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PRACTICE FOUNDATIONS

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PRACTICE FOUNDATIONS

1.1 Introduction

1.1.1 Overview of child welfare services in Virginia

The Virginia Department of Social Services (VDSS) oversees the operation of social service programs in accordance with §63.2 of the Code of Virginia. The Virginia model for social services delivery is "state supervised" and "locally administered." VDSS partners with 120 local departments of social services (LDSS), along with faith-based and non-profit organizations, to promote the well-being of children and families statewide.

Local departments of social services (LDSS) are an integral part of the social services delivery system and serve as the focal point within all local communities for the delivery of family-focused and family-based preventive and protective services. LDSS use federal, state, and local funds to deliver services.

The State Board of Social Services was created by the state legislature in July 1974. The members are appointed by the Governor and include representatives from various regions of the state. Terms are for four years and board members may serve no more than two successive terms. The State Board has responsibility for the adoption of rules and regulations consistent with federal and state law.

The Commissioner of Social Services, who is appointed by the Governor, directs VDSS at the state level. VDSS, under the direction of the Commissioner, develops policies, procedures, regulations, training, and standards for social service programs. It is responsible for the monitoring and evaluation of these programs, and allocation and management of funding to LDSS. As of July 1, 2019, in accordance with §63.2-904, the Commissioner has the authority to place, remove, or direct the placement or removal of a child in foster care and is required to do so when the child is in a placement which fails to meet requirements related to the child's health, safety, or well-being. The Commissioner also has the authority to intervene when a LDSS fails to provide foster care services or acts in a manner that poses a

substantial risk to the health, safety, and well-being of any child in foster care. Intervention may include the development of a corrective action plan or the assumption of temporary control of the LDSS' foster care services and associated funds.

VDSS has five regional offices: the Northern office in Warrenton; the Eastern office in Virginia Beach; the Central office in Henrico County; the Piedmont office in Roanoke; and the Western office in Abingdon. There is a director assigned to each region who works collaboratively with state staff housed in both the VDSS and Regional offices to support VDSS initiatives. VDSS staff who work in the regional offices provides program oversight, consultation, monitoring, analysis of performance, and technical assistance to support LDSS and community organizations.

VDSS supervises the administration of programs by the LDSS. The LDSS is the setting for direct contact with individuals receiving or requesting services. The components through which the LDSS can assist individuals fall into two major divisions: benefits and family services programs. Benefits programs are managed by Benefit Program Specialist while family services are administered by Family Services Specialist.

The LDSS staff determines eligibility for participation in services and benefits programs, authorize payments to individuals and vendors for services, and provide direct services to individuals.

1.1.2 Program Areas

Within VDSS, the Division of Family Services (DFS) promotes safety, permanency, and well-being for children, families, and individuals in Virginia. The Division's programs are designed to address the needs of Virginia's most vulnerable citizens. The programs emphasize personal responsibility for safety, stability, and well-being, balanced with effective intervention, when necessary. The programs are state-supervised and locally administered. Those operated at the local level are composed of the following program areas:

Family Engagement: *Family engagement is a shift from the belief that agencies alone know what is best for children and families. It is a practice that allows the family to fully participate in decision-making. For additional information please see: Family Engagement*

Prevention: *The Prevention program provides services to children and families prior to, or in the absence of, a current valid Child Protective Services (CPS) referral. It includes public education and awareness activities to the general public, services directed to at-risk groups, and services to individual families at-risk of maltreatment or out-of-home care. Additional information can be found in: Prevention.*

Child Protective Services (CPS): *The CPS program is responsible for the identification, receipt and immediate response to valid reports of alleged child abuse or neglect of children. It also includes assessment, and arranging for or providing necessary protective and rehabilitative services for a child and their family when the child has been identified as abused or neglected or is at-risk of future maltreatment. Additional information can be found in: Child Protective Services. For information on how to make a CPS or APS complaint see: Hotlines for Child Protective Services & Adult Protective Services*

Foster and Adoptive Family Recruitment*: The Foster and Adoptive Family Recruitment program is responsible for recruitment, development, and support activities for foster, adoptive and kinship caregivers in the Commonwealth. The goal of this unit is to promote awareness and increase the quantity and quality of foster and adoptive parents to ensure viable family-based placement options for children in the system of care. The work of this unit is primarily done through training, technical assistance and intervention with the LDSS. Additional information can be found in Foster and Adoptive Family Recruitment.*

Foster Care: *The Foster Care program provides services to children and families when circumstances require the child to be removed from their home. Foster care provides a safe and stable environment for children and older youth until the issues that made placement outside the home necessary are resolved. When a child cannot return home, another permanent home is found for the child through adoption or legal custody transferred to a relative. Additional information can be found in: Foster Care.*

Independent living (IL) programs and services are designed to help youth in foster care, aged 14 through 21, prepare for adulthood. For information about IL services please see: Independent Living Programs & Services.

