Virginia localities offer prevention services

to families prior to CPS involvement. In accordance with this focus, the Prevention Unit and the Prevention Committee are creating guidance for local departments consisting of the following chapters:
1-Overview of Prevention
2-PreventionServices to Individual Families
3-Prevention Services to the General Public
4-Prevention Services to High-Risk Groups
5-Building Agency Capacity for Prevention Services
6-Community Collaboration
Guidance is expected to be completed and disseminated by the end of 2012. A training plan is currently being formulated.

One of the goals of the Prevention Committee involves creating a presence for Prevention Services in the DSS database, allowing local department staff to record and monitor their prevention work. A workgroup from the Prevention Committee and other local and state staff are currently working on this project, with expected completion in the fall of 2012.

Additionally, the Department's internal website, available to state and local DSS staff, has been enhanced with a Prevention area containing the following subject areas

- About Prevention Services
- Guidance and Procedures
- Foster Care Diversion
- Resources for Early Prevention
- Studies and Survey Results

The content for this website will be updated periodically.

### Prevention Collaborations

The Prevention Committee was formed to address these goals by providing direction to the Prevention Unit aimed at ensuring attention to local department practices and the inclusion of community partners in the guidance development process. The Prevention Committee is comprised on state staff, community partners, and representatives from 19 local departments. The Committee meets monthly, with ad hoc conference calls held as needed. The community partners include: Virginia Sexual and Domestic Violence Action Alliance, Quinn Rivers Agency for Community Action, Healthy Families, Prevent Child Abuse Virginia, Virginia Cooperative Extension, and Child Care Aware of Virginia.

## C. Quality Assurance

### 1. Continuous Quality Improvement *(CQI)* Unit

The Continuous Quality Improvement *(CQI)* Unit in DFS is based in a philosophy and practice of quality and process improvement and is accountable to the principles of the Virginia Children's Services Practice Model. It conducts quality reviews of LDSS and will measure child status and system performance indicators to improve outcomes for children and families.

The CQI Unit consists of five Quality Analysts and a Quality Manager. In July 2010 with the support and funding from Casey Family Programs, the CQI Unit began development of a Quality Service Review (QSR) Process. The QSR is a quality standard based on the Virginia Practice Model. The QSR is an action-oriented learning process that provides a way of recognizing what is working or not working, at the point of practice, for children and families receiving services. We will continue with a stratified sampling of case record reviews; however we will expand our process to speak with family members, the child, and

the caseworker and service providers. The QSR process now will focus on the quality of practice rather than the quality of compliance.

The QSR tool was piloted in November 2010 and in 2011 there were six reviews conducted covering ten local agencies. In the first part of 2012 four reviews were conducted covering 11 local departments. Plans are to conduct seven to nine reviews a year with multiple agencies to be included in a review.

The Quality Service Review will continue the three step process to form a continual cycle of practice reform and improved outcomes.

1. A stratified sample of cases are reviewed for a LDSS utilizing the QSR instrument, and interviews with the case worker, foster parent, focus child and his/her family members, legal partners, providers and others who are involved in the case. Reviewers use a structured protocol to guide their inquiry and determine the status or outcome for the child and the quality of practice contributing to that outcome
2. The information is shared with the caseworker, supervisor and the local department during the review week. A follow up comprehensive report is provided to the LDSS and then work with the Regional Consultants and analyzed from two perspectives:
    - Strengths and good performance are identified, as well as systems and processes in place to ensure good practices continue. This is also an opportunity to identify best practices in the agency to be shared across regions.
    - Opportunities for improvement are identified through an examination of root causes and strategies for addressing the issues. Gaps in performance are also identified, as well as what factors need to change to add in order to address the gaps and improve performance.
3. System Improvement Plans (SIP) are developed by identifying the nature of the issues *(e.g., practice, policy, work process, resources, training, or any combination of issues).* The process or system that needs improvement is identified. Specific objectives, strategies, implementation plans, milestones, dates and any deliverables are identified.

The Unit is currently working on mechanisms to revise the SIP process in light of the revised QSR protocol and build accountability in this three step process of continuous quality improvement. this will be based in the philosophy of Appreciative Inquiry in addition to an eight step model for process improvement, developed templates to define the problem or issues, identify root causes, identify solutions and develop specific action plans to change or improve practice. Revisions will also include a method of reporting and accountability and an annual report on Quality Service Reviews.

**System Improvement Plan Process**

A System Improvement Plan (SIP) is comprised of a series of action plans to improve practice and outcomes for children and families. There is a dual purpose of the local department SIP: 1) to outline how the LDSS will adjust their services/practice in response to the QSR results in order to improve their outcomes as reported in Critical Outcomes Report and Safe Measures, and 2) to serve as a mechanism for VDSS to report on progress made on both local and state levels to improve outcomes for children and families as outlined in Virginia's federal Program Improvement Plan in response to VA's 2009 CFSR.

Initial results are shared with the caseworker and supervisor of each case reviewed and then overall results are shared with the locality at the end of the QSR week. After the receipt of the final written report, a next steps meeting with the LDSS and Regional Consultants is facilitated by CQI state staff. The SIP process has been defined and templates for action plans and linkages to outcome measures are provided to the local department. The purpose of the meeting is to discuss the results of the QSR, the analysis by the local department, and to identify priorities for practice change and improvement that will impact outcomes for children and families. Outcome of the meeting is two-fold. First, the prioritization

and identification of one to three issues that the LDSS can commit to work on that will improve processes and outcome measures. Second, the identification of steps towards solutions and the development of specific action plans for the identified solutions. SIP results are reported on quarterly to the CQI Unit and Regional Consultants

At the time of this report, eight SIPs have been submitted; five of those have been approved and are posted on SPARK, the VDSS internal website. In response to the trends identified in the practice performance indicators in the QSRs, the majority of the SIPs are addressing teaming and engagement. These plans contain action steps around areas policy, training, and the creation of tools. Assessment and Understanding is also an area being addressed in some SIPs, specifically surrounding comprehensive family assessments and the tracking and monitoring of services stemming from those assessments.

**2. Outcome Based Reporting and Analysis *(OBRA)* Unit**

In 2008, DFS created the Outcome Based Reporting and Analysis Unit which oversees all reporting, research and information technology *(IT)* for the division. Most recently OBRA has also been given management responsibility for performance based contracting, FFATA requirements, and sub-recipient monitoring. The program manager of this unit oversees enhancements to OASIS and coordinates these changes with the OASIS Liaison. OBRA also serves as the business owner for all Division IT systems and is tasked with prioritizing all system edits and enhancements for release, as well as system training. The OASIS Liaison works with the Managing by Data Workgroup as the body that provides guidance for IT enhancements. OBRA successfully released consecutive versions of OASIS; a new iteration of OASIS was released in April 2012; and another iteration is planned for release in November 2012.

OBRA continues to increase the volume of reporting, trainings, and ad hoc research analysis. OBRA works collaboratively with the Division of Research for VDSS for statistical analysis across all VDSS programs, and is aligned with the Continuous Quality Improvement Unit within DFS to link quantitative and qualitative metrics in the child welfare system, including sampling methodology, process analyses, qualitative data analysis, cross-walking data with the Critical Outcomes scorecard, and evaluating system improvement plans.

## D. Child and Family Well Being Services

### Services to address children's educational needs

For SFY 2012 VDSS, the education workgroup and other key stakeholders continued to meet in order to promote promising strategies to improve educational outcomes that support the enhancement of educational continuity and school stability for Virginia children in out of home and adoptive care. This workgroup met throughout the year and focused on improved guidance, training and data sharing. Representatives from VDSS the courts and DOE also attended the federally sponsored Child Welfare, Education, and the Courts meeting in November 2011 at which time goals (short and long term) were set regarding training, guidance and data sharing. All goals regarding guidance and training were met and are described below.

Additional guidance that addresses the responsibility of the Comprehensive Services Act (CSA) vs. the local school district in funding transportation when a child has an IEP was clarified and the workgroup completed a joint guidance update (VDSS and DOE) that was approve by both agencies leadership and will be published in June 2012. This guidance builds on the work done in 2010 and 2011 by both agencies and the Office of Comprehensive Services to provide statewide guidance and procedures for the immediate enrollment of youth in foster care in a new school if remaining in their school of origin was not in their best interest. The Foster Care Manual and DOE guidance were jointly issued to ensure both

schools and social services agencies were addressing youth's educational needs in accordance with the Fostering connections Act.

In addition, the Educational Specialist completed 8 regional training events (192 people) on the educational requirements of children in foster care. Some of these trainings were done with the workgroup co-lead from DOE and some were done independently. Educational training continues to be a priority given the need to educate localities of the importance of this requirement for all children attending school and in foster care.

VDSS and DOE have continued to pursue sharing data on children and youth attendance and are working to overcome barriers related to confidentiality and FERPA. Virginia has contacted the Legal Center for Foster Care and Education for technical assistance in developing an MOU regarding data sharing. An initial conference call was held with Maura McInerney and follow-up strategies will occur in June and July.

**Health Care Services**

The Virginia Health Plan Advisory Committee (HPAC) advises and makes recommendations to VDSS and DMAS on improving health outcomes for children in, and at risk of, foster care across the Commonwealth. The committee ensures that children receive appropriate services to meet their physical and behavioral health needs. The committee provides ongoing oversight and coordination of health care services. It helps articulate the vision, determine effective strategies, make decisions, and follow through to ensure the health needs of children in the foster care system are met.

HPAC is now co-chaired by VDSS and the Virginia Department of Medical Assistance Services (DMAS). New members include:

- Representatives from managed care organizations.
- Director of Training and Professional Development for Child Savers, a nonprofit organization providing 24/7 immediate response and trauma counseling services for children exposed to violence and other traumatic events.
- VDSS staff person with policy and practice expertise with children who have experienced trauma.

Virginia's Health Care Oversight and Coordination Plan is attached to this plan.

## II. Primary Strategies, Goals and Action Steps

This section delineates the six primary strategies, goals and action steps for the next five years. This plan represents an evolving process that will be enhanced as Virginia continues to learn. For each strategy, the applicable Children's Services System Transformation outcomes, CFSR outcomes and Systemic Factors, and CFSR items that Virginia is striving to achieve are listed.

Virginia completed the second round of the Child and Family Services Review in July 2009. As a result of the review, a Program Improvement Plan (PIP) was developed. There are four Primary Strategies in the PIP that are incorporated into the 5 year plan strategies. Those strategies are:

1. Engage Families across the Continuum of Child Welfare
**Goal:** Ensure children, youth and parental input is heard and considered in the decision-making processes regarding safety, permanency, well-being, and service planning and placement decisions

2. Improve Assessment and Service Delivery
**Goal:** Appropriately assess safety, risk, and the needs of children and families in order to provide high quality, timely, efficient, and effective services.

3. Reengineer Competency Based Training System
**Goal:** Improve training and supervision in order to serve children and families through high quality, timely, efficient, and effective services

4. Managing by Data and Quality Assurance
**Goal:** Create a performance management system that utilizes data to inform management, improve practice, measure effectiveness and guide policy decisions

Both PIP strategies and non-PIP strategies will be reported in this section. If a PIP strategy was the same as what was indicated in the CFSP, the PIP strategy will take the place of the original strategy. PS in the follow sections stands for Primary Strategy.

# I. Safe children and stable families

These strategies strives to assure the safety of children within their homes, protect children in at risk situations, and ensure they are protected from abuse and neglect in a permanent setting responsive to their well being. It preserves and strengthens intact families who ensure the safety and well-being of their children. It strives to prevent child maltreatment among families at risk through the provision of supportive family services.

- **Applicable CFSR Outcomes or Systemic Factors:** Safety Outcome 1; Safety Outcome 2; Permanency Outcome 1; Wellbeing Outcome 1; Wellbeing Outcome 3; Systemic Factor: Service Array and Resource Development

- **Applicable CFSR Items:** Item 1, Item 3, Item 4, Item 17, Item 23, Item 32, Item 33, Item 35, Item 36,

## Goal: Protect children at risk of abuse and neglect

1. **Implement the Structured Decision Making *(SDM)* Model statewide**
   a) Gain top level administrative commitment and provide organizational structure to support SDM.
   b) Develop and implement a plan to gain support for SDM from local agency directors, supervisors, and direct child welfare staff.
   c) Incorporate SDM philosophy, processes and practices into child welfare policy and guidance manuals.
   d) Incorporate SDM tools into OASIS.
   e) Develop and/or contract for the implementation of a comprehensive training program to support SDM practice.

**PS 2 Obj. 1. Improve local department staffs' abilities to assess initial safety and risk**

**Strategy 1.1 Develop and/or revise and implement tools to improve local staffs' ability to improve response times to CPS reports**
a) review SDM intake tools to ensure consistency with VA regulations and guidance
b) develop policy on timeframes for face to face contact with victims

c) obtain input from CPS policy advisory committee
d) incorporate intake tools in guidance manual
e) disseminate manual

**<u>Strategy 1.2</u> Revise CPS guidance manual to include tools on how to more accurately and consistently assess initial child safety and risk including factors such as domestic violence, mental health issues, and substance abuse**.
a) review SDM safety and risk assessment tools to ensure consistency with VA regulations and guidance
b) obtain input from the CPS policy advisory committee
c) incorporate safety and risk assessment tools into guidance
d) disseminate guidance

*<u>2012 update</u>*
The above sections have been completed. CPS guidance was released July 1, 2011 and includes the intake and assessment tools.
See http://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2011/section_4_family_assessment_and_investigation.pdf – and- http://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2011/section_4_family_assessment_and_investigation.pdf

**<u>Strategy 1.3</u> Develop and implement statewide training for CPS supervisors and workers on the use of new initial safety and risk tools.**
a) develop training curriculum
b) select and train Trainers, to include CPS regional consultants and supervisors
c) develop statewide training schedule
d) train all CPS supervisors and workers on use of new tools

*<u>2012 update</u>*
This section has been completed. Forty Eight sessions of FAM1016 were offered with 936 workers trained.

**<u>Strategy 1.4</u> Develop OASIS screens to reflect new CPS safety and risk assessments.**
a) Outcome Based Reporting and Analysis Unit (OBRA) will review what is currently in OASIS and determine if current screens can be modified or if new screens must be created
b) meet with Family Services Managing by Data workgroup to determine requirements
c) implement new screens

*<u>2012 update</u>*
This section has been completed. The OASIS screens were incorporated into OASIS 3.9 which was released in 2011.

**<u>Strategy 1.5</u> Quality Service Review will evaluate the extent to which initial safety and risk assessments are being completed correctly and within the required timeframes**

**<u>Strategy 1.6</u> Identify and implement tools for local staff to use in assessing safety, domestic violence, substance abuse, and mental health issues present in relative and other caregiver families.**

**PS 4 Obj. 1. Increase use of data driven decision making in Virginia's child welfare system**

**Strategy 1.4 Develop a new report by locality on face to face contact with victims to be disseminated on a monthly basis**

a) train regional consultants on face to face contact report

b) introduce the report as a data management tools for state CPS staff and local departments of social services

*2012 update*

This section has been completed. The regional consultants were trained on this report in October 2011. SafeMeasures created the report and the regional consultants will work with local departments on this report.

**PS 2 Obj. 2. Improve local department staffs' abilities to conduct service needs assessments and develop relevant service plans.**

**Strategy 2.1 Revise CPS guidance manual to provide tools to support on-going assessment, risk reassessment and service planning for children and families' service needs**

a) review SDM family strengths and needs assessment tools to ensure consistency with VA regulation and policy.

b) obtain input from the Child Protective Services Advisory Committee

c) revise on-going services section of CPS guidance to enhance and strengthen workers ability to assess and provide services to families

*2012 update*

This section has been reworked. Upon further review it was determined there needed to be some background work completed before guidance was revised. Virginia has worked with the National Resource Center for In Home Services to develop a review tool to examine on-going CPS cases. The tool will help assess quality and level of service provision statewide. The tool has been finalized, and the regional consultants are being tasked with reviewing 10 cases per region, for a total of 50 cases across the state. The results of that review will be made available by the end of our PIP time period and will be shared with a subcommittee of the CPS Policy Advisory Committee as they begin the work of revising the CPS policy/guidance manual. The new action steps are listed below.

**a) Obtain input from the Child Protective Services Advisory Committee on enhancing the current services section of the CPS manual**

**b) Work with NRC in home services to develop review tool for regional specialist**

**c) review 50 in home cases to assess quality and level of service provision statewide (10 per region) in order to determine strengths and weaknesses in policy/guidance/ practice**

**Strategy 2.2 Revise Foster Care Guidance to provide specific tools to guide service workers in conducting child and family needs assessment and risk assessment prior to reunification.**

a) Create workgroup to review tools and recommend tools to be used.

b) Obtain input from the Permanency Advisory Committee on recommended tools

c) Incorporate tools into Foster Care Manual

d) Disseminate guidance

*2012 update*

This section is still in progress. The workgroup has reviewed several different tools and the PAC discussed the tools in September 2011. Guidance has been revised; however, it is still in draft form

because it is awaiting final approval from the Commissioner's office. The anticipated release of guidance is July, 2012.

**<u>Strategy 2.3</u> Create requirements for OASIS screens to reflect new CPS and Foster Care service needs assessment and service plans**

a) Utilize workgroup to review OASIS screens and make recommendations for screen changes

b) Outcome Based Reporting and Analysis Unit (OBRA) will review what is currently in OASIS and the workgroup recommendations and determine if current screens can be modified or if new screens must be created

c) OBRA and Family Services meet to develop requisition to present to the Managing by Data workgroup (MBD) to approve screen changes.

d) OBRA and Family Services meets with MBD prioritize timing for screen changes in OASIS

*<u>2012 update</u>*

The workgroup met in October 2011 and determined needed screen changes. OBRA has reviewed the recommendations and has helped create a Service Request that includes details for changes to be made to OASIS. The MBD group has also met and talked about changes to service plans for CPS and Foster Care as well as the creation of a services plan for prevention. The Service Request has been submitted to DIS.

## Goal: Keep children and families together through providing families with the necessary supports to safely raise their children.

1. **Prevent families from disrupting and children entering foster care** through providing prevention, support and family preservation services.
   a) Assess desired outcomes and service delivery in the Promoting Safe and Stable Families Program *(PSSF)*.
   b) Identify and promote best practice service models for prevention, family preservation and support to localities annually and as requested.
   c) Design and present training annually for localities on the use of the PSSF funding incorporating the principles of the Children Services Transformation and the CFSR outcome measures.
   d) Disseminate the Child Welfare Funding Package in sufficient time annually for localities to complete a community needs assessment and develop a comprehensive proposal.
   e) Collect, analyze, report and monitor the use of PSSF funds annually in accordance with federal requirements.

*<u>2012 Update</u>*

*Item 1a.*

To meet the deadline for submission of the Annual Progress and Services Report (APSR) the PSSF Year-End Report uses three quarterly reports (within the period June,2011- February, 2012) and a summary report that includes total number of children and families served, data on ethnicity, priority services and services delivered using recognized best practice models. At the time of preparation for this APSR report, 92 localities had submitted complete Year-End Reports. This is 84 percent of the 109 localities with SFY 2012 approved plans. This is an increase in total year-end reports that were received in 2011 for the APSR (total received in 2011 was 77 compared to 92 in 2012). Approval for continued SFY 2013 PSSF funds to localities is contingent upon submission of the year-end report and this requirement seems to encourage compliance with reporting.

*Item 1b.*
Family Partnership Meetings (*also known as Family Engagement Meetings*) continues as an important practice model and tool used in the delivery of services to families. Localities consistently noted in the PSSF reports that children were safely and timely diverted from foster care through the purposeful involvement of extended family and community resources/networks.

*Example 1: "The community continues to improve and enhance the way families are engaged in services. There has been increased family attendance and participation in FAPT… DSSs have begun implementing Family Partnership Meetings and making Family Finding a priority. The DSSs have developed the position of Family Partnership Meeting Coordinator and an internal Family Engagement Best Practices Committee."*

*Example 2: "The Family Engagement Model/Family Partnership Meetings have provided consistent opportunities for parents, relatives, and community partners and identified service providers to have input into the child and family service plan. Over 225 family partnership meetings have taken place since the inception of the program through DSS …The involvement of identified supports in the child's environment has continued to strengthen the commitment to children to have them remain in their own homes, in the homes of relatives or other natural support systems and to remain in the least restrictive environment…The Parental Agreement Contracts have been highly successful in maintaining youth in the community."*

There also appeared to be more reporting on parent skills training focused on different levels of child development and needs. In the table that follows, some of the curricula used by the localities are highlighted:

**Table 1: Curricula Used By Localities and by Service Types**

| Curriculum | Description |
|---|---|
| **Parents as Teachers (PAT) for Home Visitors**<br>Petersburg Health Department CHIP (Family Support) – Libby Vinsh 804.861.4720 | Identified as an evidence-based practice that focuses on three domains: Parent-Child Interactions, Development-Centered Parenting, and Family Well-Being. PAT is accomplished through four interrelated service delivery components, home visits, group connections (parent groups), screenings (ASQ), and connections to resources/services. |
| **Bright Futures**<br>Petersburg Health Department CHIP (Family Support) – Libby Vinsh 804.861.4720 | Bright Futures is a curriculum for health education. It addresses children's health needs in the context of family and community. It offers instruction and resources in improving and maintaining the health of children, while supporting parents in their effort |
| **Guiding Good Choices (GGC) Charles City (Family Support) Alisa Foley 804.652.1708** | *Guiding Good Choices* ® (GGC) is a multimedia substance abuse prevention program that gives parents of children in grades 4–8 (ages 9–14) the knowledge and skills needed to guide their children through early adolescence. GGC is designed to help parents reduce the likelihood that their children will develop problems with drugs and alcohol in adolescence. |
| **Are We There Yet? – birth to 11**<br>**Parenting Today's Teens**<br>Spotsylvania DSS (Family Preservation)<br>Mary Holloway 540.507.7845 | Uses multifaceted presentations to reach different learning styles. The key concepts covered include: child development, safety, effective communication, stressors, self-esteem, conflict resolution, problem solving, single and step-parenting, effective discipline techniques, parenting styles and community resources. These classes have a positive and strength based approach and is based on the belief that parents care about their children and need current information and effective tools to face the challenges of parenting in today's world. |
| **Kids Involved in Community Kindness (KICK) (Family Support) Shelly Latoski York/Poquoson 757.890-3948** | KICK curriculum was developed by a local private agency, Alternatives, Inc. It teaches leadership skills and community empowerment to the youth involved. |
| **Active Parenting Today** | Some of the topics covered are: how parenting is our most important job, |

| Table 1: Curricula Used By Localities and by Service Types | |
|---|---|
| **Curriculum** | **Description** |
| **Active Parenting of Teens**<br>**1,2,3,4 Parents**<br>**I Am Your Child Series**<br>Stafford DSS (All service types)<br>Kimberly Strader 540.658.4284 | instilling courage and self-esteem in our children, understanding our children, teaching our children responsibility and cooperation, and how to be an effective, active parent in today's society. |
| **Nurturing Program**– Fairfax DSS, **(Family Support and Family Preservation)** Rhonda Richardson 703.324.7734 | The Nurturing Parenting Program is an internationally recognized, group-based approach for working simultaneously with parents and their children in reducing dysfunction and building healthy, positive interactions. The program uses curriculum for the following classes: Ages 0-4 (English and Spanish), Ages 5-11 (English and Spanish), Adolescent (English), Ages 0-4 and 5-11 African American Cultural Focus (English) and Teen Parents (English). |
| **Systematic Training for Effective Parenting – STEP & Active Parenting/Padres Activos**<br>Arlington DSS<br>Cheryl Fuentes 703.228.1551 | STEP is for young children through teens. Parents in the program report they have learned helpful parenting skills, to help them to better understand their children. Individual parents are assessed using the STEP surveys. These are administered as both pre and post tests. Additionally, a Parent Feedback Form is completed by the facilitator for each parent that completes the program. This is similar to a report card and provides a snapshot of the parent's participation, engagement and application of material learned. |
| **Comenzando Bien (Family Support and Family Preservation)** –<br>Loudoun County, Contact Sharon Lloyd O'Conner 703.771.5360 | Comenzando Bien is a prenatal education program for Hispanic women. It takes into account the unique needs of the Hispanic pregnant women and their families. It is culturally and linguistically relevant and appropriate for implementation in a variety of settings.<br><br>Other Resources:<br>1. Nurturing Parenting; Teaching Empathy, Self-Worth and Discipline to School Age Children – by Stephen Bavolek, PhD<br>2. Nurturing Program for Parents and Their infants, Toddlers and Preschoolers – by Stephen Bavolek, PhD<br>3. Crianza Con Carino, Programa Para Padres E Hijos - Stephen Bavolek, PhD<br>4. Parenting Your Out of Control Teen – by Scott Sells, PhD<br>Lessons were designed to help parents acquire best practice techniques that would improve their overall parenting skills and positive ways of interacting with their children. |
| | Early Head Start uses the following curricula:<br>• Family Preservation Assessment, Ages & Stages/Denver II<br>• Early Intervention (Developmental Assessments and/or Interventions)<br>• Parents as Teachers |
| **Strengthening Families Program (SFP) (Prevention Services through the CSB)**<br>**City of Norton-Glenda Collins 276.523.5064**<br>**Radford-Leslie Sharp 540.961.8355 & other localities** | SFP (Kumpfer & DeMarsh, 1989; Kumper, DeMarsh, & Child, 1989) is an evidence-based 14 week family skills training program that involves the whole family in three classes run on the same night once a week. The parents or caretakers of high-risk youth attend the SFP Parent Training Program in the first hour. At the same time their children attend the SFP ages 6-11 Skills training Program. In the second hour, the families participate together in a SFP Family Skills Training Program. |

Bristol Family Resource Center reported they use to periodically hold 4 or 6 week parenting series based on a set curriculum, but it was almost impossible for parents to attend all sessions. Based on this, the Bristol Department of Social Services (DSS) requested a more flexible format on a more ongoing basis.

The DSS or courts can determine how many sessions they want parents to attend. Bristol Family Resource Center documents attendance for these or other agencies as requested.

Additional Programs and Initiatives

It is also worth noting the frequent identification by localities of the **Virginia Cooperative Extension Service** to conduct parent skills training and to train families around meal planning and nutrition. The Extension Service was also identified as a resource for after school and summer activities for older children, and for incarcerated fathers.

PSSF is one of several funding streams that help fund services delivered under the Healthy Families Program in localities. Localities report that **Healthy Families** consistently produces excellent child abuse prevention outcomes at the local, state and national level. The Healthy Families Virginia Statewide Evaluation Summary, 2011 reported that less than 1% of families served had founded cases of child abuse or neglect on the target child, despite the fact that 50% of participating mothers report they were abused as children.

**Family Strengthening & Fatherhood Initiative**

VDSS awarded $245,488 during October 1, 2010 – September 30, 2011 and $449,614 during December 1, 2011 – November 30, 2012 to support 11 community-based programs addressing the areas of responsible fatherhood, healthy marriage and relationships, effective parenting, and youth development. The target populations include families with children ages 0-12, families with youth ages 13-19, non custodial parents and custodial parents. Key focus areas of this funding include strengthening the non‐custodial father's everyday emotional and financial role in the family and in the lives of his children; and supporting evidenced-based fatherhood, family preservation and family strengthening projects and programs. Contractors undergo a rigorous sub-recipient monitoring evaluation during the grant year. Grantees were the following:

1. Capital Youth Empowerment Program (CYEP), Alexandria, VA – "Fathers in Touch" (FIT) program for non-custodial fathers ages 16 and older involved in child abuse and neglect, domestic violence, foster care and child support cases.

2. Center for Child & Family Services (CCFS), Hampton, VA – "Not in the Home but in the Heart" program for fathers, 15 and older, unmarried, married, separated, or divorced with at least one child from newborn to 19 years of age.

3. Chesterfield Community Services Board (CCSB), Chesterfield, VA – *"Within Our Reach,"* is an empirically based program designed to strengthen low-income couple relationships in committed relationships and parenting children under the age of 18.

4. Child Development Resources (CDR), Norge, VA – "*Building Secure Families"* (BSF) program targeting expectant families and those with newborns and families with incarcerated fathers and with children under age 12. *Linkages: Building Strong Connections* that provides one-on-one coaching, parenting education and family support services for incarcerated fathers and their child's birth mother or caregiver.

5. Clinch Valley Community Action Program (CVCA), North Tazewell, VA – The service focus areas included effective parenting; father engagement and involvement; the promotion and support of healthy and safe family practices and responsible fatherhood; and increasing knowledge of healthy relationship skills and healthy family outcomes.

6. Community Lodgings (CL), Alexandria, VA – CL provided Transitional Housing (THP) and Family Learning Center programs to help homeless and low-income families gain knowledge and develop skills for stronger parent engagement, healthier relationships, better family communication and increased personal responsibility.

7. For the Children Partners in Prevention (FTC), Martinsville, VA – Partners in Prevention program involves a network of 40 health and human services groups, with a focus on youth development, responsible fatherhood, marriage and relationship education and marriage mentoring.

8. Highlands Community Services Board (HCSB), Abingdon, VA – Developed a project identified as "Project Dads." The project targets noncustodial/nonresident fathers and is implemented through the 24/7 Dad curriculum, by offering a 12-session educational program focusing on key fathering characteristics such as, masculinity, discipline and work-family balance.

9. New Jubilee Education & Family Life Center (NJEFLC), Richmond, VA - The project includes **"**Connections: Relationships and Marriage curriculum" delivered to 100 selected males at Armstrong High School which has a predominately African American student population. It includes 25 weeks of one-hour in class sessions, five weeks each on the topics: Personality, Relationships, Communication, Marriage, and Money & Budgeting.

10. Rubicon, Inc**.** (RI), Richmond, VA – Developed a program focusing on single and married fathers in its residential and/or outpatient substance use disorder treatment community. The program promotes participation in various kinds of relationship-enhancing activities through increased exposure to healthy lifestyle options, character building, and broadening of cultural and artistic exposure.

11. Total Action against Poverty (TAAP), Roanoke, VA – "Step Up" program targeting non-custodial fathers and youth servicing 11 localities in Southwest VA. Step Up provided parenting education to parents to help them establish or to re-establish a connection with their children. The activities included job readiness and retention training and job placement assistance to better position parents to meet child support obligations.

| ***Table 2:*** **Family Strengthening & Fatherhood Grantees Children and Families Served** | |
|---|---|
| Total Children | 628 |
| Total Families | 614 |

| ***Table 3:*** **Curricula Used By Family Strengthening & Fatherhood Grantees** | |
|---|---|
| **Curriculum** | **Description** |
| **24/7 Dad , InsideOut Dad, Boyz2Dads , DoctorDad, Mom As Gateway, and Why Knot**<br>Capital Youth Empowerment,<br><br>Center for Child and Family Services<br><br>Clinch Valley | The National Fatherhood Initiative (NFI) has developed a large series of curricula to meet the needs of fathers that are researched, evaluated, and/or evidence-based. NFI has conducted a number of evaluations on the effectiveness of its products and programs. The evaluations show positive, statistically-significant increases occurred in parenting skills and knowledge among the fathers who participated in the program.<br><br>24/7 Dad™ is a comprehensive fatherhood program available with innovative tools, strategies, and exercises for fathers of all races, religions, cultures, and backgrounds. Developed by fathering and parenting experts, it focuses on the characteristics men need to be good fathers 24 hours a day, 7 days a week. Independent, third-party research shows that 24/7 Dad™, improves attitudes towards fathering, fathering |

| *Table 3:* **Curricula Used By Family Strengthening & Fatherhood Grantees** | |
|---|---|
| **Curriculum** | **Description** |
| Community Action Program,<br><br>Highlands Community Services Board | knowledge, and fathering Skills**.**<br><br>InsideOut Dad™ is the only **evidence-based** reentry program in the country designed specifically for incarcerated fathers. It develops pro-fathering attitudes, knowledge, and skills, and provides fathers with strategies to connect them with their families and prepare them for release. Standardized programming for 24 states and Washington, D.C., and the City of New York's corrections system, InsideOut Dad™ helps reduce recidivism rates by reconnecting incarcerated fathers to their families.<br><br>Boyz 2 Dads™ helps teen boys connect their choices to consequences and guides their attitudes around important decisions and risky behaviors. Dads, moms, educators, mentors, social workers, or any concerned adult can use this program to help prepare boys to make healthy choices on topics like relationships, sex, and peer pressure. Research shows that Boyz 2 Dads™ has positive effect on teen boys' attitudes and knowledge of how their choices affect their lives.<br><br>DoctorDad™ is a workshop designed to reach new and expectant Dads to help increase fathers' health literacy by providing men with the knowledge and skills they need to successfully care for their young children right from the start.<br><br>Mom As Gateway™ is a workshop that helps to break down barriers between mothers and fathers by addressing what is known as Maternal Gatekeeping - when a mother's belief about a father, as well as her behaviors, hinder a father's involvement - and facilitate helpful discussions and efforts towards co-parenting.<br><br>Why Knot? ™ is a Marriage-Readiness curriculum for men that prepares them for healthy relationships and equips them in making decision around marriage. This training helps men breakdown common misconceptions about relationships and marriage, equips them with important relationship skills, and helps assess their readiness for marriage. Created for men ages 18-30, to compliment programs that provide relationship skills critical to sustaining healthy marriages. |
| **Within Our Reach and Within My Reach**<br>Chesterfield Community Services Board<br><br>Clinch Valley Community Action Program | *Within Our Reach,"* is an empirically based program designed to strengthen low-income couple relationships in committed relationships and parenting children under the age of 18. The curriculum is designed to build on the existing strengths of couples and add critical life and relationship skills that will help them create safer, more stable couple relationships, and by extension, better environments for children. This program is a product of the Center of Marital and Family Studies at the University of Denver. It is an adaptation of the PREP curriculum (Prevention and Relationship Enhancement) curriculum, which has been taught by Chesterfield Prevention Services for 15 years. Both *Within Our Reach* and PREP are founded on best practices, including strategies that are empirically informed, both are currently being empirically tested in outcome studies, and both are regularly refined based on new scientific knowledge in the field of research on relationships.<br><br>*Within My Reach* (WMR) is an adaptation of the PREP curriculum a relationship skills and decision making program for helping individuals achieve their goals in relationships, family, and marriage. The curriculum is especially tailored for those who have struggled with economic disadvantage. WMR is a 15 hour program developed by PREP that is a non-couples based curriculum designed to help economically disadvantaged adults (most typically who are already parents, but not necessarily) who are at risk for poorer quality relationships and relationship instability. |
| **Rookie Dads and** | Rookie Dads' trains expectant dads to be involved in the care of their new baby. The |

| *Table 3:* **Curricula Used By Family Strengthening & Fatherhood Grantees** | |
|---|---|
| **Curriculum** | **Description** |
| **Linkages: Building Strong Connections**<br>Child Development Resources | two-hour class gives men a chance to gather with other men to talk about what to expect from their new role; discuss concerns; and learn about feeding, diapering, bathing, and sleeping techniques in a safe, supportive arena.<br><br>Rookie Dads PLUS is a special program for Rookie Dads graduates. It offers dad/child playgroups; developmental screening; home visits; resources and information on behavior, potty training, and development; dad discussion groups; and dinner out gift cards for couples.<br><br>Linkages: Building Strong Connections provides weekly parenting education sessions, one-on-one coaching, and family support services for incarcerated fathers and their families. The sessions address parenting topics such as child growth and development, positive discipline, communication, and co-parenting. The program is operated in collaboration with Virginia Cooperative Extension's Family Focus program and the Virginia Peninsula Regional Jail. |
| **Out of Poverty**<br>Community Lodgings | An educational experience designed to be used with a comprehensive program of client social services. The training focuses on the acquired mindset of clients and how it interferes with their efforts to escape the conditions of poverty they are experiencing. The program was designed to assist groups of individuals to free themselves from their past and to seek, find and keep good paying jobs.<br><br>The curriculum consists of twelve lessons, each having one or more specific learning outcomes. Participants work on these outcomes in groups that meet for approximately 90 minutes. A trained facilitator guides participants through a standard session sequence. The entire curriculum consists of approximately fifty hours of instruction. |
| **PREARE/ENRICH**<br>For the Children | PREPARE/ENRICH is a customized couple assessment completed online that identifies a couple's strength and growth areas. It is one of the most widely used programs for premarital counseling and premarital education. It is also used for marriage counseling, marriage enrichment, and dating couples considering engagement. Based on a couple's assessment results, a trained facilitator provides 4-8 feedback sessions in which the facilitator helps the couple discuss and understand their results as they are taught proven relationship skills. |
| **Connections: Relationships and Marriage**<br>New Jubilee Education & Family Life Center | Developed by the Dibble Institute for Marriage Education, a nonprofit organization, that helps young people learn how to create healthy romantic relationships now and in the future. It offers tools for teaching the practical skills essential for enhancing friendships, dating and love.<br><br>Connections is based on decades of research developed and refined through the Prevention and Relationship Enhancement Program (PREP). PREP is the core of Connections, being empirically informed and tested. The Connections curriculum has been evaluated to be successful at improving healthy relationship knowledge and behaviors when implemented in high school settings. It is designed to teach students to develop healthy relationships and marriages It also is effective at improving parent-child relationships, and reducing the risk factors associated with teen pregnancies. It has been effective for diverse groups of participants and widely used across the country in classrooms, social agencies, after school programs and other youth settings.<br><br>One study evaluated the effectiveness of this curriculum with 375 students from rural Midwest high schools who were in either the Connections group or in another Family and Consumer Sciences course. Findings suggest that students taking the Connections curriculum improved in their conflict resolution skills, became less likely to see divorce as a good option for troubled marriages, and were more likely to take |

| *Table 3:* **Curricula Used By Family Strengthening & Fatherhood Grantees** | |
|---|---|
| **Curriculum** | **Description** |
| | advantage of pre-marital and post-marital programs to build better marriages. |
| **Prevention and Relationship Enhancement Program (PREP)**<br>Chesterfield Community Services Board<br><br>New Jubilee Education & Family Life Center | Based on over twenty years of research, PREP teaches marital/premarital couples essential skills: how to communicate effectively, work as a team, solve problems, manage conflict, and preserve and enhance love, commitment and friendship. PREP has extensive experience in training mental health professionals and clergy in civilian and military settings to conduct PREP Workshops and/or use the concepts in their practice.<br><br>The goal of PREP is to modify or enhance those dimensions of couples' relationships that research and theory have linked to effective marital functioning. Using techniques of cognitive-behavioral marital therapy and communication-oriented marital enhancement programs, PREP aims to help couples maintain high levels of functioning and prevent marital problems from developing. |
| **Fatherhood Development: A Curriculum for Youth Fathers**<br>Total Action Against Poverty | The Responsible Fatherhood Curriculum is intended to assist fathers in more effectively fulfilling their roles as parents, partners, and workers. It was developed over a number of years' use in the peer support groups that were the "glue" of the Parents' Fair Share (PFS) Demonstration for low-income noncustodial fathers. The curriculum provides useful, down-to-earth material organized into 20 sessions on dealing with issues such as male-female relationships, fathers as providers, managing conflict and anger (on and off the job), and race and racism.<br><br>Targeted at underemployed or unemployed noncustodial fathers who owed child support and had children receiving welfare, PFS aimed to increase child support payments, employment and earnings, and parental involvement. PFS encouraged some fathers, particularly those who were least involved initially, to take a more active parenting role. Many of the fathers visited their children regularly, although few had legal visitation agreements. There were modest increases in parental conflict over child-rearing decisions, and some mothers restricted the fathers' access to their children.<br><br>Men referred to the PFS program paid more child support than men in the control group. The process of assessing eligibility uncovered a fair amount of employment, which disqualified some fathers from participation but which led, nonetheless, to increased child support payments. |

*Item 1c.*
Due to staffing changes within the Division of Family Services, statewide training for PSSF was not provided. However, one-on-one technical assistance was provided to localities regarding how to complete the reporting forms and how to apply for funding.

