



VERMONT

Department for Children and Families

Family Services Division

Vermont's 2020 Annual Progress and Services Report

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Introduction

The 2020 Final Progress and Services Report (APSR) report will focus on changes since the Vermont Department for Children and Families (DCF) Family Services Division (FSD) submitted its 2015-2019 Child and Family Services Plan (CFSP) as well as the 2016, 2017, 2018, and 2019 APSRs. All these reports and other federal reports can be found here:

<http://dcf.vermont.gov/fsd/publications>

In the Spring of 2015, Vermont's Family Services Division participated in Round 3 of the Child and Family Services Review (CFSR). Vermont conducted a traditional review of 65 cases which involved a week-long onsite review by the Children's Bureau in the Burlington, St. Johnsbury, and Bennington district offices. Vermont received the final CFSR report in September of 2015:

<http://dcf.vermont.gov/sites/dcf/files/FSD/Docs/CFSR-2015.pdf>

In collaboration with the Children's Bureau, Vermont developed a Program Improvement Plan (PIP) which was approved effective July 1, 2016. Vermont's PIP highlighted practice improvements related to safety for both children and staff as well as strengthening how the division integrates the information from the assessments of risk and safety into ongoing safety and case planning. An overview of Vermont's entire Program Improvement Plan can be found here: <http://dcf.vermont.gov/sites/dcf/files/FSD/pubs/FSD-PIP-2016-2018.pdf>

Vermont will be closing out our Program Improvement Plan by fall of 2019. This report will highlight the agency's successes as well as areas that we still need to focus our attention and make improvements moving forward.

General Information

Collaboration

Family Services continues to strive to ensure key stakeholders are engaged in providing input on practice and policy updates, so the division can best serve the children, youth, and families in Vermont. In Round 3 of the CFSR, Vermont received a Strength rating for Item 31: *Engagement and Consultation with Stakeholders* and Item 32: *Coordination of CFSP Services with other Federal Programs*. The following is a list of the various stakeholder groups FSD engages with throughout the year.

- The **Vermont Foster and Adoptive Family Association (VFAPA)** hold monthly board meetings and quarterly networking meetings, which division staff attend. At VFAPA's annual conference, an open forum with partners and FSD leadership is traditionally held, as a mechanism for attendees to have direct access to the commissioner and deputy commissioner. In addition, the **Foster Parent Workgroup** meets bi-monthly and is jointly led by FSD's Deputy Commissioner and foster parents and includes the voices of foster parents, central office staff, district directors, supervisors, social workers, resource coordinators, youth, and community partners. This group develops and oversees a workplan designed to make practice improvements addressing issues the Department and foster parents have jointly identified.

- The **Forward** is the youth advisory board for current and former foster youth. This group meets monthly to provide input to Family Services around practice and policy related issues.
- **Vermont Kin as Parents (VKAP)** is a state-wide non-profit organization serving grandparents and relatives who are raising a family member's child when the parents are unable. With the increase of kin foster care, Family Services and VKAP continue to work together discuss how to best support family members who are currently raising relatives. Both Family Services post permanency manager and foster and kin care manager are on the board.
- The **Vermont's Citizen Advisory Board** was established by Family Service in 1998 per the federal Child Abuse Prevention and Treatment Act (CAPTA), under the CAPTA Reauthorization Act of 2010. VCABS meets quarterly regarding a variety of issues related to child protection, to review and improve Vermont' child welfare system.
- **Vermont Network Against Domestic and Sexual Violence** and Family Services collaborates in various ways including:
 - Through a collaboration grant, the Rural Domestic Violence and Child Victimization, Teen dating violence and stalking. This project helps to fund 2.5 DV Specialists and the leadership team meets monthly to meet the grant goal expectations.
 - Child Victim Treatment Director coordinates with Sexual Assault Nurse Examiner coordinator who is housed at the VT Network, as well as sexual violence prevention and education efforts with the Youth Advocacy Coordinator.
 - VT Network are members on the VT Citizen Advisory Board
- The **Vermont Coalition of Residential Programs (VCORP)** meets monthly, with division representatives attending.
- **Justice for Children Task Force** convened by the Chief Justice of the Vermont Supreme Court, is a collaborative, interdisciplinary effort bringing together those in charge of decisions impacting outcomes for children who are not in the custody or guardianship of a parent. Family Services commissioner and deputy commissioner participate on this task force and collaborates with the Court Improvement Project to improve outcomes for children and families. Other Task Force members include lawmakers, juvenile attorneys, Department of Health, states attorney, mental health, court administrator, Agency of Education, and an assistant attorney general. One of the sub-committees includes the Best-Practices Sub-Committee which focuses on practice related strategies to improve outcomes for children, youth and families.
- **FSD Stakeholders Meetings-** Family Services coordinates quarterly meetings involving various stakeholders to provide policy and practice updates to help strengthen partnerships and the greater child welfare system. Family Services also uses this venue to get feedback on draft policies, practice guidance, and brochures for example. The quarterly meeting invitation goes out to individuals from the following fields: court, mental health, corrections, education, local services providers, treatment providers, law enforcement, placement providers, and various advocacy groups.
- **Vermont Center for Crime Victim's Services-** DCF Family Services receives funding from the Department of Justice, Office of Violence Against Women, Rural Domestic Violence and Child Victimization grant and funds from the Office of Victims of Crime. These grant fund 2.5 FTE Domestic Violence Specialists to provide case consultation and expertise to four regional FSD offices, as well as

direct service and appropriate referrals to community service providers. In addition, formal Memorandum of Understanding are in place and revisited on an annual basis between the local district office and the community domestic and sexual violence program to improve collaboration and referrals. Funds from this grant allowed FSD to leverage technical assistance from our statewide experts on LGBTQQ youth, Outright VT.

- The **Vermont Children’s Justice Act Task Force**- members of the Task Force include: Law Enforcement, Criminal/Civil Court Judges, Prosecuting Attorney, Defense Attorney, Child Advocate, Court Appointed Special Advocate (GAL), Mental Health, Child Protective Service, an individual experienced in working with children with disabilities, parent/representative, adult former victim, and an individual experienced in working with homeless children or youth.
- **Multi-Disciplinary Teams 33 VSA § 4917** - The DCF Commissioner may empanel a multidisciplinary team when there may be a probable case of child abuse which warrants the coordinated use of several professional services. The commissioner shall appoint members which may include persons who are trained and engaged in work relating to child abuse or neglect such as medicine, mental health, social work, nursing, child care, education, law, or law enforcement. Additional persons may be appointed when the services of those persons are appropriate to any particular case. The empaneling of a team shall be authorized in writing and shall specifically list the members of the team.

Teams assist the department in identifying and treating child abuse or neglect cases by providing:

- case diagnosis or identification;
- a comprehensive treatment plan; and
- coordination of services pursuant to the treatment plan.
- Teams may also provide public informational and educational services to the community about identification, treatment, and prevention of child abuse and neglect.
- Team shall also foster communication and cooperation among professionals and organizations in its community and provide such recommendations or changes in service delivery as it deems necessary.

Update on Assessment of Performance

Vermont completed Round 3 of the Child and Family Services Review (CFSR) in the spring of 2015. The Division did a traditional review of 65 cases. The outcome of the review was the following:

Data Element	Required Performance	State Performance
<i>Safety Outcome 1 -- Children are first, and foremost, protected from abuse and neglect.</i>		
Item 1 -- Timeliness of investigations	90% Strength	72% Strength
<i>Safety Outcome 2 -- Children are safely maintained in their homes whenever possible and appropriate.</i>		
Item 2 -- Services to protect child(ren) in home and prevent removal or re-entry into foster care	90%	97% STRENGTH
Item 3 -- Risk and safety assessment and management	90% Strength	57% Strength

<i>Permanency Outcome 1 -- Children have permanency and stability in their living situations.</i>		
Item 4 -- Stability of foster care placement	90% Strength	75% Strength
Item 5 -- Permanency goal for child	90% Strength	57.5% Strength
Item 6 -- Achieving reunification, guardianship, adoption, or other planned permanent living arrangement	90% Strength	67.5% Strength
Item 7 -- Placement with siblings	90% Strength	90% STRENGTH
<i>Permanency Outcome 2 -- The continuity of family relationships and connections is preserved for children.</i>		
Item 8 -- Visiting with parents and siblings in foster care	90% Strength	76% Strength
Item 9 -- Preserving connections	90% Strength	85% Strength
Item 10 -- Relative placement	90% Strength	80% Strength
Item 11 -- Relationship of child in care with parents	90% Strength	77% Strength
<i>Well-Being Outcome 1 -- Families have enhanced capacity to provide for children's needs.</i>		
Item 12 -- Needs and services of child, parents, and foster parents	90% Strength	52% Strength
• Sub-Item 12A -- Needs assessment and services to children	90% Strength	75% Strength
• Sub-Item 12B -- Needs assessment and services to parents	90% Strength	56% Strength
• Sub-Item 12C -- Needs assessment and services to foster parents	90% Strength	81% Strength
Item 13 -- Child and family involvement in case planning	90% Strength	60% Strength
Item 14 -- Caseworker visits with child	90% Strength	63% Strength
Item 15 -- Caseworker visits with parents	90% Strength	39% Strength
<i>Well-Being Outcome 2-- Children receive appropriate services to meet their educational needs.</i>	95% Substantially Achieved	88% Substantially Achieved
Item 16 -- Educational needs of the child	90% Strength	88% Strength
<i>Well-Being Outcome 3-- Children receive adequate services to meet their physical and mental health needs.</i>	95% Substantially Achieved	74% Substantially Achieved
Item 17 -- Physical health of the child	90% Strength	87% Strength
Item 18 -- Mental/behavioral health of the child	90% Strength	74% Strength

After reviewing the results of the CFSR, the division negotiated with the Children’s Bureau to focus on the following item measures for the agency’s PIP. In the fall of 2016, the division collected baseline data through another round of case reviews. The results of that review are highlighted below, along with the established PIP goal which was calculated by the Children’s Bureau.