For youth who turn 18 in foster care or while committed to the Department of Juvenile Justice from foster care, the Fostering Futures program facilitates the extension for foster care services including placement and treatment services until the youth's 21st birthday.

Adoption: *The Adoption Program's function is to place children, who have been permanently and legally separated from their birth parents, with a new family. Adoption is a social and legal process which gives new parents the same rights and obligations as birth parents.*

Virginia's Adoption Program works to promote permanency by increasing adoption awareness, developing policies and procedures for adoption, and by improving the service systems that support adoption. VDSS is committed to achieving permanency for all children in foster care. Additional information can be found in: Adoption. For information about obtaining adoption records see: Adoption Records /Disclosure

***Domestic Violence**: Domestic Violence (DV) prevention programs provide services to survivors of DV and their children. These programs include public, private, and non-profit agencies that may receive federal and state funding. Local DV programs provide for the safety of battered adults and their children through the provision of emergency housing, transportation, crisis intervention, peer counseling, support, advocacy, and information and referral. Funding also supports public awareness initiatives and the statewide Family Violence and Sexual Assault hotline.*

1.1.2.1 State administered DFS programs

***Interstate Compact on the Placement of Children (ICPC):** The ICPC is a statutory agreement between all 50 states, the District of Columbia and the US Virgin Islands. The agreement governs the placement of children from one state into another state. It sets forth the requirements that must be met before a child can be placed out of state. ICPC ensures prospective placements are safe and suitable before approval, and it ensures that the individual or entity placing the child remains legally and financially responsible for the child following placement. Additional information can be found in FUSION by clicking here: Interstate, Intercountry, ICAMA.*

***Training:** Training for LDSS workers is primarily offered by VDSS which provides training on-line and through five regional training centers. See the DFS Training webpage for additional information. Virginia Learning Center (VLC).*

1.2 Practice philosophy

1.2.1 Practice model

A practice model is a clear, written explanation of how a social service agency successfully functions in its mission to secure safety, well-being, and permanence for children and families. The Virginia Children's Services Practice Model is the broad framework which includes Virginia's vision, clear statements of values, and core principles.

1.2.2 Purpose

The model provides a guide for LDSS in daily interactions among staff, children, families, stakeholders, and community partners, and helps workers understand their job priorities. Additionally, it helps families and other stakeholders understand the agency's purpose. The practice model invites families, service providers and the community at-large to be integral to the decision-making process.

1.2.3 Origins

Developed in 2009, the Virginia Children's Services System Practice Model *sets forth a vision for the services that are delivered by all child-serving agencies across the Commonwealth. VDSS takes a leadership role in translating the practice model to everyday use in the field. The practice model is central to decision making; present in all meetings; and in every interaction with a child or family. Guided by this model, VDSS is committed to continuously improving services for children and families by implementing evidence-based practices, utilizing the most accurate and current data available, and improving safety and well-being of children and families.*

1.2.4 Practice Principles

The guiding principles for child welfare services in Virginia are incorporated in all decision-making meetings and service delivery for children and their families. These principles are essential in ensuring the safety, permanency and well-being of children. All service provisions should be timely and based on the following principles in the practice model:

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

- Safety comes first. Every child has the right to live in a safe home, attend a safe school, and live in a safe community. Ensuring safety requires a collaborative effort among family, agency staff, and the community.
- We value family strengths, perspectives, goals, and plans as central to creating and maintaining child safety, and recognize that removal from home is not the only way to ensure child or community safety.
- In our response to safety and risk concerns, we reach factually-supported conclusions in a timely and thorough manner.
- Participation of parents, children, extended family, and community stakeholders is a necessary component in assuring safety.
- We separate caregivers who present a threat to safety from children in need of protection. When court action is necessary to make a child safe, we use our authority with respect and sensitivity.

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

- Children and families have the right to have a say in what happens to them and will be treated with dignity and respect. The voices of children, youth, and parents are heard, valued, and considered in the decision-

making regarding safety, permanency, and well-being as well as in service and educational planning and in placement decisions.

- Each individual's right to self-determination will be respected within the limits of established community standards and laws.

- We recognize that family members are the experts about their own families. It is our responsibility to understand children, youth, and families within the context of their own family rules, traditions, history, and culture.