*Item 1d.*
This is report year three of the five year funding cycle. The comprehensive Community Needs Assessment was completed leading up to year one (SFY 2009-2010). Only when a locality is making major changes to its services is a new Community Needs Assessment required. This approach reflects efforts by PSSF home office staff to streamline the annual application process. At this time, May, 2012, 109 of the 120 localities have approved plans for SFY 2012. Localities renewing their application for funding in a timely manner reflect outcomes of staff sub-recipient monitoring through desk-top assistance and telephone feedback.

*Item 1e.*

Information is reported by localities on a fillable report form that is then entered into an Excel database by PSSF state staff. The tables below show the children and families served by service type and the ranking of most frequently provided services.

***Table 4: Children and Families Served by Service Type***
***92 Agencies Reporting***

| ***Service Type*** | ***Total Children*** | ***Total Families*** |
|---|---|---|
| ***Preservation*** | *5845* | *3718* |
| ***Support*** | *9553* | *6294* |
| ***Reunification*** | *1073* | *699* |
| ***Adoption (1)*** | *18* | *15* |
| ***Other PSSF Services (2)*** | *54,380* | *52,002* |
| ***Total*** | *70,869* | *62,728* |

*(1) $2M PSSF funds were allocated for adoption initiatives at the home office level, therefore, localities were not required to spend 20% on adoption promotion. This number includes localities that provided local adoption services.*

*(2) Some localities provided services that do not lend themselves to identifying data, as they are not targeted toward specific individuals or families (e.g., community fairs, brochures, information and referral, newsletters, library resource centers, websites, etc.)*

***Table 5: SFY 2011-2012***
***Top Five Services Most Often Provided to Families***
***(rankings based on a total of 31 possible service codes)***

| ***Service Type*** | ***1st*** | ***2nd*** | ***3rd*** | ***4th*** | ***5th*** |
|---|---|---|---|---|---|
| ***Family Preservation*** | *Housing & Other Material Assistance* | *Intensive In-Home Services and Parenting Education* | *Case Management* | *Counseling Treatment: Individual* | *Transportation* |
| ***Family Support*** | *Parenting Education* | *Housing & Other Material Assistance* | *Case Management* | *Parenting Skills Training* | *Transportation* |
| ***Reunification*** | *Counseling Treatment: Individual* | *Transportation* | *Housing or Other Material Assistance* | *Parenting Education* | *Assessment* |

Examples of program challenges cited in the year end reports:

*Complexity of problems, including mental health and substance abuse, presented by parents receiving in-home and/or parenting class services. During the reporting period, there was a need for a parenting*

*education class for a Vietnamese speaking parent. After extensive research, no resources to meet this need were found within a reasonable driving distance (Spotsylvania County)*

*Homelessness continues to impact many of our families. Families live in motels and have frequent moves. The instability impacts the continuation of services and often impacts a youth's ability to focus on education. (Williamsburg) Note: [Homeless students on the rise- May 15, 2012 Daily Press: If you took a walk down the halls of any school in the Williamsburg-James City County school district the chances are pretty high that you'd pass by at least one homeless student. "It's probably the worst trend we've seen in close to five or six years of tracking the data," said David Gaston, Senior Director for Specialized Education Services. Gaston said more than four percent of students in the district are now considered homeless and believes that increase is from the slumping economy. That doesn't necessarily mean those kids are living on the street, but it does mean the students don't have a place to call home, which makes identifying them tough.]*

*Families with increased financial stressors alone present more challenges for staff who try to help move them in a more positive direction while also helping them focus on their children's needs. Adding renewed and increased drug usage, diagnosed but untreated mental illness, and/or undiagnosed mental health issues presents greater challenges for staff when working with families on goal plans and parenting skills. Mental health service providers have raised criteria for what meets individual needs and increased group counseling sessions. Many parents are in need of counseling are not comfortable in a group setting and are therefore finding more reasons not to go to counseling sessions. (Montgomery)*

*One of the biggest needs is to help them with gas for them to get to counseling and appointments since there is no public transportation in this area. (Scott)*

*With the economic downturn and the increases in the cost of food, gas and other living expenses, more parents are working longer hours or multiple jobs, making it difficult to schedule home visits. Staff attempt to schedule visits early in the morning (before the parent goes to work), in the early evenings and occasionally on a weekend. (Alexandria)*

*On-going child care is a continuing concern when reunifying children and the agency maintains a waiting list for fee child care (Campbell)*

*Major challenges are the lack of parenting skills and the limited abilities and emotional immaturity of some parents. Many parents do not understand childhood development or the need for teenagers to differentiate themselves from their caregivers. There also is little if any awareness of how early traumas impact the behaviors of children who have been abused/neglected or exposed to violence in their homes. The serious mental health issues of some of our youthful clients also challenge the ability of some families to remain together. (Hanover)*

***Table 6: Children and Families Referred to the PSSF Program***

| *Measures: Outputs and Outcomes* | *FY 2009 74 localities reporting* | *FY 2010 90 localities reporting* | *FY 2011 77 localities reporting* | *FY 2012 92 localities reporting* | *FY 2013* | *FY 2014* |
|---|---|---|---|---|---|---|
| *Number of families receiving PSSF services* | *9,790 families 13,316 children* | *8,572 families 11,417 children* | *7,807 families 9419 children* | *10,726 families 18,867 children* | | |
| *Of this number, children who* | *331=2%* | *181 = 1%* | *228 = 2%* | *191=1%* | | |

| *Table 6: Children and Families Referred to the PSSF Program* | | | | | | | |
|---|---|---|---|---|---|---|---|
| *Measures: Outputs and Outcomes* | | *FY 2009 74 localities reporting* | *FY 2010 90 localities reporting* | *FY 2011 77 localities reporting* | *FY 2012 92 localities reporting* | *FY 2013* | *FY 2014* |
| | *enter foster care will not exceed 5%* | | | | | | |
| *Number of families whose children are in foster care 15 mos. or less who receive reunification services* | | *1,409 children in 889 families* | *1,104 children in 692 families* | *985 children in 731 families* | *1,048 children in 699 families* | | |
| | *Number of children targeted for Reunification at the end of the year* | *1268* | *488* | *436* | *512* | | |
| | *Number of children reunited with their birth family during the year* | *376* | *289* | *218* | *184* | | |
| *Number of children placed w/relatives other than the natural parent who was the last custodian* | | *195(1.5%)* | *142 ( 1%)* | *154 (1.6%)* | *180(1%)* | | |
| *Number of children for whom a new abuse complaint was made/baseline = 6.1%* | | *79 (less than 1%)* | *45 (less than 1%)* | *56 (less than 1%)* | *118 (less than 1%)* | | |
| *Number of families by ethnicity*<br><br>*(*based on the ethnicity report)* | | *42% African American 44% Caucasian 10% Hispanic 3% Asian or other race* | *50% African American 54% Caucasian 13% Hispanic 3% Asian or other race* | *39% African American 41% Caucasian 13% Hispanic 7% Asian or other race* | *34% African American 49% Caucasian 13% Hispanic 4% Asian of other race* | | |

*Localities are asked to discuss how staff communicates effectively with families where English is their second language. Below are some of the responses:

> *"Many forms and applications are available in other languages and translation devices are used, including those online. Social Services use VDSS certified interpreters when needed. Spanish versions of electronic publications and community resources are provided as needed to effectively relay information to Spanish speaking individuals. Spanish parenting literature and child development screenings are disseminated to clients. Spanish to English dictionary is used for translating specific words and several staff members are bilingual including three at DSS and one at Healthy Families who are fluent in Spanish. There are volunteer interpreters in the community who often accompany clients who do not speak English. (Campbell)"*

> *"…The two Asian speaking customers were able to understand and speak some English. However, if they were not able to understand English we have one Asian staff person who offered his services. It was*

*brought to our attention that there are so many variations of the Asian language there would not have been any guarantee his services would have been helpful." (Chesapeake)*

*"Several staff on the Home Based team are bilingual in Spanish. If other language is spoken, staff accesses the City of Alexandria language line or request that a translator is provided by the referral source." (Alexandria)*

**Summary of Service Array Findings**

Based on locality reports, (Tables 7 – 9) that follows are a composite of the most frequently used services during Fiscal Years 2010, 2011 and 2012. The rankings are based on the frequency by which each service was applied to assist a family. Based on the PSSF Service Array 31 allowable services; Assessments, Parenting Education, Housing and Other Material Assistance, and Transportation were most often applied to prevent family crisis and/or to achieve the goal of return home. These findings are consistent with those reported in the statewide assessment for the 2009 CFSP. At that time, VDSS requested local departments of social services and their local partners (localities) to complete two surveys. The findings are in Virginia's Five Year Plan for Children and Family Services 2010 – 2014 available at: http://www.dss.virginia.gov/family/cfs_plan.pdf

Based on the 2009 survey findings, Assessments and Parenting Education are widely used in local agencies; 95% of the respondents indicated they conduct client needs assessments; and that parent education services are available in their locality. The majority of respondents *(80%)* felt that parenting education programs were community-based and family-centered.

Localities indicated substantial gaps in the availability of primary services such as Transportation, Housing and Substance Abuse Counseling; that would allow parents to more fully participate in parenting and other family strengthening services. Transportation was a 'Gap' and/or 'Need' for all VDSS regions.

**Table 7: Family Preservation Summary**
**Most Frequently Provided Services**

| Year | Ranking | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 2012 | | #3 | #4 | #1 | #2 | #2 | | #5 |
| 2011 | #4 | #5 | | #1 | #3 | #2 | | |
| 2010 | | #5 | #4 | #1 | #3 | #2 | | #4 |
| | | | | | | | | |
| **Service Code** | 020 | 030 | 050 | **130** | 150 | 211 | 235 | 260 |

**Table 8: Family Support Summary**
**Most Frequently Provided Services**

| Year | Ranking | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 2012 | | #3 | | #2 | | | | #1 | #4 | #5 |
| 2011 | #4 | #3 | | #2 | | #5 | | #1 | #5 | |
| 2010 | #5 | #4 | #5 | #2 | | #4 | #3 | #1 | | |
| | | | | | | | | | | |
| **Service Code** | 020 | 030 | 090 | 130 | 140 | 150 | 180 | **211** | 213 | 260 |

**Table 9: Time-limited Family Reunification Summary**
**Most Frequently Provided Services**

| Year | Ranking |
|---|---|

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2012 | **#5** | | **#1** | **#3** | | **#4** | | | **#2** |
| 2011 | **#1** | | **#3** | **#2** | | **#5** | | **#3** | **#4** |
| 2010 | **#1** | | **#2** | **#2** | **#5** | **#2** | | | **#1** |
| | | | | | | | | | |
| **Service Code** | **020** | 030 | **050** | 130 | 150 | 211 | 213 | 235 | **260** |

**Service Array Code Legend:**

| | | | |
|---|---|---|---|
| **020** | **Assessment** | **050** | **Counseling and Treatment-Individual** |
| **030** | **Case Management** | **090** | **Educational/School Related Services** |
| **130** | **Housing or Other Material Assistance** | **140** | **Information and Referral** |
| **150** | **Intensive In-Home Services** | **180** | **Mentoring** |
| **211** | **Parenting Education** | **213** | **Parenting Skills Training** |
| **235** | **Substance Abuse Services** | **260** | **Transportation** |

## II. Family, child and youth-driven practice

This strategy fulfills the mission of transforming how services are delivered by giving a stronger voice to children and families in decision-making. The state practice model enables families to actively engage with child welfare staff and other important stakeholders in facilitated meetings to collaborate on the key decisions *(such as placement or moves)* that affect a child's life. Through collaboration, the practice model is achieved according to individual circumstances while empowering families to participate in the process.

- **Applicable Children's Services System Transformation Outcomes:** Permanency Outcomes: Increase Permanency Discharges, Decrease Time to Permanency Discharge; Family Based Care: Increase Family Based Care, Increase Kinship care; Congregate Care Reduction: Decrease number of youth in congregate care, Decrease time spent in congregate care

- **Applicable CFSR Outcomes or Systemic Factors:** Safety Outcome 2; Permanency Outcome 1; Permanency Outcome 2; Wellbeing Outcome 1; Systemic Factors: Staff and Provider Training, Service Array and Resource Development, Foster and Adoptive Parent Licensing, Recruitment, and Retention

- **Applicable CFSR Items:** Item 3, Item 4, Item 6, Item 7, Item 8, Item 9, Item 10, Item 11, Item 12, Item 14, Item 15, Item 16, Item 18, Item 32, Item 33, Item 34, Item 35, Item 44 & Item 45

**Goal: Engage families in decision making** using a strength-based, child-centered, family-focused and culturally competent approach

1. **Implement a state-endorsed Family Engagement Model**
   a) Develop and implement a plan for providing a consistent statewide approach to family engagement.
      - Enhance and increase the involvement of parents, children, youth, and other significant social network members in service delivery, policy and program development and evaluation.
      - Assess LDSS' needs, training, intersection with CSA, documentation in OASIS, and evaluation of practice.

- Develop resources and tools for service providers to more fully engage parents, youth and other significant individuals in planning, implementation and evaluation processes.

b) Train selected service providers and state/regional staff on strategies for engagement on a regional basis.
c) Establish a plan for regional staff to provide training and technical assistance to localities on family engagement strategies.
d) Survey selected programs to determine the level of change in involvement and recommendations for improvements.
e) Develop and implement recommendations to improve parent, youth and other significant individual's involvement.

*2012 update*

Continued efforts have been made by VDSS to support the implementation and continued practice of family engagement. A family engagement newsletter featuring promising local agency practice, tips and training information is published quarterly. VDSS has developed a Family Engagement Facilitator Project to support local agency facilitators across the state. Forty two participants, comprised of both local agency facilitators and private providers, participated in this pilot during FY 2012. The participants attended a two day summit and facilitated a capacity-building activity within their region for other facilitators. A second Family Engagement summit is planned for July 2012 and a new cohort of facilitators will be selected to participate in the FY 13 Facilitator Project. Additionally, FY 12 participants will be invited to participate in a Master Facilitator project through which they will receive additional training and assist with the development of a protocol for providing coaching to newer facilitators in their regions.

An additional effort to support local agencies includes the availability of funding. Local agencies are eligible to receive FPM Incentive Funds for valid documented meetings in OASIS. Incentive funds were distributed quarterly to local agencies in FI 12 and were used to fund facilitators or facilitator coaches, transport family members to Family Partnership Meetings, purchase equipment for FPM, fund staff training, or create resources to support families. FPM Incentive funds will be available again in FY 13. They will continue to be awarded for the completion of valid, documented FPMs and additionally, to support participation in the Facilitator Projects mentioned above.

Finally, a 90 minute presentation regarding family engagement and teaming is being developed for child welfare supervisors. During FY 13 it will be given at the regional supervisors' meetings. Subject matter will include how to evaluate workers' understanding of and comfort with family engagement, how to promote family engagement practice among workers and the importance of teaming as an agency practice. Supervisors will also be provided with tips sheets and instruments for use with workers. This presentation is a precursor to training which is being developed in the Training Unit for workers on family engagement principles.

**PS 1 Obj. 1. Utilize Family Partnership meetings as a way to involve families, youth, and significant others**

**<u>Strategy 1.1</u> Develop Family Partnership resources and tool kit for service providers, relevant family service contractors, and LDSS to share with families**

a) Post local and national sample documents such as brochures, forms, contact information
b) Post family engagement guidance

Completed

**<u>Strategy 1.2</u> Train LDSS workers and members of the bar on Virginia's Family Engagement Model including Family Partnership meetings, Diligent Family Search and Engagement.**

a) develop curricula, in conjunction with VISSTA, based on FEM guidance
b) develop training phases for LDSS and determine which localities will be trained in which phase
c) schedule training for members of the bar
d) evaluate trainings

Completed – By the end of August 2011, 481 people had taken the Intro to Family Engagement course and 438 people had taken the Facilitator course. Training for members of the bar took place in the fall of 2011. Evaluations of the intro and facilitator's course indicated participants were overall satisfied with the content of the course, however, they were dissatisfied with the length of the course.

**<u>Strategy 1.3</u>. Revise CPS and Foster Care guidance manuals to support family engagement philosophy and partnership meetings**.

a) review Family Engagement guidance
b) review current program guidance to identify key decision points
c) obtain input from the Permanency Advisory Committee and the Child Protective Services Advisory Committee
d) coordinate language across CPS and foster care programs and incorporate consistent language in the respective guidance manuals
e) disseminate guidance in CPS and foster care manuals

Completed

**<u>Strategy 1.4.</u> Increase the number of family partnership meetings**

a) Set the expectation that each locality within the state will implement Family Partnership Meetings at at least one decision point by the end of the calendar year 2010
b) Review the Family Partnership report to inform technical assistance needs
c) Provide technical assistance through Regional Consultants

*<u>2012 update</u>*

The Regional consultants for CPS, Permanency and Resource Families continue to provide T/TA around use of FPMs to LDSS. FPMs are frequently recommended as a strategy for addressing case issues around which the LDSS is seeking consultation. Regional consultants continue to periodically observe FPMs, provide updates and resources to supervisors at Regional Supervisors' meetings and reinforce guidance around required decision points in all contacts with LDSS.

The FPM Incentive Broadcasts include regular updates to all LDSS about the statewide increase in the number of FPMs being held. Additionally, a report is now available in SafeMeasures which counts the number of FPMs by LDSS per month. Regional Consultants and VDSS staff are able to use this data to provide technical assistance on FPM practice with particular LDSS who are having fewer than expected FPMs.

**<u>Strategy 1.5</u> CIP to fund facilitation of 20 of family partnership meetings at LDSS**

a) RFA developed in conjunction with CIP and Family Engagement Manager and sent to all local departments
b) Selected localities will be notified and included in a pilot project for Family Partnership training
c) Judges from the pilot site localities will be trained on Family Partnership meetings

d) Develop a process for formally notifying the Court about the outcome of the family partnership meeting.

*2012 update*

A sample court report form has been placed on the SPARK page with information about the form shared in the FEM newsletter. The form asks for the decision point, who participated in the meeting, strengths/needs, an action plan, placement/resource options, recommendations, and signature lines.

2. **Enhance the current CPS Differential Response System *(DRS)* Practice Model** to ensure a more family-focused and family-driven approach
   a) Incorporate the Children's Services Practice Model into the CPS DRS Family Assessment Track.
   b) Revise and align the CPS policy and guidance manual consistent with strengthened family engagement philosophy, procedures and practices.
   c) Develop and/or contract for the development of training for local CPS workers in implementing the Family Engagement Model when conducting Family Assessments.

**Completed**

**3. Collaborate with the Office of Comprehensive Services to support engaging families in service delivery:**
   a) Provide opportunities for LDSS and local CSA staff to receive training about family engagement policy approved by the State Executive Council.
   b) Develop a cross-systems family satisfaction survey.

## Goal: Engage youth at the service, program and policy levels.

1. **Increase youth involvement** in service planning and developing transitional planning to promote permanency and self-sufficiency.
   a) Develop strategies to increase the level of youth involvement in program planning, implementation and evaluation.
   b) Involve the Virginia Youth Advisory Council *(VYAC)* and regional councils in the development and improvement of state and local child-serving policies and practices by creating and/or supporting initiatives and partnerships that promote permanency, self-sufficiency, and networking.
   c) Involve youth in providing input into foster care policy development, conducting life skills and self-advocacy training, and increasing youth's understanding of the concept of achieving permanency.
   d) Provide training and technical assistance to LDSS in developing appropriate youth-driven service plans that focus on transitional living plans for older youth.

2012 Update

Project LIFE, a private/public partnership between VDSS and United Methodist Family Services (UMFS), has been instrumental in getting youth in and transitioning out of foster care involved in trainings, activities, and events that promote permanency and self-sufficiency. The goal of Project LIFE is to support permanency for older youth in care through the coordination and enhancement of independent living services by collaborating with local departments of social services, private providers and community stakeholders. Five regional Independent Living (IL) Consultants and two Best Practice Consultants are responsible for carrying out the vision, mission and goals of the Chafee Foster Care Independence Act, the principles of the Virginia Children's Services Practice Model and family engagement by collaborating with LDSS and private providers for adulthood by offering;

- Hands-on training
- Structured, uniform program of services
- Technical assistance and
- Best practice development

Project LIFE offered the following training, technical assistance (T/A), and services:

- Ansell Casey Life Skills Assessment (ACLSA)
- National Youth Transition in Database (NYTD)
- Independent Living Program (ILP); ETV; Transition Living Plan (TLP); Permanency for Youth
- Facilitation of IL skills group
- Development of youth advisory councils
- Regional youth conferences/events

Project LIFE provided the following activities/services with youth:

| **Topic/Activities** | **# of Activity** | **# of youth participants** |
|---|---|---|
| Transition Living Plan | 1 | 35 |
| IL Life Skills (i.e., health/wellness, IL workshops) | 3 | 82 |
| Permanency Events (i.e., Family Engagement/ Family Partnership Meetings, Family Academy) | 9 | 132 |
| Generosity activities-(i.e., giving back, service learning projects, community services) | 8 | 51 |
| Youth Leadership Institute, Know Your Rights, Shout Out | 4 | 27 |

During this fiscal year, the Project LIFE team achieved the following:

- Coordinated two VYAC weekend conferences with at least 65 youth participants at each. Older youth co-facilitated some of the workshops and activities and served as mentors;
- Participated in state work groups and committees representing the needs of older youth including the National Youth and Transition Database (NYTD), Family Engagement, Fostering Connections to Success Education Workgroup, and the statewide Permanency Advisory Committee;
- The State council worked in partnership with The National Foster Youth Action Network to develop strategies for expanding regional council membership and providing leadership and advocacy training to improve the foster care system; and
- Developed a Speaker's Bureau and conducted formal training for current and former youth in care. Youth and young adults from around the state learned how to effectively make presentations and give personal testimonies to community stakeholders, policy makers, social workers, foster parents and other foster care youth throughout Virginia.

In order to increase the LDSS' capacity to meet the goals of establishing permanent connections for older youth and developing adult living skills, Project LIFE and VDSS are committed to assisting LDSS in providing necessary services to eligible youth on a statewide, regional and local basis. For FY 2013,

Virginia is moving toward Performance-based Contracting with UMFS. VDSS will provide the leadership necessary for Project LIFE to accomplish the following goals:

- Strengthen the capacity of LDSS to more effectively support youth in conducting life skills assessments and transition plans in preparing youth to make successful transitions to adulthood,
- Promote youth's meaningful engagement in case planning and in advocating for themselves; and
- Increase the capacity of public and private service providers to engage in IL Best practices with older youth in foster care.

Virginia is committed to having youth's voice and involvement in their own service planning, foster care policy, NYTD workgroup and other state committees.

## III. Achieving Permanency

This strategy ties directly to the Children's Services Practice Model. We believe that all children and youth need and deserve a permanent family. It is VDSS' responsibility to promote and preserve kinship, sibling and community connections for each child. Permanency is best achieved through a legal relationship such as parental custody, adoption, kinship care or subsidized custody.

- **Applicable Children's Services System Transformation Outcomes:** Permanency Outcomes: Increase Permanency Discharges, Decrease Time to Permanency Discharge; Family Based Care: Increase Family Based Care, Increase Kinship care
- **Applicable CFSR Outcomes or Systemic Factors:** Permanency Outcome 1; Permanency Outcome 2; Wellbeing Outcome 1; Systemic Factors: Staff and Provider Training; Service Array Resource Development; Foster and Adoptive Parent Licensing, Recruitment, and Retention
- **Applicable CFSR Items:** Item 7, Item 8, Item 9, Item 10, Item 12, Item 14, Item 15, Item 17, Item 32, Item 33, Item 34, Item 35, Item 44, Item 45

### Goal: Find and support permanent families and/or life-long connections with a responsible, caring adult for every youth in foster care.

1. **Evaluate and recommend changes in the processes and procedures to achieve legal permanency** for children in foster care that are consistent with research and best practices related to stability and permanent families.
    a) Assess OASIS data on achieving permanency for children under the current permanency goals allowed under Virginia law.
    b) Review, as indicated, other states' permanency goals and data to assess how Virginia could improve its legal permanency options for children in foster care.
    c) Using the Process Improvement Team model, make recommendations to the Division Director for improving the processes, procedures and how the legal permanency options available for children in care are used.

<u>2012 Update</u>

Due to changes in state law, the LDSS can no longer assign the goal of IL to youth. This law allows youth ages 16 and over with the goal prior to July 1, 2011 to retain this goal with no changes required; however LDSS must provide a program of care and services. IL services are not affected. In FY 2012, state staff developed and is in the process of implementing, in collaboration with key stakeholders including youth, a work plan that will provide technical support, resources, tools, policy and practice guidance on achieving permanency with a sense of urgency for all youth. Virginia requested and received approval for training and technical assistance (T/A) from the National Resource Center on Permanency and Family Connections (NRCPFC). Eliminating the goal of IL is a major change for Virginia and training and T/A are needed in assisting local workers in achieving youth permanency and lifelong connections. NRCPFC will assist the VDSS in developing and implementing an integrated approach to permanency and preparation for adulthood. Gary Mallon, consultant with NRCPFC, met with representatives from VDSS and LDSS on May 9, 2012 and collaboratively a work plan was developed to address permanency for older youth. For FY 2013, NRCPFC will provide detailed information and T/A to inform three action groups focusing on; Family Finding; integration of youth voice in Family Partnership meetings, and Permanency Roundtables.

**2. Increase kinship care services for families involved with the child welfare system.**

a) Explore multiple options for supporting kinship care relationships *(including subsidized custody)* for children at risk of entering or in the foster care system.
b) Explore the use of Subsidized Custody as another permanency option for children who are in foster care and placed with a relative foster parent in accordance with the Title IV-E requirements of The Fostering Connections to Success and Increasing Adoptions Act, 2008.
c) Establish the decision process, plan and timeline regarding the option of a Subsidized Custody *(guardianship)* goal in foster care by July 2009.
d) Support state collaborations that focus on increasing awareness and training of kin *(relatives)* as valuable resources in creating permanency options for children who cannot live with their birth parents.
e) Provide ongoing support and involvement of staff in local and regional initiatives to train and support kinship care providers.

**PS 1 Obj. 4. Implement Subsidized Custody as a permanency option for children in foster care**

**Strategy 4.1. Develop guidance in foster care manual for subsidized custody as one of two options for the foster care permanency goal of placement with relatives**

a) workgroup formed
b) determine what sections of foster care manual will be amended
c) determine definition of relative
d) clarify the process of ruling out reunification and adoption as not appropriate for the child
e) clarify how the VEMAT will apply to relative subsidy payments
f) develop tools for assessing families and children as appropriate for subsidized custody
g) create guidance regarding all siblings qualifying for a subsidy
h) develop post-custody review procedures
i) Provide process for continued Medicaid eligibility when a family with custody moves to another state
j) Collaborate with Office of Comprehensive Services to amend CSA guidance to include requirements for subsidized custody consistent with guidance in the foster care manual.
k) PAC to review guidance

*2012 update*

**Custody Assistance (previously called "Subsidized Custody") Policy and Tools Work Group:** Beginning March 1, 2010 and working continuously through August, 2010, the Policy and Tools Work Group met weekly to frame and define processes for the Custody Assistance guidance. The workgroup continued to meet as needed throughout SFY 2012 to finalize plans for custody assistance implementation. Draft Custody Assistance guidance was added to section 10 of the Foster Care Manual. This addition to the manual clarified what must be done to rule out adoption and reunification; addressed how to use the VEMAT in custody assistance; defined who may be considered a relative in Virginia; created guidance as to the qualifications of a sibling for being considered for custody assistance; developed post-custody review processes and provided a process to continue Medicaid when the family moves out-of-state. The Office of Comprehensive Services, overseer of the CSA, was involved in the development of the guidance and their input is also included in the manual.

**Strategy 4.2. Identify OASIS updates**

a) Outcome Based Reporting and Analysis Unit (OBRA) will review what is currently in OASIS and determine if current screens can be modified or if new screens must be created

b) meet with Managing by Data workgroup to determine requirements

Completed

**Strategy 4.3 Examine and amend CPS guidance to determine revisions required to support subsidized custody.**

a) With CPS policy person, draft guidance around identification and notification of relatives within 30 days of removal and the process to inform them of the right to participate in the care of the child

b) review guidance with CPS policy advisory team

c) disseminate guidance

Completed

**Strategy 4.4 Develop training for workers on the appropriate use of Subsidized Custody as an option under the goal of Placement with Relatives**

a) Provide Subsidized Custody policy and procedures to VISSTA to incorporate into new worker policy training for both CPS and Foster Care workers

b) Provide Foster Care Guidance Transmittal Training including Subsidized Custody procedures to local social worker coordinators and staff

c) Work with NRC to plan and conduct skills training on assessment and preparation of relatives for taking custody of kin for local staff

d) Provide Child Welfare Training committee a training curriculum, consistent with the NRC skill training on assessment and preparation of relatives, to incorporate into the array of competency based courses

2012 update

Custody assistance guidance was provided to the curriculum developers in the Department's new training Unit and will be built into new worker training on foster care guidance. The regional Family Resource and the Permanency Consultants have transmittal training planned for July 2012 that will be available to all workers and supervisors statewide.

Work was begun in April this year with the NRC on Permanency and Family Connections to build a curriculum and develop additional guidance as necessary on approving and assessing relatives as caregivers. An initial meeting with state representatives and Gary Mallon of the NRC was held and three workgroups were formed as a result of that meeting. A work plan was also developed to ensure that the necessary skills training are developed and a curriculum for assessing relatives can be developed.

**<u>Strategy 4.5</u> Educate judges and attorneys on subsidized custody in collaboration with Court Improvement Office.**

a) provide Foster Care guidance on Subsidized Custody to support development by CIP of curriculum to train judges

b) meet with CIP staff to discuss CIP training schedule and determine options for training judges

c) provide training in conjunction with CIP

<u>2012 Update</u>

Permanency Unit staff worked with the Court Improvement Program staff to develop training for both juvenile court judges and local attorneys on custody assistance. The training was delivered in fall of 2011 at two separate conferences of judges and attorneys and reported on in the CFSR PIP quarterly report.

**<u>Strategy 4.6</u> Develop evaluation plan in conjunction with VDSS research department**

a) Identify variables to be tracked

b) Determine methods of evaluation (i.e. surveys, interviews, etc)

c) set baselines

<u>2012 Update</u>

VDSS' research team developed evaluation guidance for the custody assistance option. Information regarding the evaluation process was submitted with the CFSR PIP 5th quarter report.

**3. Evaluate and implement best-practice models that are consistent with the Family Engagement Model.**

a) Increase local capacity for locating absent parents, siblings, other relatives and significant others to engage them in service delivery and establishing permanent, life-long connections.

b) Research the benefits and challenges of statewide implementation of: concurrent planning and using the Child and Adolescent Needs and Strengths Assessment *(CANS)* tool for every child in foster care.

c) Obtain National Resource Center technical assistance to access lessons learned by other states and to assess the benefits of, and processes for, implementing multiple best practices.

d) Convene ad hoc workgroups involving key stakeholders to assist in the analysis *(including evaluating current needs and the status of these practice models in Virginia and other states)* and to provide input on formal recommendations for implementation.

e) Develop plans and implement additional best-practice models as indicated.

**4. Develop a wider array of options for local department use of respite funding to support connections with relatives and siblings for children in foster care with a community-based focus.**

a) Establish and convene a respite advisory team in each region, to include local departments, respite care providers, and key members of local communities;

b) Utilize regional respite advisory teams to determine the needs for, current uses of, and barriers to use of respite care program funding;

c) Explore respite programming options beyond those that current exist (utilizing resources from the Collaboration to AdoptUsKids), particularly those that would encourage collaborations among local departments and the faith community, business community, civic groups, and/or other key stakeholders;

d) Include expanded respite options in the FY2012 applications for respite care program funding

2012 Update

Virginia's regulations for resource family approval now include specific approval processes for those families wishing to provide respite care only so as to increase the likelihood for approval of relatives to provide respite care. Guidance provides information and resources for locating and approving relatives (for full or respite only approval). Applications for respite care program funding encouraged use of funds to promote visits among siblings and connections with relatives. Regional consultants worked with local agencies to implement opportunities for resource families who do not have current placements to serve as respite providers for youth in congregate care settings to promote lifelong relationships.

The Resource Family Consultants are continuing to work with their local agencies to increase the use of respite. As a result of being responsive to the changing needs of local departments, the eligible population for the respite program has been expanded to include children who are receiving CPS ongoing or prevention and stabilization services. Local agencies are also able to apply for funds to support a group respite care program. The program may include but is not limited to a summer camp for youth receiving foster care services, a time-limited experiential learning experience or alternate activity that would serve as a respite resource to the resource parent. The program must serve a minimum of 12 children.

## Goal: Recruit, develop and support resource families

The continuum of work with resource families includes recruitment, development, and support such families, which include foster, adoptive, and kinship parents. Research has shown that children experience better outcomes, with fewer disruptions and greater family retention, when agencies actively pursue resource family development.

**1. Increase the availability of viable resource families through diligent recruitment (including kin), thorough development, and targeted training and support.**

a) Develop a framework for and engage service providers in best practice across the recruitment, development and support continuum.

b) Implement dual approval for resource families and increase options for formal and informal kinship care.

c) Increase local skills and capacity for locating extended family and non-relative significant relationships for children and youth in system of care.

d) Provide direct pre-service training to families, utilizing the PRIDE Model, and increase local utilization of this model or comparable pre-service that is competency-based.

e) Provide direct in-service training to families, using PRIDE and other in-service curricula, with a focus on topics related to engaging families.

f) Increase provider *(family)* approval regulations to reach greater consistency in the provision of pre-service and in-service *(e.g., mandate the number of hours required)*.

**2. Engage youth in child-specific recruitment efforts to achieve permanency, as appropriate.**

a) Develop resources and provide training to service providers regarding child-specific recruitment.

b) Provide training and technical assistance to service providers to better engage youth in understanding the options and planning for permanency.

c) Develop tools, strategies and guidelines for preparing youth for child-specific recruitment.

*2012 update*

To ensure that agencies have the tools, knowledge and technical assistance needed to fully realize a system of recruitment and retention for resource families, the RFU implemented a series of structured meetings and information based on Casey's Breakthrough Collaborative methodology, called "Regional Peer Collaborative" (RPC) which continued through December 2011.

Within each region, local agencies come together approximately every 6-8 weeks to "staff" their practices regarding resource families. Approximately half of the Commonwealth's local agencies participating. This enabled the State to promote inter-jurisdictional cooperation and, when necessary for the best interests of a child, placement and sharing of homes. For each agency, a consistent "working" team attended the RPC meetings; agencies also had an internal implementation "home" team to ensure that practices and changes are supported system-wide. A framework for best practice with resource families not only set the standards for this work, it was also used to structure and sequence the RPCs. The RPCs began with a focus on development, training and assessment activities—how to create a welcoming and responsive system. Next, the focus went to supporting families so that they are better able to meet children's needs *and* they are more likely to be retained over time. Lastly, the RPCs shifted to recruitment; agencies were better prepared to accommodate and meet the needs of its current families, and also those who entered the system because of recruitment.

Integrating CRAFFT efforts into the RPCs as a part of the overall family engagement movement extends these messages directly to resource families. During FY 2012, CRAFFT increased training to families on family engagement topics (e.g., working with birth families) as well as offer training opportunities specifically to kinship caregivers.

The RPC process for the upcoming year will be structured in each region to meet the needs of that region. Many agencies expressed concern regarding the time commitment required of the RPC as previously designed, and requested targeted recruitment needs and support. In addition, agencies that participated last year have requested to continue meeting at least quarterly because of the benefits of information sharing and peer to peer networking. The Resource Consultants are also reviewing monthly data reports that provide agency information regarding family-based placements and kinship placements. The Consultants will develop targeted strategies to assist the agencies that are below the national practice standards.

Through consultation from the Annie E. Casey Foundation, the Resource Family Consultants received training in this area of family search and engagement. In an effort to increase the number of kinship providers, the Resource Family Consultants continued to offer a minimum of two sessions per region open to both local departments and private providers. In additional to the family search and engagement training, the Consultants will provide technical assistance to local agencies regarding the use of Accurint, the internet search system used to locate relatives and permanent connections for youth.