CFSR Items	Item Description	Baseline	PIP Goal
Item 1	Timeliness of Initiating Investigations of Reports of Child Maltreatment	79.3%	86.9%
Item 3	Risk and Safety Assessment and Management	60.0%	66.2%
Item 4	Stability of Foster Care Placement	70.0%	77.3%
Item 5	Permanency Goal for Child	45.0%	53.0 %
Item 6	Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement	45.0%	53.0%
Item 12	Needs and Services of Child, Parents, and Foster Parents	35.4%	41.4%
Item 13	Child and Family Involvement in Case Planning	50.8%	57.1%
Item 14	Caseworker Visits with Child	58.5%	64.7%
Item 15	Caseworker Visits with Parents	44.4%	50.8%

The following tables provides data on Safety, Permanency, Well-being, and Youth Justice outcomes. All the Item measures below come from the recent district case reviews where 65 cases are reviewed each round using the online Onsite Services Review Instrument (OSRI) developed by the Children’s Bureau. The reviews consist of a case file review as well as interviews from the family, family services worker, and potentially foster parents, GALs, or other key individuals. There are other State and Federal Indicators also listed in the tables below.

Safety Outcomes

Item Label	Item Description	2015 CFSR or CY2015 State Data	PIP Baseline or CY2016 State Data	PIP Targets or National Standards	Spring 2017 Reviews or Jan- Jun 2017 Data	Fall 2017 Reviews or Jul-Dec 2017 Data	Spring 2018 Reviews or Jan- Jun 2018 Data	Fall 2018 Reviews or Jul- Dec 2018 Data
SAFETY		65 cases or statewide data	65 cases or statewide data	65 cases or statewide data	65 cases or statewide data	65 cases or statewide data	65 cases or statewide data	65 cases or statewide data
OSRI Item 1	Timeliness of Initiating Investigations of Reports of Child Maltreatment	72.00%	79.30%	86.90%	86.10%	79.31%	73.33%	93.10%
OSRI Item 2	Services to Family to Protect Children in the Home and Prevent Removal or Re-Entry Into Foster Care	97.00%	77.00%	N/A	63.00%	60.00%	78.13%	82.76%
OSRI Item 3	Risk and Safety Assessment and Management	57.00%	60.00%	66.20%	49.00%	47.69%	55.88%	56.92%
Federal Indicator	Recurrence of Maltreatment	6.40%	4.70%	9.10%	4.80%	5.70%	5.50%	4.90%
Federal Indicator	Maltreatment in Foster Care	2.8	3.1	8.5	3.0	Not Available	Not Available	Not Available

Permanency Outcomes

Item Label	Item Description	2015 CFSSR or CY2015 State Data	PIP Baseline or CY2016 State Data	PIP Targets or National Standards	Spring 2017 Reviews or Jan-Jun 2017 Data	Fall 2017 Reviews or Jul-Dec 2017 Data	Spring 2018 Reviews or Jan- Jun 2018 Data	Fall 2018 Reviews or Jul- Dec 2018 Data
PERMANENCY		65 cases or statewide data	65 cases or statewide data	65 cases or statewide data	65 cases or statewide data	65 cases or statewide data	65 cases or statewide data	65 cases or statewide data
OSRI Item 4	Stability of Foster Care Placement	75.00%	70.00%	77.30%	60.00%	80.00%	55.00%	80.00%
	Placement Stability	7.0	7.8	4.1	7.0	8.0	7.6	7.0
OSRI Item 5	Permanency Goal for Child	58.00%	45.00%	53.00%	28.00%	50.00%	27.50%	45.00%
OSRI Item 6	Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement	68.00%	45.00%	53.00%	63.00%	50.00%	47.50%	60.00%
Federal Indicator	Permanency in 12 Months	33.60%	30.60%	40.50%	30.90%	34.80%	35.10%	31.80%
Federal Indicator	Permanency in 12 Months for Children in Foster Care 12-23 Months	44.20%	45.70%	43.60%	47.20%	54.30%	47.80%	43.50%
Federal Indicator	Permanency in 12 Months for Children in Foster Care 24+ Months	33.20%	39.60%	30.30%	40.30%	43.60%	44.20%	43.20%
Federal Indicator	Re-Entry to Foster Care	19.00%	21.90%	8.30%	19.40%	22.80%	22.60%	14.08%
OSRI Item 7	Placement With Siblings	90.00%	95.00%	N/A	94.00%	86.36%	88.89%	100.00%
State Indicator	Siblings Placed Together	61.70%	59.30%	N/A	60.20%	59.80%	60.80%	57.90%
OSRI Item 8	Visiting With Parents and Siblings in Foster Care	76.00%	77.00%	N/A	80.00%	73.53%	62.16%	80.65%
OSRI Item 9	Preserving Connections	85.00%	90.00%	N/A	83.00%	80.00%	80.00%	92.50%
OSRI Item 10	Relative Placement	80.00%	75.00%	N/A	81.00%	77.78%	58.33%	81.08%
State Indicator	Placement Type with Relatives	32.60%	29.60%	N/A	28.20%	27.40%	30.19%	28.41%
OSRI Item 11	Relationship of Child in Care With Parents	77.00%	79.00%	N/A	88.00%	81.82%	63.64%	83.87%

Well Being Outcomes

WELL-BEING		65 cases or statewide data						
OSRI Item 12	Needs and Services of Child, Parents, and Foster Parents	52.00%	35.40%	41.40%	34.00%	29.23%	29.41%	43.42%
OSRI Item 13	Child and Family Involvement in Case Planning	60.00%	50.80%	57.10%	46.00%	40.00%	47.06%	58.46%
OSRI Item 14	Caseworker Visits with Child	63.00%	58.50%	64.70%	63.00%	53.85%	50.00%	69.23%
Federal Indicator	Months Worker-Child Visit Made	85.70%	87.50%	95.00%	81.90%	89.90%	91.88%	89.84%
OSRI Item 15	Caseworker Visits with Parents	39.00%	44.40%	50.80%	33.00%	41.38%	24.59%	44.93%
State Indicator	Monthly Contact With Adults of Involved Children	37.40%	38.10%	N/A	36.80%	38.00%	Not Available	Not Available
OSRI Item 16	Educational Needs of the Child	88.00%	86.00%	N/A	85.00%	78.00%	78.26%	85.71%
State Indicator	Educational Stability	Not Available	Not Available	N/A	Not Available	Not Available	Not Available	Not Available
OSRI Item 17	Physical Health of the Child	87.00%	78.00%	N/A	58.00%	64.15%	72.00%	67.92%
OSRI Item 18	Mental/Behavioral Health of the Child	74.00%	77.00%	N/A	71.00%	62.00%	66.67%	79.59%

Update to the Plan for Improvement and Progress Made to Improve Outcomes

	Goal	Objectives	Outcomes for Children, Youth and Families OR Service Delivery Elements	Rationale/ Data Analysis/ Measures	Implementation Supports Needed
1	Placement Stability: <i>Increase placement stability for children</i>	➤ The Placement Stability Project continues to roll out Trauma Informed Training for the Workforce, Evidence-based Treatment (ARC, CPP, PCIT), and	❖ Decrease child/youth trauma ❖ Placement moves are intentional and	Placement Stability: Moves per 1,000 days in care, by federal fiscal year FFY2014 6.48	• Results Oriented Management (ROM) reporting tool will assist in timely availability of data

	<p><i>and youth who are in DCF custody.</i></p>	<p>Caregiver Training (RPC+) and Mentoring in all 12 districts</p> <ul style="list-style-type: none"> ➤ Support implementation of new licensing application ➤ Support implementation of new assessment of suitability tool for kinship care providers ➤ Continue work with the Capacity Building Center around creating VTs Diligent Statewide Recruitment Plan ➤ Continue work related to our partnership with the Quality Improvement Center for Adoption and Guardianship, with a focus on identifying and implementing best practices for post-permanence services ➤ Foster Parent Workgroup continues to address issues which can result in unplanned placement moves ➤ Augment community-based resources (ex: Becket, NCSS) 	<p>support permanency goals</p> <ul style="list-style-type: none"> ❖ Increase likelihood for children and youth to create life-long connections 	<table border="0"> <tr> <td>FFY2015</td> <td>5.96</td> </tr> <tr> <td>FFY2016</td> <td>6.21</td> </tr> <tr> <td>FFY2017</td> <td>6.88</td> </tr> <tr> <td>FFY2018</td> <td>5.87</td> </tr> </table> <p>Data Source: Vermont Child and Family Services Review (CFSR 3) Observed Performance Data Profile dated January 2019, based on AFCARS and NCANDS data submissions for FFY 16, 17 & 18. FFY 14 & FFY 15 data based on Data Profile, dated May 2017.</p>	FFY2015	5.96	FFY2016	6.21	FFY2017	6.88	FFY2018	5.87	<p>with drill down capability</p> <ul style="list-style-type: none"> • Policy & CQI staff to provide best practice information, trend data, and guidance on engaging in CQI practices
FFY2015	5.96												
FFY2016	6.21												
FFY2017	6.88												
FFY2018	5.87												
<p>2</p>	<p>Youth Justice: <i>Youth in custody are free from repeat delinquent and/or criminal activity.</i></p>	<ul style="list-style-type: none"> ➤ Explore ways to increase diversionary practices and refashion probation into an effective intervention for the population of youth that need greater oversight ➤ Continue implementation of Juvenile Justice Reform (Acts 72 and 201) so youth who are charged with a crime receive a response that is aligned with brain development research and best practice 	<ul style="list-style-type: none"> ❖ Decrease in recidivism rates ❖ Increase in-home support to youth at-risk and their families ❖ Increase likelihood for children and youth to create life-long connections 	<p>We continue to see a steady decline (40% over the past six years) in youth on probation and in custody for delinquency. This follows national trends and we would like to focus on increasing our efforts to youth at-risk to avoid them</p>	<ul style="list-style-type: none"> • Continue to collaborate with the courts and share data inform implementation of Acts 72 and 201 • Results Oriented Management (ROM) reporting tool will assist in timely availability of data 								