- Children have a right to connections with their biological family and other caring adults with whom they have developed emotional ties.

- We engage families in a deliberate manner. Through collaboration with families, we develop and implement creative, individual solutions that build on their strengths to meet their needs. Engagement is the primary door through which we help youth and families make positive changes.

We believe that children do best when raised in families.

- Children should be reared by their families whenever possible.

- Keeping children and families together and preventing entry into any type of out-of-home placement is the best possible use of resources.

- Children are best served when we provide their families with the supports necessary to raise them safely. Services to preserve the family unit and prevent family disruption are family-focused, child-centered, and community-based.

- People can and do make positive changes. The past does not necessarily limit their potential.

- When children cannot live safely with their families, the first consideration for placement will be with kinship connections capable of providing a safe and nurturing home. We value the resources within extended family networks and are committed to seeking them out.

- When placement outside the extended family is necessary, we encourage healthy social development by supporting placements that promote family, sibling, and community connections.

- Children's needs are best served in a family that is committed to the child.

- Placements in non-family settings should be temporary, should focus on individual children's needs, and should prepare them for return to family and community life.

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

- Lifelong family connections are crucial for children and adults. It is our responsibility to promote and preserve kinship, sibling, and community connections for each child. We value past, present, and future relationships that consider the child's hopes and wishes.

- Permanency is best achieved through a legal relationship such as parental custody, adoption, kinship care, or guardianship. Placement stability is not permanency.

- Planning for children is focused on the goal of preserving their family, reunifying their family, or achieving permanency with another family.

- Permanency planning for children begins at the first contact with the children's services system. We proceed with a sense of urgency until permanency is achieved. We support families after permanency to ensure that family connections are stable.

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

- We are committed to aligning our system with what is best for children, youth, and families.

    - Our organizations, consistent with this practice model, are focused on providing supports to families in raising children. The practice model should guide all of the work that we do. In addition to practice alignment, infrastructure and resources must be aligned with the model. For example, training, policy, technical assistance, and other supports must reinforce the model.

    - We take responsibility for open communication, accountability, and transparency at all levels of our system and across all agencies. We share success stories and best practices to promote learning within and across communities and share challenges and lessons learned to make better decisions.

    - Community support is crucial for families in raising children.

- We are committed to working across agencies, stakeholder groups, and communities to improve outcomes for the children, youth, and families we serve.

    - Services to families must be delivered as part of a total system with cooperation, coordination, and collaboration occurring among families, service providers, and community stakeholders.

    - All stakeholders share responsibility for child safety, permanence, and well-being. As a system, we will identify and engage stakeholders and community members around our practice model to help children and families achieve success in life; safety; life in the community; family-based placements; and lifelong family connections.

    - We will communicate clearly and often with stakeholders and community members. Our communication must reinforce the belief that children and youth belong in family and community settings and that system resources must be allocated in a manner consistent with that belief.

- We are committed to working collaboratively to ensure that children with disabilities receive the supports necessary to enable them to receive their special education services within the public schools. We will collaboratively plan for children with disabilities who are struggling in public school settings to identify services that may prevent the need for private school placements, recognizing that the provision of such services will maximize the potential for these children to remain with their families and within their communities.

We believe that how we do our work is as important as the work we do.

- The people who do this work are our most important asset. Children and families deserve trained, skillful professionals to engage and assist them. We strive to build a workforce that works in alignment with our practice model. These professionals are supported in this effort through open dialogue, clear policy, excellent training and supervision, formal and informal performance evaluation, and appropriate resource allocation.

- As with families, we look for strengths in our organization. We are responsible for creating and maintaining a supportive working and learning environment and for open, respectful communication, collaboration, and accountability at all levels.

- Our organizations are focused on providing high quality, timely, efficient, and effective services.

- Relationships and communication among staff, children, families, and community providers are conducted with genuineness, empathy, and respect.

- The practice of collecting and sharing data and information is a non-negotiable part of how we continually learn and improve. We will use data to inform management, improve practice, measure effectiveness, and guide policy decisions. We must strive to align our laws so that collaboration and sharing of data can be achieved to better support our children and families.

- As we work with children, families, and their teams, we clearly share with them our purpose, role, concerns, decisions, and responsibility.

1.2.5 Practice Profiles

The Practice Profiles consist of 11 core skill sets central to child welfare practice that operationalize the Practice Model in measurable and observable terms. Virginia's Practice Profiles cover the continuum of practice, "from first contact to permanency," in order to reflect a holistic approach. In 2016, VDSS, in partnership with Casey Family Programs, convened the Virginia Learning Collaborative Series by bringing together LDSS teams to learn about and apply innovative practices and strategies. Using a trauma-informed lens, with engagement as the centerpiece, the following practice profiles were created: advocating, assessing, collaborating, communicating, demonstrating cultural and diversity competence, documenting, engaging, evaluating, implementing, partnering, and planning.