The Resource Family unit is continuing to work closely with the CRAFFT Coordinators to ensure the resource family training needs within the region are met.

## Goal: Increase timely and sustained adoptions

1. **Increase timeliness of adoptions** of children discharged from foster care.
   a) Implement case practice strategies *(~~Concurrent Planning and~~ Family Team Meetings)* statewide that support decision making and action related to achieving the goal of adoption.
   b) Support other case management strategies that increase the number of and timeliness of adoptions (e.g., concurrent planning; permanency roundtables).

~~c) Promote and support interjurisdictional adoptions among local agencies and between local departments and child placing agencies through request for proposals and/or memorandum of agreement.~~

~~**2. Increase the number of youth, aged nine and older, who achieve the goal of adoption.**~~

~~a) Provide training and other supports for youth in foster care to explore the option of adoption as a lifelong event.~~

~~b) Establish a youth adoption project that will identify youth with TPR and promote adoption and/or other permanent options for these youth.~~

3. Increase the number of youth adopted with the goal of adoption but not placed in pre-adoptive homes.
    a. Contract with public and private child placing agencies to focus on achieving finalized adoptions of a specified group of eligible children and youth.
    b. Work with the contractors to set specific milestones to achieve and a set number of adoptions to finalize each year.
    c. Work with the faith-based community to explore holding additional rally's for children waiting for adoption.

*2012 update*:
In 2010, the Department instituted Family Partnership Meetings (FPM) across the state and identified a change in permanency goal as one decision point at which such meetings should occur. By 2012, LDSS continued to increase their implementation of Family Partnership Meetings and additional fiscal and training resources continued to be made available to the LDSS to increase their use of this best practice

The Department has decided not to implement concurrent planning as a statewide initiative. Although family partnership meetings have been implemented, on-going work to institutionalize this practice and expand the FPM's to all decisions points in all agencies is an on-going issue. Adding concurrent planning as a new statewide initiative is not conducive to ensuring that FPM is fully implemented to the required standard. The state does support localities use of concurrent planning through its foster care guidance manual and the service plan in OASIS and will continue to do so. Because concurrent planning will not be an area of focus under this plan, implementing it statewide is being deleted from the plan for the upcoming year.

The Department continued contracting with licensed and public private adoption agencies (13 agencies) to assist local agencies with adoption services. In 2012, these contracts were changed to focus on specific outcomes related to finalizing adoptions of children who had a goal of adoption, Termination of Parental Rights and were not placed in an adoptive home. Recipients of awards were asked to develop working relationships with LDSS who had specific children whose adoptions were lagging due to lack of placements. More emphasis was placed on the contractual agency assuming responsibility for achieving clear finalized adoption –related milestones (e.g., completed home study; matching the child with a family). The Adoption Through Collaborative Partnerships (ATCP) contacts were based on the data that showed the real need for adoption services was to children of all ages who were clear for adoption but not in adoptive homes. As a result, the goal to increase the number of youth aged nine and older has been deleted and a new goal reflecting the ATCP has been included. The ATCP is reported on in the **Permanency - Adoption Services** section of this report.

Interjursidictional adoptions remained a problematic area for Virginia although some gains were made through the Adoptions Through Collaborative Partnerships. With the better defined goals of these contracts, contractors were more assertive in identifying families for children and working across jurisdictions. In addition, the new requirements that social workers are required to register waiting children in AREVA before accessing and printing the court-required adoption progress report has helped get more children on the

AREVA list. Discussion took place with a group of localities around the suggestion to use MOU's to facilitate interjurisdictional adoptions. This was not a recommendation supported by localities who noted that many LDSS would refuse to enter into such agreements and those that did may not abide by the requirements. MOU's to create increased interjurisdictional adoptions were seen as ineffectual and are removed from this plan for the next year. Working with the adoption contractors to continue developing relationships with the LDSS who need help achieving adoptions is seen as a much better approach to increasing these interjurisdictional adoptions. .

In May of 2012 the faith-based community under the leadership of Pastor Christopher Barras held two adoption rallies called "Change Who Waits". These rallies were the culmination of several months of planning and activities in local churches to bring the need for adoptive families to the attention of the faith-based community. A minimum of 500 people attended the rallies (one held in Richmond the other in the eastern region). The adoption contractors were present at the rallies and able to begin work with families that were interested in adoption or fostering. Seven LDSS were also present. Rev. Barras has been asked to do similar rallies in northern Virginia and the Piedmont region.

3. **Sustain adoptions through the provision of post adoption services** for children adopted from foster care and for children adopted from other countries.
   a) Maintain the Adoption Preservation System with added components to provide services for children adopted through inter-country adoptions.

*2012 update:*
Virginia utilized Title IV-B, Subpart 2 funding to create an Adoptive Family Preservation Services *(AFP*) system. Through United Methodist Family Services, the AFP serves families who have adopted domestically and may also serve families that have adopted internationally. The AFP provides post legal adoption services to address presenting issues and concerns of the adoptive family. AFP began serving adoptive families in June 2000 and has served over 1500 children and 750 families. The contract funding has not increased since its inception despite a need for more post-adoption services.

The Department also contracts with the Mary D. Ainsworth Clinic to provide unique services to adoptive children and families. The Ainsworth Clinic provides Attachment training to localities and therapy to children and families throughout the state. The contract is limited in funding and therefore, the areas to which it can provide services are also limited. Through competency building work conducted by the Ainsworth Clinic, additional therapists are available in some areas around the state to provide parenting classes that focus on interventions with attachment disordered children. These services are available on a post-adoptive basis.

## PS 1 Obj. 2. Increase timeliness and discharges to permanency

**Strategy 2.1. Target children who have the goal of adoption, with TPR who are not in adoptive placements to achieve permanence.**

a) Generate list of children with TPR who are not in a pre-adoptive placement
b) Send the list of children to LDSS to find out if there is any progress towards adoption
c) Revise the list of children and share with contractors
d) Meet with contractors to inform them about changes to the renewal process
e) Revise current adoption contracts so that contractors will be required to increase the number of children and families served by 25% over previous year
f) revise current adoption contracts so that contractors use child specific targeted recruitment
g) Hold regional meetings to inform local departments about contract changes & negotiate agreements with contractors

**Completed**

**<u>Strategy 2.2</u> Revise current contractor reports**

a) process measures incorporated into reports
b) reformat reports to include all contacts with child and family
c) create roles and responsibilities agreement form for LDSS and contractors

*<u>2012 update:</u>*

Quarterly reports were revised but did not include process measures. In reviewing the data on adoptions in Virginia and looking at where the need was, the state also recognized that milestone measures that clearly move the adoption process along toward a finalized adoption were much more critical to reaching adoptions than process measures. An 8 item milestone measure was developed and contractors were required to provide monthly and quarterly data on the number of milestones achieved, including finalized adoptions, Feedback from the contractors over the course of the contract year have been favorable, feeling like they knew what exactly was expected of them under the ATCP contract.

**<u>Strategy 2.3</u> Provide training on child specific, targeted recruitment**

a) gather input from LDSS and contractors on training needs
b) review quarterly reports to determine training needs
c) contract for training

*<u>2012 update:</u>*

No training was conducted. Training efforts made in previous years provided adequate information to the contractors and LDSS regarding the value of child-specific and targeted recruitment efforts. In addition, the states five regional Family Resource Consultants are responsible for assisting localities in developing improved recruitment strategies. The ATCP contractors wee, by nature of the contract design, focused on child-specific recruitment. Assessment of the need for such training in the upcoming year will occur between the Permanency Unit and the Family Engagement Unit.

**<u>Strategy 2.4</u> Analyze information gathered during contract year**

a) compile and review data from contractor reports
b) solicit and discuss feedback from contractors about what is working, barriers, etc
c) solicit and discuss feedback from participating LDSS

*<u>2012 update:</u>*

The Department continues to review adoption data from quarterly reports as well as data now available on SafeMeasures, the Departments child welfare report data base. The data has been discussed at quarterly meeting with the contractors which provides the Department with input for the on-going needs of adoptive youth. The data also helps to shape the discussion of barriers and challenges since it provides a factual baseline from which to start the discussion. The contractors have noted that they have less challenges with their LDSS partners since there is a relationship that they have built with them which facilitates good collaboration to achieve finalized adoptions.

**<u>Strategy 2.5</u> Using data gathered from quarterly reports, revise upcoming RFP for new adoption contracts**

a) highlight positive approaches from contractors and share with others
b) working with advisory committee make decisions about how to achieve desired outcomes for children awaiting adoption and design RFP accordingly

**Completed**

## PS 1 Obj. 3. Collaborate with CIP to promote child welfare outcomes

**<u>Strategy 3.1</u> Reevaluate the Adoption Progress Report in collaboration with CIP for LDSS to better utilize the report**

a) Create a collaborative work group to review the report and make any necessary changes
b) incorporate revised report into guidance
c) Train staff on use of the report
d) Train court personnel on use of the report

*<u>2012 update</u>:*

A small workgroup met to review the Adoption Progress Report and how it is used in OASIS. Two issues were addressed:

1. What changes were needed in the Adoption Progress Report itself to better capture adoption progress for individual children with the goal of adoption and living with an adoptive family; and
2. Changes to the Adoption Progress Report in OASIS to more effectively use the report to promote adoption.

The workgroup determined that few changes were actually needed as the Adoption Progress Report adequately captured information needed by the Courts to track the progress of finalizing adoptions for children in foster care with the goal of adoption. Changes included:

1. Updates to language in the report to reflect verbiage consistent with AdoptUsKids and the National Adoption Exchange;

Entering an error message that prohibited workers from completing the Report until the TPR date was entered and the child was registered in AREVA. These changes ensured that:
1) TPR was being appropriately documented on the Report which could then be verified by the Court; and
2) workers were entering available children into AREVA (Virginia's adoption resource exchange).
Entry of appropriate cases into AREVA is required by policy and is an item workers must complete on the Adoption Progress Report screen. (The workgroup discovered sometimes workers were not registering children in AREVA although they checked the box stating the child had been registered). This change ensured that the State AREVA Specialist can monitor that all children available for adoption are posted nationally for interested families.

Foster Care Guidance includes updated information on the Adoption Progress Report (APR). Regional Permanency Consultants have begun reviewing the importance of the APR in their quarterly Supervisors meetings (Both Central and Piedmont regions have completed this training and Eastern is scheduled to conduct the training). These supervisors meetings include both foster care and adoption supervisors.

Since no changes were made to the actual APR document and the guidance changes relate to the social worker's responsibility for managing the report, no training with Judges was deemed necessary. Judges already are familiar with the report and expect to receive it at the appointed timeframes.

## IV. Comprehensive child welfare training program

This strategy strives to develop a consistent training program, built with state and local partners, as an engine for supporting all of the Transformation building blocks and for spreading the practice model among all of the system's stakeholders.

- **Applicable CFSR Outcomes or Systemic Factors:** Systemic Factors: Staff and Provider Training; Foster and Adoptive Parent Licensing, Recruitment, and Retention

- **Applicable CFSR Items:** Item 32, Item 33, Item 34, Item 44, Item 45

**Goal: Develop and maintain trained and skilled professionals and resource families who work in alignment with the state practice model**.

### PS 3 Obj. 1. Establish training requirements for front-line and supervisory staff that align with child welfare competencies

**Strategy 1.1. Establish sets of core competencies for child welfare supervisors**

a) Identify a point person(s) to lead establishment of core competencies for child welfare supervisors
b) Develop a process for establishment of competencies
c) Identify a group of LDSS supervisors and managers to participate in process
d) Collect and summarize feedback
e) Present core competencies to Steering Committee for approval

*2012 update:*

The majority of the work to establish the core competencies for supervisors took place before a major change in training development and delivery within VDSS. Using the support of the Institute for Human Services (IHS), Virginia modeled its competencies after the model Ohio uses. The Family Services Steering Committee was meeting regularly and a group of local workers and state staff met together to finalize the work. The steering committee met in January 2011 and approved the competencies.

**Strategy 1.2. Establish sets of core competencies for child welfare staff**

a) Identify a point person(s) to lead establishment of core competencies for child welfare staff
b) Develop a process for establishment of competencies
c) Identify a group of LDSS supervisors managers to participate in process
d) Collect and summarize feedback
e) Present core competencies to Steering Committee for approval

*2012 update:*

Due to the VDSS internal changes around training, the family services steering committee no longer exists. The Virginia League of Social Service Executives (VLSSE) Professional Development Subcommittee (PDC) has agreed to take on some of the responsibilities the family services steering committee had committed to do for the PIP. The development of core competencies for child welfare staff followed the same basic process as the development of the supervisor competencies. A workgroup of local and state staff came together to create the core competencies and the PDC approved those competencies in April 2012.

**Strategy 1.3. Guide the revision of existing curricula to reflect core competencies.**

a) Modify VCU-VISSTA contract language to include the development of curricula that will reflect core competencies
b) Collaborate with VCU-VISSTA around the integration of core competencies into curricula through the Steering Committee

*2012 update:*

VDSS no longer has a contract with VCU-VISSTA. Instead, VDSS has brought training back "in house". Training is now housed under the Organizational Development division. There is a training program manager, curriculum developers, and a training developer, along with other VDSS staff that work in the

Professional Development unit. Because of these changes the action steps for this strategy are being changed.

a) VDSS curriculum developers will develop curriculum that reflects the core competencies

The curriculum developers are currently working on developing curriculum and ensuring that the current curriculum reflects the core competencies.

**Strategy 1.5. Establish training requirements for child welfare workers and supervisors to reflect core curriculum**

a) Develop a process to reevaluate training requirements through the Steering Committee once core curriculum is finalized
b) Develop recommendations for new training requirements
c) Present recommendations to Steering Committee for approval

**Strategy 1.6. Establish standards for completion time frames for required initial in-service training**

a) Develop a process to reevaluate standards for timeliness of completion for initial in-service training through the Steering Committee once core competencies are finalized
b) Develop recommendations for timeframes
c) Present recommendations for timeframes to Steering Committee for approval

**Strategy 1.7. Establish annual in-service training requirements for child welfare supervisors and front-line workers**

a) Develop a process to establish annual in-service training requirement for child welfare supervisors and front-line workers through the Steering Committee once core competencies are finalized
b) Develop recommendations for annual in-service training requirements
c) Present recommendations for annual in-service training requirements to Steering Committee for approval

## PS 3 Obj. 2. Ensure ongoing training opportunities for experienced staff

**Strategy 2.1. Develop VCU-VISSTA and ATC capacity to engage, develop, and evaluate subject matter experts as both trainers and workshop curriculum developers through training and consultation with IHS**

a) Conduct assessments of each Area Training Center to evaluate strengths, knowledge and understanding of a competency based system, relationship with LDSS, and relationship with host agency
b) Assess VCU-VISSTA capacity through consultation with IHS and ongoing collaboration with VDSS
c) Modify VCU-VISSTA and ATC contract language to reflect expanded roles with LDSS and expectations regarding workshop development

*2012 update:*

This strategy was completed in quarter one of the PIP reporting period. IHS completed the assessment in June 2010. The VCU-VISSTA and ATC contract language was modified through 2011.

**Strategy 2.2. Establish process to provide ongoing training that is based on staff and supervisors' assessed needs**

a) Develop process through the Steering Committee for ATCs and VCU-VISSTA to work together to develop and deliver trainer-developed workshops

b) Pilot process through the development and delivery of one trainer-developed workshop in each ATC region
c) Evaluate pilot findings and refine process through Steering Committee if necessary

*2012 update:*
Because of the changes to VDSS training provision, the ATC structure has changed. Now, there are Regional Training Offices. Virginia has been able to conduct pilot workshops in three regions. There is now a process in place for developing subject matter expert workshops to address regional needs. There has been an evaluation of the pilot.

### PS 3 Obj. 3. Assess and evaluate training system

**Strategy 3.1. Explore better utilization of existing participant evaluation tool through the current Learning Management System**
a) Assess current functionality around participant evaluation through the Knowledge Center
b) Develop a process to better utilize participant evaluation
c) Submit recommendations for improvement of the function to the Steering Committee

**Strategy 3.2. Establish evaluation process for trainers**
a) Assess existing processes for evaluating trainers
b) Develop strategies to improve evaluation process for trainers as needed
c) Submit recommendations for trainer evaluation process to Steering Committee

*2012 update*
Due to the reorganization of VDSS training, this action step was completed by the DFS Trainer Developer and members of the Division of Workforce Planning and Development, not by the Family Services Steering Committee. The DWPD has professionals responsible for curriculum development, trainer development, information systems, e-learning, and training delivery. A document has been created that covers the action steps. It has not yet been submitted to the Professional Development Committee.

**Strategy 3.3. Establish a training needs assessment process to inform training delivery and system development and management**
a) develop ATC capacity to support needs assessment process and analysis
b) develop learning management system functionality to support needs assessment information management
c) develop needs assessment protocol

**Strategy 3.4. Establish a process to promote transfer of learning for training participants**
a) Modify FY2011 contract language with VCU-VISSTA
b) Develop a process for integration of existing curricula through the Steering Committee

### PS 3 Obj. 4. Ensure delivery of state-approved pre-service and in-service training for resource, foster, and adoptive parents

**Strategy 4.1. Conduct annual needs assessment of current pre-service and in-service training needs**
a) Create work group made up of LDSS, CRAFFT, and VDSS to develop needs

assessment
b) CRAFFT to administer needs assessments with LDSS

**<u>Strategy 4.2.</u> Create regional pre-service and in-service training plans for resource families based on needs assessment data**

**<u>Strategy 4.3.</u> Establish a Steering Committee subcommittee to address resource family training**
a) review models of resource parent competencies
b) develop Virginia universe of competencies
c) make recommendations to Steering Committee

*<u>2012 update:</u>*
These strategies have been renegotiated with the Children's Bureau. They are now as follows:

**<u>Strategy 4.1.</u> Revise format and structure for the needs assessment of current pre-service and in-service training needs**
**<u>Strategy 4.2.</u> Conduct annual needs assessment of current pre-service and in-service training needs**
**Strategy 4.3. Identify outcomes for resource parents to measure skills and knowledge gained and impact of training on behaviors**
a) review and refine resource parent training evaluation
b) compile results of training evaluation regionally and statewide and distribute to resource and regional consultants
**4.4 Create regional pre-service and in-service training plans for resource families based on needs assessment data**

The CRAFFT Program conducted its annual Needs Assessment for fiscal year 2012 between the months of July 2011 and October 2011. The purpose of the Needs Assessment is to ascertain the training needs of LDSS resource families. The CRAFFT Coordinator assigned to one of five respective regions disseminated the Needs Assessment. The Needs Assessment was then completed by a designated LDSS social worker with specific knowledge of the agencies resource families training needs at the time of the assessment. The needs assessments have been reviewed and the information has been shared with VDSS staff. Currently the training plans are being created based on the needs assessment data.

## V. Strengthening community services and supports

All of these strategies contribute to developing an accessible array of community-based services across the Commonwealth. This strategy addresses the nature, scope, and adequacy of existing child and family and related services. This approach, which includes wraparound services when indicated, reduces the need for more intensive levels of service such as residential care – and shortens length of stay when placement is required. It contributes to the well-being of children and families.

- **Applicable Children's Services System Transformation Outcomes:**

- **Applicable CFSR Outcomes or Systemic Factors:** Safety Outcome 2; Permanency Outcome 1; Wellbeing Outcome 1; Well Being Outcome 2; Well Being Outcome 3; Systemic Factors: Staff and Provider Training, Service Array and Resource Development

- **Applicable CFSR Items:** Item 3, Item 4, Item 10, Item 17, Item 21, Item 22, Item 23, Item 32, Item 33, Item 35, Item 36,

**Goal: Expand community services and supports that are child-centered, family-focused and culturally relevant.**

1. **Expand services to prevent and treat child abuse and neglect** through supporting and advocating for interdisciplinary resources.
   a) Utilize child abuse and neglect prevention funds to support evidenced-informed and evidenced-based programs and practices.
   b) Utilize child abuse and neglect treatment funds for support services to child victims.

**Completed**

2. **Expand services that allow children to remain safely in their own homes**
   a) Evaluate the recent survey on service array from local departments of social services where 52% responded that services to allow children to remain safely at home were available in their communities.
   b) Convene a group of LDSS staff to further examine the problem and identify areas of the State where these services are not available.
   c) Request assistance from the National Resource Center on In-Home Services.
   d) Develop and implement a plan to improve services that allow children to remain safely in their own homes in underserved areas of the State.

**Completed**

**3. Help meet the educational and health needs for all children in, or at risk of foster care through developing and implementing a comprehensive plan for improving LDSS staff understanding and skills related to advocacy and effective practice.**

a) Implement the health-related advisory group's ongoing recommendations to ensure the health *(physical, emotional and mental health)* needs of children in foster care are being addressed in a timely manner.
b) Increase LDSS workers ability to enhance the educational success of children in, and at risk of, foster care through training for LDSS workers on educational advocacy through Virginia resources.

2012 update

For SFY 2012 VDSS, the education workgroup and other key stakeholders continued to meet in order to promote promising strategies to improve educational outcomes that support the enhancement of educational continuity and school stability for Virginia children in out of home and adoptive care. Additional guidance that addresses the responsibility of the Comprehensive Services Act (CSA) vs. the local school district in funding transportation when a child has an IEP was clarified and the workgroup completed a joint guidance update (VDSS and DOE) that will be published in June 2012. In addition, the Educational Specialist completed 8 regional training events (192 people) on the educational requirements of children in foster care. Some of these trainings were done with the workgroup co-lead from DOE and some were done

independently. Educational training continues to be a priority given the need to remind localities of the importance of this requirement for all children attending school and in foster care.

**4. Increase the full array of independent living services and resources through implementing strategies to prepare youth in, and aging out of, foster care for successful transition to self-sufficiency.**

a) Implement the Ansell Casey Life Skills Assessment statewide to assess youth's independent living *(IL)* skill needs.
b) Select a contractor to accomplish the deliverables of the Best Value Acquisition *(BVA)*, including, but not limited to:
   - Establishing 5 regional IL specialists and regional youth councils;
   - Training on the Ansell Casey Life Skills Assessment; and
   - Training youth to develop or enhance their life, leadership, and advocacy skills.
c) Establish an effective statewide educational program through local, regional and state partnerships and linkages to assist youth in completing secondary education and enrollment assistance and support for post-secondary education.

## Goal: Partner with stakeholders to strengthen and expand the continuum of community based services.

1. **Collaborate with CSA's Community Service Development Steering Committee** and its workgroups on:
   a) Managing the array of community services through designing and using existing resources and tools to help localities:
      - Assess trends in how services are changing over time, compare services utilization with peer communities with similar demographics, and prioritize service gaps *(using CSA management team reports, Critical Services Gap Survey, vendor reports, and Comprehensive Community Based Service Array Guide).*
      - Gather family input on improving services and measuring program progress though family satisfaction surveys.
      - Create services through a new tool for estimating program costs, workload volumes, and alternative revenue models and guidance on how to quantify gaps in local service arrays, being developed by the Casey Strategic Consulting Group.
   b) Engaging providers through developing:
      - Toolkit on how to recruit and sustain non-traditional providers;
      - Public/private partnerships, including a Model Memorandum of Understanding *(MOU)* to facilitate multi-locality or regional procurement of services;
      - Model contract that includes family engagement and outcomes;
      - Model process for expedited provider authorization for licensing new programs; and
      - Vendor evaluation tool.
   c) Using tools for utilization management and review:
      - Using the CSA Model Utilization Management Plan;
      - Developing a model utilization review process, using data from CANS, the CSA data set, OASIS, SafeMeasures, and other relevant systems; and
      - Incorporating the family and youth voice into these processes.

2. **Collaborate with state and local stakeholders on developing and strengthening services that preserve families, achieve permanency, and promote child health, safety and well being.**

a) Participate on state level inter- and intra-agency workgroups tasked with coordinating service and program initiatives.
b) Develop and provide education materials to inform key stakeholders on effective strategies *(e.g., mandated reporters and the general public on child abuse and neglect; kinship care providers; judges)*.

**A. Goal: Provide culturally relevant and diverse services in collaboration with families and children to meet their needs.**

1. **Address the disproportional representation of youth of color** and the system's responsiveness to cultural diversity.
   a) Establish a workgroup to identify issues and make recommendations.
   b) Develop and implement a plan to provide culturally relevant and diverse services.
   c) Track and disseminate information on best practices, resources and approaches to delivering culturally relevant and diverse services to LDSS.

## VI. Continuous quality improvement

Using the right data to manage performance is a key driver of the Transformation. Virginia is developing and implementing a consistent process statewide for capturing and using data to support decision-making, improve practice quality, and promote accountability. Virginia is defining outcomes based on the Transformation goal of developing lifelong family connections for children within their own community, and then creating measures to track progress.

- **Applicable CFSR Outcomes or Systemic Factors:** Systemic Factors: Statewide Information System; Quality Assurance System, Staff and Provider Training
- **Applicable CFSR Items:** Item 24, Item 30, Item 31, Item 32, Item 33

**Goal: Promote a seamless continuum of policy and guidance across the child welfare programs.**

1. **Align policies and guidance in child protective, foster care and adoption services** to provide consistency and improve coordination and integration across programs on a regular basis.
   a) Examine other states' approaches.
   b) Solicit input from committees comprised of key stakeholders.
   c) Develop consensus on definitions, structure and format for policies, guidance and procedures.
   d) Revise the manuals to provide consistency, integration and linkages across programs and to incorporate the state practice model.
   e) Routinely update and revise materials as needed.

**COMPLETED**

**Goal: Use data to inform management, guide policy decisions, improve practice, measure effectiveness and promote accountability.**

**1. Create a robust reporting system for the Division of Family Services**

a. Continue to produce and disseminate reports created by OBRA that provide outcome and process data to LDSS. Increase the use of longitudinal data in Virginia's child welfare system:

- Continue membership to Chapin Hall's Multi-state Foster Care Data Archive; and
- Routinely share analyses completed by the Outcome Based Reporting and Analysis Unit with state and local stakeholders.

b. Implement SafeMeasures in all 120 LDSS, regional offices and the VDSS home office. Seek funding to extend subscription annually starting 2010.

c. Create an automated data system for ad hoc requests by 2012.

### PS 4 Obj. 1. Increase use of data driven decision making in Virginia's child welfare system

**Strategy 1.1 Conduct Translating Outcomes to Practice (TOP) meetings quarterly.**

a) Routinely examine data to determine both best practices and opportunities for improvement across program areas.

b) Provide data to program staff/process improvement teams as they develop and implement process improvement plans.

c) Monitor outcomes to determine if process improvement plans are moving the outcomes.

*2012 update*

This strategy is ongoing. The Outcome Based Reporting and Analysis Unit (OBRA) has not held TOP meetings on a quarterly basis. The TOP meetings will begin again in June 2012.

**Strategy 1.2 Utilize available reporting tools in all 120 LDSS, regional offices, and the VDSS home office.**

a) Train and monitor the use of SafeMeasures

b) Expand the use and awareness of the Virginia Child Welfare Outcomes Reporting Utility (VCWOR)

*2012 update*

This strategy is ongoing. SafeMeasures usage continues to remain at around 400 active users in any given month. Local department and state staff continue to utilize SafeMeasures as a supervisory tool and for reporting.

**Strategy 1.3 Improve programmatic performance by monitoring process and outcome data.**

a) Develop a method of tracking children at risk of aging out of foster care that will focus on children with long term permanency goals, TPR without placement in pre-adoptive homes, and children in congregate settings for more than 180 days.

b) Develop a report that monitors participation in Family Partnership Meeting

c) Develop and disseminate to regional staff reports on case worker visits with children, parents, foster parents, sibling visits, and child and family visits

*2012 update*

This strategy is ongoing.

a) COMPLETED

b) Ongoing. OBRA has successfully designed multiple FPM reports that are produced on a monthly and quarterly basis. In addition FPM reports are also in development for inclusion in SafeMeasures.

c) Ongoing. Multiple reports are produced by OBRA that monitor visits. Currently SafeMeasures includes a report that measures client visits with family members, monthly worker visits for both foster care and CPS Ongoing cases.

**Strategy 1.5. Develop a method to track recurrence in Family Assessment cases**.

**Develop and implement the National Youth in Transition Database *(NYTD)*** to collect and report required data on independent living services for youth in and transitioning out of foster care.

a) Work collaboratively with OASIS staff to ensure that required data elements are in the system.
b) Provide training to LDSS on the database.
c) Develop initiatives to help youth in foster care and those aging out to understand and participate in the NYTD.

*2012 update*

Virginia implemented the National Youth in Transition Database (NYTD) on October1, 2010 as required by the federal government. During federal fiscal year (FFY) 2011, a total of 1,959 youth were eligible to receive independent living services, and 85 percent received at least one service. Virginia analyzed the results of the initial independent living services data collection for foster youth in Virginia between October 1, 2010 and September 30, 2011. The data include the NYTD independent living service data for FFY 2011. These records were linked with Adoption and Foster Care Analysis and Reporting System (AFCARS) data files for the same time period to provide additional demographic information. The analysis summary includes the following key findings:

**IL Services:**

**The majority of youth (85%) received at least one independent living service during the reporting period .**The most frequently received services were budget and financial management (41% of youth) and educational support (39%). Less than one third (28%) of youth had received an Independent Living Needs Assessment during the reporting period. In general youth were most likely to receive services in the areas of household management and health education3 and least likely to receive financial assistance.

**The likelihood of a youth receiving services varied substantially by region.**

About half (49%) of youth in the Western region had no record of services in FFY 2011, more than twice as high as the rest of the state. In almost every service category, Western region youth were half as likely to receive a service as their counterparts in the Central, Northern, and Piedmont regions. Youth in the Eastern region were much less likely to receive education (21%) and employment (24%) services than youth from the Central, Northern, and Piedmont regions.

**The amount and type of services received varied by age.** Youth aged 16 to 17 were less likely to receive services than older or younger youth. A number of 17 year old youth did not have a service recorded in OASIS. Youth age 18 and over were much more likely than other age groups to receive financial assistance as well as more specialized services such as employment services/vocational training, post secondary educational support, and supervised independent living.

**With a few exceptions, demographic characteristics were similar across age groups for these youth.** About half (51%) of youth were female – this result was consistent across age groups. Over half (57%) of youth 18 and older were Black or African American. Youth between the ages of 14 and 17 were more likely to be White (57%) than older youth (45%). Younger youth were less likely to be Hispanic (5%) than middle and older youth (10%). Most youth (89%) did not have a diagnosed disability

or medical condition, and youth aged 14 to 15 were most likely to have a disability documented in OASIS.

FFY 2011 was the initial year that local workers administered the NYTD survey and recorded Independent Living services for each youth in OASIS. Youth may have received Independent Living services that were not recorded due to changes in the information system and reporting procedures. Reportedly, 519 youth were eligible to take the NYTD baseline survey; however, 409 youth actually participated resulting in a response rate of 79 percent**.** Local agency workers administered a survey to foster care youth who turned 17 during FFY 2011 and recorded the survey responses in the Online Automated Services Information System (OASIS).4 In addition, local workers documented the Independent Living services provided to the youth during FFY 2011 in OASIS. For those youth completing surveys, 73 percent completed the survey within 45 days of their 17th birthday.

**NYTD Survey:**
Although nearly all (95%) of respondents were enrolled in school at the time of the survey, very few respondents were currently employed either full-time (2%) or part-time (12%). Only one quarter (25%) of these youth indicated that they had completed an apprenticeship, internship, or other on-the-job training in the past year. The likelihood of employment or the receipt of employment-based training did not differ between female and male youth.

**Many survey respondents reported difficult life experiences.**
Even though respondents were only 17 years old, over one-third (35%) had been incarcerated, with nearly half (45%) of male respondents reporting incarceration. In addition, over one-fourth (28%) of the respondents had been referred for substance abuse treatment. One out of six (17%) of these youth reported that they had been homeless at some point in their life. Thirteen percent of female respondents reported having ever given birth, and three percent of male respondents reported fathering a child. More positively, nearly all survey respondents (97%) indicated that they had a significant connection to an adult.

**NYTD data indicate that nearly half of these youth (48%) did not have records of Independent Living services during FFY 2011.** It is unclear if these youth did not receive services or if some services were not documented in OASIS. Respondents were slightly more likely to have records of services than non-respondents. The most commonly recorded services were budget/financial management (26%) and academic support (24%). Less than one fifth (17%) of youth had an Independent Living Needs Assessment recorded in OASIS within the previous year.

**For the most part, survey respondents did not have different demographic characteristics than non-respondents.** A majority (84%) of youth did not have a disability documented in OASIS. Non-respondents were slightly more likely to have "mental retardation" indicated in their OASIS records (7%) than respondents (2%).

For FY 2013, VDSS has the following objectives:

- Finalize a plan to track and/or locate youth who left foster care and are included in the follow-up population;
- Identify promising practices among LDSS in collecting NYTD data;
- Further strengthen VDSS Foster Care Guidance Manual to include promising practices in collecting NYTD data among LDSS; and
- Produce meaningful reports for stakeholders based on the NYTD and other IL data collected from LDSS.

VDSS and Project LIFE will continue to provide training and TA to LDSS to support young people and comply with federal NYTD requirements.

**Develop a comprehensive quality assurance system that measures child status and system performance indicators.**

a) Establish a mechanism and process with accountability and feedback loop to review each LDSS agency
b) Establish protocol and process for Quality Improvement Unit to work with regional consultants to establish system improvement plans by July 2009.
c) Develop a report template to be used by regional consultants and LDSS to track system improvement goals by July 2009.
d) Develop a process to gather and report on child status and system performance indicators by July 2010.

**PS 4 Obj. 2. Develop a comprehensive quality assurance system that measures child status and system performance indicators.**

**<u>Strategy 2.1</u> Develop and implement QSR as Virginia's quality assurance system.**
a) Finalize work plan for 2010
b) Communicate & educate stakeholders on the plan
c) Develop and pilot instrument Fall of 2010
d) Make modifications and finalize the instrument
e) Train reviewers in January 2011 and June 2011
f) Conduct 5 reviews in 2011 beginning in February

*<u>2012 update:</u>*
Virginia Department of Social Services (VDSS) began utilizing the Quality Service Review (QSR) in November 2010. From November 2010 through November 2011, seven Quality Service Reviews were completed involving ten local Departments of Social Services, with representation from each VDSS region within the state. The QSR instrument was developed in September 2010 at a design meeting with assistance and support through a contract with Child Welfare Policy and Practice Group (CWPPG) and Human Systems and Outcomes (HSO) Pilot of the instrument was November 2010. The QSR protocol operationalizes the Virginia Children's Services Practice Model also addressing safety, permanency, and well-being.

**Initial Results from first year**

Results of the QSR are provided in several ways. First, at the close of a two day review the caseworker and supervisor participate in a feedback session with the QSR team who identify strengths, opportunities and next steps in case practice. At the end of the review week there is a public meeting with community partners and stakeholders at which the aggregate results are provided. The local department will then receive a written report of the QSR.

In this twelve month period a total of 123 cases were randomly selected for review from the ten local departments and 885 interviews were conducted overall for these cases. The use of small, stratified random samples enables users of the QSR to discover patterns and trends in practice. There are both strengths and opportunities evident in both the Child and Family Status and Practice Performance domains as follows.

**Child and Family Status Indicators – STRENGTHS:**

- **Safety** –Overall, the children in Virginia are safe. Safety and exposure to harm in homes, caretaker homes, school, and childcare situations were assessed and all agencies received high marks in safety.
- **Living Arrangements** – Children are in the most appropriate placement (either birth home or substitute care) and the necessary resources are often available where they reside to meet their needs.
- **Physical Health and Learning & Academics** – Children in this sample are healthy and their academic and developmental needs are identified and services provided to meet these needs.

**Child and Family Status Indicators – OPPORTUNITIES:**

- **Permanency** – The confidence that children are in placements that will sustain them until they reach adulthood is limited for some children in this sample. The opportunities in the realm of permanency are often related to opportunities in other areas such as teaming, long-term view, planning for safe case closure, and engagement.
- **Stability** – When assessing stability for risk of disruption or the management of these risks both in home and school situations, there were opportunities for improvement identified.
- **Path to Independence** – This assesses the delivery of Independent Living services for children 14 and older. In this smaller results show there is action needed in the area of Independent Living services for these youth.

**Practice Performance – STRENGTHS:**

- **Engagement** – The engagement of the child and substitute caretakers has been found to be an overall strength in these reviews. However, engagement of birth parents was found to be an opportunity. Review findings show that the more regular contact between workers and children and substitute caretakers helped facilitate a higher level of engagement, whereas the less-frequent contact with birth parents has impacted their level of engagement.
- **Cultural Awareness& Responsiveness** – With the exception of fathers, any significant cultural issues, family beliefs and customs of the children and families are identified and addressed in practice. For some culturally diverse areas, the identification of team members of the same culture and language has been utilized to help achieve this level of practice.
- **Resource Availability** – The necessary supports, services and resources to affect change are available when needed for/by the child and family. For those areas with fewer formal resources available, the utilization of informal supports has aided in achieving some of the same outcomes.

**Practice Performance – OPPORTUNITIES:**

- **Teaming** – This indicator is assessing both team formation and team functioning. Team formation had stronger results than team functioning, with both components with opportunities for improvement. Case review and interviews identified team members who were often found to be working in silos resulting in having differing goals for the family.
- **Assessment & Understanding –** This indicator looks at whether adequate assessments either formal or informal have been conducted and then how the team uses this information to define services and how the team uses this knowledge to regularly monitor progress and adjust services as needed. Progress in team functioning is often linked and improves assessment & understanding.

- **Maintaining Quality Connections** – Results have shown that the efforts to maintain positive connections for children with their parents, siblings and other important people in their life are lacking. For example, while some siblings in foster care are placed together, others have had minimal, if any, contact.