			interacting with the juvenile justice system.	with drill down capability	
3	<p>Safety <i>Maintain compliance with national standard so that children and youth are safe from repeat maltreatment.</i></p>	<ul style="list-style-type: none"> ➤ Continue to review the implementation of revised SDM tools and new reunification tool, provide training and coaching ➤ Support implementation of new case plan which improves the linkage between the safety concerns with the action steps ➤ Strengthen home visiting practices to increase effectiveness of informal needs and safety/risk assessment ➤ Develop guidance and expectations around case documentation ➤ Continue improving practice around the screening, identification of potential human trafficking victims 	<ul style="list-style-type: none"> ❖ Identify safety and risk related concerns ❖ Identify substance abuse related risks and assist clients in accessing treatment 	<p>Recurrence of Maltreatment Recurrence of maltreatment, by federal fiscal year FFY2014-2015: 7.00% FFY2015-2016: 5.60% FFY2016-2017: 5.70% FFY2017-2018: Not Available</p> <p>Data Source: Vermont Child and Family Services Review (CFSR 3) Data Profile dated January 2019, based on AFCARS and NCANDS data submissions for FFY 14, 15, & 16.</p> <p>Goal: Maintain</p>	<ul style="list-style-type: none"> • Results Oriented Management (ROM) reporting tool will assist in timely availability of data. • Policy & CQI staff to provide best practice, trend data, and guidance on engaging in CQI practices. • Support and training from CRC
4	<p>Permanency</p>	<ul style="list-style-type: none"> ➤ Implement new kinship care policy and associated documents/tools. ➤ Continue implementation of newly developed SDM reunification tool, provide training and coaching ➤ Continue to review district CQI processes to ensure initial case plans are created with parents and filed timely with courts 	<ul style="list-style-type: none"> ❖ Decrease child/youth trauma ❖ Increase likelihood for children and youth to create life-long connections ❖ Safely reunify when appropriate 	<p>Increase discharge to permanence baseline incrementally each year.</p>	<ul style="list-style-type: none"> • Results Oriented Management (ROM) reporting tool will assist in timely availability of data • Policy & QA staff to provide best practice, trend data, and

		<ul style="list-style-type: none"> ➤ Continue work related to goals and objectives with the Quality Improvement Center for Adoption and Guardianship, with a focus on identifying and implementing best practices for post-permanence services. ➤ Continue to review practice and provide district support related to post-adopt contact agreements (PACAs) ➤ Continue to review practice related to CCOs ➤ Review implementation policy 126: Reinstatement of Parental Rights ➤ Continue to work with courts to address the TPR backlog and timeliness to adoption 	<ul style="list-style-type: none"> ❖ Children and youth achieve permanency timely 		<p>guidance on engaging in CQI practices</p> <ul style="list-style-type: none"> • Ongoing discussions with the courts on addressing systemic issues primarily resulting from increase caseloads, delayed court hearings which have impacted permanency timeframes.
5	Well-Being	<ul style="list-style-type: none"> ➤ Continue to enhance practice around normalcy which has been included in the new case plan format ➤ Improve referral rates for youth over 14 to access services through YDC and for transitioning age youth ➤ Continue to strengthen practice related to LGBTQ population to ensure staff are properly assessing for appropriate needs and services 	<ul style="list-style-type: none"> ❖ Improve results for Well-Being Outcomes 1 and 2 for our QRCs ❖ Resolve credit issues for youth prior to their 18th birthday ❖ Increase opportunities for children and youth in custody to experience normal childhood experiences ❖ Improve supports and outcomes for transitioning youth 	<ul style="list-style-type: none"> ✓ Review QCR data ✓ Utilize NYTD and YDC data as a source for measuring youth well-being 	<ul style="list-style-type: none"> • Results Oriented Management (ROM) reporting tool will assist in timely availability of data • Policy & CQI staff to provide best practice, trend data, and guidance on engaging in CQI practices

			❖ Improve supports and services to LGBTQ population												
6	CQI System: <i>Family Services Division regularly assesses the quality of services in the CFSP and has measures to address identified problems.</i>	<ul style="list-style-type: none"> ➤ Continue utilization of the statewide CQI Steering Committee to seek feedback on new initiatives, policy, and other practice related areas. ➤ Data Integrity Team will continue to address and monitor data issues including accuracy and timeliness ➤ Implement Results Oriented Management (ROM) reporting tool to enhance access and ability to analyze data and monitor progress on outcomes ➤ Continued to improve upon the critical incidents review structure/format 	<ul style="list-style-type: none"> ❖ Staff are aware of CQI efforts and understand their role in these efforts ❖ Staff have support from the QA team on how to access and interpret available data to improve outcomes 	<ul style="list-style-type: none"> ✓ QCR system ✓ Ongoing data integrity team work. ✓ ROM Implemented 	<ul style="list-style-type: none"> • Training and T/A on review tool • Best practice information on other states to learn from where things are working well. 										
7	Rate of Kinship Placement: <i>Utilize Placement with Kin when safe and appropriate.</i>	❖ Implement a consistent statewide approach to assessing caregivers through new licensing application and kinship care policy and guidance	<ul style="list-style-type: none"> ✓ Children and youth will experience greater placement stability ✓ Children and youth will maintain life-long connections ✓ Children and youth will experience less trauma by being placed with someone they know 	<p>Kinship Placement Children placed in kinship foster care, by federal fiscal year</p> <table border="1"> <tr> <td>FFY2014</td> <td>35.62%</td> </tr> <tr> <td>FFY2015</td> <td>37.00%</td> </tr> <tr> <td>FFY2016</td> <td>32.80%</td> </tr> <tr> <td>FFY2017</td> <td>33.71%</td> </tr> <tr> <td>FFY2018</td> <td>30.70%</td> </tr> </table> <p>Data Source: Vermont Family Services Division Quarterly Management Reporting. Data Note: Data is point-in-time, as of the last day of the federal fiscal year.</p>	FFY2014	35.62%	FFY2015	37.00%	FFY2016	32.80%	FFY2017	33.71%	FFY2018	30.70%	<ul style="list-style-type: none"> • Increased allocation specific for Family Finding
FFY2014	35.62%														
FFY2015	37.00%														
FFY2016	32.80%														
FFY2017	33.71%														
FFY2018	30.70%														

	Systemic Factor	Current Status	Planned work for next year
1	<p>Information System <i>The state is operating a statewide information system that, at a minimum can, readily identify the status, demographic characteristics, location and goals of every child who is in foster care.</i></p>	<ul style="list-style-type: none"> Item 19: <i>Statewide Information System</i> was rated as a <u>Strength</u> in Round 3 CFSR System has capacity to submit AFCARS, NCANDS and NYTD data to HHS. Low AFCARS error rate Continued development of ROM (Results Oriented Management) 	<ul style="list-style-type: none"> Continue to work with IT to make upgrades and improvements to our current system FSDs information systems are very antiquated. The division will continue to explore developing a CCWIS Continued development work to implement ROM
2	<p>Case Review System <i>The state provides a process that ensures each child has a written case plan, to be developed jointly with the child's parents, that includes the required provisions.</i></p>	<ul style="list-style-type: none"> Items 21: <i>Periodic Reviews</i>, Item 22: <i>Permanency Hearings</i>, and Item 23: <i>Termination of Parental Rights</i> were rated as a <u>Strength</u> in Round 3 CFSR Items 20: <i>Written Case Plan</i> and 24: <i>Notice of Hearings and Reviews to Caregivers</i> were <u>Area Needing Improvement</u> in Round 3 CFSR Continue to QCR data and solicit feedback from the Foster Parent workgroup 	<ul style="list-style-type: none"> Implement new case plan format Draft new case plan policy Improve face-to-face contacts with children, youth, and family to improve engagement in case planning process and overall outcomes Continue to verify systems are in place in each district to ensure foster parents receive the newly developed foster parent notification rack card prior to all hearings
	Systemic Factor	Current Status	Planned work for next year
3	<p>Quality Assurance System <i>The state is operating an identifiable quality assurance system that is in place in the jurisdictions where the services included in the CFSP are provided, evaluates the quality of services, identifies strengths and needs of the service delivery system, provides relevant reports, and evaluates implemented program improvement measures.</i></p>	<ul style="list-style-type: none"> Item 25: <i>Quality Assurance System</i> was an <u>Area Needing Improvement</u> in Round 3 CFSR due to lack of ongoing case review system Continue to review, evaluate, and modify QCR process Continue to review, evaluate, and modify CIES review process QA team supports the districts with data requests and analysis of their data 	<ul style="list-style-type: none"> Continue to identify and train new case reviewers for the district QCRs Create fidelity questions to use during QCRs to measure success in implementation and identify further support/needs Determine post-PIP QCR structure/format starting fall 2019