Each profile describes child welfare practice across a spectrum of proficiency and differentiates between optimal, developmental, and unacceptable practice.

***Optimal:** Practice is defined by consistent application of skills and abilities to a wide range of settings and contexts. The most favorable solution or approach is utilized by the worker to ensure that the other party is respected and included, to the extent possible, in achieving a common goal. The worker demonstrates independence and is able to adapt their response to a variety of contexts and situations while continuing to grow and improve in their position. They are able to use the larger child welfare system and a family's natural resources to achieve positive outcomes.*

***Developmental:** Practice at this level is often only minimally sufficient and inconsistent across multiple contexts or settings. Focus is on short-term and immediate needs rather than long-term goals. The worker is expanding their knowledge base and refining their approach with families, and often needs consultation or coaching from their supervisor. While continuing to improve, they*

need frequent guidance, especially when encountering new or unique situations. They may occasionally make an avoidable error but are learning to utilize their strengths and recognize their challenges.

Unacceptable: *Practice at this level is fragmented, lacking in necessary intensity or misguided. Workers in this category are unable to implement required skills and abilities in any context. Through both inaction and direct intervention, the worker is not helpful, and possibly harmful, to families, which results in poor outcomes. Unacceptable practice is not only an indication of deficiency on the part of the worker, it can suggest a lack of training or support from their agency.*

The proficiency levels can be used as a learning tool for workers by promoting self-awareness and highlighting opportunities for growth. The practice profiles define best practice and emphasize the importance of having well-trained and competent service workers.

1.2.5.1 Practice Profile definitions:

- ***Advocating*** *- Recognizing and supporting the power of individuals and families to speak about their well-being, find solutions, and continue to grow. Working on behalf of a client, family and/or community, communicating with decision-makers, and initiating actions to secure or enhance a needed service, resource or entitlement.*

- ***Assessing*** *- Gathering and synthesizing accurate, comprehensive and credible information concerning the strengths, needs and preferences of the child, youth, and family in order to objectively develop a plan for safety, permanency, and well-being.*

- ***Collaborating*** *- Agencies, families, and community partners working across organizational, social and/or cultural lines toward a shared vision or goal.*

- ***Communicating*** *- Sharing and disseminating oral and written information so that meaning and intent are understood in the same way by all parties involved.*

- ***Demonstrating Cultural and Diversity Competence*** *– Engaging in an ongoing developmental process that includes an acquired understanding of the patterns and potential dynamics of specific groups and cultures, including one's own. It is the understanding of how culture (i.e. the values, beliefs, attitudes and traditions acquired from affiliate groups) as well as personal circumstances, conditions, nature and experiences influence one's own and other people's thinking and behaviors.*

- ***Documenting*** *– Reporting the facts, incidents, evaluations, and observations of a specific situation and having those reports serve as the official record.*

- ***Engaging*** *- All aspects of connecting with youth and families in a deliberate manner to make well-informed decisions about safety, achieving permanency, lifelong connections, and well-being. Family engagement is an intentional practice with utilization of particular skill sets to ensure partnership. Family Engagement is founded on the principle of communicating openly and honestly with families in a way that supports disclosure of culture, family dynamics, and personal experiences. Engagement goes beyond mere involvement; it is about motivating and empowering families to recognize their own underlying needs, protective capacities, and supports. True engagement supports families in taking an active role in working toward change.*

- ***Evaluating*** *- Acquiring and reviewing information to determine if desired goals are being achieved and, if not, reconsider services and resources provided to promote safety, achieve permanency, ensure well-being, and prevent re-traumatization.*

- ***Implementing*** *- Placing a decision or plan into effect by utilizing effective and appropriate methods to support and meet goals established in the planning stage.*

- ***Partnering*** *- Partnering is based upon respectful and meaningful cooperation in the development of strength-based, trusting relationships with families to achieve safety, permanency and well-being for children. Family engagement is a true partnership and embraces the "voice and choice" of the youth, family and caregiver.*

- ***Planning*** *- Thinking about and organizing the activities required to achieve a desired goal. It requires the creation and maintenance of a plan. The finished product is based on the assessment of risk and the needs of the family, youth and children. It forecasts what the family wants to achieve in a designated period of time. Planning requires the input of the family, youth and children and should be revisited when objectives are met, changes are needed, and goals are achieved.*

The Practice Profiles provides agency staff with the tools and guidance to support skill development, coaching, and training and can also be used to communicate consistent performance expectations for employees. The Practice Profiles outline appropriate agency practices that workers should use when working with children and families.