**Fathers – OPPORTUNITIES:**

- The QSR results indicate there is an overall opportunity for working with fathers in this sample of cases. Results for fathers were lower than mothers in the following QSR practice performance indicators: Engagement, Voice & Choice, Cultural Awareness/Responsiveness, Assessment & Understanding, and Maintaining Quality Connections

Training for Virginia professionals in the use of this instrument and the QSR scoring matrix took place in October 2010, January, August, September in 2011, January and May 2012. Further training is planned in each VDSS region on an ongoing basis. Professionals from CWPPG are then paired with Virginia professionals in review teams after the training for onsite training and mentoring. In this way we will develop a cadre of Virginia professionals to conduct reviews. An additional benefit to this process of training peer reviewers is often the development of quality practice and standards in the local departments from which we will draw the peer reviewers. This results in an additional internal capacity for evaluating quality practice standards.

**<u>Strategy 2.2</u> Implement a System Improvement Plan (SIP) to be used after the Child Welfare Quality Review (CWQR) by regional consultants and LDSS to track continuous progress towards performance outcomes.**

a) Regional consultants conduct feedback meeting with LDSS after a CWQR focused on outcomes.

b) SIP developed by LDSS, distributed and monitored by regional consultants based on outcome measures.

c) VDSS compiles semi annually SIPs and status and distributes to LDSS and stakeholders.

d) Develop link with System Improvement Plan process in order to help inform training priorities

<u>2012 update</u>

**System Improvement Plan Process**

After a QSR a System Improvement Plan (SIP) is developed and is comprised of a series of action plans to improve practice and outcomes for children and families. There is a dual purpose of the local department SIP: 1) to outline how the LDSS will adjust their services/practice in response to the QSR results in order to improve their outcomes as reported in Critical Outcomes Report and Safe Measures, and 2) to serve as a mechanism for VDSS to report on progress made on both local and state levels to improve outcomes for children and families as outlined in VA's federal Program Improvement Plan in response to VA's 2009 CFSR).

Initial QSR results are shared with the caseworker and supervisor of each case reviewed and then overall results are shared with the locality at the end of the QSR week. After the receipt of the final written report, a Next Steps Meeting with the LDSS and Regional Consultants is facilitated by Continuous Quality Improvement (CQI) state staff. The purpose of the meeting is to discuss the results of the QSR, the analysis by the local department, and to identify priorities for practice change and improvement that will impact outcomes for children and families. Some of these areas may include regulatory and policy compliance, casework processes, supervisory processes, case management, gaps in performance measures, training competencies, best practices and resource needs. Outcome of the meeting is two-fold.

First, the prioritization and identification of one to three issues that the LDSS can commit to work on that will improve processes and outcome measures. Second, the identification of steps towards solutions and the development of specific action plans for the identified solutions.

After the Next Steps Meeting the LDSS completes a SIP which is forward to Regional Consultants and CQI staff. The LDSS reports on the status of the implementation and achievements of their SIP quarterly to the CQI Unit. On-going monitoring of the SIP is part of the ongoing technical assistant provided by Regional Consultants.

**System Improvement Plan Contents**

At the time of this report, eight SIPs have been submitted; five of those have been approved and are posted on SPARK, the VDSS website. In response to the trends identified in the practice performance indicators in the QSRs, the majority of the SIPs are addressing teaming and engagement. These plans contain action steps around areas policy, training, and the creation of tools. Assessment and Understanding is also an area being addressed in some SIPs, specifically surrounding comprehensive family assessments and the tracking and monitoring of services stemming from those assessments. A summary of issues identified and proposed action steps are as follows:

| System Improvement Plan Contents | |
|---|---|
| **Identified Issue** | **Identified Action Steps** |
| **Enhance Family Engagement** | • Educate community (private providers, schools, etc.) on family engagement<br>• Train staff & community on engaging fathers<br>• Develop fatherhood engagement initiative<br>• Create workgroup for fatherhood engagement workgroup<br>• Identify and utilize Genogram software<br>• Utilize ACCURINT/Family finding tools<br>• Create/distribute parent involvement handbook when child enters foster care |
| **Increase Team Formation & Function through increased understanding & effectiveness of team meetings** | • Refine/update treatment team meeting policy & procedures<br>• Create Family Team Meeting unit – conduct Family Partnership Meetings, Family Group Conferences & Family Finding<br>• Hold team meetings every 90 days<br>• Create system for documenting assessments & meetings<br>• Create team meeting and member tracking tool<br>• Educate community (private providers, schools, etc.) on family engagement and in particular Family Partnership Meetings<br>• Training for staff on conducting effective team meetings<br>• Implement Family Partnership Meetings<br>• Utilize Family Partnership Meeting debrief sessions |
| **Assessment & Understanding** | • Develop/implement protocol on assessment & ongoing monitoring<br>• Create family assessment tool<br>• Conduct comprehensive family assessment (train staff to do so) |

**Strategy 2.3 Develop a report on child status and system performance indicators from the QSR.**

2012 update

With the development of the new QSR protocol and process and the revised SIP we will create linkages to create an annual report in August each year. This report will link critical outcome measures with aggregate measures from the QSR and the work of system improvement plans. This report will address the feedback loop at the state and local level to inform practice and outcome improvements in child welfare . The first report is in development and will be distributed each August beginning in August 2012.

**Feedback Loop at State Level**

Outcomes of the QSRs have been shared at the state level with Regional Consultants and Program Managers in Family Services. Specifically, findings in the engagement and teaming areas have led to discussion surrounding some potential training needs identified and the contracting of Child Welfare Policy and Practice Group (CWPPG) for engagement training and curriculum development in December 2011. Training has been provided by the state to local staff on this engagement effort.

Additional dialogue has occurred regarding further needs for local staff on the practice of the engagement continuum and plans are underway for training and support in this area. Any concerns regarding practice in a specific locality have been communicated to Regional Consultants. Results and trends have also been shared with the VDSS Family Services Leadership Team and the Child Welfare Advisory Committee (CWAC). CWAC is comprised of community stakeholders who are part of the child welfare delivery system and the sharing with this group has facilitated further discussion about the involvement of system members, such as courts, in the QSR process.

# III. Additional Reporting Information

## A. Monthly caseworker visits

LDSS have significantly improved their percentage of monthly worker visits in part, as an artifact of reducing the number of children in foster care and improving placements in the child's local community. Instituting Family Partnership Meetings as a statewide initiative has also contributed to children's placement in their home community and increased availability to workers by keeping children in their community. Workers have been able to increase visitation despite receiving very few additional resources.

Federal Title IV-B funds to support worker visits have been used to pay for additional staff, purchase laptops computers as a time-saving measure, allowing for quicker documentation and downloading of the visit information in to OASIS; transcribers; and travel costs for increased visitation. Because federal allocation of these funds are limited to five years, the finance division of the VDSS has retained their commitment to identify and allocate equivalent funds to each locality as part of their base administrative cost base once federal funding ends.

Aggregate data for the year indicates Virginia did not reach the goal for monthly visits during FFY 2011. Although not at the 90% level for the year, Virginia has continued to improve and looks for strategies to

reach federal measures. The quality of these visits has been an on-going emphasis as well and the Quality Services review team reviews worker contacts in their scheduled agency visits.

The state continues to publish a monthly visit report as part of the "Critical Outcomes Report" available to all LDSS staff through SafeMeasures. The report provides monthly updates on worker visits and allows users to "drill down" to the worker level to identify where improvements in visits need to be made to reach and surpass federal goals. Staff of the OBRA unit who travel the state to work with localities on understanding and using their data to improve performance prioritize the monthly worker visits as one data report that localities should use to assess the level of the care provided to children.

## B. National Youth in Transition Database

Virginia implemented the National Youth in Transition Database (NYTD) on October1, 2010 as required by the federal government. During federal fiscal year (FFY) 2011, a total of 1,959 youth were eligible to receive independent living (IL) services, and 85 percent received at least one service. Virginia analyzed the results of the initial independent living services data collection for foster youth in Virginia between October 1, 2010 and September 30, 2011. The data include the NYTD independent living service data for FFY 2011. These records were linked with Adoption and Foster Care Analysis and Reporting System (AFCARS) data files for the same time period to provide additional demographic information. The analysis summary includes the following key findings:

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**Many survey respondents reported difficult life experiences.**
Even though respondents were only 17 years old, over one-third (35%) had been incarcerated, with nearly half (45%) of male respondents reporting incarceration. In addition, over one-fourth (28%) of the respondents had been referred for substance abuse treatment. One out of six (17%) of these youth reported that they had been homeless at some point in their life. Thirteen percent of female respondents reported having ever given birth, and three percent of male respondents reported fathering a child. More positively, nearly all survey respondents (97%) indicated that they had a significant connection to an adult.

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For FY 2013, VDSS has the following objectives:

- Finalize a plan to track and/or locate youth who left foster care and are included in the follow-up population;
- Identify promising practices among LDSS in collecting NYTD data;
- Further strengthen VDSS Foster Care Guidance Manual to include promising practices in collecting NYTD data among LDSS; and
- Produce meaningful reports for stakeholders based on the NYTD and other IL data collected from LDSS.

For FY 2013, VDSS and Project LIFE will continue to provide training and TA to LDSS to support young people and comply with federal NYTD requirements.

## C. Timely home studies

**Goal: Monitor timeliness of homes study documents going to the sending state**

1. *Manual spreadsheet is developed.*

**Placement Requests Into Virginia**
**May 1, 2011 to May 31, 2012**

| Type o f Placement | Public Agency | Private Agency | Court | Individual | None |
|---|---|---|---|---|---|
| Parent(s) | 182 | 3 | | | 2 |
| Relative | 6 | | | | |
| Foster Home | 524 | 8 | | | 1 |
| Adoptive | 209 | 54 | | 7 | 1 |
| Group Home | | | | | |
| Residential | 256 | 6 | | | 2 |
| Institutional Care (Article VI) | | | 4 | 45 | |
| Child Care Institution | | | | | |
| Other | 2 | | | | |
| **Total** | **1179** | **71** | | | **6** |

| **Sex of Children** | **Male** | | **Female** | | **Unknown** | |
|---|---|---|---|---|---|---|
| | 675 | | 540 | | 2 | |
| **Ages of Children** | **Under 1** | **1-5** | **6-10** | **11-15** | **16-18** | **19-21** |
| | 205 | 304 | 228 | 324 | 151 | 2 |
| **Ethnic Group** | **White** | **African American** | **Asian** | **American Indian** | **Hawaiian/ Pacific Islander** | **Unable to determine** |
| | 601 | 345 | 13 | 11 | 7 | 240 |
| **Hispanic** | **Yes** | **No** | **Unable to determine** | **Declined** | | |
| | 85 | 877 | 254 | 1 | | |

| # of Calendar Days Between Sending ICPC-100A and Receipt Back with Decision | 0-30 | 31-60 | 61-90 | Over 90 |
|---|---|---|---|---|
| | 589 | 240 | 202 | 476 |

**Adoption Assistance Subsidy: 44**

**Total Number of Agreements Into Virginia Terminated**

| | | |
|---|---|---|
| **Adoption Finalized** | 317 | |
| **Age of Majority/Emancipation** | 116 | |
| **Legal custody returned to parents (concurrence)** | 24 | |
| **Legal custody to relative (concurrence)** | 72 | |

| | | |
|---|---|---|
| **Treatment complete** | 122 | |
| **Sending state jurisdiction terminated (concurrence)** | 5 | |
| **Unilateral termination** | 15 | |
| **Child returned to sending state** | 273 | |
| **Child moved to another state** | 27 | |
| **Proposed placement request withdrawn** | 79 | |
| **Approved resource will not be used for placement** | 141 | |
| **Other** | 582 | **Total: 1773** |

**Number of children returned to Virginia: 263**

**Placement Requests Out of Virginia**
**May 1, 2011 to May 31, 2012**

| Type o f Placement | Public Agency | Private Agency | Court | Individual | None |
|---|---|---|---|---|---|
| Parent(s) | 193 | | 1 | | |
| Relative | 11 | | | | |
| Foster Home | 431 | 5 | | | 3 |
| Adoptive | 50 | 66 | | 8 | 1 |
| Group Home | | | | | |
| Residential | 46 | | 6 | 91 | 1 |
| Institutional Care (Article VI) | | | | | |
| Child Care Institution | | | | | |
| Other | 2 | | | | |
| **Total** | **733** | **71** | **7** | **99** | **5** |

| **Sex of Children** | **Male** | | **Female** | | **Unknown** | |
|---|---|---|---|---|---|---|
| | 392 | | 341 | | 1 | |
| **Ages of Children** | **Under 1** | **1-5** | **6-10** | **11-15** | **16-18** | **19-21** |
| | 117 | 188 | 159 | 159 | 109 | |
| **Ethnic Group** | **White** | **African American** | **Asian** | **American Indian** | **Hawaiian/ Pacific Islander** | **Unable to determine** |
| | 384 | 201 | 7 | 2 | | |
| **Hispanic** | **Yes** | **No** | **Unable to determine** | | | |
| | 44 | 545 | 145 | | | |

| # of Calendar Days Between Sending ICPC-100A and Receipt Back with Decision | 0-30 | 31-60 | 61-90 | Over 90 |
|---|---|---|---|---|
| | 265 | 99 | 111 | 543 |

**Adoption Assistance Subsidy: 19**

**Total Number of Agreements OUT OF Virginia Terminated**

| | | |
|---|---|---|
| **Adoption Finalized** | 119 | |
| **Age of Majority/Emancipation** | 60 | |
| **Legal custody returned to parents (concurrence)** | 33 | |
| **Legal custody to relative (concurrence)** | 60 | |
| **Treatment complete** | 36 | |
| **Sending state jurisdiction terminated (concurrence)** | 2 | |
| **Unilateral termination** | 10 | |
| **Child returned to sending state** | 64 | |
| **Child moved to another state** | 8 | |
| **Proposed placement request withdrawn** | 78 | |
| **Approved resource will not be used for placement** | 64 | |
| **Other** | 446 | **Total: 980** |

**Number of children returned to Sending state: 98**

2. *ICPC elements will be evaluated and recommendations made.*

The data fields have been cleaned up however the report writing program continues to have problems. The ARRIS system is outdated and as such is not at the top of the priority list for enhancements. The Program Manager is identifying and discussing the issues that have been identified with the Information Technology Department and issues that have been identified have been resolved. As previously states, the report program continues to have problems.

3. National information system

The national data information system was discussed at the May 2012 meeting of the Association of Administrators of the Interstate Compact on the Placement of Children (ICPC). There are a number of challenges related to the development of a national data system because not all states use the same federal reporting system. Those states that use SCAWIS have a built in ICPC reporting mechanism. However, those of us who use other systems continue to have unreliable reports.

## D. Inter-country adoptions

In October 1, 2009, the Adoption Programs expanded an existing contract with United Methodist Family Services for the Adoptive Family Preservation system to provide additional services for families who adopt children from other countries. VDSS provided $125,000 to provide an array of services these families. Adoptive Family Preservation is a post-legal adoption service system managed by UMFS under contract with the Virginia Department of Social Services. Services provided include community based services, assessment, Regional Response Teams that include a family counselor, mental health clinician and an adoptive parent, information and referral, crisis intervention, education advocacy, weekend retreats and a small client funds for special services and incentives.

**Inter-country Adoptions and Services available in Virginia**
Virginia has two approaches to gather data related of children adopted from other countries that may enter foster care and the services they require and receive. OASIS data is used as well as information and data from the delivery of services through a private contractor.

Virginia captures data from local departments of social services on children who were adopted from other countries as well as children who entered foster care as a result of an adoption disruption or dissolutions and who were previously adopted from another country. For SFY 2011, 107 children were adopted from foreign countries. OASIS data indicates that 14 adoptions were disrupted (7) or dissolved (7). Those disruption that dissolved resulted in the child being placed in foster care.

The data and service information is from United Methodist Family Services, the private contractor that manages the statewide Adoptive Family Preservation Program for Virginia's adopted families. This program is funded through the Title IV-B, Subpart II funds. At the beginning of FFY 2011, VDSS provided additional funds to the UMFS in the amount of $125,000 to increase services to these families. Below is the report from the contractor according to the data and analysis by their subcontractor evaluator Policy Works Inc.

## AFP Data Excerpt on Disruption/Dissolution of Families Served with International Adoptions – May 2012

**Families with International Adoptions:**

- No disruptions/dissolutions

| **Four-year profile** | | **One-year profile** | |
|---|---|---|---|
| Families with international adoptions served since 4/1/08 | | Families with international adoptions served since 4/1/10 | |
| Total served: 113 (unduplicated count) | | Total served: 33 (unduplicated count) | |
| Breakout of all cases closed: | | Breakout of all cases closed | |
| **Reason for Case Closure** | **Count** | **Reason for Case Closure** | **Count** |
| Disruption/Dissolution | 0 | Disruption/Dissolution | 0 |
| Child out of home (no dissolution) | 3 | Child out of home (no dissolution) | 0 |
| Family moved | 6 | Family moved | 2 |
| No longer need services | 16 | No longer need services | 6 |
| No contact for 60 days | 16 | No contact for 60 days | 4 |
| | 41 | | 12 |

**All Families Served:**

- In past 4 years (since 4/08), 10 disruptions and 1 dissolution.
- In past 1 year (since 4/11), 0 disruptions.

| **Four-year profile** | | **One-year profile** | |
|---|---|---|---|
| All families served since 4/1/08 | | All families served since 4/1/11 | |
| Total served: 501 (unduplicated count) | | Total served: 339 (unduplicated count) | |
| ▪ Total 11 families whose cases were closed due to dissolution/disruption | | ▪ Total 2 families whose cases were closed due to dissolution/disruption | |
| ▪ Adoption types for families with dissolution/disruption: | | ▪ Adoption types for families with dissolution/disruption: | |
| - 8 Foster Parent Adoptions | | - 3 Foster Parent Adoptions | |
| - 1 Matched | | - 1 Matched | |
| Breakout of all cases closed: | | Breakout of all cases closed | |
| **Reason for Case Closure** | **Count** | **Reason for Case Closure** | **Count** |

| | | | |
|---|---|---|---|
| Disruption/Dissolution | 11 | Disruption/Dissolution | 2 |
| Child out of home (no dissolution) | 26 | Child out of home (no dissolution) | 9 |
| Family moved | 15 | Family moved | 9 |
| No longer need services | 82 | No longer need services | 47 |
| No contact for 60 days | 70 | No contact for 60 days | 31 |
| | 204 | | 98 |

## E. Licensing waivers

The Resource, Foster, and Adoptive Family Home Approval Standards became effective September 2, 2009. The guidance to support the implementation of these regulations was disseminated to the field in June 2010. The regulations allow variances from a standard on a case by case basis and the variance must not jeopardize the safety and proper care of the child or violate federal or state laws or local ordinances. A local department of social services is required to submit the request for a variance to the regional Resource Family Consultant for review and approval. Any variances granted must be reviewed on an annual basis by the Department. As of July 1, 2012, Virginia state law will limit variances to relative foster families. This change will be communicated to the LDSS by Broadcast and reinforced by Resource Family Consultants through ongoing consultation.

## F. Juvenile Justice Transfers

Through the OASIS data system, Virginia tracks reasons why children exit foster care. For SFY 2011, 42 children left foster care due to a commitment to corrections.

Defining when a child should be considered to have left foster care to the custody of DJJ was clarified in Foster Care Guidance. When the child's commitment to corrections terminates, Virginia Code specifies that for youth under 18 who were previously in foster care, they are to be returned to foster care unless another arrangement has been made (e.g., return to the parent).

## G. Collaboration with tribes

Virginia has no federally recognized tribes. Therefore, a child belonging to a Virginia tribe is not subject to the Indian Child Welfare Act, and the local court has jurisdiction. Foster Care policy was strengthened in 2011 and 2012 to provide additional information, to be consistent with CPS guidance and to provide updated tribal contact information. It directs that if the LDSS suspects or knows that a child in foster care or one about to be placed in foster care is of American Indian or Alaskan Eskimo or Aleut heritage, and the child belongs to a tribe located outside Virginia, the LDSS must contact the designated tribal agent about the child. However, when a child entering care is believed or known to have Virginia Indian heritage, the LDSS must immediately contact the Bureau of Indian Affairs Eastern Regional Office for guidance on ICWA for notification procedures of the proper tribe. The guidance also stresses that LDSS should consider any tribal culture and connections – including Virginia tribes - in the placement and care of the child.

The guidance links to more comprehensive information available in the CPS Manual. This guidance provides:

- Information on the Federal Act, including background, purpose and overview of applicable children.
- Responsibilities of local service workers.

- Requirements that apply to four types of custody proceedings, including foster care placements, termination of certain parental rights, pre-adoption placements, and adoption placements.
- Information on how Virginia tribes are organized and the federal funding they receive for education and community development.
- Specific Virginia Tribes that are recognized by the Commonwealth of Virginia, including the Chickahominy, Eastern Chickahominy, Mattaponi, Monacan,Nansemond, Pamunkey, Rappahannock, and Upper Mattaponi.

Efforts to consult with Virginia's tribes to review and revise procedures related to their role in child welfare services were minimal.

## H. Child Maltreatment Deaths

1. Describe all sources of information relating to child maltreatment fatalities that it currently uses to report data to NCANDS

The Virginia Department of Social Services currently uses data from child deaths investigated by local departments of social services and determined to be founded when reporting the number of child maltreatment-related deaths to NCANDS. This data comes from information reported and documented into OASIS (Online Automated Services Information System) by local CPS workers in local departments of social services. The reported death must first meet the criteria to be determined valid. The validity criteria are specified in regulation 22 VAC 40-705-50 B:

1. The alleged victim child or children are under the age of 18 at the time of the complaint and/or report
2. The alleged abuser is the alleged victim child's parent or other caretaker
3. The local department receiving the complaint or report is a local department of jurisdiction; and
4. The circumstances described allege suspected child abuse and/or neglect as defined in §63.2-100 of the *Code of Virginia.*

In determining if the report is founded or unfounded, the evidence must meet the standard of preponderance of the evidence.

2. If the State does not use information from the State's vital statistics department, child death review teams, law enforcement agencies and medical examiner's offices when reporting child maltreatment fatality data to NCANDS, explain why any of these sources are excluded.

The main reason that the State does not use information from the State's vital statistics department, child death review teams, law enforcement agencies and medical examiner's offices when reporting child maltreatment fatality data to NCANDS, is because the persons who investigate these cases have very different roles, laws and policies governing these investigations. While the various investigators work together and clearly overlap, they do not duplicate each other's roles and tasks. The numbers will likely be different because the reporting entities have different tasks and responsibilities. The Department of Social Services is the only entity in Virginia charged by statute with determining whether or not a child was abused or neglect by a caretaker. The roles and tasks of the various entities are described below.

**Virginia Department of Health, Office of the Chief Medical Examiner**

- Reports all deaths that occurred in a Virginia jurisdiction, regardless of residence of the decedent. Does not typically investigate or report on deaths to Virginia residents occurring outside of Virginia.

- Investigates infant and child deaths that are sudden, unexpected, violent, traumatic, suspicious for sudden infant death syndrome, suddenly while in apparent good health, etc.
- Medico-legal death investigation to determine cause and manner of death, not whether or not child abuse or neglect occurred:
    - Cause of death: a medical diagnosis about the disease, abnormality, injury, or poison that set the lethal chain of events in motion.
    - Manner of death: depending on circumstances, could be homicide, suicide, natural, accident, or undetermined.
    - Homicide occurs when the injury reveals intent on the part of person who injured the decedent.
- Some injury patterns clearly linked to child abuse and neglect: in infants and toddlers, abusive or inflicted head trauma, blunt force trauma to abdomen, or failure to thrive directly related to caretaker neglect.
- Others injuries are accidental because the injury was not inflicted on the child in an intentional way; e.g., a child drowning in a bathtub or dying in a fire; a child unintentionally forgotten in an automobile. In these cases, the caretaker may be deemed neglectful by a department of social services, but it does not mean they intentionally inflicted the injuries on the dead child.
- **Task:** To determine how a person died and the intention behind the fatal injury if manner of death was unnatural.

**Virginia Department of Health, Division of Health Statistics**

- Part of Vital Records system.
- Reports deaths occurring in Virginia and including Virginia residents and non-residents. Also reports on death events, which includes all deaths to Virginia residents where Virginia was notified of the death, regardless of where they died.
- Uses ICD-10 coding system, which is established and maintained by the World Health Organization. ICD-10 means *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision.* Although mostly overlapping with how the Office of the Chief Medical Examiner signs a case out, this coding system is not exactly the same as the schema used by the Office of the Chief Medical Examiner.
- **Task:** To report deaths, but uses a national reporting and coding schema that differs from the other reporting entities.

**Virginia Department of Social Service, Child Protective Services**

- Cases are identified only when reported to the state hotline or a local department of social services as suspicious for child abuse or neglect.
- Complaint must be valid. (See above for validity criteria)
- Investigates the death to determine if abuse and/or neglect occurred and who abused and/or neglected the child;
- Makes a finding of either founded or unfounded using preponderance of the evidence as the standard of evidence;
- The only entity in Virginia legally charged with determining whether or not a child was abused or neglect by a caretaker.
- **Task:** To determine whether a child was abused or neglected.

**Law Enforcement/Commonwealth's Attorney**

- Law enforcement uses *Code of Virginia* framework to investigate whether or not a crime was committed: murder, manslaughter, felony child abuse, felony child neglect, etc. Works with our state prosecutors, called Commonwealth's Attorneys, to investigate, develop evidence, etc.
- Differences in how they might determine whether or not a crime occurred. E.g., a gunshot wound death where a person who killed another person when "playing" with a gun, pointing it at the decedent in play, pulling the trigger because they didn't think it was loaded, etc. would typically be called a homicide by the Office of the Chief Medical Examiner (because they person playing with the gun knew it was a lethal weapon and pointed it at another anyway) while a criminal investigation would result in an accidental death outcome; and the department of social services would likely consider it a founded case of neglect due to a lack of supervision. Likewise, if a child drowned in a swimming pool, social services might decide the child was neglected by inadequate supervision, but law enforcement could decide no crime was committed because there was no criminal intent.
- **Task:** To determine whether a crime was committed.

3. If not currently using all sources of child maltreatment fatality data listed in the previous bullet, describe the steps the agency will take to expand the sources of information used to compile this information.

The Department of Social Services will begin by first exploring in detail the extent to which the numbers of child deaths reported and investigated by other sources are in agreement taking into account our various roles and tasks. The *Code of Virginia*, §63.2-1503 D requires that departments of social services upon receipt of a complaint regarding the death of a child to report immediately to the attorney for the Commonwealth and the local law enforcement agency and make available to them all records. The *Code of Virginia*, §63.2-1503 E requires that when abuse or neglect is suspected in any case involving the death of a child, the local department of social services report the case immediately to the regional medical examiner and to the local law enforcement agency. All cases that are investigated by the Office of the Chief Medical Examiner are made available to the Office of Vital Records.

Assuming that there will likely be some discrepancies in cases of reported deaths, the Department of Social Services will work with the Office of the Chief Medical Examiner to determine the extent of agreement or overlap in reported cases of child fatalities for SFY 2012 involving children ages 0 to four. This group of children is being targeted because these are the children who are at the greatest risk of child death due to their vulnerability. If the Department finds that cases are being missed, we will ascertain how, where, and why the numbers differ and develop a plan to gain greater consistency. We suspect that the areas of discrepancy will be in cases determined to be homicides, accidents and in cases involving non-caretakers. Furthermore, we suspect that the types of deaths will involve abandoned infants and family annihilation.

In addition, the State Child Fatality Review Team and Virginia's regional child fatality review teams review child death cases by a multidisciplinary group including social services, law enforcement, and the medical examiner. These teams are also in a position to identify cases that may have been screened out by CPS or never reported.

## I. Services for Children under the Age of Five

Virginia estimates approximately 343 children ages 5 and under who will not be with a permanent family in FY 2013. This estimate does not include those children who are in permanent foster care with an older sibling, a pre-adoptive placement waiting termination of parental rights or on trail home visits. These children are tracked by case number through the Active Foster Care report from OASIS and are predominantly male, African-American and closer to age 5. Targeted services for these youth include the following:

- For those with the goal of adoption and where TPR has been ordered, these children are identified as available for adoption through the ATCP adoption project
- Family engagement and family partnership meetings are used to involve relatives in the caretaking of thee children. When possible, these children are placed with relatives.
- For those children with the goal of reunification, visits with parents are to be scheduled weekly if not more often.
- Concurrent planning practices and placement with a resource family (i.e., a family that will take the child and support both reunification and adoption).
- Placement with siblings.

All of these services respond to the need to keep the family together as much as possible; to build on the attachment needs of the young child to their parent (when reunification is likely); and to identify and place the child in an adoptive home (or make the home an adoptive home) as quickly as possible once reunification has been ruled out. Virginia has started the process to implement the SDM reunification tool for children who were removed due to abuse or neglect. This tool is valuable to workers who have young children with a goal of reunification where the child was removed due to abuse and neglect. Although not implemented as of the date of this report, Virginia has revised its new foster care guidance to include the risk assessment tool and expects to implement its use during SFY2013. No effort to specifically focus on the training of workers, foster parents or supervisors on the needs of these youth have been put in place as of the date of this report. As Virginia revises its child welfare training competencies and courses, more effort will be seen in this area. Current courses do address the developmental needs o children in care but do not specifically focus on this age population. Despite the lack of state child welfare courses that specifically focus on this population, many Virginia localities send staff to training on attachment disorders and implication for case management. Through this venue, workers and supervisors are able to get increased knowledge as to the needs of very young children related to attachment and lifelong problems that can result from the lack of permanency at an early age.

## J. Education, qualifications, and training requirements established by the State

VDSS does not current collect demographic information, education, qualifications, or training requirements on local department workers. Virginia is a state supervised, locally administered system for social services. Because localities are responsible for hiring workers, there are no education, qualification, and training requirements established by the State. The state's human resources department has occupational title descriptions for social work professionals that can be modified by local departments including Social Worker Program Manager, Social Work Supervisor, and Social Worker I-IV. Each title description include the level of supervision suggested for each level and upon completion of a training program or other requirements the person may be redefined to a higher level social worker. There is an educational and experience section of the title description that states: "Minimum of a Bachelor's degree in a Human Services field or minimum of a Bachelor's degree in any field with a minimum of two years of appropriate and related experience in a Human Services area as mandated in Section 22VAC40-670-20 of the Administrative Code of Virginia and implemented by the Virginia Board of Social Services. Possession of a BSW or MSW degree and a Commonwealth of Virginia Social Worker license are desirable."

The "caseload" tab on the attached spreadsheet "Active Caseload SFY 2012 2nd Qtr.xlsx" details, by locality, the number of cases, the number of workers, and an average caseload size per case type. The "referrals tab" details the same information for CPS referrals. This report counts any worker that was assigned to a child at any given so the count may be inflated.

# K. Continuation of operations planning

## Division of Family Services Continuity of Operations Plan

*As of 5/30/12*

The Virginia Department of Social Services' *(VDSS)* Division of Family Services is responsible for developing policies, programs and procedures to guide local social service agencies in providing direct services to Virginia's citizens in need of social services assistance. The Division provides administrative direction through comprehensive planning, policy oversight, program monitoring and technical assistance to regional offices, local agencies, and private vendors.

The Division of Family Services participates in the DSS overall emergency/disaster plan development. This process is ongoing and our plan is changing as each division within the agency develops, evaluates and refines its plans to be incorporated into the overall Department and Commonwealth plans. In the Commonwealth's plan, VDSS has responsibility for sheltering individuals displaced during a disaster. Division of Family Services staff will participate in the establishment and manning of shelters as necessary in the immediate aftermath of a disaster. In addition to its role in sheltering victims, the Division of Family Services must plan for recovery of its normal functions in the event of an emergency or disaster and the continuity of services during that process where possible.
The division submitted its formal COOP plan in January 2011 and it was incorporated into VDSS's larger agency COOP plan.

### I. Primary Functions of the Division of Family Services to be Recovered

1. Establishment of off-site capacity for the Child Protective Services and Adult Protective Services *(CPS/APS)* 24-Hour Hotline. During normal time there is a rotation of 4 workers per shift. This is a state hotline that is used to report abuse and neglect. Information from the report is immediately sent to the local departments of social services for investigation.

2. Establishment of a system for gathering and providing information on children in foster care. A provision in the placement agreement provides the hotline phone number and requires foster parents to call and report their location and contact information if they are required to evacuate during an emergency. In addition, there are social services workers at shelter locations identifying foster care and other clients and forwarding that information to DSS.

3. Maintaining communication with local agencies and ensuring the continuation of services. The OASIS child welfare information system is a "Priority 1" for recovery during an emergency. If this system goes down the Virginia Information Technology Agency *(VITA)* is to have it up and running within 24-hours.

4. Through DSS regional consultants, Family Services maintains a line of communication with local department of social services. In the state structure, regional offices are in direct contact with local departments. VDSS will contact regional consultants and regional directors to assist with communication.

5. Ensuring the safety of the Commonwealth's adoption records. Currently, records are stored in a secured room within the home office. In addition, copies of records are maintained off-site.

**II. Secondary Functions to be Recovered**

Once the primary functions have been addressed the Division of Family Services must ensure its capacity to meet its state and federal requirements including reporting and grants management. DSS' disaster recovery plans include maintaining or recovering the numerous information systems that support the agency's programs. Such systems that need to be operational for the central, regional and local social service agencies are OASIS, VACIS, and ARRIS. Plans for the protection and recovery of information systems and finance systems are developed by those divisions and are part of the overall agency plan.

**III. Notification of Key Personnel**

In the event of an emergency, the Commissioner of Social Services or his designee will contact the Division of Family Services' primary or secondary contact who will be responsible for notifying program mangers and staff.

Primary Contact: Division Director
Jack Ledden: Work: 804-726-7501
Home:
E-mail: jack.ledden@dss.virginia.gov

Secondary Contact: Assistant Division Director
Alex Kamberis : Work: 804-726-7084
Home: 804-594-7276
E-mail: alex.kamberis@dss.virginia.gov

Family Services COOP coordinator:
Phyl Parrish Work: 804-726-7926
Home: 804-320-5121
E-mail: phyl.parrish@dss.virginia.gov

Family Services back up COOP coordinator:
Deborah Eves Work: 804-726-7506
Home: 804-270-2365
Email: deborah.eves@dss.virginia.gov

Each program manager, division director, assistant director, and COOP coordinators will maintain off-site lists of contacts and descriptions of their unit's job functions. Staff will be notified if the emergency requires the relocation of the DSS home office. DFS conducted its second tabletop exercise in 2010 in conjunction with the Emergency Operations Staff. The exercise pin pointed the need for improved preparations for sheltering in place. Limited supplies for sheltering in place were obtained for staff who may have to spend an extended period of time in the home office. In late 2011 and 2012 there has been a focus in working with the VDSS COOP coordinator on refining the Business Impact Analysis for each unit within the Division.

In addition, staff with appropriate skills may be called upon to assist in areas outside of their normal job duties and geographic locations. Regional Offices will maintain lists of contact information for the local departments of social services and will stay apprised of the local department's plans including alternate emergency locations and will relay that information to the Director of Family Services and program managers.

All management staff, regional consultants and some program specialists must have laptop computers or home computers that enable them to communicate and access necessary systems through dial-up or internet connections. Workers are advised upon hiring that they are required to report for work in the event of any disaster or emergency.

**IV. Implementation of Plans for Relocation**

In the event of the destruction of DSS' physical plant, some child welfare functions could be operated from nearby locations including local departments of social services or regional offices. Relocation of the entire DSS would fall under the Commonwealth's plan and the Division of Family Services staff would cooperate and help ensure a smooth transition. In the DSS Continuity of Operations Plan (COOP) each central office facility has one alternate location selected where operations can be relocated depending on the nature of the emergency.

In the event of destruction of a local department of social services physical structure, many localities have formed agreements with neighboring localities to make temporary facilities available for staff for essential activities. They also use other facilities within their own jurisdictions when needed such as the sheriff's departments and the health departments. They use the Red Cross and the schools for shelters. Local departments of social services are part of local government and follow the COOP guidelines for localities per the Virginia Department of Emergency Management.

**Continued Communication with Local Staff**
Virginia's child welfare services are carried out in a state supervised and locally administered system, with regional offices serving in the capacity of liaison between the state and local departments. Additionally, local departments, as part of local government, must develop individual emergency procedures as they are aware of emergency resources and supports within their area as well as the unique disasters to which each region of the state is particularly exposed. It is recommended that all local agencies have at least one laptop computer configured for dial-up access. Regional staff is the primary connection between the local departments of social services and the Home Office and both state and regional staff works to keep the flow of communication ongoing. In order to maintain communication with caseworkers and staff on the local level, the regional staff will be the primary point of contact between state and local staff in an emergency situation. The regional staff has an established relationship with the local departments and will be knowledgeable of their emergency plans. It is essential that local agencies maintain close communication with their Regional Specialists during system outages. This will enable the regional offices to contact other regional and state staff to enlist support from available staff statewide. Regional staff will be in touch with local agency staff in their regions and will be responsible for forwarding home office broadcasts and communications to key local agency personnel when those agencies are unable to access the VDSS system.

Primary responsibility for the recovery of key automated systems is with the Division of Information Systems (DIS). The Email servers as well as the OASIS system are Priority 1 and are to be recovered within 24 hours. In Virginia applications such as OASIS are within the responsibility of DSS. Information system infrastructure is the responsibility of the Virginia Information Technology Agency (VITA) through a contract with Northrop Grumman. The VITA Customer Care Center (VCCC) provides 24/7 support. The Director of Family Services will work with DIS and ensure the division provides programmatic or other support as requested, to recover these functions.

**Contact with clients**
The Active Foster Care Report will be maintained in an Excel file on external hardware ("jump drive") which will be in the possession of both the Foster Care Program Manager and the Title IV-E specialists. Placement agreements will contain a provision requiring foster parents to contact the Hotline in the event

they must evacuate an area due to an emergency situation. The Hotline will collect contact information for these families and this information will be entered into the OASIS system as well as forwarded to Regional Consultants who will alert the agency with custody as well as the agency in the location in which the family is currently residing. Families will be given contact information for the local department of social services. Social Services staff will be at the state run shelters and will collect similar information from individuals who are being sheltered. This will be added to the list of families forced to new locations by the crisis.