4	<p>Staff Training <i>The state is operating a staff development and training program that provides ongoing training for staff that addresses the skills and knowledge needed to carry out their duties with regard to services included in the CFSP.</i></p>	<ul style="list-style-type: none"> Item 26: <i>Initial Staff Training</i> and Item 27: <i>Ongoing Staff Training</i> were both <u>Areas Needing Improvement</u> in Round 3 CFSR. Continue to refine new pre-caseload employee training requirements Utilizing different formats for delivery of information (online, GoTo Meetings, district consultation and coaching) 	<ul style="list-style-type: none"> Develop policy around staff training requirements Utilize new online training system to track successful completion of staff trainings and identify training needs.
Systemic Factor		Current Status	Planned work for next year
5	<p>Services Array and Resource Development <i>The state has services that are accessible in all districts that assess the strengths and needs of children and families</i></p>	<ul style="list-style-type: none"> Item 29: <i>Array of Services</i> and Item 30: <i>Individualizing Services</i> were both <u>Areas Needing Improvement</u> in round 3 CFSR The division continues to analyze priorities needs, identify service gaps, and target those within our budget capacity The division continues to have discussions with community partners about existing service needs and identify ways to address gaps 	<ul style="list-style-type: none"> Continue ongoing dialogue with partners, and seek opportunities to collaborate with new partners to help address services gaps particularly in the areas of Children’s Mental health, Early Childhood Services System, and Adult Substance Use
6	<p>Agency Responsiveness to the Community <i>The state engages in ongoing consultation with our partners and consumers about services delivery.</i></p>	<ul style="list-style-type: none"> Item 31: <i>Engagement and Consultation with Stakeholders</i> and Item 32: <i>Coordination of CFSP Services with other Federal Programs</i> was rated as a <u>Strength</u> in Round 3 CFSR 	<ul style="list-style-type: none"> Continue to engage and consult with stakeholders on policy and practice Train and utilize stakeholders for ongoing district QCRs Identify ways to improve how the division solicits input from youth and families on an ongoing basis
Systemic Factor		Current Status	Planned work for next year
7	<p>Foster and Adoptive Parent Licensing Recruitment, and Retention</p>	<ul style="list-style-type: none"> Item 33: <i>Standards Applied Equally</i>, and Item 34: <i>Requirements for Criminal Background Checks</i> were rated as a <u>Strength</u> in Round 3 CFSR 	<ul style="list-style-type: none"> Continue to develop and implement a Diligent Recruitment and Retention plan for foster homes Receive TA from the Capacity Building Center Analyze data to inform strategies and adjust approaches as needed

<p><i>The state licensing standards are aligned with national standards and are applied to all approved FHs and child care institutions receiving IV-E or IV-B funds. In addition the state complies with Federal background check requirements, has a diligent recruitment plan in place, and has an effective process to handle cross-jurisdictional placements.</i></p>	<ul style="list-style-type: none">• <i>Item 35: Diligent Recruitment of Foster and Adoptive Homes, and Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements</i> were both <u>Areas Needing Improvement</u> in round 3 CFSR.• The division is currently receiving technical assistance from Capacity Building Center	
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Update on Service Description

Services for Children Adopted from Other Countries

In September of 2019, Vermont will have completed a five-year project with the Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG). Goals of this project include the development and implementation of evidence-based interventions and the testing of promising practices. Effective interventions are expected to achieve long-term, stable permanence in adoptive and guardianship homes for waiting children as well as children and families after adoption or guardianship has been finalized.

Vermont was not identified by the QIC-AG as one of the sites that primarily focused its intervention on children or youth who were adopted domestically or internationally. We do however, have an awareness that these youth can have complex needs that sometimes require similar access to the system of care that a youth who was adopted through foster care. For that reason, the VT Family Services Division, outreached to all private adoption agencies in VT to ask them to engage the families they have relationships with to ask those families to participate in completing a version of the QIC survey, designed by the Vermont team.

The revised survey was administered to 131 families formed by private or international adoption. An astounding 89% response rate provided interesting and robust data.

CHILD DEMOGRAPHICS			
About the Child	Public N=166	Private N=65	International N=47
Child's Current Age	12.4 years	12.6 years	14.0 years
Percent Female	47%	49%	55%
Percent Male	53%	51%	45%
Asian	0.6%	1.5%	53.2%
Black/African-American	3.0%	32.3%	19.1%
White/Caucasian	87.3%	47.7%	14.9%
Multi-racial	6.0%	18.5%	4.3%

QIC-AG 14

The following summarizes findings related to children and their families who adopted domestically as well as details for those children and their families who were joined through an international adoption process.

Domestic Adoption

65 out of 117 families that responded to the Vermont Permanency Survey identified as families formed through private domestic adoption.

Through their survey responses, we learned that 52.3% (34) of caregivers adopted their child 10 or more years ago and 47.7% (31) of those children were White/Caucasian, 32.3% (21) were Black/African-American, and 18.5% (12) were Multi-racial. When asked if they identify their family as a transracial or transcultural family, 53.8% (35) said yes. Of those 35 families, 94.3% (33) of caregivers reported that they talk about being a transracial or transcultural family.

In terms of educational well-being, 33 out of the 65 children were currently enrolled in school (K-12). Of those: 21.2% (7) had an IEP, 78.8% (26) had a teacher who really understands his or her needs, 75.8% (25) were rated as good or excellent in language arts by their caregiver, and 69.7% (23) were rated as good or excellent in math by their caregiver.

We also learned that some of our families have children with special health needs, specifically: 13.8% (9) of the children had a physical health issue, 24.6% (16) had a mental health issue, 18.5% (12) had a physical disability, and 27.7% had been exposed to alcohol or drugs prenatally (18).

Caregivers reported high levels of commitment to their children, evidenced by the following:

- 95.5% (62) of caregivers **strongly agreed** with the statement “I am committed to my child for life, no matter what.”
- 83.1% (54) of caregivers were **very to extremely confident** that they could meet the needs of their child.
- 98.4% (63) of caregivers rated the impact of the adoption as **slightly to extremely positive**.
- 93.8% (61) of caregivers reported that they **definitely would have** adopted their child if they knew then what they know now.

Caregivers were also asked how often they are discussing adoption with their child. The most frequent response was that caregivers are talking about adoption with their child less than monthly (44.6%, 29), followed by monthly (30.8%, 20). Children are less likely to be initiating these conversations with 53.6% (3) asking about adoption less than monthly, and 25% (14) never asking about adoption. Only 7.7% (5) caregivers indicated that they never talk to their child about their adoption story.

Out of the 65 private adoptive families, 43 knew that their child had biological siblings living outside of the home. In most cases, children did not have any contact with their biological sibling(s) (55.8%, 24). An additional 11.6% (5) of caregivers indicated that contact is not possible.

Overall, parents who adopted a child through a private domestic agency felt very or extremely prepared to meet the needs of their child at finalization (78.5%, 51), and rated their adoption agency as good or very good in preparing them to meet the needs of their child (79.7%, 51).

After finalization, families turned to a variety of supports and services. The most frequently accessed services for this sample were: individual counseling for the child through a community mental health agency (18.5%, 12), psychiatric medication management for the child (12.3%, 8), and individual counseling through a private provider for the caregiver (12.8%, 3). Caregivers who accessed these services were largely satisfied with them.

Of those who used family support services in the past six months, 69.2% (9) said that those services met the needs of their family some of the time to always. Of those who had used mental health services for their child, 81.3% (13) indicated that those services met the needs of their family about half the time to always. Lastly, 72.7% (8) caregivers reported that mental health services for them met their needs about half the time to always.

These findings suggest that caregiver commitment is a strength of the families formed through private domestic adoption, and that these families are supported by strong educational systems. Families report feeling comfortable with and discussing their child's adoption story with their child, and those who have accessed services are satisfied with the support they are receiving. One area of potential improvement for families formed through private domestic adoption is providing more information on the importance of birth sibling contact and tips on how to facilitate those relationships.

Intercountry or International Adoption

Additionally, 47 out of 117 families that provided responses to the Vermont Permanency Survey identified as families formed through intercountry or international adoption.

Through their survey responses, we learned that 61.7% (29) of caregivers adopted their child 10 or more years ago and 53.2% (25) of those children were of Asian descent. When asked if they identify their family as a transracial or transcultural family, 89.4% (42) of caregivers said yes. Of those 42 families, 88.1% (37) of caregivers reported that they talk about being a transracial or transcultural family.

In terms of educational well-being, 30 out of the 47 children were currently enrolled in school (K-12). Of those: 16.7% (5) had an IEP, 73.3% (22) had a teacher who really understands his or her needs, 76.6% (23) were rated as good or excellent in language arts by their caregiver, and 83.4% (25) were rated as good or excellent in math by their caregiver.

We also learned that some of our families have children with special health needs, specifically: 19.6% (9) of the children had a mental health issue, 13.0% (6) of the children had a food or eating issue, and 8.9% (4) had an alcohol or substance misuse/abuse issue.

Caregivers reported high levels of commitment to their children, evidenced by the following:

- 100% (all 47 caregivers) **strongly agreed** with the statement "I am committed to my child for life, no matter what.
- 78.7% (37) caregivers were **very to extremely confident** that they could meet the needs of their child.
- 97.9% (46) caregivers rated the impact of the adoption as **slightly to extremely positive**.
- 97.9% (46) caregivers reported that they **definitely would have** adopted their child if they know then what they know now.

Caregivers were also asked how often they are discussing adoption with their child. The majority of caregivers are initiating these conversations monthly or less than monthly (74.4%, 35). Children are also initiating these conversations monthly or less than monthly (63.9%, 30). Only 10.6% (5) of caregivers report never talking about adoption with their child, and only 14.9% (7) report that their child never asks about the adoption.