Additional information regarding Practice Profiles can be found in Fusion, please see: Practice Profiles and Coaching. Information can also be found in the following courses: FSWEB1003: The Journey to Practice Enhancement, SUP5710: Foundations in Coaching, SUP5720: Coaching in Supervision, FSWEB1011: Using the Practice Profiles Assessment Toolkit, and FSWEB1013: The Coaching Conversation. These courses can be found in the VLC.

1.3 Trauma and the child welfare system

The child welfare system benefits from the work being done in the fields of trauma and adverse childhood experiences (ACEs). Many of the children who become involved in the child welfare system do so after experiencing some type of traumatic experience. Even for very young babies and children, exposure to events that threaten their safety or their caregiver's safety carries the potential for negative symptoms and effects that may be felt throughout their life. All children in foster care have experienced at least one traumatic event. The majority have experienced complex trauma, which involves exposure to two or more forms of trauma, including sexual, physical, or emotional abuse, domestic violence, neglect, severe caregiver impairment, and school or community violence. Studies have shown that adults who were previously in foster care have higher rates of posttraumatic stress disorder (PTSD) than adults not previously in foster care.

Unfortunately, when child welfare practice is not trauma-informed, children and youth in the child welfare system are at risk for further trauma during the course of CPS investigations, removals, and foster care placements. These experiences can lead to a sense of chaos, betrayal, confusion, fear of the unknown, failure or guilt, overwhelming change, and conflicting experiences of loyalty felt towards the "new family" and birth family. It is imperative that workers who interact with children in the child welfare system understand what trauma is; how it impacts children and is evidenced through behaviors; and, best practices for providing trauma-informed services. While each child's experience is unique, there are common characteristics of trauma exposure that span all events. The effects of trauma can be seen in every aspect of a child's life, through cognitive, behavioral, and physiological symptoms. Traumatic experiences impact relationships, attachment, emotional responses, self-concept, and even long-term health.

Some common symptoms displayed in children exposed to trauma can include the following:

Cognitive Symptoms	Behavioral Symptoms	Physiological Symptoms
• Poor verbal skills • Memory problems • Attention problems • Poor skill development • Learning difficulties	• Aggressive • Verbally aggressive • Imitating the trauma • Withdrawn • Startles easily • Excessive screaming • Lacking self-confidence • Regressive behavior • Anxious, fearful, avoidant • Separation anxiety • Self-blame • Inability to trust others • Difficulty making friends • Irritability, sadness, crying	• Poor appetite, low weight • Digestive problems • Stomach/headache • Nightmares, trouble sleeping • Bed-wetting (after trained)

1.3.1 Trauma-informed practice

Trauma-informed practice involves understanding the impact of trauma on children and youth. It includes the awareness that the methods through which services are delivered can potentially re-traumatize children and youth. It requires providing appropriate supports and referrals to minimize the effects of trauma on clients. While trauma-informed practice requires an expanded knowledge base from which to operate, this work can be achieved without the addition of work-related tasks. For example, in each of the following practice areas, there are ways to provide services that are trauma-informed, which decrease the likelihood of further traumatization for children and their families.

Child Protective Services

- *plan investigations/family assessments/possible removals ahead of time as much as possible so as to reduce the element of surprise*
- *keep things calm during the investigation/assessment/removal*
- *provide the child with sensory comfort and help with adjusting to a new environment*
- *connect with the child and try to understand what the child is experiencing*
- *support the child's relationships and family connections* [1]

[1] Center of Improvement for Child and Family Services

Foster Care

- *minimize placement disruptions*
- *maintain school stability*
- *ensure that foster parents are trained to recognize trauma response as more complex than "bad behavior"*
- *maximize the young person's sense of trust and safety*
- *offer strengths-based services*
- *facilitate connections between birth and foster parents*
- *provide as much information as possible to the birth parents and children and youth so as to establish trust, promote transparency, and eliminate a sense of surprise*
- *coordinate with additional service providers as necessary*

Prevention

- *educate families about resources available for caregivers who have experienced traumas of their own*
- *actively engage with children and birth parents in a way that emphasizes their strengths*
- *perform comprehensive screening and refer for additional assessment, when indicated*
- *coordinate with additional service providers, as necessary*

Adoption

- *work with adoptive parents to ensure they are able to provide a predictable and consistent environment for the youth they are adopting*
- *continue to educate adoptive families on the symptoms of trauma*
- *coordinate with additional service providers as necessary*