The regional offices serve as operation centers for service referrals and information throughout the state. VDSS staff will be available by a centralized toll- free number for the community to contact for child welfare related service needs referral information for services, and to notify the state office of displaced clients. The toll-free number will be given to the media and disseminated to local departments of social services. Virginia also operates "211" Information and Referral hotline that is available for locating services and assistance.

**Hotline Contingency Plan**

The CPS/APS telephone system is operated by the CISCO Automatic Call Distribution system. This system may be inoperative during inclement weather conditions and/or disasters; therefore a plan has been devised to continue services to the public and mandated reporters. Several tests of moving the hotline have been completed successfully. Twenty-four hour technical assistance for the hotline is provided through VITA/NG VCCC. The contact number for DSS to use is: 1-866-637-8482. Specific instructions for the family services' hotline have been updated in the online application for the VCCC, to assist in their technical issue response.

**V. Continued Review and Revision of Plan**

In addition to the above-mentioned procedures, the Division of Family Services is continuing to work with the Disaster Coordinator for the Department to develop more specific procedural guidance for child welfare programs. As a result, the plan will be modified to ensure compliance with state emergency procedures and the needs of other divisions within the Department and with the Continuity of Operations Plans of the Commonwealth of Virginia. Updates to the COOP plan as related to child welfare programs and services will be made available to regional and state staff as necessary. State and local staff will continue to work together to find ways to ensure continuation of services.

# VI. Outcomes, Goals and Measures

Virginia has integrated the outcomes, goals and measures of two important initiatives into Virginia's Five Year State Plan for Children and Family Services:

- Virginia's Children's Services System Transformation; and
- The Federal Child and Family Services Review *(CFSR).*

The charts below list the goals Virginia is tracking for the Virginia Children's Services System Transformation and some of the CFSR outcomes. For each goal, the quantitative measure, national comparative, and Virginia's goal, baseline and trend data will be provided. The last column highlights whether this goal is an area of strength or needs improvement based on Virginia's performance.

Virginia will provide insights with each APSR on trends as well as potential reasons for the strength/need designation. This section will be updated with PIP measurements as soon as they have been indicated.

| **A. Safety of Children** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Children are, first and foremost, protected from abuse and neglect** | | | | | | | |
| **CFSR Indicator/ Transformation Outcome** | **Safety Goal** | **Measure** | **National** | **Virginia** | | | |
| | | | | **Goal** | **Baseline** | **Trend** | **Strength/ Need** |
| **SafeMeasures Critical Outcome** | **1) Increase the number of children remaining safely in their own homes.** | Reduce rate of child abuse and neglect per 100,000 children | | Below 3.0 in June 2009 | | | |
| **<u>CFSR Safety Indicator 1</u>: More children do not experience repeat abuse and neglect** | **2) Increase the percentage of children who do not have repeat incidents of abuse and neglect.** | Increase percent of all children who were victims of substantiated or indicated abuse or neglect allegation during the first 6 | 94.6% or higher | 94.6% or higher | | 97.98% (2011)<br>94.5% (2012) | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | months of the fiscal year who <u>were not</u> victims of another substantiated or indicated abuse or neglect allegation within 6 months following that incident | | | | | |
| **<u>CFSR Safety Indicator 2</u>: More children in foster care do not experience repeat abuse and neglect** | **3) Increase the percentage of children who are not abused or neglected in foster care.** | Increase percent of all children served in foster care during the fiscal year who were not victims of a substantiated or indicated maltreatment by a foster parent or facility staff member during fiscal year | 99.67% or higher | 99.67% or higher | | 99.84% (2011)<br>99.7% (2012) | |
| **<u>CFSR Item 1</u> – Timeliness of initiating investigations of reports of child maltreatment** | **4) Children are seen in a timely manner.** | How effective is the agency in responding to incoming reports of child maltreatment in a timely manner? | TBD | | | 71.9% contact made on time (2012) (SafeMeasures report) | |
| **<u>CFSR Item 3 –</u> Services to family to protect child(ren) in the home and prevent removal or reentry into foster care** | **5) Services are in place to prevent removal from the home or reentry into foster care** | How effective is the agency in providing services, when appropriate to prevent removal of children from their homes? | | 82.0% | 73.2% | 95.3% (from case reviews conducted for PIP) | |
| **<u>CFSR Item 4 –</u> Risk assessment and safety management** | **6) Risk and safety assessments are in place** | **How effective is the agency in reducing the risk of harm to children, including** | | 76.4% | 70.1% | 92.8% (from case reviews conducted for PIP) | |

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| | | **those in foster care and those who receive services in their own homes.** | | | | | |

| **B. Children Achieving Permanency** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Children have permanency and stability in their living situations** | | | | | | | |
| **CFSR Indicator/ Transformation Outcome** | **Permanency Goal** | **Measure** | **National** | **Virginia** | | | |
| | | | | **Goal** | **Baseline** | **Trend** | **Strength/ Need** |
| **SafeMeasures Critical Outcome** | **1) Decrease the number of children in out of home care** | Reduce rate of children in foster care per 1,000 children | Declined from 7.5 in 2000 to 7.0 in 2006 | | 3.05 (2011) | | |
| **<u>Transformation Outcome:</u> More children in foster care achieve permanency** *(SafeMeasures Critical Outcome)* | **2) Increase percentage of all children in foster care who achieve permanency.** | Increase percentage of all children in foster care who are discharged to reunification, adoption, or custody transfer to relatives | | 81.00% or higher | 73.77% (2011) | 72.5% (2012) (SafeMeasures) | |
| **<u>Transformation Outcome:</u> Children achieve permanency with shorter length of stays.** *(SafeMeasures* | **3) Decrease the amount of time it takes for a child to achieve permanency** | Decrease the time to permanency for all children who are reunified, transferred to a relative, or adopted. | | TBD | 25.02 months (2011) | | |

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| *Critical Outcome)* | | | | | | | |
| **<u>Transformation Outcome:</u> More children are placed in relative foster homes** *(SafeMeasures Critical Outcome)* | **4) Increase placements of children in kinship care *(relative foster family)*** | Increase percentage of all children currently placed in relative foster family | | TBD | 6.16% (2011) | 6.8% (2012) (SafeMeasures) | |
| | | Increase percentage of all children whose first placement was in relative foster family | | TBD | 4.0% (2011) | | |
| **<u>Transformation Outcome:</u> More children are placed in family based care** *(SafeMeasures Critical Outcome)* | **5) Increase placements of children in family based care** | Increase percentage of all children currently placed in relative or non relative foster care *(therapeutic foster care included),* non-finalized adoptive homes, or trial home visits. | | 85.00% or higher | 82.64% (2011) | 84.4% (2012) (SafeMeasures) | |
| | | Increase percentage of all children whose first placement was in relative or non relative foster care *(therapeutic foster care included),* non-finalized adoptive homes, or trial home visits | | 85.00% or higher | 80.7% (2011) | | |
| **<u>CFSR</u> Permanency Composite 1: Timeliness and Permanency of Reunification** | **6) Children have permanency and stability in their living situations.** | From State Data Profile: Component A: Timeliness of Reunification and Component B: Permanency of Reunification | 122.6 | 121.3 | 117.9 (2008b09a) | 110.2 (2009ab) 120.2 (2010ab) 123.0 (2011ab) | |

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|---|---|---|---|---|---|---|---|
| **CFSR Permanency Composite 2: Timeliness of Adoptions** | **7) Children are adopted in a timely manner.** | From State Data Profile Component A: Timeliness of Adoptions of Children Discharged From Foster Care Component B: Progress Toward Adoption for Children in Foster Care for 17 Months or Longer. Component C: Progress Toward Adoption of Children Who Are Legally Free for Adoption. | 106.4 | 78.2 | 75.1(2007 B08a) | 73.5 (2009ab) 83.7 (2010ab) 93.5 (2011ab) | |
| **CFSR Permanency Composite 3: Permanency for Children and Youth in Foster Care for Long Periods of Time** | **8) Children exit care to a permanent situation** | From State Data Profile; Component A: Achieving permanency for Children in Foster Care for Long Periods of Time. Component B: Growing up in foster care | 121.7 | 105.4 | 102.5 (2007b08a) | 107.9 (2009ab) 108.4 (2010ab) 111.0 (2011ab) | |
| **CFSR Item 7: Permanency goal for child** | **9) The child's permanency goal is appropriate and established in a timely manner.** | How effective is the agency in determining the appropriate permanency goal for children on a timely basis when they enter foster care? | | 83.7% | 76.7% | 69.8% (2011) (case reviews for PIP) | |
| **CFSR Item 10: Other planned permanent living arrangement** | **10) Alternative goals are appropriate for the child and services are provided** | How effective is the agency in establishing planned permanent living arrangements for children in foster care, who do not | | 63.2% | 46.7% | 76.4% (2011) (case review for PIP) | |

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| | | have the goal of reunification, adoption, guardianship, or permanent placement with relative, and providing services consistent with the goal | | | | | |
| **Transformation Outcome: Fewer children are placed in congregate care** *(SafeMeasures Critical Outcome)* | **11) Reduce placements of children in congregate care** | Decrease percentage of all children currently placed in congregate care | | 15% or fewer | 15.10% (2011) | | |
| | | Decrease percentage of all children whose first placement was in congregate care | | 15% or fewer | 18.5% (2011) | | |
| | | Decrease average number of months children spent in congregate care | | TBD | 33.42 months (2011) | | |

| **C. Child and Family Well Being** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Families have enhanced capacity to provide for their children's needs** | | | | | | | |
| **CFSR Indicator/ Transformation Outcome** | **Well Being Goal** | **Measure** | **National** | **Virginia** | | | |
| | | | | **Goal** | **Baseline** | **Trend** | **Strength/ Need** |

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| **CFSR Item 17:** **Needs and services of child, parents, and foster parents** | **1) Services are provided to children, parents, and foster parents** | How effective is the agency in assessing the needs of children, parents, and foster parents, and in providing needed services to children in foster care, to their parents and foster parents, and to children and families receiving in-home services? | | 67.6% | 60.9% | 72.4% (2011) (case reviews for PIP) | |
| **CFSR Item 18:** **Child and family involvement in case planning** | **2) Children and family are involved in case planning** | How effective is the agency in involving parents and children in the case planning process? | | 77.2% | 70.7% | 74.7% (2011) (case reviews for PIP) | |
| **CFSR Item 19:** **Caseworker visits with child** | **3) Caseworkers visit children monthly face to face with the majority of the visits in the child's residence and those visits are quality visits** | How effective are agency workers in conducting face-to-face visits as often as needed with children in foster care and those who receive services in their own homes? | | 75% | 68.6% | 81.7% (2011) (case reviews for PIP) | |
| **CFSR Item 20:** **Caseworker visits with parents** | **4) Caseworkers visit parents monthly face to face and those visits are quality visits** | How effective are agency workers in conducting face-to-face visits as often as needed with parents of children in foster care and parents of children receiving in-home services? | | 59.4% | 51.5% | 61.4% (2011) (case reviews for PIP) | |

# Virginia Child Welfare Staff and Provider Training

Virginia continues to have a variety of sources for training state and local staff as well as providers and community partners. The following will describe the training as well as the funding sources. The organization and resourcing of training changed from a set of contracts to being largely accomplished by state staff as the Virginia Department of Social Services (VDSS) brought that work "in-house" completely as of October 1, 2011.

Despite the changes in organization, the "Reengineering of Child Welfare Training" from previous reviews has progressed and many of the advances are integral to the whole VDSS training organization.

## I. BRINGING TRAINING "IN-HOUSE"

The administration of training was brought into the Department in stages. By the target date of July 1, 2011, three of the five regional training centers were being administered by VDSS staff rather than employees of local agencies through contract. The final two regions were placed under the administration of the Regional Training Manager, located in Richmond, on October 1, 2011. Three of the five regional offices remained in place and the two others are in or in the process of being located in their own centers close to the VDSS Regional Offices.

The central administration, formerly done via contract with Virginia Commonwealth University School of Social Work (VCUSSW), was also transferred to VDSS on October 1, 2011. All of the active curricula for both on line and class room training were transferred to the department electronically at that time.

The VDSS restructured in 2011 to include a newly established department of Organizational Development. Training for local agency child welfare staff has been placed under the management of the Deputy Commissioner for Organizational Development. Currently the training staff involved include a Local Programs Training Manager, a Family Services Training Manager, a Trainer Developer, two curriculum developers, a support staff person and 16 wage status trainers. These staff also have access to other resources within local programs training such as an eLearning professional, editors and administrative support staff. There are now three Regional Training Managers administering the five Regional Training Offices.

Noteworthy is the fact that the three Regional Training Managers are the same individuals that were in place the previous year. This continuity is also reflected amongst the curriculum developers and the trainer management.

## II. REENGINEERING CHILD WELFARE TRAINING

Decisions made regarding which child welfare courses are trained with what frequency continue to be made at the Regional Training Office level. This continues to be based on input from the local departments to Regional Training Managers (RTMs). Beginning July 1, 2012, the VDSS will begin a needs assessment process that includes both formal and informal gathering of relevant information. The formal needs assessment will include surveys at the statewide and regional level as well as opened ended questions about training needs on all participant class evaluations. This will also include information about needed training from local and state level administrators' and program managers' requests. Coordination with the Quality Service Review Unit in the Division of Family Services has already been established and a new course content is being developed for inclusion in the fall 2012.

In the spring of 2011, subsequent to the approval of Supervisor/Manager Core Competencies, a set of Core Competencies for Child Welfare Caseworkers, (used by the Ohio Child Welfare Training Program), were vetted by local agency staff and supervisors across Virginia. This vetting included five regional meetings where presentations of the competencies included a discussion of their role in training, the levels of learning and a familiarization with how these competencies differ from those designed for more specialized staff. The results of feedback received were shared with consultants at the Institute for Human Services (IHS), the designers of *Competency –Based In-service Training for Child Welfare,* for reworking to include the input. Once that work had been done, the lead IHS consultant for competency development and VDSS child welfare training staff developed a final document that fully included Virginia practice and language. This "final draft" was presented to the Professional Development Committee (PDC) of the Virginia League of Social Service Executives. The PDC agreed to take over the review and comment role of the Virginia Child Welfare Training Steering Committee and to review and adopt the Child Welfare Caseworker Core Competencies which they did on April 13, 2012.

The Deputy Commissioner for Organizational Development has committed to forming a training advisory group that includes a broad cross section of local agency staff and will be working closely with the PDC and other representative groups to continue the partnership developed with the Steering Committee**.**

## III. TRAINING DELIVERY

Child welfare courses are trained through a combination of instructor led, classroom training and some online courses. There are currently sets of mandated courses that were originally developed by the VISSTA program at VCUSSW, some of which are now being updated by VDSS curriculum developers to reflect up to date guidance and practice. Courses have been and will continue to be approved by the federal Region III child welfare liaison.

### A. Funding

Administrative functions relating to child welfare that are eligible for Title IV-E will be charged at the regular rate with the application of the penetration rate. Administrative functions not supporting the Title IV-E plan will be charged to state funds. Training courses focused on activities that are necessary for the proper and efficient administration of the Title IV-E plan will be charged at the enhanced rate subject to the application of the penetration rate. Other child welfare courses will be charged at the regular rate (with the application of the penetration rate) or paid for from state funds. **Attachment A** to this Training Plan lists the courses related to child welfare that are currently intended to be offered through the VDSS training system in the coming year, the funding source and the Title IV-E rate, if applicable. Additional courses that may be added, depending on availability of funding, will be submitted.

### B. Attendance

The average attendance for sessions in SFY2011 is 12 participants. Child welfare trainees for SFY11 numbered 3125. The days of mandated, initial in-service child welfare trainings planned for all of SFY12 are 271.

### C. Local Agency Training Plans

Fifty eight LDSS submitted plans to provide child welfare training under this category for SFY2012. These plans described the type of training to be provided (i.e., new worker or on-going training for staff) as well as the topic area to be covered and the over-all plan for training.
Approval of LDSS training plans is contingent upon the plan's compliance with federal guidelines regarding allowable expenses. Total funding approved for SFY 2013 for this category of training is

$2,074,916. This amount includes funding for purchase of services such as travel, hotel accommodations, conference fees, training supplies and/or curriculum, training equipment, contractual services for the purpose of administering training, etc. It does not include the salary and related costs incurred by LDSS staff providing training. Training activities that are necessary for the proper and efficient administration of the Title IV-E plan will be charged at the enhanced rate of 75 percent subject to the application of the penetration rate. Approved training at the enhanced rate is $1,984,201 and approved training at the administrative rate is $90,715.

Administrative costs such as the salary of a LDSS employed training staff are part of VDSS' Random Moment Sampling (RMS) process. (Administrative functions, excluding salaries and related expenses, relating to trainings that are eligible for Title IV-E will be charged at the federal financial participation (FFP) rate of 50 percent with the application of the penetration rate. LDSS provide the appropriate match.)

### D. Employee Educational Award Program (EEAP)

LDSS can establish an Employee Educational Award Program (EEAP) that is eligible for reimbursement through Title IV-E. The EEAP provides limited financial support (tuition and reimbursement of fees and travel to class) to employees who are interested in pursuing a Master of Social Work (MSW) or those who are completing their final year of a Bachelor of Social Work (BSW) degree. Employees may enroll as full-time or part-time students in an accredited social work program. To be eligible for this educational assistance, an employee must be a current child welfare employee or an employee who wishes to pursue employment in the area of child welfare. Employees who receive an educational award must make a commitment to work in a designated child welfare program position in the LDSS for a period of time equal to the period for which financial assistance is granted. The work commitment is counted from the completion or termination of the educational program. Employees who fail to fulfill their employment commitment are required to pay back the amount of the assistance received.

To receive available funding, LDSS must submit an annual application for approval by VDSS including the LDSS requirements and protocols for how the EEAP is administered, managed and monitored by the LDSS. No employee may be funded by the EEAP Program until VDSS approves the LDSS policy document which must clearly address all federal requirements.

Total anticipated expenditures for the EEAP approved for SFY 2013 are $142,385. Because the only allowable costs to be paid under this training program are federally approved items such as tuition and fees, there are no administrative costs allowed for this program. LDSS provide the appropriate match. For SFY 2012 eight LDSS submitted applications which were approved for this program. Title IV-E EEAP will be charged at the enhanced rate of 75 percent subject to the application of the penetration rate.

### E. Resource, Foster and Adoptive Family Training

A total of 54 LDSS applied for and received approval to use Title IV-E funding to support training for their resource, foster and adoptive families in SFY 2013.

The purpose of this training is to enhance the knowledge, skills, and abilities of current and prospective resource, foster, and adoptive families in order for them to meet the needs of Title IV-E children. Training is comprised of two major components: pre-service training and in-service training.

Pre-service training provides resource, foster, and adoptive families with knowledge, skills, and abilities that prepare them to meet the needs of the child. In FY 2010, Agency-Approved Provider Regulations (22VAC40-211) were approved that require specific core competencies consistent with the Parent

Resource for Information, Development and Education (PRIDE) pre-service curriculum. PRIDE is made available to LDSS who wish to use this as their training curriculum. LDSS that do not use PRIDE are able to purchase or develop an alternative curriculum and submit a copy to VDSS for approval. Such curricula will be approved so long as all required core competencies are included.

In-service training is for current resource, foster and pre-adoptive parents to refresh and enhance their knowledge and skills related to working with the LDSS and children in foster care. According to the newly approve Agency-Approved Provider Regulations (22VAC40-211), local departments are required to provide opportunities for in-service training on an annual basis. Families are surveyed no less than annually to determine training needs and the determination is practiced uniformly and fairly across families and involves the family in the determination of training needs.

Total program costs approved for SFY 2013 for resource, foster and adoptive family training is $1,417,959. Of that amount $1,355,243 is approved at the enhanced rate and $62.715 is approved at the administrative training rate. This amount includes only funding for purchase of services such as travel, hotel accommodations, conference fees, training supplies and/or curriculum, training equipment, contractual services for the purpose of administering training, etc. It does not include salaries and related expenses of LDSS staff that provide training. Training activities that are necessary for the proper and efficient administration of the Title IV-E plan will be charged at the enhanced rate of 75 percent subject to the application of the penetration rate.

Administrative costs such as the salary of a LDSS employed training staff are part of the RMS process. Administrative functions relating to training that are eligible for Title IV-E will be charged at the FFP 50 percent rate with the application of the penetration rate. Training activities that are necessary for the proper and efficient administration of the Title IV-E plan will be charged at the enhanced rate subject to the application of the penetration rate. Other resource, foster, and adoptive parent training will be charged at the regular rate with the application of the penetration rate. LDSS will provide appropriate matching funds. Expenses related to this program not allowable under Title IV-E will be borne by the LDSS.

The following training courses were offered through December 2011. The RPC process for the upcoming year (FY 13) will be structured in each region to meet the needs of that region. Many agencies expressed concern regarding the time commitment required of the RPC as previously designed, and requested assistance with targeted recruitment needs and support. In addition, agencies that participated last year have requested to continue meeting at least quarterly because of the benefits of information sharing and peer to peer networking. The Resource Consultants are also reviewing monthly data reports that provide agency information regarding family-based placements and kinship placements. The Consultants will develop targeted strategies to assist the agencies that are below the national practice standards.

**Resource Families 101:** one-day, regional training offered to local agency staff who work with resource families to understand best practices in recruitment for families in for children in foster care.

**Advanced Resource Family Recruitment, Development and Support:** One day course offered once in each of the five state regions. Curriculum reviewed the best practice framework for obtaining, training and keeping Resource families. A part of the training focused on sharing examples of local recruitment innovations from CORE initial Transformation agencies.

**Recruitment, Development, and Support-Regional Peer Cooperative (RPC)**: RPC is a series of six training / working sessions that each focus on different areas of Recruitment, Development and Support of Resource Families. This is a voluntary program for agencies. The RPC series begins with 2 sessions focusing on the Support of Resource Families. This is followed by two sessions focusing on the

Development of Resource Families. The series ends with two sessions focusing on Recruitment of Resource Families. The RPC follows a curriculum that was developed by the Family Resource Unit based on the framework below.

CRAFFT promotes the safety, permanency and well-being of children through the training of LDSS foster, adoptive, and resource parents (collectively referred to as resource parents) to meet the needs of children in Virginia's child welfare system. CRAFFT's goal is to increase the knowledge and skills of resource parents through the development and delivery of standardized, competency- based, pre-and in-service training, as required by VDSS. The standardized curricula used if the PRIDE training curriculum. CRAFFT delivers statewide pre-service and in-service PRIDE training in each region, based on the completion of an annual needs assessment completed with each local department of social services. In larger agencies, CRAFFT collaborates with LDSS training staff to prepare the LDSS staff to deliver the training. CRAFFT staff can serve as the PRIDE co-trainer with a local foster parent trainer when the LDSS has no professional trainer available. CRAFFT Coordinators also conduct the following activities:

- Develop and deliver additional in-service training for resource families, based on input from families as well as local agencies and VDSS;
- Collaborate with LDSS and Virginia Foster, Adoptive and Kinship Parents Association (FACES) to promote membership, participate in the annual FACES conference/training, and develop relationships with regional FACES board members and FACES staff;
- Develop and maintain a regional training plan, updated as needed, based on the results of the needs assessment demonstrated in LDSS' local training plans;
- Work closely with the Regional Resource Family consultants and training, meetings, conference calls, and activities related to the regional Family Engagement Roundtables and implementation of a family engagement model; and,
- Conduct regularly scheduled regional roundtable meetings with LDSS staff and other key stakeholders to provide training and resources regarding resource parent development and support; inform agencies of current state or program initiatives related to resource parent training; and allow agencies to collaborate, exchange resources and share challenges and solutions.

During the 2012 fiscal year, the CRAFFT program was successful in providing eleven (11) pre-services series. Each PRIDE pre-service series is comprised of 9 weeks and a total of 27 hours. A total of one-hundred and thirty-eight (138) resource family individuals started the pre-service training series facilitated by a regional CRAFFT coordinator and one-hundred and thirty-one (131) completed the series. In addition to the pre-service series, the CRAFFT coordinators facilitated twenty (20) PRIDE-pre-service sessions. These sessions were held for family members that were unable to attend a session in a series or for agencies that needed assistance with facilitating a particular session but not the entire series. A total of two-hundred and six (206) resource family individuals attended these sessions. An additional pre-service series and five (5) pre-service sessions are scheduled between May and June 2012.

A total of thirty-two (32) in-service sessions for four hundred and nineteen (419) resource family members were facilitated by the CRAFFT Coordinators between July 1, 2012 and April 30, 2012. An additional eleven (11) in-service sessions are scheduled between May and June 2012. May is National Foster Care month and traditionally there is an increase in the number of resource families that attend in-service sessions during this month. It is estimated that an additional three-hundred and fifty (350) resource family members will be in attendance for in-service sessions that will be facilitated by a CRAFFT coordinator between May and June 2012.

In addition to the in-service sessions that the CRAFFT coordinators facilitated, they also assisted with the coordination of six (6) regional training events for resource families entitled "The Family Academy." The Family Academies are sponsored by CRAFFT; FACES of Virginia Families, Foster, Adoptive and Kinship Association; Virginia One Church One Child; and Project Life. The Family Academies are scheduled between January and June 2012. Each Family Academy is an eight hour Saturday event. Five Family Academies were held between January and April 2012 and there were a total of one-hundred and forty (140) adults in attendance and thirty-one (31) youth. The final Family Academy will occur in June and it is estimated that fifty (50) adults and fifteen (15) youth will be in attendance. The CRAFFT Coordinators also coordinated one additional regional special event for families with a guest speaker from VDSS and there were a total of fifteen (15) resource individuals in attendance.

Many of the agencies use the PRIDE curriculum, however some need assistance in increasing their capacity for offering training more frequently and in response to this need, the CRAFFT Coordinators have provided nine (9) of the 2-day Introduction to PRIDE course for approximately eighty-seven (87) LDSS Workers and four (4) of the 2-day Mutual Family Assessment course for approximately thirty-eight (38) LDSS workers. Additionally, there are two (2) Mutual Family Assessment courses scheduled between May and June 2012 and an estimated twenty (20) LDSS workers will be in attendance.

The CRAFFT Coordinators have also facilitated six (6) roundtable meetings for LDSS workers to network and exchange ideas for training resource families. One-hundred and six (106) workers attended the CRAFFT roundtable meetings and an additional three (3) roundtable meeting are scheduled between May and June 2012 for an estimated sixty (60) LDSS workers. The CRAFFT Coordinators have also co-facilitated eight (8) Regional Peer Cooperative (RPC) meetings (approximately 52 attendees) and two (2) Family Engagement Roundtable Meetings (approximately 45 attendees).

In FY 2013, in addition to continuing the above activities, CRAFFT will expand its focus to include kinship caregivers in in-service training for resource families, enhance the collection of statewide data and implement measurable outcomes for each region, and develop and offer one day specialized training for trainers to LDSS staff who provide PRIDE training within their agencies.

The CRAFFT Program employs six staff (five regional CRAFFT Coordinators throughout the state, and a Program Manager who oversees the program) based at three universities in Virginia (Norfolk State University, Radford University and Virginia Commonwealth University) with whom VDSS has a Memoranda of Agreement (MOA) for the provision of statewide competency-based training. The total of the CRAFFT contract budgets is $563,119. All CRAFFT coordinator activities are directly related to the development and delivery of federally approved training.

### F. Department Training Initiatives

*Engaging Families and Building Trust-based Relationships:* In the December, 2011, VDSS conducted training with this title at a site in the Central Region (New Kent County) and at another in the Northern Region (Prince William County). This training was targeted to child welfare supervisors and was initiated as a result of findings of the VDSS Quality Service Reviews in the Indicator for "Teaming". The curriculum will be used to make major revisions to the current course: CWS4020 Introduction to Virginia's Family Partnership Meetings. The training was written and conducted by staff of the Child Welfare Programs and Policies Group (CWPPG) and included the following activities:

- Explore characteristics of family culture and information in policies and practices that support the engagement process with families.
- How to develop a working agreement with families.

- Learn to connect personal experiences with change and the experiences families have in order to better engage with family members and assess in a non-judgmental manner.
- Assist workers to identify and address primary and secondary losses resulting from change and help families' transition from their discomfort zone to practicing the desired behavior.
- Understand the various types of resistance often encountered in working with families and learn specific techniques to work with resistance.
- Practice specific engagement and trust building skills of exploring, focusing, and guiding to help the worker and the child and family gain insight into their current situation.
- Learn and practice solution-focused questions to surface family member's strengths, needs, culture, and solution patterns.
- Define and practice the use of self-disclosure, normalization, and universalization to help to normalize feelings and experiences.
- Identify ways to formulate, evaluate and refine options with families.
- Learn to define and identify essential underlying needs that are often a description of the underlying conditions and source of the behavioral expressions of problems that a family may be encountering.
- Evaluate the use of Core Conditions and Engagement Skills used by workers with family members.
- Define and practice the steps of the working agreement and how these steps are used to build a partnership relationship with the family.
- Develop a plan to practice the strategic use of the working agreement, core conditions and core helping skills to build a trusting relationship with families.

This training was supported by funding from Casey Family Programs at no cost to VDSS

*Methamphetamine Labs* Virginia State Police delivers training concerning Methamphetamine Labs Competencies include: 1. Know behavioral and emotional indicators of Methamphetamine use and how they contribute to child maltreatment, parental mental illness or mental health problems, and or domestic violence 2. Know the signs of a clandestine methamphetamine lab and the actions to be taken when recognizing those signs or entering a home when those signs are recognized. This training was conducted on two occasions in the Regional Training Center in Roanoke VA and was no cost to VDSS.

*Reactive Attachment Disorder* The parent-child attachment relationship is the prototype for all future relationships and the basic building block for most developmental tasks. This training will address the formation of healthy and unhealthy attachment relationships. Participants will be able to identify: the causes, signs, and symptoms of attachment disorders; the effect of disordered attachment on children's behaviors, development, and on the family dynamic; the difference between Reactive Attachment Disorder and other attachment "disorders"; attachment evaluations, treatment options and behavior management strategies for children with disordered attachments and for their families. Attachment related problems and disorders, including PTSD, will also be covered. In addition, attachment trauma and its effect on the child's developing brain will be a topic and books, websites, and other helpful resources for families and providers will be reviewed. Competencies and Learning Objectives: The Child Welfare Worker can define Reactive Attachment Disorder and recognize indicators and symptoms of possible Reactive Attachment Disorder. The Child Welfare Worker will be able to: a. Identify and explain causes and triggers of reactive attachment disorder; b. Recognize signs and symptoms of reactive attachment disorder and its affect on child development; c. Explain the signs and symptoms of Disorganized Attachment Disorder and how it differs from Reactive Attachment Disorder; d. Identify signs and symptoms of related conditions of Reactive Attachment Disorder, such as object attachment, anxiety, development disorders and personality disorders; e. Can refer for testing, treatment and support for children and families coping with Reactive Attachment Disorder.

This training was supported by funding from Casey Family Programs and was presented in both the Piedmont (Roanoke), Central (Richmond), and Eastern (Virginia Beach) Regional Training Centers between October and December 2011. This was a "Subject Matter Expert" written workshop that was the result of our Regional Training Managers working with staff from the School of Social Work at VCU as a strategy to address the needs of experienced child welfare staff and supervisors statewide.

*WHY CAN'T YOU HEAR ME?* This training was developed to address the following learning objectives: Knows how to use empathic listening, reframing, and strengths-based supervisory strategies to engage and empower a worker to jointly assess work performance and develop a performance improvement plan • Sneak Peak: • Communication and listening...the processes • Communication best practices: time, place, methods • Communication snafus. This training was presented in the Roanoke Regional Training Center in November, 2011 and was done at no cost to VDSS.

*Synthetic Drugs* The learning objective of this training was: Knows how to identify synthetic drugs and various associated drug paraphernalia. This training was presented in the Roanoke Regional Training Center in November, 2011 and was done at no cost to VDSS by local law enforcement experts in the topic.

**G. Independent Living Program (ILP)**

VDSS is responsible for providing IL training, tools and technical assistance (TA) to local department of social services (LDSS) workers to strengthen their program of services to foster care youth. Most of the training and TA is provided by Project LIFE which is a public/private partnership between the VDSS and United Methodist Family Services (UMFS). The goal of Project LIFE is to support permanency for older youth in care through the coordination and enhancement of independent living services by collaborating with local departments of social services, private providers and community stakeholders. During SFY 2012, Project LIFE staff (five regional IL consultants and two best practice consultants) provided the following:

- Ansell Casey Life Skills Assessment (ACLSA) trainings/TA
- National Youth in Transition Database (NYTD) trainings/TA
- Guidance and training on the Independent Living Program (ILP); Education and Training Vouchers Program (ETV); Transition Living Plan (TLP); and Permanency for Older Youth

| Topic | # of Trainings/TA | # of Adult Participants |
|---|---|---|
| ACLSA | 26 | 125 |
| NYTD | 14 | 134 |
| ETV | 10 | 61 |
| General( i.e., Transition Plans, Permanency) | 4 | 23 |

Also, VDSS provided training and technical assistance to LDSS on the SFY 2012 ILP/ETV Funding package including using up to 30% of their basic allocation for room and board for young people who left foster care at age 18 but have not turned 21, or who have moved directly from foster care to IL programs. In Virginia, room and board includes security deposits, apartment application fees, utilities and telephone connection fees, emergency shelter, and rent payments if youth are at risk of being evicted.

Approximately 20% of Virginia's Chafee grant was spent on room and board for eligible youth. In Virginia, youth who are receiving IL services can continue to receive Medicaid coverage until the age of 21 as long as they continue to meet eligibility requirements.

FY 2013 VDSS and Project LIFE will continue to collaborate to ensure older youth and LDSS staffs are receiving the support, training and technical assistance needed for an integrated approach to youth permanency and preparation for adulthood.

## I. REQUIRED TRAINING

### A. Child Protective Services Staff

All CPS workers in the state are mandated to complete skills and policy training within the first year of employment. Since 1996 Virginia has had regulations addressing CPS training.
22 VAC 40-705-180 mandates uniform training requirements for CPS workers and supervisors:

"*The department shall implement a uniform training plan for child protective services workers. The plan shall establish minimum standards for all child protective services workers in the Commonwealth of Virginia*."

22 VAC 40-705-180 (B) requires CPS workers to complete training within their first year.

"*Workers shall complete skills and policy training specific to child abuse and neglect investigations within the first year of their employment*."

Within the first three months of their employment, CPS staff that provide responses to reports of abuse of neglect or manage/supervise any CPS investigation or family assessment shall complete the Course CWS 2000 Child Protective Services New Worker Policy training. In addition during their first year, new CPS workers must complete the following mandatory courses offered by Local Programs Training:

- CWS 2011 Intake, Assessment and Investigation in Child Protective Services
- CWS 2021 Sexual Abuse
- CWS 2031 Sexual Abuse Investigations

CPS staff are also required to complete the mandatory course, CWS 2010 Ongoing Services in Child Protective Services.

The following courses shall be completed by all CPS workers within two years of the start of employment:

- CWS 5305 Advanced Interviewing: Motivating Families for Change
- DWS 1001 Understanding Domestic Violence OR
- DVS 1031 Domestic Violence and its Impact on Children pursuant to 63.2-150 of the Code of Virginia.
- CWS2141 Out of Family Investigations – if conducting designated out of family investigations pursuant to 22 VAC40-730-130.
-

CPS policy further requires that all CPS workers complete the following Local Programs Training courses within two years of employment if a specific need is assessed by the worker and supervisor. Even when a specific need is not identified, VDSS encourages workers to complete the following courses:

- CWS 1001 Exploring Child Welfare
- CWS 1011 Casework Process & Case Planning Child Welfare
- CWS 1021 Effects of Abuse & Neglect on Child and Adolescent Development
- CWS 1031 Separation and Loss Issues in Human Service
- CWS 1051 Crisis Intervention
- CWS 5011 Case Documentation

- CWS 53037 Assessing Safety, Risk and Protective Capacities in Child Welfare
- CWS 5701 Child Welfare Supervision

State funds are used to support CPS training.

**B. Permanency Staff**

The Code of Virginia requires that," The Department shall, pursuant to Board regulations, establish minimum training requirements and shall provide educational programs for foster and adoption workers employed by the local department and their supervisors."

The Department has promulgated regulations and developed guidance to specify the curriculums that local foster care and adoption staff and supervisors are required to attend including time frames for existing staff as well as future hires. To date the courses identified as the State's required courses for child welfare workers and supervisors are listed below:

Minimal training for new foster care and adoption workers during the first six months of employment:

- CWS 1031 Separation and Loss Issues in Human Services Practice
- CWS 3000 Foster Care New Worker Policy Training w/OASIS
- CWS 3010 Adoption New Worker Policy Training with OASIS
- CWS 1061 Family Centered Assessment in Child Welfare
- CWS 1071 Family Centered Case Planning
- CWS 3041 Working with Children in Placement

Minimal training for new foster care and adoption workers who have been employed seven to 12 months:

- CWS 3061 Permanency Planning for Teens-Creating Life-long Connections
- CWS 3081 Promoting Family Reunifications
- CWS 5011 Case Documentation
- CWS 5305 Advanced Interviewing: Motivating Families for Change

The State will continue to offer the new worker foster care and adoption policy courses which include training on Virginia's automated child welfare information system (OASIS) and are offered on a regular basis in all regions of the state to ensure an understanding of federal and state requirements related to the safety, permanency and well-being of children. LDSS encourage workers to attend training beyond that offered. Attendance at child welfare conferences and seminars related to case management in foster care and managing hard to place youth are samples of the types of additional training LDSS staff receive beyond the regularly offered courses. Such conferences and courses, when not offered as part of the VDSS approved coursework, are approved by VDSS in advance to ensure that LDSS are seeking reimbursement for training costs at the appropriate rate. Because LDSS report all training attended and the expenditures related to this training on a quarterly basis, VDSS is able to cross check LDSS reports with actual federal dollars claimed to ensure all costs are allowable and are claimed at the appropriate rate.