Out of the 47 caregivers who responded, 25.6% (12) were aware that their child had birth siblings outside of the home. Of those 12, 41.7% (5) had contact with at least one sibling living outside of the home. Due to the

nature of the sample (families formed through international adoption), it is important to point out that an additional 33.3% (4) of caregivers reported that contact was not possible and that 44.7% (21) of the caregivers didn't know whether their child had any birth siblings.

Overall, parents who adopted a child internationally reported feeling very or extremely prepared to meet the needs of their child at finalization (80.9%, 38), and rated the adoption agency that assisted them as good or very good in preparing them to meet the needs of their child (72.3%, 34).

After finalization, families turned to a variety of supports and services. The most frequently accessed services for this sample were: online supports and blogs (21.3%, 10), individual counseling for the child through a community mental health agency (19.1%, 9), or individual counseling for the child through a private provider (14.9%, 7). Unfortunately, caregivers were not satisfied with the services available to them in their community. Of those who used family support services, 50% (4) felt that those services never met the needs of their family. Caregivers had slightly higher ratings for mental health services for their child, with 66.7% (8) rating that services met the needs of their child some of the time to always. However, the remaining third (4) felt that mental health services never met the needs of their child. A similar pattern emerged for caregivers rating of mental health services for themselves, with 60% (6) reporting that mental health services met their needs about half of the time to always. The remaining 40% (4) reported that mental health services never met their needs.

These findings suggest that caregiver commitment is of these families formed through international adoption. In addition, the caregivers reported several positive educational outcomes for their children. The majority of these caregivers are also discussing their child's adoption story with their child between once a month and less than monthly. The primary area for improvement identified from our survey findings are in the areas of service array and delivery, including the need for service professionals to receive more training on issues of adoption.

Historically, as a state we have operated from a place that indicated that information about the needs of private or internationally adopting families would not be readily available to the state system. We were pleasantly surprised by the willingness of most of our private adoption agencies to support the outreach to their families. Gathering this data will help us to increase our ability to understand and meet the needs of families formed through private or international adoption. Families who have adopted privately or internationally are able to access the same services that are available to families who have adopted through foster care. This is long standing practice in Vermont.

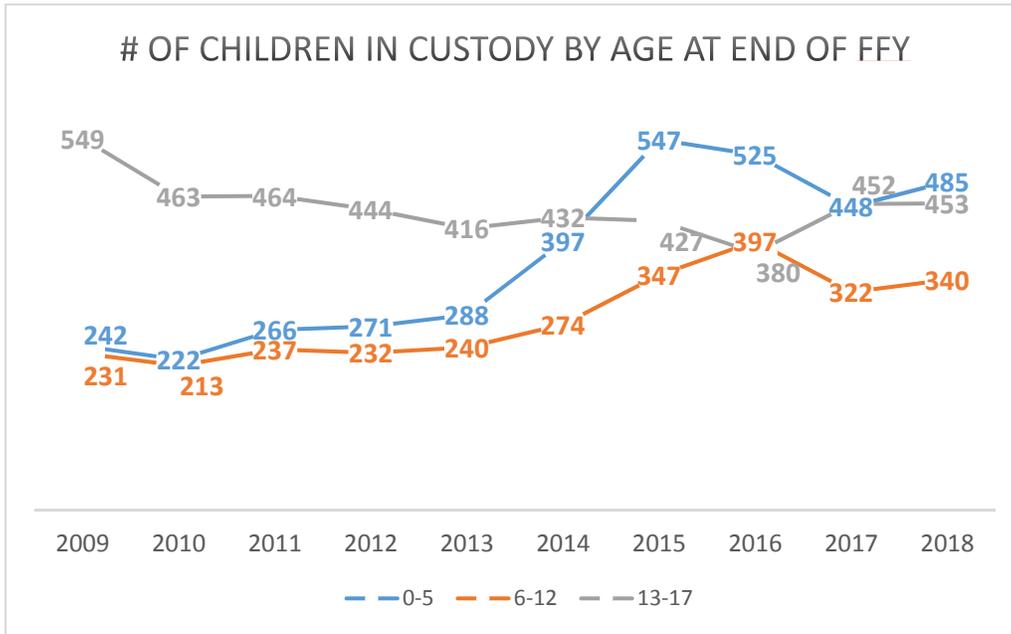
In this last year, Vermont has also implemented a practice of collecting information from private agencies related to any family who has participated in a home study for the purpose of adoption regardless of the outcome of that process.

Vermont, is also experiencing a consistent downtrend in the number of families who are adopting privately and internationally.

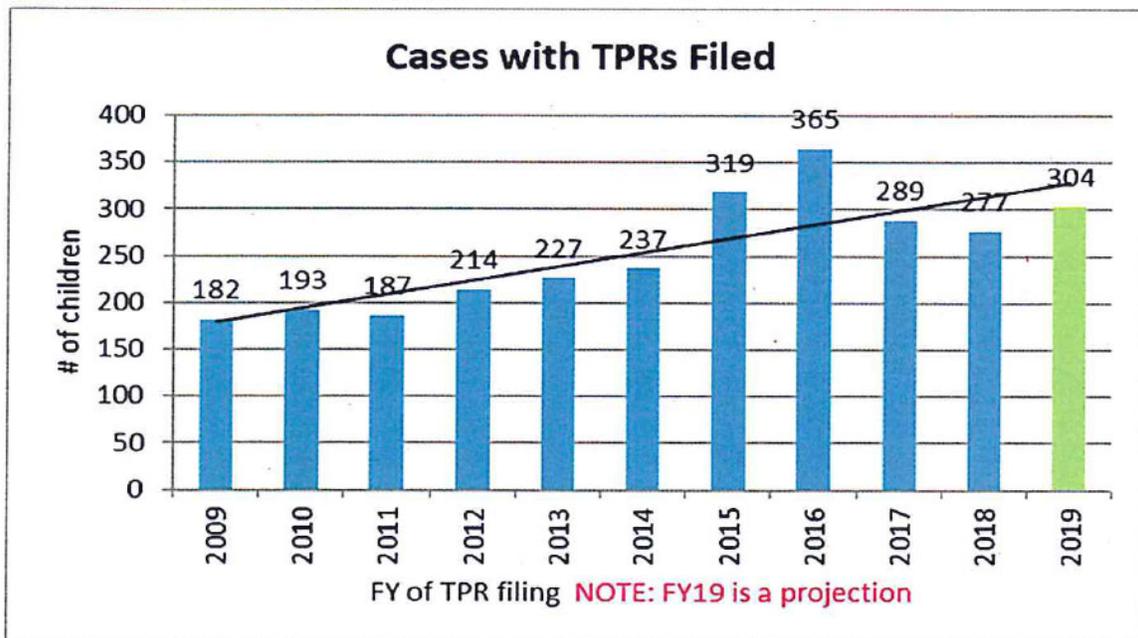
Services for Children Under Age of Five

Activities to reduce the length of time in care

From 2010- 2015, Family Services experienced an increase in the number of children under 5 coming into custody. The most significant spike occurring between 2013-2015 where for the first time the number of children 0-5 surpassed the number of older youth in custody. The two main drivers for this increase are believed to be the systemic impact from the 2 child deaths in 2014 and the current opioid epidemic. The divisions recent data however reflects a slight decline in the number of children 0-5 over the last three years.

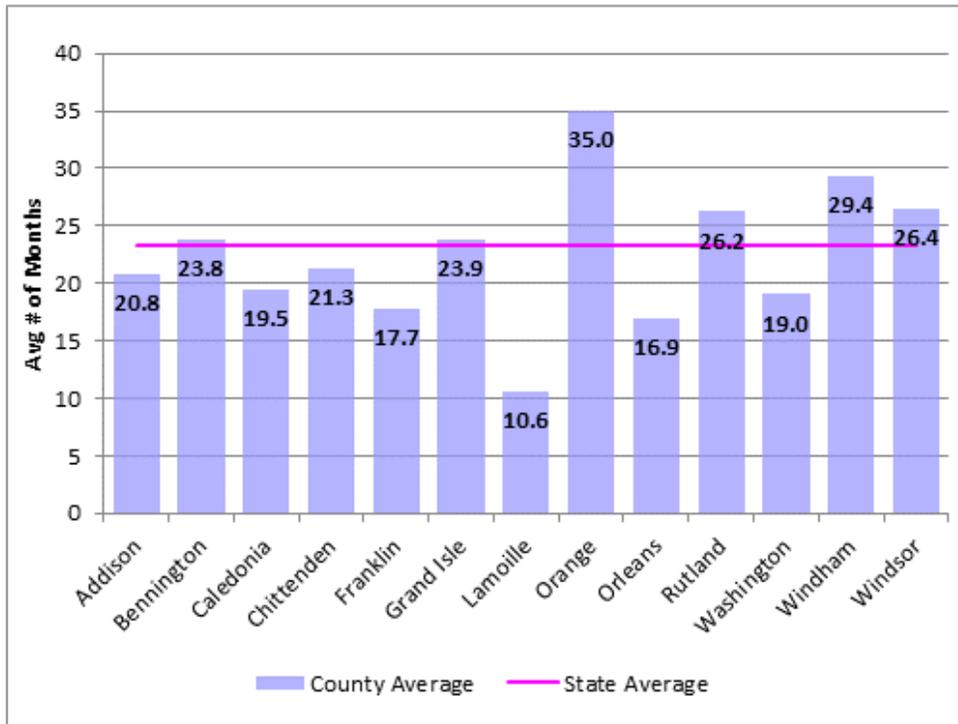


This increase of younger children in custody over the last several years, in addition to the increased number of conditional custody and youthful offender cases, has also put a significant strain on our judicial system and has caused a TPR backlog in most courts.