Foster and Adoptive Family Development

- *educate foster and adoptive families on the importance of making a youth feel that they are safe*
- *work to establish predictable and consistent environments for youth*
- *address the impact of trauma and related behaviors and their impact on a child's development and relationships*
- *provide information, as is age-appropriate, about traumatic events to help the child reduce self-blame*
- *consider ways to maintain or strengthen the child's current relationships when considering placement and visitation options*
- *address the respite needs of birth and foster families to reduce caregiver stress*
- *encourage caregivers to participate in therapy, when appropriate*
- *coordinate with additional service providers, as necessary*

1.3.2 Secondary traumatic stress

Professionals who work with clients who have experienced or are currently experiencing traumatic events can begin to internalize the observed trauma and experience distress in their professional and personal lives. Service workers are exposed to trauma frequently through work with vulnerable clients, with the degree of exposure largely dependent on the type of work in which they are engaged. Service workers providing services to children and families who have histories of trauma are at high risk of secondary traumatic stress (STS), which occurs when post-traumatic stress disorder (PTSD) symptoms are present after indirect exposure to trauma.

Symptoms of STS include the following [2] :

- *Hypervigilance*
- *Hopelessness*
- *Guilt*
- *Avoidance*
- *Social Withdrawal*
- *Minimizing*
- *Anger and Cynicism*
- *Sleeplessness*
- *Insensitivity to violence*
- *Illness/ physical ailments*
- *Fear*
- *Chronic exhaustion*
- *Loss of creativity*
- *Inability to embrace complexity*
- *Diminished self-care*

2 *National Child Traumatic Stress Network*

There are also factors that increase the likelihood of STS. These include working with traumatized children, being new to the field, carrying a heavy caseload, social or organizational isolation, feeling professionally unprepared due to inadequate training, and unresolved personal trauma.

The effects of trauma on service workers, which result from hearing or observing traumatic experiences, can be mitigated through utilizing supervision effectively and engaging in adequate self-care practices. If supervision is reflective and relationship-based, the safe space created in supervision can provide an appropriate venue in which to process secondary trauma and receive additional support. Additionally, maintaining a consistent self-care routine is a good way to protect oneself against the potential for STS, as well as burnout. Burnout is typically distinguished from STS in that burnout is not trauma-related but rather tied to work load or organization/agency stressors.

Self-care has multiple components and involves a personal commitment to addressing the needs of one's whole self in order to maintain balance and experience greater satisfaction in one's personal and professional life. Any professional's self-care strategy should begin with an awareness of the stressors experienced and the level of exposure to trauma in the course of day-to-day work. Self-care also includes self-awareness of one's own coping strategies and whether or not they are beneficial mechanisms. Lastly, self-care requires developing a personal self-care plan, comprised of activities and exercises that serve to counteract the negative effects of STS and support well-being.

Self-care looks different for everyone. Some people find the following helpful: exercise, creating space for enjoyable activities, engaging in centering and mindfulness practices, breathing exercises, meditation, and mindful movement (such as yoga). The following ideas can serve to guide and inform the development of an individualized self-care plan [3]:

3 Sources: National Association of Social Workers, Reachout.com, University of Buffalo School of Social Work

Workplace/ Professional Self Care	Personal/Physical Self Care	Psychological Self Care	Emotional/Social/Spiritual Self Care
Engage in regular supervision Participate in a peer-support group Maintain appropriate boundaries with clients and staff Seek professional development opportunities	Develop a regular sleep routine Aim for a healthy diet Take lunch breaks Practice yoga, tai chi, other centering/mindful exercises Exercise regularly	Keep a reflective journal Engage with a non-work hobby Make time for relaxation Make time to engage positively with friends and family	Develop friendships that are supportive Start a gratitude journal Engage in an enjoyable activity (movie, hike, etc.) Attend religious services or participate in a supportive community outside of work Meditation, prayer, reflection

1.3.3 Additional trauma resources

Center for Disease Control and Prevention: Adverse Childhood Experiences (ACE), provides an in-depth look at the longitudinal ACE study conducted to determine rates of the U.S. population with a history of trauma, or adverse experiences in childhood. Provides an overview of how to prevent and address negative effects of ACEs.

Center for Improvement of Child and Family Services, supported by Portland State University's School of Social Work; produced a training entitled Reducing the Trauma to Children, which provides guidance on assessing and addressing trauma in children.

Child Trauma Academy, a free, web-based course that provides an introduction to trauma, secondary trauma and self-care activities.