## IV. FUNDING

Funding for child welfare training is provided by VDSS either directly, through LDSS or through contracts or agreements with other entities comes from different sources including federal, state and local funds.

Training costs are subject to all routine cost accounting procedures. In instances where a cost is supporting only one activity (e.g., PRIDE Training), those costs are directly charged to the appropriate funding source using the appropriate federal match rate. Costs for activities that support one or more activities are collected in one or more cost codes. Quarterly, these costs are assigned to a cost pool and statistical formulas are used to determine the allocation of funds.

Title IV-E funds may be used for the following types of training:

- Title IV-E Eligibility Training
- Resource, Foster, and Adoptive Parent Training, and
- Foster Care/Adoptive Worker Training.

# Attachment A
# VDSS Child Welfare Training Activity

**CWS 1002 Exploring Child Welfare**
On-line, self-paced course for child welfare workers with less than twelve months experience working in a local agency

Introduction to basic concepts and skills necessary to ensure the safety, permanency, and well being of children
Topics include: historical evolution of child welfare; examination of key child welfare legislation; basic assumptions and guiding principles of Virginia practice; ethics and values clarification; cultural awareness; and, roles, rights, and responsibilities of the worker, child, parents and the community.
Fund: IV-E IV-E rate: 75%

**CWS 1021 The Effects of Abuse and Neglect on Child and Adolescent Development**
2-day course for child welfare workers with less than six months experience in a local agency, or experienced workers in need of this training
Learn new information or refresh existing knowledge and skills in basic child and adolescent development theory.
Topics include: characteristics associated with abuse or neglect and impact on survivors; and, referral services and effective intervention techniques
Fund: IV-E IV-E rate: 75%

**CWS 1061 Family Centered Assessments**
2-day course for child welfare workers with less than 6 months experience in a local agency; workers with non-human service college degrees; experienced workers with no formal training in Child Welfare

CWS 1061 provides an overview of the fundamental assessments skills used in all phases of the child welfare practice continuum (CPS, Foster Care, Adoption and Home Studies) and provides trainees a solid foundation for using critical thinking skills and avoiding bias in their assessments. The course focuses on using family centered assessment skills to build effective helping relationships and gain relevant, accurate information as the basis for making correct and timely decisions.
Fund: IV-E IV-E rate: 75%

**CWS 1071 Family Centered Case Planning**
2-day course for child welfare workers with less than six months experience in a local agency, or experienced workers in need of this training.
Case planning is a collaborative effort between families, caseworkers, and other providers. It helps identify, organize, and monitor activities and services to families needed to achieve and document case outcomes. This foundational course discusses how these formal "action plans" are based on family assessments that identify high need areas and help determine service objectives. Learn how the planning process is dynamic and occurs throughout the life of a case

**CWS 1031 Separation and Loss Issues in Human Services Practice**
2-day course for human service workers with less than six months working experience in a local DSS agency and experienced workers with no formal training.

Understand the dynamics of separation and loss in children and families.
Topics include: feelings commonly associated with separation; impact of loss on children and families in placements; crisis intervention theory; and strategies to minimize impact of trauma on children and families.
Fund: IV-E IV-E rate: 75%

**CWS 1041 Legal Principles in Child Welfare Practice**
2-day course for child welfare workers and supervisors with limited experience working with the juvenile

court system.

Gain an understanding of the court structure in Virginia; learn how to use it to protect children.
Topics include: Civil and criminal courts systems, reasonable efforts and burdens of proof, roles and responsibilities of professionals in the court process, problem solving for best practices in court
Fund: IV-E IV-E rate: 50%

**CWS 1051 Crisis Intervention**
2-day course for human services workers and supervisors

Learn about the dynamics of crisis and the principles, goals and steps of intervention
Topics include: Crisis assessment; effective strategies for defusing crisis; worker safety in crisis.
Fund: IV-E IV-E rate: 50%

**CWS 2000 Child Protective Services New Worker Training with OASIS**
4-day training for local staff new to the CPS program

Learn the policy requirements of the CPS program in Virginia.
Become knowledgeable about the laws, regulations and policy that guide CPS practice and practice documenting the policy requirements in OASIS
Topics include: purpose and basic assumptions of CPS; definitions of child abuse and neglect in Virginia; receiving and responding to a report of child abuse or neglect; conducting family assessment or investigation; best practices; ongoing services in open cases; how to document in OASIS.
Fund: State IV-E rate: N/A

**CWS 2011 Intake, Assessment, and Investigation in Child Protective Services**
3-day course for child welfare workers

Learn practical skills and techniques for interviewing children and their families in abuse and neglect assessments and investigations. Learn best practices to be used throughout the process.
Topics include: interpersonal, family and environmental factors that increase the risk of abuse and/or neglect; how to gather pertinent information; how to interview children, non-offending caretakers, and the alleged offending caretaker; how to assess information to make safety plans, informed case decisions and identify service needs.
Fund: State IV-E rate: N/A

**CWS 2021 Sexual Abuse**
2-day course for child welfare , including foster care and adoption workers who require an overview of child sexual abuse

Understand the dynamics and scope of child sexual abuse. Examine the implications for best practice interventions.
Topics include: definitions of child sexual abuse; consequences of sexual abuse from a developmental perspective; treatment needs of the non-offending caregiver; and, dynamics of sexual abuse and intervention strategies to promote safety and well-being in children and families.
Fund: State IV-E rate: N/A

**CWS 2031 Sexual Abuse Investigation**
3-day course for child welfare workers and supervisors responsible for investigating child sexual abuse complaints.

Explore critical issues that impact the investigation of child sexual abuse. Practice the skills necessary when interviewing victim, non-offending caretaker, and alleged offender.
Topics include: forensic investigation – goals, roles and preparation; developmental issues to consider for child interview; interview processes for child; interviewing teens, credibility and evidence collection; focusing on safety, legal issues.
Fund: State IV-E rate: N/A

**CWS 2141 Out of Family Investigations**

2-day course for CPS workers and supervisors who conduct out-of-family investigations.

Provides an understanding of the policy requirements and special challenges and dynamics of out-of-family investigations. Increase skill level in interviewing strategies to assess and intervene effectively in out of family situations.
Topics include: risk factors related to the out-of-family caregiver; collaborating with regulatory agencies; facility administrators, and family members; working with legal representatives; strategies for supporting the family; and, policy unique to out-of-family investigations
Fund: State IV-E rate: N/A

**CWS 3000 Foster Care New Worker Policy Training With OASIS**
4-day course for local staff new to the Foster Care program

Become knowledgeable about the laws, regulations, and policy that guide foster care practice at the local level. Practice documenting policy requirements in OASIS.
Topics include: purpose and guiding principles of foster care services; legal requirements for foster care, foster care prevention, and family preservation; how children enter care, safeguards, and placement authorities and options; requirements for opening a case and completing all required referrals; assessment and service planning, and choosing the permanency goal; reassessments, reviews and re-determinations; policy and practice related to closing cases, funding maintenance and service provision; and documenting in OASIS.
Fund: IV-E IV-E rate: 75%

**CWS 3010 Adoptions New Worker Policy Training With OASIS**
3-day course for local agency staff new to the Adoption Program

Learn the policy requirements of the agency placement Adoption program in Virginia. Become knowledgeable about the laws, regulations and policy that guide Adoption practice at the local level and practice documenting the policy requirements in OASIS.
Topics include: purpose and guiding principles of providing agency placement adoptions; provisions of pre- and post- adoption services; how to register and update information in the Adoption Resource Exchange of Virginia (AREVA); policies and funding sources related to provision of Adoption subsidies; best practice, as well as policy requirements for conducting adoptive home studies; how to respond to appeals regarding the adoptive home approval process; and how to document all policy requirements in OASIS.
Fund: IV-E IV-E rate: 75%

**CWS 3021 Promoting Partnerships Between Birth Parents & Foster Parents**
1-day course for local agency directors, child welfare supervisors, social workers (CPS, permanency, adoption and stabilization/prevention program areas), all local child-serving agencies, private and public community partners, resource/foster parents, and community stakeholders.

This course will specifically deal with one of the core principles of family engagement; that of promoting meaningful partnerships between foster and birth families as partners in promoting safety, well being and permanency for children.
Topics include: The benefits and challenges of working with the child's family, roles and responsibilities of birth parents, foster parents, and social workers in promoting birth and foster family partnerships, demonstrate ways in which they can work with the child's family and/or support on-going communication between the birth family and foster family, ways to minimize the challenges of working with the child's family recognize the application of working with the child's family or with various resource family situations such as foster/resource and adoptive families and foster families and extended birth family, how to conduct an Ice-breaker Meeting with all interested stakeholders, engaging fathers in the permanency planning process, visit-coaching techniques and strategies.
Fund: IV-E IV-E rate: 75%

**CWS 3041 Working with Children in Placement**

2-day course for child welfare workers and supervisors

Learn practical skills and techniques for working with children in placement.
Topics include: Assessing children's needs; managing behavior and preventing disruptions.

Fund: IV-E IV-E rate: 75%

**CWS 3042 Orientation to Interstate Compact on the Placement of Children**
1-day course for child welfare workers and other local staff who may prepare ICPC documents and materials or supervise the placement of children across state lines.

Learn basic knowledge of the Interstate Compact for the Placement of Children including requirements and practices. The ICPC procedures are to assure that children placed across state lines receive the same protections and services as children placed within state.
Topics include: History of ICPC; legal base and placement authority; placing or receiving a child across state lines; and unusual circumstances in the ICPC process.
Fund: IV-E IV-E rate: 75%

**CWS 3061 Permanency Planning for Teens – Creating Life-long Connections**
2-day course for Foster Care and Adoption workers and those individuals involved in the permanency planning process.

Learn how to help teens identify and establish emotional connections and build the family support necessary for navigating the difficult transition into adulthood. Strategies for finding maternal and paternal relatives and permanent connections are discussed.
Topics Include: Developmental issues and the need for permanency for teens, impact of the Child Welfare system and barriers to permanency, the key elements of loyalty, loss, self-esteem, behavior management, and self-determination as the foundation of permanency, making connections through a teen-centered planning process, maintaining sibling and family connections, the role of youth-specific recruitment in making permanent connections, strategies for preparing teens for family living and supporting permanency, diligent relative search techniques.
Fund: IV-E IV-E rate: 75%

**CWS 3071 Concurrent Permanency Planning**
2-day course for child welfare workers and those individuals involved in the permanency planning process

Learn about Concurrent Permanency Planning, a means of working towards family reunification while, at the same time, developing an alternative permanent plan.
Topics include; impact of ASFA on permanency for children in foster care; six essential processes and practices; assessment for the potential for reunification; strategies to motivate clients and facilitate movement through the change process; and documenting concurrent plan in case records.
Fund: IV-E IV-E rate:75%

**CWS 3081 Promoting Family Reunification**
1-day course for foster care workers, child welfare workers and others involved in the permanency planning process

This course will examine the planned process of reconnecting children in out-of –home care with their families or prior custodians by means of a variety of services and supports to the children, their families, their foster families, and other service providers.
Topics include: principles of reunification; maintaining connectedness; planned visitation; partnership and collaboration; role of foster parents, birth parents, or prior custodians in the casework process, service delivery, and case planning.
Fund: IV-E IV-E rate: 75%

**CWS 3101 Introduction to the PRIDE Model**

2-day training for agency staff including child welfare workers and supervisors, community partners, foster, resource, and adoptive parents who wish to be PRIDE trainers, conduct PRIDE mutual family assessments, or who are associated with agencies implementing PRIDE.

This course offers an overview of the PRIDE Model. It is a practice model for recruiting, supporting, and developing resource, adoptive, and foster families. The PRIDE Model emphasizes teamwork and collaboration, selecting appropriate families through the use of a joint pre-service and mutual assessment process, and developing skills and knowledge in the PRIDE Core Competencies.
Fund: IV-E IV-E rate: 75%

**CWS3103 PRIDE Family Assessment**
2-day training for child welfare workers in localities employing the PRIDE model for developing foster/adoptive family assessments

This course prepares VDSS staff to implement the mutual assessment process for foster, adoptive and resource families. The course takes trainees through the process of the home assessment using the PRIDE connections and pre-service training. This course builds upon skills and knowledge acquired in CWS 3101: Introduction to the PRIDE Model
Fund: IV-E IV-E rate: 75%

**CWS 4020 Family Engagement and Building Trust Based Relationships**
Family engagement as it includes "family voice and choice" and "communication and coordination between family partnership meetings"
Fund: State IV-E rate

**CWS4030: Facilitator Training for Virginia Family Partnership Meetings**
This training prepares experienced child welfare professionals to facilitate Family Partnership Meetings (FPMs) using the principles of the Virginia Family Engagement Model. This training explores and provides practice opportunities for each phase of the FPM and prepares facilitators to build teams, direct the meeting process, resolve differences, and develop consensus. A detailed overview of meeting implementation is provided, thus local agencies are encouraged to have prospective facilitators complete this training prior to beginning the process of engaging families in placement decision meetings.
Fund: State IV-E rate 75%

**CWS 5011 Case Documentation**
2-day course for child welfare workers and supervisors

Learn writing skills that support case documentation and build upon skills to enhance their ability to document casework activity, assessment, decision-making, and planning in child welfare cases.
Topics include: purpose, goal and strategy (focusing on your reader's needs); how to recognize the difference between fact and opinion; child welfare case narrative (how much is too much); the elements of a child welfare assessment; service planning in child welfare the SMART way; and tips for correspondence and intake.
Fund: IV-E IV-E rate: 75%

**CWS 5305 Advanced Interviewing: Motivating Families for Change**
2-course for child welfare workers and supervisors

Course will assist workers to engage families in a mutually beneficial partnership and assess a family's readiness for change. Workers will learn engagement models and the recommended strategies for sustaining motivation and commitment to change.
Topics include: Engagement and the strengths perspective; the stages of change; and solution-focused interviewing techniques.
Fund: IV-E IV-E rate: 75%

**CWS 5411 Emotional Disorders**
3-day course for child welfare workers and supervisors

Learn to recognize the symptoms of emotional disorders to assess needs and refer for appropriate

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|---|
| treatment. Address issues in case management.<br>Topics include: healthy emotional development; symptoms of diagnoses in the DSM-IV and implications for case management; biopsychosocial assessment and appropriate treatment modalities; and collaboration with community resources<br>Fund: IV-E IV-E rate: 75% |
| **CWS 5701 Child Welfare Supervision**<br>3-day course for local agency supervisors who direct the work of child protective services or permanency workers<br><br>Acquire the specific knowledge, skills, and abilities needed to fulfill responsibilities to ensure their staff provide effective and efficient child welfare services. Nationally recognized standards and techniques are addressed in order for supervisors to instill in workers the capacity to improve safety, permanency, and well-being outcomes for the children and families they serve.<br>Fund: IV-E IV-E rate: 50% |
| **DVS 1001 Understanding Domestic Violence**<br>**1**-day course for workers and supervisors in all LDSS programs<br><br>Gain basic knowledge about domestic violence.<br>Topics include: abusive behaviors used to maintain power in an intimate or family relationship; theories and dynamics of domestic violence; arrests and protective services; relationship between domestic violence and gender; and violence in society and how it contributes to domestic violence.<br>Fund: IV-E IV-E rate: 75% |
| **DVS 1031 Domestic Violence and its Impact on Children**<br>2-day course for workers and supervisors in all service programs, particularly Child Welfare<br><br>Learn core principles of domestic violence intervention techniques and discuss assessment skills necessary to determine risk for all family members.<br>Topics include: impact of domestic violence on children's development; essential procedures and techniques for interviewing children in violent homes; appropriate community referrals and proper monitoring techniques; and Virginia law and legal options available in domestic violence situations to ensure safety. Fund: IV- E IV-E rate: 75% |

# Virginia State Plan for the Child Abuse Prevention and Treatment Act (CAPTA)

## Commonwealth of Virginia

### Department of Social Services

### Division of Family Services

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# CAPTA Update for 2012

- Describe substantive changes, if any, to State law or regulations, including laws and regulations relating to the prevention of child abuse and neglect, that could affect the State's eligibility for the CAPTA State grant (section 106(b)(1)(C)(i)). The State must also include an explanation from the State Attorney General as to why the change would, or would not, affect eligibility. Note: States do not have to notify ACF of statutory changes or submit them for review if they are not substantive and would not affect eligibility.

Effective July 1, 2012, the *Code of Virginia* will reflect changes that bring the Commonwealth in stronger compliance with CAPTA as reauthorized on December 20, 2010. The *Code of Virginia*, § 63.2-1509 relating to the reporting of substance exposed newborns will be amended to include Fetal Alcohol Spectrum Disorder replacing Fetal Alcohol Syndrome. It will also require health care providers to report suspected cases of substance exposed newborns instead of attending physicians. The safety requirements of these newborns and service provisions remain the same.

Effective July 1, 2012, the *Code of Virginia* will reflect changes to eliminate § 63.2-1528 related to the Governor's Advisory Board on Child Abuse and Neglect (GAB) and to consolidate the GAB into The Family and Children's Trust Fund (FACT) Board, § 63.2-2102. While plans for transition are still taking place, it is expected that a standing committee of FACT will be established to assume the responsibilities and duties of the GAB including serving as one of the Citizen Review Panels.

- Describe any significant changes from the State's previously approved CAPTA plan in how the State proposes to use funds to support the 14 program areas (section 106(b)(1)(C)(ii)).

The majority of the previously approved CAPTA plan remains in effect. Three new or enhanced areas of work include the implementation of regional child fatality review teams, new and enhanced training for mandated reporters, and increased emphasis in the area of child abuse prevention. These program areas include section 106(a)(2)(A) creating and improving the use of multidisciplinary teams and interagency protocols to enhance investigations; (8) developing and facilitating training protocols for individuals mandated to report child abuse or neglect; and (12) developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level. This new work will be incorporated into the attached plan in *italic*.

The State Board of Social Services has established a Child Fatality Committee to study the increase of child deaths to gain a better understanding of the factors surrounding these deaths. One of the recommendations of the Committee and the Board was the development and implementation of five regional child fatality review teams. In addition, a statewide conference for all regional team members will be planned for the spring of 2012. The CAPTA plan will be revised to address the work in this area.

During the 2012 General Assembly session there were 14 bills introduced regarding mandated reporters. Several of the bills were combined; however, seven bills passed. These bills include naming additional persons as mandated reporter, additional requirements for mandated reporter, stronger penalties and authorities. Revised policy/guidance is being developed, revisions to online curricula, revisions to written materials and guide books, and a revised training curriculum. The CAPTA plan will be revised to highlight work to be done with mandated reporters in the coming year.

The CAPTA plan will be revised to address the work to be done in the area of prevention services. Along with a comprehensive prevention survey of local departments of social services, a study was conducted involving six localities around the practice of kinship care diversion. The purpose of the study was to learn current practices and philosophies around using kin to prevent agencies from having to assume custody and to inform development of a kin diversion practice model. CAPTA funds may be used to support a part-time staff person to work collaboratively with staff from the Prevention Unit.

- Describe how CAPTA state grant funds were used, alone or in combination with other Federal funds, to meet the purposes of the program since the submission of the CAPTA State Plan (section 108(e) of CAPTA).

In Virginia, CAPTA funds align and support the overall goals for the delivery and improvement of child welfare services, Title IV-B, the Community-Based Child Abuse Prevention (CBCAP) program, and the goals and strategies outlined in Virginia's Program Improvement Plan (PIP). CAPTA state grant funds were used, alone or in combination with Title IV-B, CBCAP, and other child welfare programs in three major areas: Safe Children and Stable Families; Family, Child and Youth Driven Practice, and Strengthening Community Services and Supports. Below is a summary of the accomplishments for 2011-12. The plan will identify areas of work that have been completed, items being currently worked on, as well as ongoing activities.

Last year, the Department of Social Services (VDSS) concentrated efforts in improving local department staffs' abilities to assess initial safety and risk, revised the CPS policy/guidance manual to include tools on how to more accurately and consistently assess initial child safety and risk including factors such as domestic violence, mental health issues, and substance abuse, and assessed local staffs' ability to improve response times to CPS reports. State CPS staff developed and implemented statewide training for CPS supervisors and workers on screening, assessment, decision making and referral for investigating suspected child abuse and neglect using new intake, safety and risk assessment tools. Fifty, two-day sessions were held across the state using the Structured Decision Making (SDM) model in May through July 2011. State CPS staff and local supervisory staff were paired to conduct this training. An additional 15 one-day sessions designed for those staff performing on-call functions took place in August through September 2011. In addition, two, one-day sessions for all State Hotline staff on the screening intake functions was held on June 22 and 23, 2011. Over 1,500 CPS supervisors and workers participated in the training sessions.

State staff is continuing to work with localities to support and sustain the practice change around intake, safety and risk assessments. Focus groups have been held to assess continued needs, field guides have been developed and are currently being piloted in 10 localities, support groups for supervisors are being held bi-monthly for supervisors to review the case monitoring tools and discuss outstanding issues. New reports have been generated by locality from Safe Measures to assist the State in evaluating the current use of the intake, safety and risk assessment tools as well as to evaluate local agency response times to reports of suspected child abuse and neglect. A new report has been developed in Safe Measures to assess how well local CPS workers are adhering to the new policy on timeframes for face to face contact with victims. Regional CPS consultants are working with individual localities to help them improve in all of these identified areas.

In terms of improving local department staffs' abilities to conduct service needs, risk re-assessments and develop relevant service plans, State CPS staff have reviewed the SDM family strengths and needs assessment tools to ensure consistency with Virginia policies and regulation, and have completed a case review of approximately 50 cases to assess the quantity and quality of services being provided. This work is being done in conjunction with the National Resource Center for In-Home Services.

Another area of CPS policy/guidance that has needed attention is the investigation of CPS reports in out-of-family settings. To date, State CPS staff has established a committee composed of local CPS workers and supervisors to review the current policy/guidance manual and identify areas needing revision and/or clarification. Many of the CPS cases that are amended or overturned on appeal involve out of family caretakers. Draft policy/guidance is being developed and will be shared with the Out of Family Advisory Committee to the State Board of Social Services and other interested parties prior to release.

The State Board of Social Services has established a Child Fatality Committee to study the increase of child deaths in order to gain a better understanding of the factors surrounding these deaths. One of the recommendations of the Committee and the Board was the development and implementation of five regional child fatality review teams. In December 2011, a Broadcast was distributed to local departments of social services alerting them to the establishment of regional child fatality review teams. State CPS staff has been working closely with the Office of the Chief Medical Examiner in training CPS regional consultants to serve as chairs for the regional child fatality review teams. Training took place in October 2011and included a discussion about VA statute establishing local/regional child fatality review teams, the purpose of the teams including guiding principles, major objectives of the review, identifying risk factors, team membership, time commitments and roles of team members. The teams are charged with reviewing all child deaths that were investigated by local departments of social services in state fiscal year 2011. There are a total of 86 cases statewide including both founded and unfounded cases. Multidisciplinary teams have been established and training of team members took place in January through March of 2012. The training for the team members was similar to that provided to the CPS regional consultants and included more detailed information on the steps in the review process, confidentiality, data collection, and a detailed discussion about recommendations and preventability Teams are beginning to review cases with an expected finish time of December 2012. Additional work in this area will be highlighted in the new CAPTA report. The teams will be using the National Child Death Review Tool and reporting their data to the National Center on Child Death Review.

On November 29, 2011, the Hampton Roads Child Fatality Review Team held a training session, "A Child Is Dead, What Do We Do? How To Do A Child Fatality Investigation and Prosecution". Approximately 100 people were in attendance. The agenda included presentations by EMS, fire and rescue, a homicide supervisor, and a medico-legal death investigator. These professionals talked about the death investigation from their prospective as first responders. The role of the forensic physician, assistant chief medical examiner, CPS worker and commonwealth attorney were also highlighted. CAPTA funds were used to support this training event.

State CPS staff is reviewing all of the CPS appeal cases to examine the current trends and to determine how well local departments of social services are interpreting CPS policies and procedures, providing consistent information to appellants, and adequately documenting their cases. During the first quarter of calendar year 2012, a total of 49 cases were reviewed. Of the cases reviewed, 29 cases were sustained, 15 cases were overturned and six cases were amended. A Broadcast to all local directors, CPS supervisors and workers was sent out identifying the strengths in cases that were sustained and identifying the areas needing improvement in the cases that were amended or overturned. Two training sessions were presented for local staff responsible for hearing local appeals in February, 2012. CPS regional consultants are working with local CPS supervisors and workers in improving case documentation, case presentation, and understanding legal requirements. Feedback will be given to localities on a quarterly basis.

VDSS has trained selected service providers and state regional staff on strategies for family engagement and kinship care. Family Partnership Meetings (FPM) are being held in several decision points including

cases that have been determined to be at very high or high risk with services are being provided and at the point of an emergency removal. CAPTA funds have been used to support FPM. A total of 3,407 FPM were held during the first 11 months of calendar year 2012.

The CPS policy/guidance manual has been amended to better support connections to relatives. Revisions included the requirement to identify and notify relatives within 30 days of removal and the process to inform them of the right to participate in the care of the child. In an effort to increase local capacity for locating absent parents, siblings, other relatives and significant others, the use of Accurint, a web-based search engine was made available to staff statewide. CAPTA funds assist in the support of Accurint. Expanding community services and supports that are child-centered, family-focused and culturally relevant is another area where CAPTA funds have been used as well as CBCAP, Promoting Safe and Stable Families (PSSF), and Victims of Crime Act (VOCA). A total of 45 programs supporting child abuse and neglect prevention have been funded with CBCAP funds and State funds to support evidenced-informed and evidenced –based programs and practices. These services include Healthy Families, parent support groups, and parent education programs.

CAPTA funds were used to support other contracts and training opportunities. For SFY 2011, 48, 812 children participated in one of the 159 performances of the child sexual abuse prevention play "Hugs & Kisses". In the fall of 2011, 63 performances were held in 45 schools involving 19,452 children.

Over 400 people attended the 2012 Virginia Child Abuse Prevention Conference "***Every Child Counts. Know Them. Nurture Them. Protect Them."*** held on Monday, April 2, 2012 in Richmond, Virginia. The conference was sponsored by the VDSS, and Prevent Child Abuse Virginia and co-sponsored by The Family and Children's Trust Fund, the Governor's Advisory Board on Child Abuse and Neglect and the Virginia Coalition for Child Abuse Prevention. CPS staff also coordinated the awards ceremony for the Governor's Advisory Board on Child Abuse and Neglect (GAB). The GAB awards were presented to seven individuals who have made outstanding contributions to the field of child abuse and neglect from across Virginia. Sandra Alexander, Expert Consultant on Child Maltreatment, with the Division of Violence Prevention at the Centers for Disease Control, was the keynote speaker. Jim Hmurovich, President and CEO of Prevent Child Abuse America served as the luncheon speaker. Six workshops were held in the morning and six were held in the afternoon. A closing panel shared first hand experiences and examples of how every child counts. The evaluations confirm that this was a very successful event. CAPTA, CBCAP, and a grant from The Family and Children's Trust Fund helped to support this conference.

VDSS has established a Prevention Unit within the Division of Family Services. A statewide Prevention Committee comprised of state staff, community partners, and representatives from 18 local agencies has been working on the development of prevention guidance to enhance the prevention capacity of local departments of social services and to increase community collaboration to strengthen families and prevent the occurrences or recurrence of maltreatment in birth, foster and adoptive families and to prevent foster care placement. A Prevention Survey was administered to identify the range of prevention services being provided by local agencies throughout child welfare, how they are staffed and funded, and to clarify the funding sources used to provide services to prevent the occurrences or recurrence of maltreatment in birth, foster and adoptive families and to prevent foster care placement. The findings from the survey include the following:

- Local departments are interested in learning more about services to strengthen and support families in their communities before serious challenges arise;
- More localities than expected are providing services to strengthen families in their communities prior to a valid referral of child abuse and neglect;

- Public private partnerships are providing a strong base for both public education and services to strengthen families;
- Comprehensive Services Act, PSSF, Social Services Block Grant, and CBCAP are primary funding sources utilized for early prevention;
- Engaging both custodial and non-custodial fathers and other related and nonrelated individuals to support families is a key component of strengthening families in local departments; and,
- The use of family partnership meetings to involve families decision-making early on is an effective tool in keeping children out of foster care.

The data from the survey supports the findings:

- 96% of agencies completed the survey;
- 94% provide at least one type of early prevention services, although only 50% have designated prevention staff;
- 80% of the families served are self referrals;
- 89% collaborate with community partners to provide early prevention services to families;
- 74% of respondents search for relatives and non-relatives to enhance parental support;
- 95% facilitated alternative living arrangements with relatives or non-relatives for a child at risk of entering foster care; and,
- 50% of respondents utilize family partnership meetings in early prevention, before any CPS involvement.

Additional work in this area will be included in the updated CAPTA plan.

A total of 39 programs utilizing VOCA funds support child abuse and neglect treatment services for child victims. A number of Court Appointed Special Advocate (CASA) programs are also funded through VOCA. There are currently 18 Child Advocacy Centers (CAC) across the state receiving State funds to support child abuse treatment services as well. CAPTA funds support a part-time staff person to administer the funding for the CACs as well as provide technical assistance and consultation to grantees.

VDSS has collaborated with the VA Department of Criminal Justice Services (DCJS) in the ChildFirst forensic training program supported by the use of CAPTA and Children's Justice Act funds. CAPTA funds are used to provide scholarships for local CPS workers and supervisors to participate in this five-day intensive forensic interviewing training program. Two sessions involving approximately 40 workers will be funded this grant year. One session was held in March and an additional session is scheduled for August.

CAPTA funds were also used to support the training on child abuse and neglect for children with disabilities sponsored by the Partnership for People with Disabilities, Child Abuse and Neglect Collaborative involving VDSS, DCJS, Virginia Department of Education, and Virginia Commonwealth University. A video teleconference is held three times a year in four sites with a facilitator available in each site to field questions and facilitate small group discussions. Participants represent social services, education, Community Services Boards, mental health advocates, court personnel, CASA, foster parents, and parents of children with disabilities.

VDSS has a contract with James Madison University for the publication of the Virginia Child Protection Newsletter. CAPTA funds are used to support this contract. In SFY 2011, the following publications were released: Serving Immigrant Families; medical Aspects of Child Maltreatment; and Parent Leadership & Family Engagement in CPS and Foster Care.

# CAPTA Virginia State Plan
## 2012 submission

The Child Abuse Prevention and Treatment Act (CAPTA) was reauthorized in 2010, Public Law 111-321. States are required to prepare and submit a State plan that will remain in effect for the duration of the state's participation in the grant program. The Plan must be prepared and submitted annually describing how the funds provided under CAPTA were used to address the purpose and achieve the objectives of the grant program (section 108(e)). In Virginia, CAPTA funds align and support the overall goals for the delivery and improvement of child welfare services, Title IV-B, and the goals and strategies outlined in Virginia's Program Improvement Plan (PIP).

Using the format from Virginia's CFSP, the CAPTA Plan will incorporate PIP strategies as well as other strategies that will address the purpose and objectives of the CAPTA program areas.
The PIP strategies are:

1. Engage Families across the Continuum of Child Welfare
**Goal:** Ensure children, youth and parental input is heard and considered in the decision-making processes regarding safety, permanency, well-being, and service planning and placement decisions

2. Improve Assessment and Service Delivery
**Goal:** Appropriately assess safety, risk, and the needs of children and families in order to provide high quality, timely, efficient, and effective services.

3. Reengineer Competency Based Training System
**Goal:** Improve training and supervision in order to serve children and families through high quality, timely, efficient, and effective services

4. Managing by Data and Quality Assurance
**Goal:** Create a performance management system that utilizes data to inform management, improve practice, measure effectiveness and guide policy decisions

To mirror the five year plan, this plan will highlight activities in three areas: Safe Children and Stable Families, Family, Child and Youth Driven Practice, and Strengthening Community Services and Supports. Strategies will be updated yearly or as activity occurs.

## VII. Safe Children and Stable Families

These strategies strive to assure the safety of children within their homes, protect children in at risk situations, and ensure they are protected from abuse and neglect in a permanent setting responsive to their well being. It preserves and strengthens intact families who ensure the safety and well-being of their children. It strives to prevent child maltreatment among families at risk through the provision of supportive family services.

- **Applicable CAPTA program areas described in section 106(a)**: 1. The intake, assessment, screening and investigation of reports of child abuse and neglect; 2. Improving legal preparation and representation, including procedures for appealing and responding to appeals of substantiated reports of child abuse or neglect; 3. Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families; 4. Enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols, including the use of differential response; 5. Develop and update systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange; 7. Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protections system, including improvements in the recruitment and retention of caseworkers; *8. Developing and facilitating training protocols for individuals mandated to report child abuse or neglect;* 14. Developing and implementing procedures for collaboration among child protective services, domestic violence services and other agencies.

## Goal: Protect Children At Risk of Abuse and Neglect

1. **Improve local department staffs' abilities to assess initial safety and risk**
   f) Assess and review how local CPS workers have implemented the new intake tools that became effective July 2011 **Completed**
   g) Hold focus groups with local supervisors and workers to assess and identify any areas of concern or need for clarification **Completed**
   h) Clarify and disseminate revised policy/guidance manual, as needed **Completed**
   i) Work with the Quality Service Review Unit to evaluate the extent to which initial safety and risk assessments are being completed correctly and within the required timeframes
   **j)** Develop new intake measures into Safe Measures to determine how well ldss are implementing the new intake tools. **Ongoing**
   k) Provide refresher training, as needed.

2. **Revise CPS guidance manual to include tools on how to more accurately and consistently assess initial child safety and risk including factors such as domestic violence, mental health issues, and substance abuse**.
   a) Obtain input from the CPS Policy Advisory Committee, the Office of Family Violence, and the Department of Behavioral Health and Developmental Services to ensure that the tools are assessing issues of domestic violence, mental health and substance abuse **Completed**
   b) Revise, if needed and incorporate these factors in the current safety and risk assessment tools and into the CPS policy/guidance manual **Completed**
   c) Disseminate guidance and make necessary changes to OASIS **Completed**

3. **Evaluate local staffs' ability to improve response times to CPS reports**
   a) Develop and review reports in Safe Measures to assess how well staff are responding to reports of suspected child abuse and neglect as a result of the new policy/guidance that was implemented in July 2011. **Completed**
   b) Develop a report in Safe Measures to assess how well staff are adhering to the new policy on timeframes for face to face contact with victims **Completed**
   c) Review the reports generated through Safe Measures with CPS regional consultants and develop a plan to work with those individual localities having problems in responding to reports in a timely manner **Completed**
   d) Clarify and disseminate policy/guidance manual, as needed **Completed**
   e) Provide consultation to ldss, as needed. **Ongoing**

4. **Develop strategies to support and sustain the practice change for CPS supervisors and workers on the use of the new intake, safety and risk assessment model.**
   a) Hold focus groups and/or survey local CPS supervisors to assess their continued needs **Current work**
   b) Develop tools for supervisors to use with workers to support the use of the structured decision making tools in casework practice. **Current work**
   c) Hold peer support groups for supervisors to practice using this tool and conduct peer reviews of cases. **Currently being held bi-monthly**
   d) Schedule and conduct refresher training as needed. **Current work**

5. **Improve local department staffs' abilities to conduct service needs assessments and develop relevant service plans.**
   a) Review SDM family strengths and needs assessment tools to ensure consistency with VA regulation and policy. **Completed**
   b) Obtain input from the CPS Policy Advisory Committee **Current work**
   c) Request assistance from the In-Home NRC to review current policy/guidance manual and recommend changes. **Current work**
   d) Revise on-going services section of CPS guidance to enhance and strengthen workers ability to assess and provide services to families by providing tools to support on-going assessment, risk reassessment and service planning for children and families' service needs
   e) Disseminate the revised policy/guidance manual.

6. **Develop and implement statewide training for CPS supervisors and workers on the use of new assessment of family strengths and needs, service plans and risk re-assessment tools**
   a) Develop training curriculum
   b) Select and train Trainers, to include CPS regional consultants and supervisors
   c) Develop statewide training schedule
   d) Train all CPS supervisors and workers on use of new policy/guidance

7. **Create requirements for OASIS screens to reflect new CPS service needs assessment and service plans**
   a) Utilize workgroup to review OASIS screens and make recommendations for

screen changes **Current work**

b) Outcome Based Reporting and Analysis Unit (OBRA) will review what is currently in OASIS and the workgroup recommendations and determine if current screens can be modified or if new screens must be created

c) OBRA and Family Services will meet to develop requisition to present to the Managing by Data workgroup (MBD) to approve screen changes.

d) OBRA and Family Services will meet with MBD prioritize timing for screen changes in OASIS

**8. Revise policy/guidance on conducting investigations in Out of Family Setting**

a) Establish a committee composed of local CPS workers and supervisors to review the current policy/guidance and identify areas needing revision or clarification**. Current work**

b) Request assistance from the NRC on CPS to review materials and make recommendations for changes

c) Solicit input from the Out of Family Advisory Committee to the State Board of Social Services

d) Revise policy/guidance manual and disseminate

**9. Develop and implement statewide training for CPS supervisors and workers on the revised policy on investigating CPS reports in Out-of-Family Settings**

a) Develop training curriculum

b) Select and train trainers, to include CPS regional consultants and supervisors

c) Develop statewide training schedule

d) Train all CPS supervisors and workers on use of new policy/guidance

**10. Review/enhance current policies and protocols on the handling of child deaths**

a) Work with the subcommittee of the State Board of Social Services to study the increase of child deaths to gain a better understanding of the factors surrounding those deaths **Ongoing**

b) Review cases of children who have been known to the child welfare system over the past several years to determine what lessons may be learned to prevent child deaths **Completed**

c) Request assistance from the In-Home NRC to assist in this review and make recommendations **Completed**

d) Explore the regional child fatality team operating in the Eastern Region and develop a plan to replicate it in the other four regions of the State. **Completed**

d) Review recommendations with subcommittee of the State Board of Social Services and the State Child Fatality Team and develop a plan to implement new practices, as appropriate **Completed**

***e) Work with the Office of the Chief Medical Examiner to implement five regional child fatality review teams***

***f) Provide technical assistance and consultation to teams in reviewing cases, making recommendations, and data collection***

***g) Prepare an annual report compiling findings and recommendations from the teams***

***h) Work with the Office of the Chief Medical Examiner to plan and co-sponsor a conference for regional child fatality team members***

**11. Examine the current trends in CPS appeals to determine if ldss are clearly interpreting CPS policies and procedures, providing consistent information to appellants, and adequately documenting their case decisions.**

a) Establish a committee of representatives from the League of Social Services Executives, State Board members, and other Department staff to identify and review the trends to determine the number of decisions that are being sustained, amended or overturned by type of abuse and neglect, in-home or out-of-family setting, and locality. **Completed**

b) Review and evaluate findings from the committee and revise/clarify policy/guidance manual, as appropriate **Quarterly updates**

c) Review and revise Appeal Handbooks, if needed

d) Develop training materials and/or provide consultation to ldss to support their practice in this area **Completed**

**12. Enhance the effectiveness and efficiency of the State Child Abuse and Neglect Hotline**

a) Review the current schedule and revise to accommodate the incoming calls to ensure that the most adequate coverage is available

b) Train the Hotline staff on the new intake, safety and risk assessment tools to ensure a family-focused, and strength–based approach to responding to calls of suspected child abuse and neglect **Completed**

c) Ensure that the Hotline phone number is published in all directories across the Commonwealth. **Completed**

**13. Develop a method to track recurrence in Family Assessment cases**

a) Develop a method of tracking recurrence in Family Assessment cases.

b) Develop a report that monitors repeat reports of cases that received a Family Assessment response.

c) Disseminate reports to ldss, CPS regional consultants to review and make recommendations for program changes, if needed.

d) Provide consultation to ldss, revise policy/guidance manual, if needed.