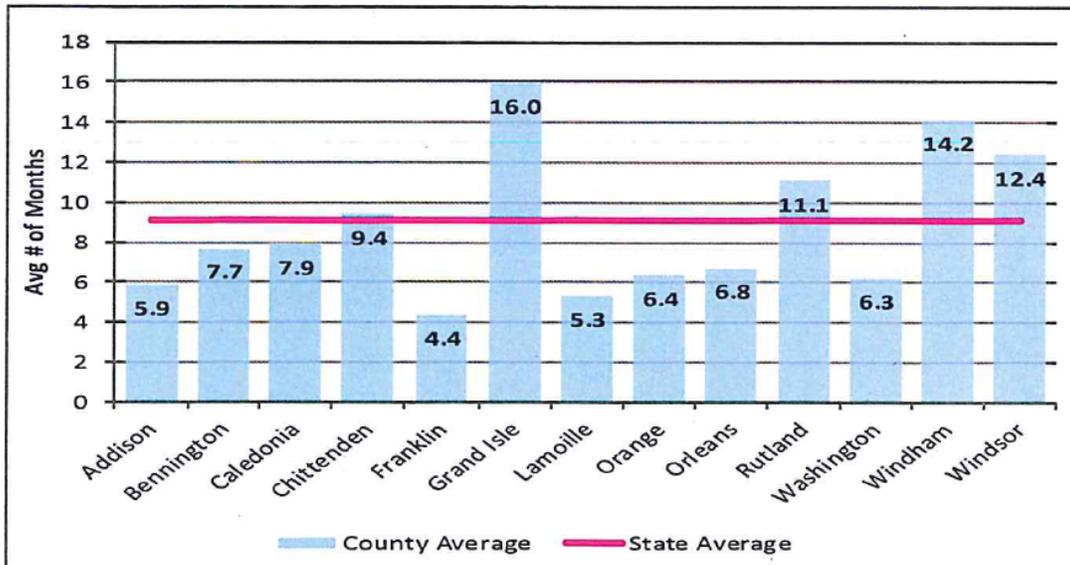
TIMELINESS OF TRIAL COURT PROCESS: Case Filing to TPR Decision (FY: 2018)

Fiscal Year: 2019



statewide avg: 23.3 months Goal: 17 months
 median: 20.3 months 34% decided within 17 mo.

Timeliness of TPRs DECIDED FY19 (as of 4/12/19)



statewide avg: 9.1 months Goal: 5 months
 median: 6.8 months 29% decided within 5 months

Act 60 of the 2015 Acts and Resolves established “a working group to recommend ways to improve the efficiency, timeliness, and process of Children in Need of Care or Supervision (CHINS) proceedings.” The CHINS working group submitted a final report on November 1, 2016 and highlighted aspects of Vermont’s legal system that were under stress and could be improved by additional resources and further evaluation. Some of the recommendations that would impact permanency timeframes that the Justice for Children’s Task force was further exploring included:

1. Developing a Visitation Protocol: A sub-committee was created however no agreement was ever reached around a protocol. In 2018, the division received a \$500,000 infusion of general funds and FSD matched it with \$800,000 to improve FSDs supports and services related to Family Time Coordination and parent-child contact groups through the Child and Family Services contract for all 12 districts (see **Appendix A** for the Family Time Coordination Practice Guidance).

2. Addressing TPR backlog: The Justice for Children’s Task Force at the time of the report had been exploring the possibility of a “mobile unit” of attorneys and judges that could be deployed to different regions of the state. A TPR workgroup was created that included representation from Trial Court Operations, the Chief Superiors Judge, AAG, and Family Services Operation. A sub-committee was formed and issued a final report and recommendations on September 1, 2017. The 2017 recommendations of the TPR Workgroup to create a two-track system for scheduling TPRs has not yet been piloted in a court. Conversations regarding this initiative are ongoing. A few developments have held up implementation of a systemic approach to hearing TPR cases. Since that time, the Justice for Children’s Task Force has struggled to reduce the TPR backlog or improve the length of time to decide TPRs.

Due to a change in Vermont statute in FY19, Youthful Offender cases are now being filed in the Family Court system. This is creating enormous pressures for the court system. In FY18, there were 33 Youthful Offender cases filed in Vermont’s Family Courts. The projected number for FY19 is nearly 500. No additional judges or court resources have been added to respond to these cases. There is also a group working to recommend reforms of the abuse/neglect docket to the Vermont legislature. Until those recommendations are formalized, there could be little momentum to implement TPR reforms.

On a positive note, Franklin Family Court has managed to maintain its good work of deciding TPRs in a timely manner. That court received additional resources in FY17 (time limited), including personnel and additional courtroom space, to help address a significant TPR backlog. Starting in FY18, Franklin Family Court has maintained a minimal backlog of pending TPRs, and TPRs continue to be decided in fewer months than the statewide average.

At the close of FY17 and FY18, approximately 50% of the State’s TPRs had been pending for 5 or more months. Ten months into FY19, 40% of the TPRs are pending more than five months.

Additional Statistics:

- The average time from TPR filing to decision (first TPR filing to last TPR decision per child) was in the 6-7 month range for the years FY11-FY15. It has been in the 8-9 month range since FY16. It’s currently at a 10 year high of 9.1 months (as of April, FY19), with a median of 6.8 months.

- The # of TPRs decided per FY peaked in FY 16 & FY17 with more than 300 TPR decisions. FY19 is projected to be in the 200 range.
- The # of TPRs filed peaked in FY 15 & FY 16 , dipped a bit in 17 & FY18, but FY19 will probably have more TPR filings than in FY17 & FY18.
- The average time from Case Filing to TPR decision has been lengthening since FY16, and currently FY19 is the longest avg length of time in a 10 yr span.

The CHINS Reform Workgroup

More recently the CHINS Reform Workgroup was created by the legislature in 2018 which is comprised of leadership from the Judiciary, the Office of the Defender General, the State’s Attorneys and Sheriffs Association and the Department for Children and Families. The purpose of this workgroup is to:

“review and propose change to the systems by which CHINS cases are processed and adjudicated. In undertaking this review the group shall evaluate successful models used in other countries, states, or cities. The proposal shall incorporate innovative approaches to holistic reform and strategies to reduce the need for court intervention, and may include the use of regional and mobile models, judicial masters, mediation, dedicated resources, and other alternative dispute resolution options to the CHINS process. The proposal for reform shall:

- (1) Support and improve child safety;
- (2) Provide early screening for substance abuse, mental health, and trauma of children and parents;
- (3) Provide early access to services designed to address screening outcomes;
- (4) Improve timeliness of adjudication, including timeliness to permanency for children, whether permanency is reunification with parents or termination of parental rights;
- (5) Ensure due process;
- (6) Serve the best interests of the affected children;
- (7) Relieve systemic resource and budget pressures; and
- (8) Lead to lasting changes.

(d) ...and shall include a recommendation on how to allocate the \$1,250,000 allocated for fiscal year 2019 to reflect the vision for reforming the CHINS docket that achieves the outcomes set forth in subsection (c) of this section:

- (1) on or before December 1, 2018 shall report to a combined meeting of the Joint Legislative Justice Oversight Committee and Joint Legislative Child Protection Committee”

The workgroup issued a report on January 16, 2019 which can be found on FSD’s public website at:

<https://dcf.vermont.gov/sites/dcf/files/DCF/reports/CHINS.pdf> . This report provides recommendations around how best to use legislative appropriated funds which include:

- Explore and implement a sustained evidence-based home visiting model
- Pilot the use of judicial masters (and associated staff) to relieve significant pressures on family court by providing timely proceedings that are related to the CHINS process but do not require a judge and evaluate long-term sustainability.
- Implement some form of alternative dispute resolution to build on parents’ intrinsic motivation and allows for all parties and their attorneys to be at the table working collaboratively to solve problems outside the formal, adversarial process.

- Implement a peer navigator program that could be layered onto the work of an existing set of organizations such as the recovery centers.

Activities to address the developmental needs of all vulnerable children under the age of 5

As outlined in Policy 52: *Child Safety Interventions- Investigations and Assessments*, the division refers a family to Children’s Integrated Services and/or Head Start and Early Head Start when there is a pregnant woman and/or child under the age of 6 and the Family Services Worker or families identifies possible concerns around health, developmental or mental health.

Populations at Greatest Risk of Maltreatment

Family Services continues to work collaboratively with community partners to improve the service array and create policy that best supports populations at greatest risk. These populations include: children ages 0-3 which includes substance exposed newborns, our LGBTQ children and youth, and those at greatest risk for human trafficking. The following are descriptions of specific work the division has focused on over the last year.

Increased childcare financial assistance to families involved in DCF

Beginning March 3, 2019, the Child Care Financial Assistance Program (CCFAP) which is managed in the Child Development Division, began making full payment for childcare services for families involved in a Family Services ongoing case when they are placed in protective services childcare. This means that the co-pay is being covered for cases where children are not in DCF custody. The CCFAP program already makes full payment for DCF custody cases when a child is in protective services childcare.

A child's childcare provider is an important member of the child's team, often spending more time with the child than any other person. Additionally, the childcare provider sees the parent(s) regularly and has informal opportunities to provide support and teaching over time. The presence of a strong and supportive childcare provider in a child and family’s life is likely to increase protective factors and allow the family to be free from DCF intervention.

Tracking and analysis of referrals to Children’s Integrated Services

The Child Abuse Prevention and Treatment Act (CAPTA) requires states to make referrals to early intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA) for all children under the age of 3 who are involved in a substantiated case of abuse or neglect.