Child Welfare Information Gateway, a service of the Children's Bureau, Administration for Children and Families, U.S. Department of Health Services that has resources and information on a number of topics related to child welfare.

Children's Services Practice Notes, a collaboration between the North Carolina Division of Social Services and the University of North Carolina at Chapel Hill School of Social Work that puts together a regular newsletter regarding different aspects of child welfare.

Encouraging Staff Wellness in Trauma-Informed Organizations, a helpful resource in regards to a brief overview of steps that can be taken to be trauma-informed within an organization.

National Child Traumatic Stress Network, provides multiple resources and guides for parents and caregivers, an extensive list of videos, articles, and other resources related to childhood trauma. NCTSN's Child Trauma Training Toolkit provides a great resource for trauma-informed practice and is free, but users must register on the website to gain access.

Resilience Trumps Aces, a website put together by the Children's Resilience Initiative (CRI) that offers webinars, presentation, and other resources focused on ACEs and resilience.

Self-Care in Social Work, a website dedicated to self-care for professionals, including a Ways of Coping self-assessment for workers to gain self-awareness and additional strategies.

Self Care Starter Kit, the University of Buffalo School of Social Work website includes this starter kit with an introduction to self-care practice, and resources to develop a personalized self-care plan.

Trauma Informed Practice with Young People in Foster Care, an issue brief and other trauma informed resources specific to child welfare, from the Annie E. Casey Foundation.

Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others (Laura van Dernoot Lipsky, 2009), a book that discusses the impact of trauma exposure on professionals and includes self-care guidelines to combat potentially harmful effects. Author Laura van Dernoot Lipsky also gave a TED Talk, "Beyond" *on secondary trauma and self-care*

Traumatic Stress Institute, a website dedicated to promoting trauma-informed care and healing relationships.

1.4 Federal child welfare laws

Federal laws have a considerable impact on how states fund and deliver child protection, child welfare, and adoption programs and services. Federal laws and policies related to child abuse and neglect, child welfare, and adoption are set forth in the following:

The Indian Child Welfare Act of 1978 (ICWA). Congress passed ICWA in response to the high number of Indian children being removed from their homes by both public and private agencies. The intent was to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families."

The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). This federal program authorized appropriations for adoption and foster care assistance to states and required states to provide adoption assistance to parents who adopt a child who is AFDC-eligible and is a child with special needs. For foster care assistance, states are required to make reasonable efforts to prevent placement or to reunify children with their families.

The federal Child Abuse Prevention and Treatment Act (CAPTA) is one of the key pieces of legislation that guides child protection. CAPTA was signed into law in 1974 (P.L. 93-247). It was reauthorized in 1978, 1984, 1988, 1992, 1996, and 2003, and with each reauthorization, amendments have been made to CAPTA that have expanded and refined the scope of the law. CAPTA was most recently reauthorized on December 20, 2010 by the CAPTA Reauthorization Act of 2010 (P.L. 111-320, or 42 U.S.C. 5101 et seq.).

The Multiethnic Placement Act of 1994 as amended by the Interethnic Adoption Provisions of 1996. These laws were enacted in an effort to promote the best interests of children by ensuring that they have permanent, safe, stable, and loving homes that will meet their individual needs, without regard to the child's or the prospective parent's race, color, or national origin.

The Adoption and Safe Families Act (ASFA) of 1997. This law was passed to promote the adoption of children in foster care.

The Foster Care Independence Act of 1999. This law was enacted to amend part E of title IV of the Social Security Act to provide States with more funding and greater flexibility in carrying out programs designed to help children make the transition from foster care to self-sufficiency, and for other purposes.

The Deficit Reduction Act of 2005. Title VII of this act provides for reauthorization of the TANF program, Healthy Marriage and Family funds, Court Improvement Program, Safe and Stable Families Program, and other child welfare programs.

The Child and Family Services Improvement Act of 2006. This law's goal is to amend part B of title IV of the Social Security Act to reauthorize the Promoting Safe and Stable Families (PSSF) program, and for other purposes.

The Safe and Timely Interstate Placement of Foster Children Act of 2006. This bill was enacted to improve protections for children and to hold states accountable for the safe and timely placement of children across state lines.

The Adam Walsh Child Protection and Safety Act of 2006. This law was enacted to protect children from sexual exploitation and violent crime; to prevent child abuse and child pornography with an emphasis on comprehensive strategies across federal, state, and local communities to prevent sex offenders' access to children; to promote Internet safety; and to honor the memory of Adam Walsh and other child crime victims.