***14. Develop, facilitate, and conduct training for mandated reporters***

*a) Update the online training curriculum for mandated reporters incorporating the changes made by the 2012 Virginia General Assembly including additional people as mandated reporters, increased penalties for failure to report especially in cases of rape, sodomy, and object penetration, and other pertinent requirements*

*b) Review and revise all printed materials including brochures and the Mandated Reporter Booklet to reflect the Code changes*

*c) Develop and implement a plan to inform persons required to report suspected cases of child abuse and neglect of these responsibilities*

***15. Revise CPS regulations and policy/guidance manual to reflect changes related to the reporting of substance exposed infants***

*a) Review and revise CPS regulation 22 VAC40-705 to reflect changes related to the reporting by health care providers of infants born with Fetal Alcohol Spectrum Disorder and the revised time frames*

*b) Review and revise CPS policy/guidance manual to reflect changes related to the reporting by health care providers of infants born with Fetal Alcohol Spectrum Disorder and the revised time frames*

*c) Provide training to local CPS supervisors and workers on the changes*

*d) Work with health care providers and substance abuse treatment providers to inform them of the changes*

*e) Revise brochure for health care providers on the reporting of substance exposed newborns*

# II. Family, Child and Youth-Driven Practice

This strategy fulfills the mission of transforming how services are delivered by giving a stronger voice to children and families in decision-making. The state practice model enables families to actively engage with child welfare staff and other important stakeholders in facilitated meetings to collaborate on the key decisions *(such as placement or moves)* that affect a child's life. Through collaboration, the practice model is achieved according to individual circumstances while empowering families to participate in the process.

- **Applicable CAPTA program areas as described in section 106(a):**
  6. Developing, strengthening, and facilitating training including – training regarding research-based strategies, including the use of differential response, to promote collaboration with families; 11. Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level

## Goal: Engage Families in Decision Making Using a Strength-Based, Child-Centered, Family-Focused and Culturally Competent Approach

1. **Develop and implement a plan for sustaining and supporting a consistent statewide approach to family engagement and kinship care**

   a) Train selected service providers and state/regional staff on strategies for engagement on a regional basis. **Completed**

   b) Implement a plan for regional staff to provide training and technical assistance to ldss on family engagement strategies **Completed**

   c) Survey selected programs to determine the level of change in involvement and recommendations for improvements. **Completed**

   d) Explore the use of CAPTA funds to ldss to support Family Partnership meetings **Completed**

**2. Examine and amend CPS guidance to determine revisions required to support subsidized custody and connections to relatives**

a) Review guidance around identification and notification of relatives within 30 days of removal and the process to inform them of the right to participate in the care of the child **Completed**

b) Support state collaborations that focus on increasing awareness and training of kin *(relatives)* as valuable resources in creating permanency options for children who cannot live with their birth parents. **Completed**

c) Increase local capacity for locating absent parents, siblings, other relatives and significant others to engage them in service delivery and establishing permanent, life-long connections by providing the use of Accurint, a web-based search engine that will be available statewide. **Completed**

**3. Enhance the current CPS Differential Response System *(DRS)* Practice Model to ensure a more family-focused and family-driven approach**

d) Incorporate the Children's Services Practice Model into the CPS DRS Family Assessment Track. **Completed**

e) Revise and align the CPS policy and guidance manual consistent with family engagement philosophy, procedures and practices. **Completed**

f) Develop and/or contract for the development of training for local CPS workers in implementing the Family Engagement Model when conducting Family Assessments.

***4. Work collaboratively with the Prevention Unit to develop guidance for local departments of social services around kinship care diversion and early prevention strategies***

***a) Serve on Prevention Committee to develop guidance manual on kinship care diversion and early prevention strategies***

***b) Collaborate on the development of a common service plan for use by local agency staff***

***c) Develop and conduct training for local dss staff as needed***

## III. Strengthening Community Services and Supports

These strategies contribute to developing an accessible array of community-based services across the Commonwealth. This strategy addresses the nature, scope, and adequacy of existing child and family and related services. This approach, which includes wraparound services when indicated, reduces the need for more intensive levels of service such as residential care – and shortens length of stay when placement is required. It contributes to the well-being of children and families.

- **Applicable CAPTA program areas as described in section 106(a):**

3. Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families; developing, facilitating the use of, and implementing research-based strategies and training protocols for individuals mandated to report child abuse and neglect; 10. Developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect, including the use of differential response; 13. Supporting and enhancing interagency collaboration among public health agencies in the child protective service system, and agencies carrying out private community-based programs – to provide child abuse and neglect prevention and treatment services (including linkages with education systems), and the use of differential response; and to address the health needs, including mental health needs, of children identified as victims of child abuse or neglect, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports

## Goal: Expand Community Services and Supports that are Child-Centered, Family-Focused and Culturally Relevant.

**2. Expand services to prevent and treat child abuse and neglect through supporting and advocating for interdisciplinary resources.**

c) Utilize child abuse and neglect prevention funds to support evidenced-informed and evidenced-based programs and practices. **Ongoing**

**d)** Utilize child abuse and neglect treatment funds for support services to child victims. **Ongoing**

e) Develop Request for Proposals, select and negotiate contracts, monitor grantees and evaluate performance for programs such as Healthy Families, parent support groups, parent education programs, Child Advocacy Centers, Court Appointed Special Advocates (CASA), etc. **Ongoing**

f) Work with the Outcome Based Reporting and Analysis Unit to develop stronger performance-based contracts.

**2. Collaborate with state and local stakeholders on developing and strengthening services that preserve families, achieve permanency, and promote child health, safety and well being.**

**c)** Participate on state level inter- and intra-agency workgroups tasked with coordinating service and program initiatives such as the Governor's Advisory Board on Child Abuse and Neglect; the Children's Justice Act/CASA Advisory Committee; and the State Child Fatality Team. **Ongoing**

d) Develop and provide educational materials to inform key stakeholders on effective strategies *(e.g., mandated reporters and the general public on child abuse and neglect; kinship care providers; judges)*. **Ongoing**

e) Participate in the Statewide Home Visiting Consortium that operates as part of Virginia's Early Childhood Initiative to increase local and state collaborative efforts around home visiting programs. **Ongoing**

**f)** Evaluate and renew contracts for performances of sexual abuse prevention play to be presented to school-aged children statewide **Ongoing**

**g)** Evaluate and renew contract with James Madison University for the publication of the Virginia Child Protection Newsletter **Ongoing**

h) Review and revise the Interagency Agreement with the VA Department of Education and disseminate to all ldss' and public school divisions

i) Participate on the Virginia Interagency Coordinating Council to collaborate on the implementation of Part C of IDEA including public awareness efforts, child find, data collection and training. **Ongoing**

**j)** Participate on the Partnership for People with Disabilities, Child Abuse and Neglect Collaborative to evaluate the current training and develop and implement training sessions for the coming year. **Ongoing**

k) Continue to collaborate with the Department of Criminal Justice Services in the Child First forensic training program by providing scholarships for local CPS workers and supervisors to participate in the training. **Ongoing**

## CAPTA Plan Description as required by section 106(b)(2)(D)

### 1) Services to be provided under the grant to individuals, families, or communities, either directly or through referrals aimed at preventing the occurrences of child abuse and neglect

The Code of Virginia, §§ 63.2-1505 and 63.2-1506 provides statutory authority to provide or arrange for services to families at the conclusion of a family assessment or investigation. 22VAC40-705, the CPS regulations, states: *"At the completion of a family assessment or investigation, the local department shall consult with the family to provide or arrange for necessary protective and rehabilitative services to be provided to the child and his family to the extent funding is available pursuant to §§ 63.2-1505 and 63.2-1506 of the Code of Virginia."* According to CPS policy: *"When the local department completes a CPS family assessment or investigation and the risk of future maltreatment is high or moderate, the identified and needed services to reduce risk should be made available to the child and his family. The identification and provision of services may also be provided to the family during the family assessment or investigation…The local department shall provide CPS services either directly or by purchase, without regard to income for a child, parent or guardian, and alleged abuser or neglector when the local department documents that other resources are not available to cover the cost of service. All service needs must be documented in the service plan and it must be documented that these services are to prevent further child abuse or neglect or to prevent placement of the child outside of the family."*

Many of the objectives under Strengthening Community Services and Supports expand community services and supports that are child-centered, family-focused and culturally relevant and address the services to be provided to individuals, families and communities. In conjunction with the Community-Based Child Abuse Prevention grant and the Victims of Crime Act grant, some of these

services include fatherhood mentoring, parent education services such as Parents as Teachers, Nurturing Parenting Programs, Systematic Training for Effective Parenting (S.T.E.P.), home visiting services such as Healthy Families and CHIP, parent support groups such as Circle of Parents, performances of a sexual abuse prevention play, "Hugs & Kisses" performed throughout the state in elementary schools, counseling for children who are victims of child abuse or who have witnessed domestic violence, mental health counseling, CASA, emergency shelter, short term crisis counseling and support, advocacy services for child victims, family partnership meetings, the use of Accurint, and counseling for adult victims molested as children. The Department also supports the 17 Child Advocacy Centers across the State.

**2. Training to be provided under the grant to support direct line and supervisory personnel in report taking, screening, assessment, decision making, and referral for investigating suspected instances of child abuse and neglect.**

A great deal of training for direct line and supervisory personnel in report taking, screening, assessment, decision making, and referral for investigating suspected instances of child abuse and neglect was implemented in May through September 2011. It is outlined under Safe Children and Stable Families. Fifty, two-day sessions on CPS intake, safety and risk assessment have taken place in May – July 2011 across the State using the Structured Decision Making (SDM) tools and model. State CPS staff and local supervisory staff were paired to conduct this training. An additional 15 one-day sessions designed for those staff performing on-call functions was held July – September 2011 across the State. Two, one-day sessions for all State Hotline staff on the screening and intake functions took place on June 22 and 23, 2011. Refresher training and other ways to help support staff and sustain the practice change are currently taking place and refresher training is being planned. In addition, the State Board of Social Services has required that all workers who perform on-call functions require the same mandated policy training as CPS workers. This requirement will become effective July 1, 2012.

In year two or three of this plan, statewide training will be planned and implemented for those workers who conduct Out-of-Family investigations. CPS policy/guidance will be revised and enhanced to strengthen practice in this area.

In year three or four of this plan, local supervisory staff and direct line workers will be trained in conducting service needs assessments and in developing service plans using the SDM tools for assessing family strengths and needs and in re-assessing risk. CPS policy/guidance will be revised and enhanced to strengthen practice in this area.

**3. Training to be provided under the grant for individuals who are required to report suspected cases of child abuse and neglect**

The Virginia Department of Social Services (VDSS) regularly receives requests from individuals and groups to train those professionals who are mandated to report suspected cases of child abuse and neglect. Requests for training come routinely from CASA volunteers, school teachers, nurses, emergency medical technicians, mediators, medical assistance services, etc.

This year the Virginia General Assembly passed legislation adding additional persons to the list of mandated reporter, as well as increased penalties for failure to report especially cases of rape, sodomy, or object penetration. In addition, changes were made to the Virginia Code sections related to the reporting of substance exposed newborns to include Fetal Alcohol Spectrum Disorders and the time frames for reporting. VDSS will be developing a plan to inform others of these responsibilities and to update the training courses and written materials listed below.

VDSS has three online training courses – one specifically for teachers, one specifically for eligibility/benefit workers and another more generic course for all other mandated reporters. These courses focus on understanding the role and responsibilities of a mandated reporter, defining the types of child abuse and neglect including definitions, recognizing the indicators of abuse and neglect, determining the appropriate responses to disclosure of abuse and neglect, following procedures for reporting suspected child abuse and neglect, knowing what information is needed by CPS when making a report, and knowing what to expect from CPS after a report is made.
http://www.vcu.edu/vissta/training/va_teacher
http://www.vcu.edu/vissta/non_vdss_employees/courses_for_non_vdss_employees.htm
http://www.dss.virginia.gov/files/division/dfs/cps/intro_page/mandated_reporters/resources_guidance/overview_resources.pdf

There is also a written booklet, A Guide for Mandated Reporters in Recognizing and Reporting Child Abuse and Neglect.
http://www.dss.virginia.gov/files/division/dfs/cps/intro_page/mandated_reporters/resources_guidance/booklet.pdf

**4. Policies and procedures encouraging the appropriate involvement of families in decision-making pertaining to children who experienced child abuse and neglect.**

Several objectives under Section 2: Family, Child and Youth-Driven Practice; the goal of Engage Families in Decision Making Using a Strength-Based, Child-Centered, Family-Focused and Culturally Competent Approach address the involvement of families in decision making. VDSS has implemented a Family Engagement Model in all 120 local departments of social services. The model is a relationship focused approach that provides structure for decision making that empowers both family and the community in the decision making process. Family partnership meetings (FPM) improve the decision making process by including a variety of professional staff, family, extended family, and community members in the decision making process. FPMs help the agency develop and sustain more consistent and accountable practices when placement is being considered, helping to assure that only those children who need to be placed are placed, and ensuring that reasonable efforts to prevent placement are made in every case. By connecting families to natural supports within their own neighborhoods, family engagement often contributes to the development of long term community safety nets for families at risk. The process also nurtures growing partnerships between public child protection systems and the neighborhood-based entities. Local departments of social services were required to implement FPMs in at least one of the five decision points: all high or very high risk cases, after emergency or when considering removal, prior to change of placement, prior to change of goal, and at the request of the parent (birth, foster, adoptive, legal guardian) or social worker by December 2010. Technical assistance and consultation is being provided to the localities to support this new practice and to continue to expand the practice throughout the child welfare

continuum. VDSS has created a report in Safe Measures to assess and document that local departments are conducting FPMs and FPS Incentive funds are being allocated to localities based on this documentation. Link to the VDSS Family Engagement manual: http://www.dss.virginia.gov/files/division/dfs/fe/manual/manual.pdf

**5. Policies and procedures that promote and enhance appropriate collaboration among child protective service agencies, domestic violence service agencies, substance abuse treatment agencies, and other agencies in investigation, intervention, and the delivery of services and treatment provided to children and families affected by child abuse or neglect, including children exposed to domestic violence, where appropriate.**

Fundamental to the CPS Program is the belief that through increased collaboration across child-serving agencies, the system can improve, children and families can be better served through existing resources, and the quality of outcomes will improve. There has been a significant increase in opportunities for stakeholder collaboration and communication regarding child welfare issues and service delivery.

The Governor's Advisory Board on Child Abuse and Neglect (GAB) was established in the *Code of Virginia*, Section 63.2-1528 to advise the Department of Social Services, Board of Social Services, and the Governor on all matters concerning the prevention of child abuse and neglect and treatment of abused and neglected children and their families. The Board is composed of nine citizen members appointed by the Governor, and representatives from the Departments of Social Services; Education; Health, Behavioral Health and Developmental Services; Criminal Justice Services, Juvenile Justice; and the Office of the Attorney General. While the Board will be consolidated into the Family and Children's Trust Fund (FACT) Board effective July 1, 2012, it is expected that a standing committee of the FACT Board will be established to carry out the responsibilities of the GAB and to serve as one of the Citizen Review Panels. 'This is an excellent forum for collaboration among the agencies serving abused and neglected children.

The Office of Family Violence Action Team works to promote and enhance collaboration between child protection agencies and domestic violence service agencies. Issues around roles and responsibilities, identification and reporting of suspected child abuse and neglect, and the need for specialized services for children who have witnessed domestic violence are issues being addressed by this work team.

The State Level Medical/Legal Forensic Workgroup is a multidisciplinary workgroup that focuses on improving the medical response to child abuse. The workgroup promotes stakeholder and general community recognition of child physical and sexual abuse. Most recently the workgroup developed a poster about these issues for distribution in hospital emergency rooms across Virginia. The workgroup also developed a power point training presentation for educating pediatric practitioners on suspected child abuse and neglect.

The Statewide Home Visiting Consortium operates as part of Virginia's Early Childhood Initiative to increase local and state collaborative efforts and to increase the efficiency and effectiveness of home visiting services. The Consortium is chaired by the Virginia Department

of Health (VDH). VDSS has a Memorandum of Understanding with VDH and has provided CAPTA funding to support the work, such as training for home visitors.

**6. Policies and procedures regarding the use of differential response, as applicable**.

The Department implemented a Differential Response System statewide in 2002. The *Code of Virginia*, section 63.2-1504 states that the Department shall implement a child protective services differential response system in all local departments. The differential response system allows local departments to respond to valid reports or complaints of child abuse or neglect by conducting either an investigation or a family assessment. The *Code of Virginia*, section 63.2-1506, addresses the use of a Family Assessment response. A number of factors can influence track decision. Certain situations, listed below must be investigated. 22VAC40-705 states: *"…Any valid report may be investigated, but in accordance with 63.2-1506(C) of the Code of Virginia, the following shall be investigated: (i) sexual abuse, (ii) child fatality, (iii) abuse or neglect resulting in a serious injury as defined in §18.2-371.1, (iv) child has been taken into the custody of the local department of social services, or (v) cases involving a caretaker at a state-licensed child daycare center, religiously exempt child day center, regulated family day home, private or public school, or hospital or any institution."* When an investigation is not mandated, the choice of the family assessment track is predicated on immediate concerns about the child's safety and the perception of the ability of the LDSS to work with the family and community service provides. The CPS policy/guidance manual outlines the procedures for making these track decisions and requirements as well as case work practices for each track. Approximately 67% of the reports statewide are handled as a Family Assessment. Link to the CPS manual: http://www.dss.virginia.gov/files/division/dfs/cps/intro_page/manuals/07-2010/manualtoc.pdf

## CAPTA Annual State Data Report

**Juvenile Justice Transfers**

Through the OASIS data system, Virginia tracks reasons why children exit foster care. For SFY 201, 42 children left foster care due to a commitment to corrections.

Defining when a child should be considered to have left foster care to the custody of DJJ was clarified in Foster Care Guidance. When the child's commitment to corrections terminates, Virginia Code specifies that for youth under 18 who were previously in foster care, they are to be returned to foster care unless another arrangement has been made (e.g., return to the parent).

**Information on Child Protective Workforce**

**Education, qualifications, and training requirements established by the State:** VDSS does not current collect demographic information, education, qualifications, or training requirements on local department workers. Virginia is a state supervised, locally administered system for social services. Because localities are responsible for hiring CPS workers, there are no education, qualification, and training requirements established by the State. The state's human resources department has occupational title descriptions for social work professionals that can be modified by local departments including Social Worker Program Manager, Social Work Supervisor, and Social

Worker I-IV. Each title description include the level of supervision suggested for each level and upon completion of a training program or other requirements the person may be redefined to a higher level social worker. There is an educational and experience section of the title description that states: "Minimum of a Bachelor's degree in a Human Services field or minimum of a Bachelor's degree in any field with a minimum of two years of appropriate and related experience in a Human Services area as mandated in Section 22VAC40-670-20 of the Administrative Code of Virginia and implemented by the Virginia Board of Social Services. Possession of a BSW or MSW degree and a Commonwealth of Virginia Social Worker license are desirable."

**CPS case loads:** Using 2010 NCANDS data, there were 380 Investigative CPS workers in Virginia. There were 32,566 completed reports which average out to 86 reports per worker. Virginia is comprised of 120 local departments that range in size. The Division of Family Services has created a report to record active caseloads of all local department child welfare workers and another report that records referrals. The attachment Active Caseload SFY 2012 2nd Qtr.xlsx (CPS referrals and cases tab) lists the number of cases, the number of workers, and the caseload for both ongoing cases and referrals. This report counts any worker that was assigned to a child at any given so the count may be inflated.

**CPS required training:** All CPS workers in the state are mandated to complete skills and policy training within the first year of employment. Since 1996 Virginia has had regulations addressing CPS training.

22 VAC 40-705-180 mandates uniform training requirements for CPS workers and supervisors:

"*The department shall implement a uniform training plan for child protective services workers. The plan shall establish minimum standards for all child protective services workers in the Commonwealth of Virginia*."

22 VAC 40-705-180 (B) requires CPS workers to complete training within their first year.

"*Workers shall complete skills and policy training specific to child abuse and neglect investigations within the first year of their employment*."

Within the first three months of their employment, CPS staff who provide responses to reports of abuse of neglect or manage/supervise any CPS investigation or family assessment, shall complete the VISSTA Course CWS 2000 Child Protective Services New Worker Policy training. In addition during their first year, new CPS workers must complete the following mandatory courses offered by VCU-VISSTA:

- VISSTA Course CWS 2011 Intake, Assessment and Investigation in Child Protective Services
- VISSTA Course CWS 2021 Sexual Abuse
- VISSTA Course CWS 2031 Sexual Abuse Investigations

CPS staff are also required to complete the mandatory course, VISSTA CWS 2010 Ongoing Services in Child Protective Services.

The following courses shall be completed by all CPS workers within two years of the start of employment:

- VISSTA Course CWS 5305 Advanced Interviewing: Motivating Families for Change
- VISSTA Course DWS 1001 Understanding Domestic Violence OR
- VISSTA Course DWS 1031 Domestic Violence and its Impact on Children pursuant to 63.2-150 of the Code of Virginia.
- VISSTA Course CWS2141 Out of Family Investigations – if conducting designated out of family investigations pursuant to 22 VAC40-730-130.

CPS policy further requires that all CPS workers complete the following VCU-VISSTA courses within two years of employment if a specific need is assessed by the worker and supervisor. Even when a specific need is not identified, VDSS encourages workers to complete the following courses:

- VISSTA Course CWS 1001 Exploring Child Welfare
- VISSTA Course CWS 1011 Casework Process & Case Planning Child Welfare
- VISSTA Course CWS 1021 Effects of Abuse & Neglect on Child and Adolescent Development
- VISSTA Course CWS 1031 Separation and Loss Issues in Human Service
- VISSTA Course CWS 1051 Crisis Intervention
- VISSTA Course CWS 5011 Case Documentation
- VISSTA Course CWS 53037 Assessing Safety, Risk and Protective Capacities in Child Welfare
- VISSTA Course CWS 5701 Child Welfare Supervision

# Health Care Services

The Virginia Health Plan Advisory Committee (HPAC) advises and makes recommendations to VDSS and DMAS on improving health outcomes for children in, and at risk of, foster care across the Commonwealth. The committee ensures that children receive appropriate services to meet their physical and behavioral health needs. The committee provides ongoing oversight and coordination of health care services. It helps articulate the vision, determine effective strategies, make decisions, and follow through to ensure the health needs of children in the foster care system are met.

HPAC is now co-chaired by VDSS and the Virginia Department of Medical Assistance Services (DMAS). New members include:

- Representatives from managed care organizations.
- Director of Training and Professional Development for Child Savers, a nonprofit organization providing 24/7 immediate response and trauma counseling services for children exposed to violence and other traumatic events.
- VDSS staff person with policy and practice expertise with children who have experienced trauma.

Virginia's Health Care Oversight and Coordination Plan addresses the following federal requirements as described below:

1. **Schedule for initial and follow-up health screenings** that meet reasonable standards of medical practice. Include how children are screened and the tools used to assess for signs of trauma.

Virginia utilizes multiple health screenings, including: Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings, developmental screenings, dental screenings, behavioral health assessments and substance abuse assessments; safety and family assessments; and functional assessments including a trauma module. These screenings are described below.

**ESPST screenings:** The Foster Care Chapter of the DFS Child and Family Services Manual requires that service workers ensure that children in foster care receive a medical examination, through the EPSDT program, no later than 60 days after placement, commitment or entrustment. (Draft permanency regulations under review by the Governor's Office require medical examination no later than 30 days after entry into foster care.)

EPSDT screenings shall occur at regular intervals in accordance with the EPSDT Periodicity Table. DMAS follows the American Academy of Pediatrics (AAP) and Bright Futures guidelines to develop the schedule. Physicians or certified nurse practitioners conduct the required periodic screens.

EPSDT screening services require:

- A comprehensive unclothed physical examination annually.
- Patient and family medical history annually including identifying risk factors for health and mental health status.
- Developmental screening administered at the 9, 18, 24, and 30 month visits or at any time when developmental surveillance indicates a risk for developmental delay
- Preventive laboratory services, including mandatory lead testing at 12 months and 24 months. If no prior history of lead testing, mandated testing at ages 3 through 6 years.
- Age appropriate immunizations according to the American Committee on Immunization Practice (ACIP) schedule.
- Vision screens administered at the 3, 4, 5, 6, 8, 10, 12, 15, and 18 year visit.
- Hearing screens administered at the newborn, 4, 5, 6, 8, and 10 year visits.

- Psychosocial/Behavioral Assessment based on AAP Recommendations for Preventive Pediatric Health Care.
- Referral to dentist for assessing oral risks at 12, 24, and 30 months. Referral for dental services at 3 and 6 years. Dental exams provided every 6 months.
- Age appropriate anticipatory guidance/health counseling.
- Referrals for medically necessary health and mental health treatment

Unscheduled check-up or problem focused assessment can occur at any time because of illness or a change in condition. Any caregiver or professional who interacts with the child may request the screening. The need for specialist referral or specialized treatment services must be documented by a physician.

**EPSDT developmental surveillance and screenings.** Developmental surveillance should be conducted at each well-child visit. Developmental surveillance is the process of recognizing children who may be at risk of developmental delays. Surveillance is longitudinal, continuous, and cumulative and is comprised of the following components: parental concerns; developmental history; observation of the child; identification of risk and protective factors; and accurately documenting the process and findings.

If at any time developmental surveillance demonstrates a risk for developmental delay, a standardized screening tool should be administered to further assess the child. As recommended by the AAP, developmental screening using a standardized screening tool should occur at 9, 18, 24 and 30 months of age or at any time when surveillance indicates a risk for developmental delay. An autism specific screening is recommended at the 18 and 24 month visit. Children should be screened for developmental concerns at least 5 times while they are younger than three years of age.

State recommended Developmental Screening Tools:

- Parents' Evaluation of Developmental Status (PEDS) - Parent-report instrument used to identify general developmental delay in the general primary care population
- Ages and Stages Questionnaire (ASQ) - Parent-report instrument used to identify general developmental delay in the general primary care population and/or broad high-risk population
- Bayley Infant Neurodevelopmental Screen (BINS) - Practitioner-administered instrument used to identify general developmental delay in the high-risk population

State recommended tools for focused screening for suspected health conditions:

- Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS) - practitioner-administered instrument used to identify general developmental delay in the high-risk population.
- Language Development Survey (LDS) - a parent-report instrument used to identify language delay in the general primary care population.
- Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS) - practitioner-administered instrument used to identify language delay in the high-risk population.
- Modified Checklist for Autism in Toddlers (M-CHAT) - parent-administered instrument used to screen for autism and developmental delay in the general primary care population.

**EPSDT dental screens.** Children in foster care are members of the Smiles For Children program which is designed to improve access to quality dental services for Medicaid and CHIP children across the Commonwealth. DentaQuest is the single dental benefits administrator responsible for coordinating the delivery of all Smiles For Children dental services.

Covered services are defined as any medically necessary diagnostic, preventive, restorative, and surgical procedures, as well as orthodontic procedures, administered by, or under the direct supervision of a dentist.

DMAS has Periodicity and Anticipatory Guidance Recommendations for Preventive Pediatric Dental Care for children ages 0 through 18 based on guidelines by the American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA) and American Academy of Periodontology. They include: oral hygiene counseling; injury, prevention counseling; dietary counseling; counseling for non-nutritive habits; fluoride supplementation; assess oral growth and development; clinical oral exam; prophylaxis and topical fluoride treatment; radiographic assessment; pit and fissure sealants; treatment of dental disease; assessment and treatment of developing malocclusion; substance abuse counseling; assessment and/or removal of third molars; referral for regular periodic dental care; and anticipatory guidance.

**Behavioral health assessments.** In the provision of children's Community Mental Health Rehabilitative Services, DMAS requires an independent assessment contracted through the Community Service Boards (CSBs). DMAS requires an independent assessment contracted through the Community Service Boards (CSBs). DMAS and the CSBs collaboratively developed an assessment form to assist with evaluations of the clinical necessity for children's mental health services. The objectives of the independent clinical assessment are to improve the care of children who are accessing mental health services, ensure appropriate utilization of services, measure outcomes, and increase the cost effectiveness of services provided. Standardized clinical assessments are performed by Licensed Mental Health Professionals. The DMAS Service Authorization Contractor continues to review treatment requests as an additional level of review to ensure the "right care at the right time by the right provider" for the child. The process helps inform and empower parents and legal guardians to understand service options and to promote their freedom of choice of qualified providers. The independent assessment provides opportunity to coordinate linkages between the primary care system, the health plans, and the behavioral health care delivery system to address comprehensive needs of the child.

**Substance abuse assessments.** When youth in foster care have substance abuse issues, the child may be screened by any physician and may be referred to the community services board or private providers for further assessment and treatment.

Three tools used by physicians for substance abuse screening across the state include:

- The Alcohol Use Disorders Identification Test (AUDIT) - a screening tool developed by the World Health Organization (WHO) to identify excessive drinking and to assist in brief assessment. The tool can help in identifying excessive drinking as the cause of the presenting illness and provides a framework for intervention to help hazardous and harmful drinkers reduce or cease alcohol consumption.
- The Drug Abuse Screening Test (DAST) – this tool was developed in 1982. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid psychometric properties" and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol."
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) - SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. The screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to

treatment provides those identified as needing more extensive treatment with access to specialty care.

Three tools most often used by community services boards across the state include the following, which are administered by individuals who have received special training in the assessment:

- The Global Appraisal of Individual Needs (GAIN) - a comprehensive biopsychosocial assessment tool. It has eight core sections: background, substance use, physical health, risk behaviors and disease prevention, mental and emotional health, environment and living situation, legal, and vocational. Each section contains questions on the recency of problems, breadth of symptoms, and recent prevalence as well as lifetime service utilization, recency of utilization, and frequency of recent utilization.
- The Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2) - used with youth ages 12 - 18 years. It has a section on special clinical issues, such as: social system impact on substance use; attitudes toward substance use; level of acknowledgement; emotional pain; risk of acting-out behavior; and substance dependence vs abuse.
- The Teen Addiction Severity Index (T-ASI) - an instrument for periodic and age-appropriate evaluation of adolescent substance abuse. The instrument gathers information about seven domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status, and psychiatric status. It is useful for adolescents with psychoactive substance use disorder, adolescents with psychiatric disorders and comorbid psychoactive substance use disorders

**Safety and family assessments.** The Code of Virginia (§ 63.2-1506 B3) requires the LDSS to complete and document the family assessment and investigation within 45 calendar days of receipt of the complaint or report. This time frame can be extended for 15 calendar days upon written justification by the LDSS, based on locally determined guidelines. In both family assessments and investigations the child protective services worker shall conduct an initial assessment of the child's circumstances and threat of danger or harm, and where appropriate shall make a safety plan to provide for the protection of the child (22 VAC 40-705-110 A).

The CPS Chapter of the DFS Child and Family Services Manual requires:

- **An initial safety assessment** conducted to:
  - Assess whether any children are currently in immediate danger of serious physical harm that may require a protecting intervention.
  - Determine what interventions should be maintained or initiated to provide appropriate protection.

    The LDSS must complete the process within 24 hours of the first meaningful contact with the family and any time safety changes. Results are documented in the CPS Safety Assessment Tool in the automated data system within 3 working days. This tool provides structured questions concerning the danger of immediate harm or maltreatment to a child. This information guides the decision about whether the child may remain in the home with no intervention, may remain in the home with safety interventions in place, or must be removed from the home.

    Two family issues that can have a major impact on safety and risk are domestic violence and drug and/or alcohol involvement by the child's caretakers.
  - The Domestic Violence INITIAL ASSESSMENT tool may be given to the caretaker to complete or the questions may be asked by the CPS worker. A "yes" answer to these questions may mean the CPS worker should make a referral to a community domestic violence service provider for a more complete assessment of need.

        - The CAGEAID tool is one tool that provides questions that can be worked into the interviews with the primary caretakers, and a "yes" to any question may indicate a need for an AOD (alcohol or other drug) evaluation in order to complete the risk assessment.
- **A Family Risk Assessment** must be completed in a family assessment to determine the likelihood of any occurrence or recurrence of abuse or neglect. This tool does not predict recurrence but assesses whether a family is more or less likely to have an incident of abuse or neglect without intervention by the agency. The Family Risk Assessment is completed based on conditions that exist at the time the incident is reported and investigated as well as prior history of the family.

The Foster Care Chapter of the DFS Child and Family Services Manual describes:

- **Structured Decision Making (SDM)** as a process that uses a set of research and evidence-based assessment tools to help service workers make appropriate decisions at key stages in the child welfare process. The primary goals of SDM are to reduce subsequent harm to children and to expedite permanency for children in out of home care. When partnered with clinical judgment and supervision, these assessments are designed to increase the consistency of service worker decisions and improve the validity of those decisions, thereby better protecting children from harm and providing permanency. SDM tools are used with all CPS investigations in Virginia.
    - The Family Strengths and Needs Assessment (FSNA) ensures that there is consistency in the assessment of caretakers and children across critical domains of functioning. There are ten domains of individual functioning for the caretaker and nine domains in the child assessment area. The FSNA identifies strengths as well as needs and prioritizes needs. The service worker completes the FSNA within 30 days of case assignment. The worker should involve the family in the discussion and identification of strengths and needs.
    - The Family Reunification Review is designed to systematically evaluate each foster care case in an effort to reduce the time to achieve permanency. The assessment tool is designed to assist in achieving reunification when it is safe to do so. The reunification review takes into account risk level to the child and the likelihood of future maltreatment; the connections between the parents and the children; and the safety of the home. Once risk, visitation and safety have been assessed, there are 3 possible decisions: return home, continue with foster care plan or change permanency plan goal.

**<u>Functional Assessment</u>**

- **Child and Adolescent Needs and Strengths (CANS)** is the mandated assessment tool for every child age 0-18 years prior to receiving services through the Comprehensive Services Act for At-Risk Youth and Families *(CSA)*. Most children in foster care receive at least one service through CSA. LDSS referred 7,894 children to CSA for services during the first three quarters of state fiscal year 2012 *(July 1, 2011 through March 31, 2012).* These children were either in, or at risk of, foster care placement.

The assessment addresses the strengths and needs of the child in the following areas: life domain functioning; child strengths; school; child behavioral/emotional needs; and child risk behaviors. It also identifies the strengths and needs of the family or caregiver, the current caregiver, the permanency planning caregiver, and the residential treatment center. Additional modules are available to assess specific situations, including: developmental needs; trauma; substance use needs; and violence needs; sexually aggressive behavior needs; runaway needs; juvenile justice needs; and fire setting needs.
If the CANS shows a child or youth requires in-depth assessments, including assessments for any health and behavioral health needs, the FAPT refers the child or youth for these subsequent assessments.

**The trauma module** addresses the characteristics of the traumatic experience, including sexual abuse, physical abuse, emotional abuse, medical trauma, natural disaster, witness to domestic violence, witness to community violence, and witness/victim to criminal activity. If the child has experienced one episode of sexual abuse or there is a suspicion that the child has experienced sexual abuse, another module is completed that includes: emotional closeness to perpetrator, frequency of abuse, duration, physical force, and reaction to disclosure. In assessing the child's behavioral and emotional needs, the service worker assesses the child's adjustment to trauma.

Every child receiving CSA funds shall initially receive a comprehensive CANS assessment, with reassessments determined based on the needs of the child and family and the intensity of services provided as described below. A comprehensive assessment is required annually and when the child is discharged from CSA.

- If the child is solely receiving basic foster care maintenance, including day care, a reassessment is a local option based on the needs of the child and family.
- If the child is receiving solely non-clinical community-based services such as mentoring or job coaching in his/her home, relative home, regular foster home or independent living arrangement, a reassessment is done every six months or more frequently based on the needs of the child and family.
- If the child is receiving, or may need, clinical services such as substance abuse treatment, sexual offender treatment, anger management and/or a combination of two or more services such as provision of a parent aide, respite, after school programs, a reassessment is done every ninety days or more frequently based on the needs of the child and family.
- If the child is receiving, or may need, intensive in-home services, therapeutic foster care, or residential care, a reassessment is done every ninety days or more frequently based on the needs of the child and family.
- If the child makes, or may need, a significant service change (i.e., either moving into or out of therapeutic foster care, or residential care), then a reassessment is done ideally before the service change is made.