In Vermont, referrals to Children’s Integrated Services (CIS) for developmental screening shall occur in the following instances:

- All children under the age of 3 who reside in a family/household where there is a substantiation of abuse or neglect – regardless of whether the perpetrator is in home or out-of-home; and
- Households where the SDM Risk Assessment is high or very high and a family support case will be opened for a family with children under the age of 3 (by completing the CIS Referral Form).

We now run a report of all the Child Safety Interventions in which there is at least 1 child in the household that is under the age of 3. We then cross reference that data with the number of children who were screened by CIS, and the number of children who received Early Intervention (EI) Services. This was introduced in the March Division Management Team meeting where directors were encouraged to go back to their districts and partner with the CIS staff to determine what, if any, families may not have been referred for screening.

A report is now run a report on a quarterly basis with current data so that local teams can examine their data and work in collaboration to ensure that 100% of our substantiated, high and very high-risk cases involving children under 3 are referred for an early intervention screen.

Division Collaboration

To ensure we are maximizing resources and opportunities, staff from three central office divisions within DCF meet monthly to develop relationships, share information and collaborate. Staff from Family Services, Child Development and Economic Services come together to collaborate in providing services to families with young children. This past year we have discussed the following topics: Family First legislation, home visiting, closer collaborations, foster care rules and regulations, high risk families, strengthening families and protective factors, and mapping prevention programs. Members of the Health Department Maternal Child Health Division have now joined this meeting for stronger collaboration across departments to best serve families with young children.

Strong Families Home Visiting

Strong Families Vermont supports pregnant people and new parents through home visits delivered by trained professionals using a continuum of services. Home visitors partner with each family to set goals and promote optimal development, health and wellbeing. Home visits also provide an opportunity for early screening and identification of potential challenges facing families, as well as connections to the broader array of Children's Integrated Services (CIS) and other local services and supports.

As part of the Strong Families model, Vermont also offers *Parent as Teachers* (PAT) which is an evidence-based home visiting program that promotes the optimal early development, learning, and health of children by supporting and engaging their parents and caregivers. Evidence shows that families engaging in PAT demonstrate:

- Improved child health and development
- Prevention of child abuse and neglect
- Increased school readiness
- Increased parent involvement in children's care and education

Through funding from Substance Abuse and Mental Health Services Administration's Project LAUNCH grant, the Vermont Department of Health Division of Maternal and Child Health piloted PAT at three Parent Child Centers in Chittenden County. Starting in 2016, PAT is expanding to Children's Integrated Services local implementing agencies across Vermont and Central Vermont Community Head Start as part of the Race to the Top, Early Learning Challenge grant (see **Appendix B** for the CIS Continuum).

Sustained Home Visiting

Nurse Home Visiting Program

Registered nurses from home health agencies deliver a long-term, structured, evidence-based home visiting program for families including at least 25 visits during pregnancy up to age two. The program improves maternal and child health and family economic self-sufficiency, promotes optimal child development, prevents child abuse and neglect, and coordinates referrals to community resources.

Family Support Home Visiting Program

Trained professionals from Children's Integrated Services partner agencies deliver a long-term, evidence-informed home visiting program for families through regular visits up to age five. The program strengthens the parent-child relationship, builds social connections, prevents child abuse and neglect, and promotes optimal child development and school readiness.

Responsive Home Visits

Children's Integrated Services teams work together to connect families with Maternal and Child Health nurses and/or Family Support Workers to provide regular home visits in response to time-limited needs. These visits support and strengthen families' health, wellbeing, parenting skills, social connections and ability to address stressors.

Department Collaboration

FSD and Department of Mental Health continue to work together around the reduction of residential placements. One major outcome from this collaboration has been the increased accessibility of in-home supports by the Becket's Support and Stabilization program to support children and youth returning from residential programs which has been very successful in Vermont. In addition, this collaboration has also explored the gaps within our local system of care around early childhood mental health which has resulted in the implementation of the following evidence-based models:

Parent-Child Interaction Therapy

Parent-child interaction therapy (PCIT) is an evidence-based treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT. Most of the session time is spent coaching caregivers in the application of specific therapy skills.

Howard Center continues to be the leader in this practice in Vermont. The following is a summary of PCIT families they served in 2018 and 2019.

How many families served in 2018: 73

Where the referrals came from:

- 24- Directly from Pediatrician
- 20- HC Early Childhood Program/Intake Supervisor

- 9- Other HC Programs (Intensive Family Based Services; School Services; Outpatient; and First Call)
- 13- Other Community Providers (DCF, Lund, School District; Childcare Program; Children with Special Health Needs; Vermont Family Network)
- 3- Parent self-referred

Average Waiting Length in 2018: 2.5 months for families who have limited flexibility with appointment options.

Moving Forward in 2019:

- In first quarter of calendar year 2019, PCIT has served 37 families.
- Howard is in process of identifying HC ECP clinician who will be trained in PCIT beginning Summer 2019. The plan is to potentially have this clinician provide up to .5FTE of PCIT services once trained, in addition to .5 FTE traditional ECP role.
- 3 staff will attend the National PCIT Symposium in Late Summer 2019
- Will review supporting a PCIT clinician to become PCIT trainer in 2020. Howard Center did not choose to join the current learning collaborative in Spring 2019, in order to focus on building capacity to serve more families with current staff.
- Interest in learning about PCIT for childcare programs to support therapeutic work in these settings.

Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is an evidence based, in home, trauma informed, therapy model for children aged 0-5 who have experienced at least one traumatic event (e.g. maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder (PTSD). The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g. cultural norms and socioeconomic and immigration-related stressors).

NFI Vermont and Easterseals Co-sponsored the Vermont state-wide Child Parent Psychotherapy Learning Collaborative, which successfully completed in November 2018. Thirty CPP clinicians and supervisors are now certified CPP providers. The Learning Collaborative trainers were from the National Child Traumatic Stress Network trainers. Clinicians are expected to complete their training in November 2018. In addition to Easterseals and NFI-VT, the training teams included representatives of four community mental health agencies (Howard, NKHS, CSAC, and Rutland), the UVM Medical Center, Community Health Center, three HeadStart mental health consultants, and private practice therapists. NFI and Easterseals are currently negotiating with CPP to conduct a second learning collaborative starting in Fall, 2019 that will include more public mental health centers and more private practice clinicians.

Building Flourishing Communities

Since August of 2017, the Building Flourishing Communities (BFC) initiative has been taking the important information about early childhood development to Vermonters. This proven public health model engages average Vermonters in discussion and action to address the factors that lead to poor health outcomes and much of the difficulty so many have in succeeding at work and in family life. We are creating an enduring vision of flourishing communities, and the actions to achieve them.

There are 23 BFC Master Trainers facilitating discussions in all regions of Vermont to increase awareness about how early, overwhelming and/or threatening events can lead to later poor health and well-being. The Master Trainers are generating interest and excitement about the potential for change through conversation based in the NEAR sciences:

- Neuroscience— early brain development and adaptations to experience
- Epigenetics— how our environment influences gene expression
- ACEs study – makes the connections to later outcomes clear
- Resilience – shows that even those who have been deeply affected by adversity can become more resilient and flourish, and those with resilience withstand life’s challenges better

The group of Master Trainers is represented by: DCF/Family Services Division, Departments of Mental Health and Health, DCF/Economic Services Division, Health Department ADAP, community mental health, child parent centers, public schools, United Ways, Building Bright Futures, a private physician, restorative justice organizations, a mentoring organization and a domestic and sexual violence prevention program. There have been over 75 community learning events held and over 1300 participants. The movies *Resilience* and *The Faces of Aces* are being shown statewide to an ever-growing number of Vermonters.

The LGBTQ Workgroup

Family Services Policy 76: *Supporting and Affirming LGBTQ Children and Youth*:

<http://dcf.vermont.gov/sites/dcf/files/FSD/Policies/76.pdf> continues to be in effect to guide FSD practice.

Through an empaneled child protection team, central office in collaboration with [Outright Vermont](#), continues to provide consultation to the field as support is needed and within circumstances required by the policy:

- Legal name changes
- Legal gender marker (the male [M] or female [F] identifier on one’s birth certificate, ID, or passport) change
- Obtaining or changing photo identification (passports or driver’s licenses)
- Situations where a young person feels unsafe, uncomfortable, or disagrees with a placement because of their identity
- Medical treatment decisions

From summer 2017 through fall 2018, FSD, Outright Vermont, the Youth Development Program, and Vermont’s UVM Child Welfare Training Partnership collaborated to develop an online training and provide in-person training through a Vermont Community Foundation's Innovations and Collaborations program grant. A news article following one of the in-person trainings is available here:

https://www.stowetoday.com/stowe_reporter/news/local_news/advocate-lgbt-youth-should-feel-accepted-and-important/article_49635d24-f6ec-11e7-a008-fb79d3e881fe.html?fbclid=IwAR3wf4O_GPOs5_F9ZUfAASveXinKupE-CyMg3iWk74DQ0410x42cB0y9Sfl

The online training is available on the Vermont Child Welfare Training Partnership ELearning Portal: <http://training.vermontcwtpt.org/course/index.php?categoryid=3>. The training is approximately 1.5 hours in length and the purpose of *LGBTQ+ 101: Caring for DCF Involved Youth* is to provide Family Services Workers, partner agency staff and foster families with a basic understanding of the experiences and needs of lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) youth who are involved with the Department of Children and Families (DCF). This training provides an overview of basic information that will help foster an understanding of how to support youth, including:

- Policies and practice requirements
- Developmental milestones and typical gender and sexual identity markers
- Affirmative language
- The statistical landscape of experiences and risks for LGBTQ identified youth
- Strategies for working with LGBTQ youth
- Local and national resources for supporting youth
- Opportunities for self-assessment and practice

The Family Services Human Trafficking Workgroup

Training & Community Response:

Vermont's Human Trafficking Task Force consists of a statewide steering committee and three sub-committees (Training/Outreach, Victim-Based Services, and Law Enforcement). The statewide task force is focused on both adult and child/youth trafficking victims. Through this task force, Vermont currently has two human trafficking case managers for the whole state.