The Fostering Connections to Success and Increasing Adoption Act of 2008. The goal of this law is to amend parts B and E of Title IV of the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, improve incentives for adoption, and for other purposes.

The National Youth in Transition Database regulations (45 CFR 1356.80 through 1356.86). This ruling adds new regulations to require states to collect and report data to the Administration for Children and Families (ACF) on youth who are receiving independent living services and on the outcomes of certain youth who are in foster care or who age out of foster care.

The Patient Protection and Affordable Care Act (P.L. 111-148). This regulation, passed in 2010, provides improvements in health care coverage for all Americans.

The Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183) was signed into law in September 2014. In addition to protecting children and youth at risk of sex trafficking, it also includes provisions for improving opportunities for children in foster care and supporting permanency. The law requires states to implement a plan to locate and respond to children who run away from foster care, report to law enforcement authorities any instances of sex trafficking, and to collect data regarding children in foster care who have been the victims of sex trafficking. Additionally, states are required to develop a reasonable and prudent parent standard for a foster child's participation in age and developmentally appropriate social, recreational and extracurricular activities. The law also limits the goals of Another Planned Permanent Living Arrangement and Permanent Foster Care to youth 16 years of age or older and prescribes requirements for approval of the foster care plan. Youth who age out of foster care at age 18 shall be provided with certain documentation and all youth age 14 and older shall be given the opportunity to participate in case planning and choose up to two members of their team.

The Family First Prevention Services Act (Family First) was enacted by Congress on February 9, 2018 as part of the larger Bipartisan Budget Act (BBA), and represents the most significant re-write of title IV of the Social Security Act since 1981. Family First enables states to use federal funds under parts B and E of title IV of the Social Security Act to provide enhanced support to children and families and prevent foster care placements by providing the following: i) mental health and substance abuse treatment, (ii) prevention and tr ent services, (iii) in-home parent skill-based programs, and (iv) kinship navigator services. Additionally, Family First provides the tools and resources necessary to allow Virginia's social services system to focus on prevention in order to

keep children safely with their families and not enter foster care so that they have a better chance of growing-up in the least restrictive setting.

The amount of financial participation by the federal government is dependent upon compliance with federal regulations. Requirements are also in state laws pertaining to foster care and the Comprehensive Services Act (§ 2.2-5200 et. seq.).

1.5 Federal child welfare outcomes

The federal Child and Family Services Review (CFSR) is structured to help states identify strengths and areas needing improvement in their child welfare practices and programs, as well as institute systemic changes that will improve child and family outcomes. The CFSR enables Virginia to: ensure conformity with federal child welfare requirements, determine what is happening to children and families as we engage in child welfare services, and assist in enhancing our capacity to help children and families achieve positive outcomes.

Engaging children, their families, and other significant adults helps LDSS achieve the following outcomes required in the federal CFSR, as well as specific outcome measures:

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.

- *The agency responded to all accepted child maltreatment reports and made face-to-face contact with children within the required timeframe 95% of the time.*

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.

- *The agency made concerted efforts to provide services to prevent the child's entry or re-entry into foster care 90% of the time.*
- *The agency made concerted efforts to assess and address the child's risk and safety concerns 90% of the time.*

Permanency Outcome 1: Children have permanency and stability in their living situations.

- *The child is in a stable placement that supports their permanency goals 90% of the time.*
- *The agency established appropriate permanency goals in a timely manner 90% of the time.*

- *The agency made concerted efforts to achieve the child's permanency goals 90% of the time.*

Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.

- *The agency made concerted efforts to place siblings together 90% of the time.*
- *The agency made concerted efforts to ensure that frequent visitation occurred between the child, their parents, and siblings 90% of the time.*
- *The agency made concerted efforts to preserve the child's family and community connections 90% of the time.*
- *The agency made concerted efforts to place the child with relatives when appropriate 90% of the time.*
- *The agency made concerted efforts to support and maintain positive relationships between the child and their parents or primary caregivers 90% of the time.*

Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.

- *The agency made concerted efforts to assess the needs and provide services to the child, parents, and foster parents 90% of the time.*
- *The agency made concerted ongoing efforts to involve the parents and the child in the case planning process 90% of the time.*
- *Service workers conducted frequent and quality visits with the child to ensure their safety, permanency, and well-being 90% of the time.*
- *Service workers conducted frequent and quality visits with the child's parents to ensure their safety, permanency, and well-being 90% of the time.*

Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.

- *The agency made concerted efforts to assess and address the child's educational needs 95% of the time.*

Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

- *The agency addressed the physical and dental health needs of the child 90% of the time.*

- *The agency addressed the mental/behavioral health needs of the child 90% of the time.*