The Foster Care Chapter includes a new **Full Disclosure of Child Information Form** for service workers to complete that summarizes all known and relevant information on the background and needs of the child and information about the child's birth family without revealing the identity of the family. This form also gathers information on potentially traumatic events experienced by the child. For example, some items are listed below. Some items capture strengths and resiliency factors which are not listed below.

- Birth information:
  - Birth weight.
  - Apgar scores.
  - Significant details of birth.
  - Type of delivery (e.g., delivery complications, tests administered and results, prenatal exposure to chemicals or sexually transmitted diseases).
- Developmental information:
  - Early attachment (include formal attachment assessments).
  - Developmental milestones (e.g., when child first crawled, walked, talked)
  - Current level of developmental functioning, including any delays.
- Critical events in child's life:
  - Trauma, separation, loss.
  - Significant family issues impacting child.
  - Living arrangements history prior to foster care experiences.
- Medical information:
  - Current physical/medical problems/conditions (summarize problem, treatment, prognosis).

- Significant medical history, including childhood diseases, medical conditions, hospitalizations, surgeries.

- Behavioral/emotional information:
  - Behavior problems
    - Problem, frequency, triggers.
    - Methods of prevention/intervention.
    - Medications.
  - Mental health conditions
    - Diagnosis.
    - How condition exhibited in behavior.
    - Type and dates of treatment(s) received.
    - Hospitalizations.
    - Medications.
    - Prognosis.
  - Child risk behaviors
    - Substance abuse.
    - Juvenile justice involvement.
    - Early sexual involvement.
    - Runaways.
- Child's Personal Characteristics:
  - Eating difficulties such as hoarding, gorging, swallowing or stealing food.
- Birth mother, birth father, siblings, and significant others non-identifying information:
  - Marital/relationship history.
  - Medical history (e.g., allergies; type and age of onset for conditions/diseases such as cancer, diabetes, high cholesterol; age and cause of early deaths).
  - Substance abuse history, including type, age started using, treatments, and outcomes.
  - Mental health history.
  - Criminal legal involvement.
  - Involvement and relationship with child
    - Age of birth parents at child's birth.
    - Involvement prior to and during foster care placement.
    - Issues and challenges.
    - Child's interaction and feelings about person.
- Reasons for foster care:
  - Child's age at entry.
  - Specific information on how and why child was placed in agency's custody.
  - Date of Termination of Parental Rights (TPR) and appeals for each parent and reasons (e.g., failure to comply with service plan, abandonment).
- Chronological placement history:
  - Placements dates.
  - Reasons for each placement.
  - Reasons for leaving each placement.
- Child's preparation for adoption:
    - Issues regarding transitioning to a new family.
    - Assessment of child's ability to trust and attach to new family by caretaker, therapist, social worker, etc.

Next steps:

- Evaluate alternative trauma assessments that can be used in addition to the CANS trauma module.
- Determine changes necessary to implement HPAC recommendations on behavioral health and developmental screening and follow-up assessments.

2. **How health needs identified through screenings will be monitored and treated**, including emotional trauma associated with a child's maltreatment and removal from home. Highlight how assessments for trauma are used to inform case planning and referral for services. Describe how staff and other providers are trained to support the treatment of emotional trauma

The Foster Care Chapter of the DFS Child and Family Services Manual provides guidance on utilizing family engagement, Family Partnership Meetings, and the foster care service plan to inform decision-making, service planning, implementation, and monitoring of services identified during screenings and assessments. The service worker plays a central and essential role in managing services for the child or youth in foster care. These same processes are used when the child has experienced trauma.

**Family engagement** is partnering with the family to make well-informed decisions about their child's safety, permanent home, lifelong connections, and well-being. It involves engaging the child's birth parents, prior custodians, and family members, as well as other community members and adults who are significant to the child and family, consistent with the child's best interests. It is based on open communication, mutual respect, and honesty. As experts on their own family, the child and family are essential sources for information on what is impacting the safety, permanency, and well-being of the child. Relatives, siblings, friends and significant adults may assume diverse roles and provide different resources and supports for the child.

**The Family Partnership Meeting** is a team approach for partnering with family members and other partners in decision making throughout the family's involvement with the child welfare system. The team is facilitated by a trained individual who is not the service worker for the child or family. It builds upon the strengths of the child, family, and community to ensure safety, a permanent family, and lifelong connections for the child. A Family Partnership Meeting should be held prior to the child's removal from home and prior to placement changes to engage the family, other significant adults, and community members in the decision-making process. The service worker may convene meetings comprised of the same team members and other appropriate partners to address other issues, including service planning, that does not require a trained facilitator. The Family Partnership Meeting should include birth parents, youth, other significant players identified by the birth parents and/or youth, and neighborhood-based community representatives. Working collaboratively with the family and other significant individuals over time provides continuity and increases the effectiveness of decision making, service planning, and implementation.

**The service worker uses the FSNA, the CANS, the risk reunification review, and the comprehensive assessment process** to identify and prioritize critical family needs and help develop effective service plans. The FSNA serves several purposes:

- It ensures that the service worker and family members consider the family's strengths and needs in an objective and consistent format.
- It serves as a mechanism for monitoring service referrals made to address family and child needs.
- The initial FSNA and subsequent reviews aide the service worker and family in assessing change in family functioning and evaluating the impact of the services on the case.

The FSNA and the risk reunification review is completed in conjunction with the review of the service plan until permanency is achieved or the goal is changed.

**The Foster Care Service Plan** must address, among other items, the child's safety, medical, developmental, dental, and behavioral health needs of the child or youth that were identified during the screening and assessment process. It also incorporates service recommendations from the EPSDT screenings, Family Partnership Meetings, and FAPT assessments. It must also identify additional

interventions and services that will be provided to the family, the caregiver, and the child in order to meet the child's needs and achieve permanency. The service plan addresses the unique needs and issues of the child and family through building on the strengths of the child, family, and providers. The LDSS service worker monitors implementation of the service plan, modifying the plan as needed.

**The LDSS service worker**, in collaboration with the child, birth or resource parent, and caretakers of the child or youth in foster care, is responsible for working with appropriate providers to address needs identified through the EPSDT, Family Partnership Meeting, FAPT, or service planning processes. The service worker:

- Obtains any subsequent in-depth health assessments.
- Uses data and information to support decision making and improve quality of practice.
- Refers the child, birth parents or prior custodians, and foster, adoptive or resource parents for appropriate services identified.
- Ensures medical care is provided when the child is ill or injured and ongoing treatment provided when the child has physical, developmental, dental, mental, behavioral, or emotional needs.
- Coordinates services and supports across providers.
- Ensures consistent and regular communication with providers of direct services and with the child and family to ensure consistent messages are being provided to the child, family, and providers.
- Assesses needs regularly through frequent contacts with the child, family members, and service providers.
- Is flexible and responsive to meeting the changing needs, circumstances, and opportunities of the child, birth parents, and family members through eliminating, adjusting, and/or adding new services and supports as needed.

For children in foster care served through CSA:

**The Family Assessment and Planning Team (FAPT)** plays an integral role in planning, implementing, and monitoring services, consistent with policies established by the Community Policy and Management Team (CPMT). The FAPT is responsible for assessing the strengths and needs of individual children and their families, developing individualized family services plans, referring children and families to services, and designating case managers to monitor children's progress. The FAPT is also responsible for providing family participation in all aspects of assessment, planning, and implementation of services.

FAPTs are comprised of a parent and representatives from the local child serving agencies (community services boards, courts service units, social services, and public schools), private provider, and other community representatives. They often include a health care representative especially when a child is known to have particular health needs that require expert consultation from health professionals.

- **The FAPT uses the CANS instrument** to help plan, make decisions, and manage services at both an individual and system of care level. It helps:
    - Guide service planning by assessing the strengths and needs of individual children and their families,
    - Capture data to track progress on child and family outcomes,
    - Identify service gaps and promote resource development, and
    - Enhance communication among participants working with the youth and their family, including the cross systems Family Assessment and Planning Team (FAPT).

The Virginia Office of Comprehensive Services for At Risk Youth and Families (OCS) provides guidelines for CPMTs on **utilization management** to manage the provision and cost of services by influencing client care and decision making through systematic data driven processes. Each CPMT must

have a plan for utilization management. A set of techniques used. Guidelines summarize processes for system level and individual child/family utilization management. They involve assessing data, identifying required services, considering mitigating circumstances in placement decisions, developing service plan including discharge plans, identifying service providers, implementing service plans, monitoring progress and treatment outcomes, reviewing individual child level needs, and evaluating the local service system. As part of the utilization management process, OCS provides guidelines for utilization review, including the elements, process, and frequency. This process involves a formal assessment of the necessity, efficiency, and appropriateness of the services and treatment plan for an individual child or youth.

**Treatment services identified through an EPSDT screen** are provided, including vision, dental, and hearing services, as well as any medically necessary health care services listed in section 1905 (a) of the Social Security Act to correct and ameliorate physical and mental conditions even if the service is not included under Virginia's State Plan for Medical Assistance. EPSDT includes a broad range of outreach, coordination, and health services distinct from general state Medicaid program requirements. The goals of Virginia's EPSDT program are to keep children as healthy as possible by assuring that health and developmental concerns are diagnosed as early as possible, assuring that treatment is provided before problems become complex, and assuring that medically justified services are provided to treat and correct identified problems. EPSDT Specialized Services are medically necessary treatment services that are not routinely covered services through Virginia Medicaid. The services must be allowed by the Centers for Medicare and Medicaid Services. The preventive services are monitored through the CMS 416 report. Data on the percentages of children who receive well child visits, screenings, and dental services and when they receive them are reported annually.

**When a developmental screening indicates the need** for diagnosis or treatment for a suspected condition or abnormality, the child may be referred for medically necessary specialty care or other health services if the screening provider is not able to provide the treatment. Two options for referrals for treatment include the EPSDT program and the Infant & Toddler Connection of Virginia. The latter program assists families of infants and toddlers under the age of three with developmental delays and/or disabilities to help their children learn and develop through everyday activities and routines so that they can participate fully in family and community activities.

DentaQuest is responsible for ensuring that **pediatric dental services** are provided as medically necessary to children under the age of twenty-one, in accordance with federal regulations. It shall demonstrate that dentists in the network are licensed by the State and have received proper certification or training to perform dental services.

Smiles For Children members are covered for all medically necessary dental services, as well as orthodontic (braces) procedures provided by a participating dentist. Dental services include relief of pain and infection, restoration of teeth, and maintenance of dental health. Routine dental exams should be provided every 6 months. Some of the other services available include: fluoride (every 6 months); crowns (some caps); sealants; cleanings (every 6 months); root canal treatments; space maintainers; X-rays; extractions (tooth pulling); fillings; anesthesia; and oral disease services.

DentaQuest provides comprehensive oversight of utilization through retrospective review of paid claims. Providers who are flagged as outliers are subjected to different levels of action; these can include but are not limited to:

- Clinical Audit of member records.
- Provider education and guidance in coding and expectations for code usage.
- Placement of a provider and/or location on an increased pre-payment review schedule.

Certain benefits are subject to a Utilization Management pre-payment review process to assure that all services are medically necessary, meet the accepted standard of care, and provide the most appropriate and cost effective treatment. Additionally DentaQuest also subjects all claims submitted for members to an extensive library of system edits and processing policies prior to adjudication.

**Behavioral health treatment services** that are determined to be clinically necessary funded by Virginia's Medicaid Program include:

- Community Mental Health Rehabilitative Services:
  - Intensive In-Home Services for Children and Adolescents
  - Therapeutic Day Treatment for Children and Adolescents
  - Day Treatment/Partial Hospitalization
  - Psychosocial Rehabilitation
  - Crisis Intervention
  - Intensive Community Treatment
  - Crisis Stabilization Services
  - Mental Health Support Services
  - Case Management
- Mental Retardation Community Services:
  - Case Management Services

The CSBs provide targeted case management for behavioral health services. The utilization of treatment services is monitored by DMAS. In addition, these services are monitored through audits performed by DMAS' provider review division.

**Substance abuse treatment services** that are determined to be clinically necessary funded by Virginia's Medicaid Program include:

- Substance Abuse Crisis Intervention
- Substance Abuse Intensive Outpatient
- Substance Abuse Day Treatment
- Opioid Treatment
- Substance Abuse Case Management

The utilization of treatment services is monitored by DMAS. In addition, these services are monitored through audits performed by DMAS' provider review division.

**Collecting information about trauma** the child experienced on the Full Disclosure of Child Information Form informs the service worker on the types of services the child requires and the types of referrals needed. In both the new adoption assistance section and the new custody assistance sections, the service worker discusses this information with prospective parents and the long term needs of children who have experienced trauma.

**Trauma informed case management.** The draft Prevention Chapter of the DFS Child and Family Services Manual includes a section on trauma informed case management. It provides strategies to:

- Support optimal brain development and healthy attachment, including
  - Prenatal development and post natal parent support. 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.
  - Building and enhancing healthy parent-child relationships. 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. 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.
    - Establishing 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. 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.
    - Supporting teenage brain development. 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.
    - Supporting health and nutrition.
- Address the effects of trauma when children have experienced trauma:
    - Children need to process their feelings after a stressful or traumatic event. 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).
    - Parents may also need help to process their feelings after a stressful or traumatic event. Case managers can discuss with parents how to help their children talk about the trauma.
    - Supporting the mental health and behavior management 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.
    - Educating schools. 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. An Individualized Education Program (IEP) may be required.
    - Providing concrete 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.
    - Using community based services. 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. 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.

- 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.

VDSS Permanency Policy Staff is incorporating in foster care guidance strategies and services for children who have experienced maltreatment and have been removed from home to address issues related to the trauma, reduce additional trauma to the child, and help ameliorate future issues. Staff are:

- Using national best practices to inform practice.
- Involving key members of HPAC, including VDSS Prevention Policy Staff and the Director of Training and Professional Development for Child Savers who both have extensive expertise in trauma.
- Finalizing guidance for 2012 dissemination of the revised Foster Care Chapter.

Training on trauma includes:

- VDSS Division of Family Services (DFS) staff was trained on serving children who experience trauma.
- VDSS DFS hired person to work full-time in new prevention unit who has expertise and experience working with children who experience trauma.
- VDSS Permanency Program Staff will provide transmittal training at regional meetings of LDSS permanency supervisors and staff on changes in foster care guidance related to trauma.

**Monitoring next steps:**

**Explore the feasibility of VDSS contracting/subcontracting with an External Quality Review Organization (EQRO)** to analyze DMAS claims data for children in foster care and adoption assistance that receive services through Medicaid. They could run relevant Medicaid reports for just children in foster care and just children receiving adoption assistance. VDSS could provide them with key VDSS data elements to run key utilization and outcome measures building on HPAC's earlier work on monitoring health outcomes.

Benefits of contracting:

- Improves accuracy of data using DMAS claims data rather than resource parent accounts and service worker documenting information in OASIS.
- Prevents duplicate work by service workers when the data is already available at DMAS.
- Allows LDSS worker to focus on serving kids and families, rather than collecting and entering data
- Reduces amount of changes in OASIS.
- Reduces amount of analyses and reports for VDSS.
- DMAS claims data is complicated, requiring someone with expertise to analyze.
- Reduces VDSS asking DMAS to conduct analyses, when they have health care reform priorities as well.

- Allows VDSS to benefit from analyses reported for all Medicaid children, but also tailor its own.
- Allows VDSS to compare information on children in foster care and receiving adoption assistance to all Medicaid children.
- The analysis is conducted by an external, independent group, which increases credibility.
- Provides accountability for the state and federal governments.

Downsides:

- Delayed timeframe prior to reporting any data. However, would take a year for VDSS to change its system, train people, and collect, clean, analyze and report data.
- Three month delay in claims data for MCOs means we may need to gather some data at VDSS.

Questions to explore:

- Cost estimate to see if financially feasible.
- Frequency of reports.
- Feasibility of locality/regional reports in addition to statewide
- Ability to access historical claims data on children.
- Feasibility of providing key data to the local service worker.

- **Finalize and implement data elements in OASIS health screens** to help local service workers monitor the delivery of health services for children in foster care.

**3. How medical information will be updated and appropriately shared, which may include developing and implementing an electronic health record.**

HPAC deferred to the larger efforts in Virginia to implement electronic medical records (EMRs) for Medicaid clients, rather than create separate electronic health record for children in foster care.

The American Recovery and Reinvestment Act of 2009 provides major opportunities for the Department of Health and Human Services, its partner agencies, and the States to improve the nation's health care through health information technology (HIT). To promote the meaningful use of electronic health records (EHRs), funding incentive payments are available and will be distributed through Medicare and Medicaid to eligible professionals, physicians, and hospitals that are "meaningful EHR users." The Act also provides for Regional Extension Centers (RECs) to provide outreach, education, and technical assistance to assist providers in adopting, upgrading, and implementing EHRs and/or attaining or exceeding meaningful use of certified EHR. RECs will provide on-site technical assistance.

As part of DMAS' administration of the incentive program, CMS requires the State to submit for approval a State Medicaid Health Information Technology Plan (SMHP). This plan describes how DMAS expects to encourage, administer, and monitor incentive payments to eligible professionals and hospitals. Virginia's SMHP was conditionally approved on March 7, 2011. The plan is being revised as Virginia nears launching its EHR Incentive Program

- The funding incentive process, as conceived by the Centers for Medicare and Medicaid Services (CMS), begins when a provider registers with the CMS Registration and Attestation System and elects consideration for incentives for a given state and program (Medicaid/Medicare). Then, in the case of a Virginia Medicaid selection, DMAS will be notified by the CMS Registration and Attestation System and will then contact the provider to begin the eligibility process.

- DMAS has established eligibility criteria for the Virginia EHR Medicaid Incentive Program and projects it will begin reviewing applications in 2012.

- DMAS contracted with VirginiaHIT (VHIT) Regional Extension Center to provide free outreach and education for the Virginia EHR Medicaid Incentive Program. Through this initiative, VHIT provides direct local assistance to help Virginia primary care physicians implement an electronic health record system, integrate it into the patient care process, and position themselves to receive Medicare or Medicaid incentive payments. They help determine eligibility, register for the incentives, and take steps to adopt, implement, or upgrade to a certified EHR system. VHIT also works with the providers as they progress to meaningful use of their EHRs and qualify for subsequent incentive payments.

  Through a rigorous selection process, VHIT has negotiated discounts with best-in-class companies that offer EHRs with demonstrated value at all-inclusive prices Almost 200 ambulatory EHR systems were evaluated to identify the best values for Virginia providers. VHIT's solution partners offer products with a proven track record and the features needed as a primary care provider. The EHRs also meet the certification standards for the Medicare and Medicaid payment incentives. The EHRs are accessible through secure Internet channels, allowing access to reliable solutions without the burden of costly hardware and maintenance. VHIT's professional consultants will assess the practice's unique situation and develop a customized roadmap to meaningful use. EHR incentive payments are just one benefit. Providers also can provide better care to patients, run a more efficient practice, and improve their bottom line.

  VHIT offers various levels of support at no cost to the provider:
  - The VHIT Help Line (1-800-207-7928)
  - In-office consultation
  - Phone and email support from your assigned EHR coordinator
  - Bimonthly educational webinars and e-newsletters
  - An online resource center to access information and tools related to EHR implementation, meaningful use, change management and other health IT topics.

**ConnectVirginia** is the Statewide Health Information Exchange (HIE) for the Commonwealth of Virginia. It provides a safe, confidential, electronic system to support the exchange of patient medical records among healthcare providers, in Virginia and beyond. This initiative is being led by Community Health Alliance, Inc., a Virginia-based not-for-profit company, and a Governing Body of health care professionals and executives from across the Commonwealth.

The ConnectVirginia mission is to foster and sustain trust, collaboration and information sharing among consumers, providers and purchasers of healthcare services in the Commonwealth of Virginia, leading to measurable improvement in outcomes and cost-effective delivery of services.

The vision is that consumers and providers of health services are empowered to make good decisions based on secure, timely, accurate, comprehensive and easily-accessible information, available to authorized users for coordination of care, improvements in safety and quality, and advancements in the provision of health care.

ConnectVirginia utilizes secure, electronic, internet-based technology to allow medical information to be exchanged by participating health care providers. As a result, health care providers will have more complete medical information to provide higher quality care for patients and will be able to more easily coordinate treatment with other health care providers. Patients will need to give permission to ConnectVirginia in order for their information to be shared among the health care providers who care for them.

Better access to vital information about prior conditions, medications, allergies, and tests may improve the accuracy of diagnoses, enhance the quality of care, and eliminate duplicate tests. ConnectVirginia will allow health care professionals the ability to quickly share and view patient information electronically with other participating providers, called Health Information Exchange or "HIE". In addition, the ability to exchange clinical information with other providers is a key component of achieving Meaningful Use of EHRs and CMS financial incentives.

ConnectVirginia will provide health care providers with two ways to exchange patient records:
DIRECT Messaging allows providers to share health information electronically in a method similar to regular email but with the added security required for sensitive health information.
EXCHANGE is a collection of standards, policies and message-based services providing a secure method to query and retrieve patient data across all ConnectVirginia EXCHANGE Participants. ConnectVirginia EXCHANGE is based on the Nationwide Health Information Network specifications and standards supported and maintained by the Office of the National Coordinator of Health Information Technology (ONC) within the U.S. Department of Health and Human Services

**4. Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.**

Virginia is moving children in foster care from Medicaid fee-for-service to Medicaid managed care to improve access to preventive and coordinated care and to provide continuity of health care services. A managed care organization (MC0) is a managed care health plan in which a group of doctors and other health care providers work together to provide the child health care services. Statewide coverage is provided by seven MCOs across Virginia.

This initiative was first piloted in the Richmond Foster Care Medicaid Pilot Program. The goal was to provide more coordinated care for children in foster care. DMAS, Richmond City DSS, and the four MCOs in Richmond worked together from January to December 2011 to implement the pilot. These groups painstakingly worked through many procedural and logistical solutions to issues. Key factors essential to success and a smooth transition were identified. For example, the pilot documented:

- Eligibility requirements for MCO enrollment.
- MCO enrollment process.
- Provider verification process.
- Process for changing MCOs.
- Process when loss of and reinstating Medicaid coverage.
- Transportation provisions.
- MCO member service responsibilities vs medical management responsibilities.
- Training materials for service workers, foster parents, and providers.
- What if scenarios.

Based on the success of the pilot program, DMAS received permission from the Governor and the 2012 General Assembly through budget language to move children in foster care and children receiving adoption assistance statewide into managed care health plans.

Statewide planning for the transition to managed care is currently underway through monthly meetings with DMAS, MCOs, LDSS from across the state, and other key players. Official managed care implementation begins with the Managed Care Central and Tidewater Regions in Spring 2013 and statewide implementation is anticipated by April 2014.

Benefits include:

- A primary care provider (PCP) who is a doctor or other health provider for each child in foster care and each child who receives adoption assistance. The PCP will manage the child's health care and refer the child to other providers when necessary.
- Care coordination for children who need assistance with medical issues and do not have access through another program.
- Increased access to credentialed physicians and other providers.
- Disease management services (e.g., asthma, COPD, child weight management).
- Services for children with special health care needs.
- Transportation for children to a physician or a health care facility when foster, adoptive, and resource parents do not have any other means of transportation. Trips must be for a Medicaid covered service, medically necessary, and pre-approved.
- 24-hour nurse advice line.
- Member outreach and health education materials.
- Health education programs (e.g., exercise, smoking cessation, women's health, nutrition and weight management classes, prenatal classes).
- Home health and durable medical equipment to address needs.
- MCO handbook and provider directory.
- Toll-free member helplines.
- Access to free translation services /language telephone line.
- Families can have children in foster care in one MCO and with one primary care physician. However, multiple children in foster care living in the same household do not need to be enrolled in the same MCO or PCP.

The following services will be carved out and will continue to be paid through Medicaid fee-for-service for children in foster care and who have adoption assistance.

- Community Mental Health Rehabilitative Services
- Mental Retardation Community Services
- Private Duty Nursing for HCBS waiver enrollees
- Substance Abuse Treatment Services
- Dental (Smiles For Children)
- School Health Services
- Specialized Infant Formula for Children Under Age 21
- Health Department Lead Investigations
- Early Intervention Services
- Personal Care services

The PCP, care coordination, and improved communication between LDSS and MCOs will improve continuity of health care and improve health outcomes for children in foster care and for children receiving adoption assistance. Statewide MCO coverage only requires a child to come out of an MCO if the child moves to another state permanently.

5. **The oversight of prescription medicines, including protocols used to monitor the appropriate use of psychotropic medications** for children and youth in the foster care system. States must support their choice of protocols and provide additional information on how the child welfare workforce and providers are trained on the appropriate use of psychotropic medications. The State's protocol must address:

- Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs (including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication);
- Informed and shared decision-making (consent and assent) and methods for ongoing communication between the prescriber, the child, his/her caregivers, other healthcare providers, the child welfare worker, and other key stakeholders;
- Effective medication monitoring at both the client and agency level;
- Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible Child and Adolescent Psychiatrist (at both the agency and individual case level); and
- Mechanisms for sharing accurate and up-to-date information related to psychotropics to clinicians, child welfare staff, and consumers. This should include both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials.

DMAS' Drug Utilization Review Board implemented a service authorization requirement for any atypical antipsychotic prescribed for a child under the age of six in the fee-for-service population, which includes children in foster care. Requests for service authorization (SA) must include:

- Child's name, Medicaid ID#, date of birth, and weight.
- Drug name, dosage form and strength, administration schedule or dosing frequency
- Quantity requested and total daily dosage.
- Diagnosis being treated.
- The prescribing provider's specialty as psychiatrist, neurologist, or a developmental/behavioral pediatrician, or date of consult with such a provider before prescribing the required medication.
- The child received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented.
- Psychosocial treatment has been in place for at least 12 weeks without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy.
- Informed consent for this medication has been obtained from the parent or guardian.
- Information on the child's current behavior health program, including the name of the program, date of enrollment, list of pharmaceutical agents attempted and outcome.
- Prescriber information, including phone number, if the request is denied or more information is required, for peer to peer consultation with the program's Board Certified Pediatric Psychiatrist.

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.

HPAC decided that monitoring the appropriate use of psychotropic medications must be addressed at the individual child level and at the systems level. HPAC established a work group comprised of members with clinical, program, and legal expertise to develop Virginia's protocols.

**At the child level**, steps for the draft protocol are based on the expertise of the HPAC Workgroup on Monitoring Psychotropic Drugs and national best practices, including information from the *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents (2009)* and *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents (2012)* by the American Academy of Child & Adolescent Psychiatry and *Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care (ACYF-CB-IM-12-03; April 11, 2012).*

The draft protocol includes:

- Conduct child and adolescent mental heath evaluation by licensed mental health professional.

    - Interview youth, parents/guardians, significant family members, and caregivers.
    - Obtain history, including:
        - Current symptoms and concerns.
        - Youth's developmental, medical, and mental health history. Ensure symptoms not indicative of medical problem. Identify medical conditions such as obesity or diabetes that could affect medication use.
        - Youth's strengths, interests, significant others, and natural supports.
        - The family's situation including supports and stressors.
        - Youth's education status.
        - Other community and environmental factors impacting the youth and family, including experiences with trauma.
    - Review records of assessments, services, treatment, and medications.
    - Obtain pediatric examination and/or laboratory work, when necessary.
    - Discuss youth and family with the service worker and other involved professionals.
    - Identify communication strategies for educating and engaging youth in decision-making, consistent with the youth's development level.
    - Identify mental health diagnoses, when applicable.
- Educate the youth, parents/guardians, significant family members, and service worker about the youth's condition and options for treatment.
- Participate actively in developing and implementing a service plan with the youth, family, service worker, and other key partners, including the youth's team (e.g., Family Partnership Team, Family Assessment and Planning Team, treatment team) that:
    - Addresses the identified and prioritized youth's needs.
    - Builds on the strengths and natural supports of the youth and family.
    - Respects the youth's and family's culture and takes into account their preferences.
    - Provides comprehensive, integrated, and community based services and supports.
- Develop psychopharmacological treatment plan with the youth, parents/guardians, family and caregivers, if psychosocial treatment not sufficient and incorporate medication as complementary component of overall service plan:
    - Consult with board-certified (eligible) Child and Adolescent Psychiatrist, when needed. Obtain ongoing supervision via phone for children with complex mental health needs, when needed.
    - Identify medication options based on best available research evidence
    - Communicate with youth, family, caregivers, service worker, and other key professionals:
        - Involve youth, parents/guardian, significant family members, and caregivers in ongoing decision making.
        - Identify all prescription and over-the-counter medications youth is taking.
        - Discuss efficacy, risks, and benefits of medication options, including risk of interactions between drugs when multiple drugs are necessary and the potential benefits of improved outcomes.
        - Discuss side effects and strategies for monitoring and addressing them.
        - Discuss options for alternative or complementary treatments.
    - Develop plan for medication trial, including plans to monitor child short and long term
    - Educate child, family/guardian, caregivers, and service worker about treatment and monitoring plan
- Obtain assent of youth and consent of parents/guardians before starting medication and at key points during treatment
- Implement medication trials using adequate dose for adequate duration with manageable side effects.

- Follow-up within two weeks and at least monthly until youth's symptoms are improved and stable.
    - Obtain input from youth, parents/guardians, significant family members, service worker, caregivers, and other professionals on symptoms and side effects.
    - Conduct lab tests, including medication blood level tests when needed to monitor dosage and side effects.
    - Use rating scales or logs to document frequency of symptoms and/or side effects.
- Adjust medications as necessary, scheduling follow-up visits based on monitoring needs. Identify upcoming changes in the youth's life and routine to minimize dosage changes during these changes.
- Reassess if youth does not respond as expected.
- Once stable, visits may be less frequent and based on the needs of the youth and family.
- Implement plan for gradually reducing and discontinuing medication if youth's behavior is stabilized and circumstances in the youth's environment are stable.

Next steps include:

- Finalizing the protocol, including tailoring it to address differences when child is living in a family setting vs residential treatment program.
- Incorporating relevant components in foster care guidance.
    - Disseminating guidance to the field.
    - Providing transmittal training at regional supervisors meetings.
- Discussing with DMAS and HPAC other appropriate venues for incorporating and disseminating the protocol.

**At the systems level,** HPAC developed a survey instrument to identify oversight and monitoring strategies currently being used by DMAS fee-for-service for Medicaid clients, including children in foster care, and the seven MCOs for their members. The survey will identify what currently exists in Virginia and national best practices in a matrix format. The survey was developed based on the expertise of the HPAC Workgroup on Monitoring Psychotropic Drugs and national best practices, including information from the *Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents (2009)* and *Multi-State Study on Psychotropic Medication Oversight in Foster Care (2010)*

The survey gathers information on:

- Name of organization completing matrix
- Contact information of person completing matrix
- Type of standard/protocol (e.g, MCO, state, national standard, best practice)
- Source of standard/protocol
- Written policy/procedures for monitoring psychotropic drugs
- Consultation available by board-certified (eligible) Child and Adolescent Psychiatrist (to whom, under what circumstances, and what type)
- Drug formulary
    - List of drugs for children under age 21
    - Description of tiers
    - What allows you to go to next tier
    - What copays are involved
    - Which level requires authorization
- What happens if child switches MCOs, how is child transitioned to new formulary.
- Pharmacy and therapeutic committee
    - Number of pediatricians

    - Number of child and adolescent psychiatrists
    - Number of pharmacists
    - Other types of committee members
    - Total number of members
    - Names of people
    - How often do they meet
    - How often is formulary updated
- Pre-authorization requirements
    - What is process
    - What is automatically approval
- Process for getting non formulary drug approved
    - What paperwork is involved
    - Who must approve
- Strategies used to monitor drugs
    - Evaluating utilization data
    - Chart reviews
    - Visits
    - Other
- Data elements used to monitor drug usage
    - Age ranges used
    - Gender
    - Ethnicity
    - Diagnosis
    - Class of drugs
    - Dosage exceeds maximum recommendation
    - Duration longer than recommended
    - Number drugs per child
    - Multiple drugs used before single drug
    - Multiple drugs within class
    - Frequency in number of drug changes over period of time
    - Individual provider
    - Type of provider
    - Placement type
    - Geographic area
    - Follow-up visits
    - Labs conducted
    - Monitoring side effects
    - HEDIS visits within one month after diagnosis, after medication prescribed
    - Other

Next steps include:

- Finalize the survey instrument.
- Have DMAS complete for fee-for-service and 7 MCOs complete
- Use matrix to compare across organizations and with national standards/best practices.
- Develop standard for monitoring psychotropic drugs primarily based on national standards tailored to Virginia's unique needs.
- Implement statewide standards for monitoring psychotropic drug use.

Additional steps on monitoring psychotropic drugs for children in foster care include:

- Complete review of literature, materials, and best practices available nationally and from other states.
- Attend national meeting "Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medication Use for Children and Youth in Foster Care," on August 27-28, 2012 in DC.
- Convene HPAC Workgroup on Monitoring Psychotropic Drugs to develop further recommendations for HPAC consideration.
- Convene HPAC to review and advise DMAS and VDSS on recommended actions.
- Work with DMAS and seven MCOs to assess feasibility and implement consistent protocols statewide that are in the best interests of children and youth in foster care.

6. **How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals** in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

   HPAC members include health care providers, specifically pediatricians, social workers, nurses, child psychiatrist, clinical pharmacists, dentist, managed care organizations, case manager, and utilization management staff. These members include:
   - Former President of the Virginia Chapter of the American Academy of Pediatrics.
   - Professor of Psychiatry and Pediatrics; Chair of the Child and Adolescent Psychiatry Division of Virginia Commonwealth University (VCU) Medical Center.
   - Clinical Pharmacist, Psychiatry Division in the VCU Health System.
   - Pharmacy Program Manager, DMAS.
   - Pharmacist, DMAS.
   - Office of Behavioral Health Manager, DMAS.
   - Child and Adolescent Program Specialist, Virginia Department of Behavioral Health and Developmental Services.
   - Virginia Behavioral Health UM Manager, Anthem HealthKeepers Plus.
   - Program and Utilization Management Consultant, Virginia Office of Comprehensive Services for At Risk Youth and Families.
   - Associate Professor and Graduate Program Director in the Department of Pediatric Dentistry VCU School of Dentistry.
   - Director of Training and Professional Development for Child Savers, a nonprofit organization providing 24/7 immediate response and trauma counseling services for children exposed to violence and other traumatic events.
   - Coordinator, Child Assessment & Treatment Center for Health.
   - Director, Case Management/Health Services, Coventry Health Care/Southern Health Services.
   - Pediatric Case Manager, Amerigroup Corporation.
   - Social Work Case Manager, Coventry Health Care/Southern Health Services.
   - Executive Director, Capital Area Health Education Center.
   - Child Health Programs Manager, Virginia Department of Health.
   - School Health Specialist, Virginia Department of Education.
   - Managed Care Programs Manager, DMAS.
   - Associate Vice President, Heath Care Management Services, Amerigroup Corporation.

   A small group of HPAC members with clinical and medical expertise relevant to issues convene to help develop recommended protocols (e.g., outcome measures; screening and follow-up assessments; and monitoring psychotropic drugs).

7. **Steps to ensure that the components of the transition plan development process required** under section 475(5)(H) that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met.

   Section 11.14 of the Foster Care Chapter of the DFS Child and Family Services Manual, currently available online, addresses the health care requirements in the transition plan for the older youth aging out of foster care. Relevant excerpts are provided below. Italicized language shows new language to be incorporated in the next revision.

**11.14 Transition plan prior to youth turning age 18 or no longer receiving foster care services**

The service worker, youth, and youth's team shall develop a transition plan during the 90-day period immediately prior to the youth turning age 18 and prior to an older youth no longer receiving foster care services. This plan should represent the culmination of all prior efforts and document the specific plans for the youth to successfully transition from foster care services to independence.

*Written notice shall be documented in the youth's transition plan of his or her right to request that independent living services be restored within 60 days of services ending, if he chooses to leave foster care anytime after turning 18 years old and before the age of 21 years*.

The transition plan shall be created at least 90 days prior to the youth choosing to leave foster care or terminate independent living services before his or her 21st birthday (§ 63.2-905.1). The transition plan may be documented by updating the youth's foster care service plan in the OASIS, or the independent living services and transition plan if it is a separate document, which is in the paper case file (see Section 11.8.3).

The transition plan shall be directed by the youth, and shall be as detailed as the youth chooses. The planning process should engage the youth's family and the youth's team. See Section 11.8 on service planning for older youth.

The service worker and the youth's team shall help the youth understand the importance of including specific areas in the transition plan. These areas include, but not limited to:…

- Options for health insurance. Youth who leave foster care at age 18, and emancipated minors, may apply for the Family Access to Medical Insurance Security (FAMIS) program and receive health insurance until the youth's 19th birthday. A four-month waiting period does not apply since the youth's prior insurance was Medicaid. There are no enrollment fees or monthly premiums. For some services, there may be a small co-payment. Covered services include: doctor visits, well-baby checkups, hospital visits, vaccinations, prescription medicine, tests, x-rays, dental care, emergency care, vision care, and mental health care. See the FAMIS Teens section of the FAMIS website for more information.
- Designating someone to make health care treatment decisions on the youth's behalf, if the youth becomes unable to participate in the decisions and does not have or want a relative who would otherwise be authorized by State law to make these decisions. The youth, after reaching age 18, may designate a health care power of attorney by completing the form, entitled Virginia Advance Medical Directive, on the Virginia Department of Health (VDH) website, which complies with Virginia law (Patient Protection and Affordable Care Act P.L. 111-148; § 54.1-2995). The LDSS should encourage and assist the youth in seeking guidance from an attorney to address any questions. The youth should provide a copy of this document to his or her physician, close relatives, and/or friends….

The youth should also address the topics contained in the document, My Transition Plan for Success in Adulthood. This document allows youth to gather important information in one place that they will need when they end foster care services. It also addresses several state and federal legal requirements.