The state of Vermont was awarded a \$1.2 million grant to combat human trafficking. This grant is designed to support the delivery of comprehensive and specialized services for all victims of human trafficking and the investigation and prosecution of sex and labor trafficking cases. Through the grant, at least three new positions entirely dedicated to promoting victim-centered and trauma-informed investigations and comprehensive service delivery will be developed and funded. The \$1.2 million grant covers a three-year period beginning October 1, 2018. The Department of Justice announcement is available here:

<https://www.justice.gov/usao-vt/pr/vermont-awarded-12-million-grant-combat-human-trafficking>

Prior to obtaining this grant, statewide trainings included: all Special Investigations Units (SIUs) (including child protection workers and investigators), the police academy, SANE nurses, the UVM College of Medicine students, clinicians and mental health workers, and county specific trainings upon request.

DCF Family Services Division offers an advanced practicum on child abuse and neglect, which includes interactive advanced training covering sexual abuse, serious physical injury, human and sex trafficking, and neglect.

Policy & Practice:

Each January for *Human Trafficking Awareness Month*, the designated trafficking consultant shares updated information and statistics with the field. Since 2014, Vermont DCF has accepted 107 child protection reports with concerns about human trafficking.

Within 2018, there have been:

- 23 accepted reports
- 8 unaccepted reports
- Youth victims ranged in age from 8-17 years old
- Cases involving both male and female identifying youth
- Cases involving youth being trafficked by both non-caregivers and caregivers

During November of 2018, a new consultation policy was issued. While the policy speaks to more than human trafficking consultations, the requirement was added to policy for the designated consultant to be notified when a child protection report about trafficking is received, when any open/ongoing case involves known or suspected trafficking, and instances where a youth is missing or on the run and suspected to be heading out-of-state. The designated consultant follows up with every family services worker with a missing child or youth to inquire if they think the youth is headed across state lines or if there are any concerns around trafficking. If so, consultation is offered.

This year, emphasis has been placed on supporting consultation and multi-disciplinary team meetings because no one can combat trafficking alone. Consultation and MDTs have supported family services workers in obtaining ideas for potential resources in the community, learning more about a youth's individual risk factors, developing safety plans and case plans specific to trafficking, connecting youth to victims' services providers, and supporting criminal prosecution processes.

The DCF-FSD Human Trafficking Workgroup has recently been grappling with how to provide practice guidance to the field on human trafficking safety planning and case planning. In addition to child/youth trafficking victims, DCF also works with parents who are victims of trafficking where the non-custodial parent is the alleged trafficker.

Substance Exposed Newborns

Please refer to the CAPTA section of this report.

Kinship Navigator

The State of Vermont accepted the \$211,745 allocation made available through the The Family First Prevention Services Act (FFPSA), Title VII of the Bipartisan Budget Act of 2018 to develop, enhance and/or evaluate our Kinship Navigator programming.

Brief History and Current Status

Beginning in 2007, prior to the Fostering Connections Act, Casey Family Services partnered with a group of grandparents caring for their grandchildren to form a grandparent support and advocacy group. In the ensuing years, this grassroots organization developed a statewide presence now known as Vermont Kin as Parents (VKAP). DCF contracts with VKAP to deliver a cadre of services to Vermont kin families.

These services and supports include:

- **Offering** information about resources available to kinship families and makes referrals to agencies as needed.

- **Helping** families understand and navigate the different systems in which they may be involved, including courts, Department for Children and Families, mental health and substance abuse agencies.
- **Collaborating** with state and private agencies about specific family needs.
- **Meeting** with families and those supporting them to help families better understand what resources are available.
- **Offering** small respite grants to families as funding is available; partners with local Agencies on Aging who may have funds available to those 55 and older.
- **Helping** communities develop kinship support groups, which can be a lifeline for relatives and the children they are raising.
- **Offering** an annual kinship conference for caregivers and those who work with them.
- **Hosting** an annual potluck picnic for kinship caregivers and the children they are raising.
- **Publishing** a quarterly newsletter, *VKAP Voices*, which updates families and professionals about what is happening in the state and nationally and includes kinship stories and information on resources.
- **Hosting** the VKAP website.
- **Testifying** before the Legislature on bills that affect the daily lives of families and works to pass those bills.
- **Meeting** regularly with the DCF Commissioner and Deputy Commissioner to discuss kinship issues and ways to address them.
- **Advocating** through national and state connections, by maintaining awareness of proposed legislation impacting kinship families, offering the kin perspective whenever possible, and informing caregivers of the changes.

VKAP is a vital partner to DCF and to families caring for kin. We believe that our relationship with this organization and the work that they do with kin caregivers continues to satisfy the requirements that allow us to draw down federal funding. VKAP is aware of the new Kinship Navigator funding opportunity and has expressed an ongoing commitment toward collaborating with the Department to understand and meet the needs of kin caregivers.

Practice Areas and Funding

Developing Increased Capacity to Implement Family First Legislation

In order to effectively prepare for the ongoing implementation of the Families First Legislation overall and more specifically, as it relates to the goal of developing, enhancing and evaluating kinship navigator programs, Vermont proposes to access training and technical assistance opportunities.

The State of Vermont would like to send a group of direct service staff to the CWLA conference in Phoenix, AZ. Kinship Traditions of Caring and Collaborating: A Trauma Informed Model of Practice. The identified staff have been participating in Vermont's Diligent Recruitment Technical assistance work with the Capacity Building Center for States. The group participated in the conference with the goal of bringing ideas for improvement

and enhancement of kin programming back to Vermont. Ideally, this learning will help us to become more knowledgeable about what evidence-based programming might be available for us to consider as we grow our programming in this area.

In this same vein, Vermont sent staff to both the April CWLA conference: Meeting the Challenges of the Family First Prevention Services Act and the State Team Meeting in April. We expect that implementation of the FFPSA in Vermont will be a heavy lift given the size of our state and resources available to support implementation. We need to engage additional staff, who aren't typically included in these activities to broaden the existing capacity of our workforce to support successful FFPSA implementation.

Production and Dissemination of Educational Materials

In recent conversation, VKAP Board president noted that an area of practice that could benefit from additional attention is the work that the division and its partners do to inform and support kin who are being considered by the court to take conditional custody of a minor relative. With Kin Navigator funding, the division has developed materials to inform relative caregivers about the conditional custody order (CCO), with a focus on what specific supports and resources will or will not be made available to the family. At this time print materials have been created and online content is under development. The goal of these materials will be to equip families who are considering caregiving with the information they need to support decision making.

At this time, caregivers who are awarded Conditional Custody (CCO) are not receiving any formal training/support to assist them with caregiving under a CCO. Kin Navigator funds are earmarked to develop online video training modules to provide useful information about what relative caregivers might expect in the CCO process, as well to share information about resources.

With the enactment of the Fostering Connections in 2008, Vermont revised law and policy to support the placement of children with kin when that can be done safely. At that time DCF, engaged with our 2-1-1 information and referral system to ensure that resource information was available to support kin caregivers who might be having a first experience with "the system." DCF has reached out to the 2-1-1 program to determine what types of concerns are coming to their attention from their connections with kin. Based on this engagement, additional resource materials, like tip sheets or frequently asked questions documents, will be developed to improve communication and information sharing. This activity is in process.

Training for Partners

In that same vein, it is unclear whether our partners in the Economic Services Division (ESD) have stayed current in their understanding of the needs related to families caring for kin. Funding is necessary in order to support the creation and dissemination of additional materials for ESD staff to ensure that they have the tools necessary to support caregivers financially, as well as to support an ESD staff to make appropriate referrals, as needed.

Guardianship Assistance Program

Vermont has stood up its Guardianship Assistance Program. Services available to guardians are generally the same supports and services available to a licensed relative or non-relative caregiver. At this time there are no specific components of this practice that are supported by this funding.

Focus on Family Finding

Vermont is focused on enhancing outreach to and engagement of potential kin caregivers. One area of practice that needs continued attention is our practice related to family finding. We have recently expanded one of our service delivery contracts to ensure that we have partners whose role is to support family finding work. We have heard from the field that even when a tool like Lexus Nexus is used to identify potential connections, staff do not feel confident with the follow through. We have engaged Family Finding expert, Kevin Campbell to consult with our jurisdiction to re-introduce a model of Family Finding. A Family Finding Working Group has been established to plan our approach to improved family finding practice in Vermont. This effort would tie in nicely with the statewide recruitment and retention work currently being implemented.

A kick-off conference is scheduled for October 2019 to include direct service supervisors, resource coordinators (who support caregivers) as well as the contracted providers would support a practice shift in this area. Ongoing coaching, related to family finding, will be supported by the Permanency Planning Manager at the monthly district permanency planning consultation meetings as well as through consultation with the Foster Kin Care Manager who will be supporting the implementation of the statewide diligent recruitment plan. Originally funding for the Family Finding conference was scheduled to come from this Kin Navigator allocation. However, due to a misunderstanding about when the funds needed to be spent, we will need to shift this portion of our request to the 2019 allocation request.

Caregiver Peer Mentoring

Further development of our statewide peer-to-peer mentoring program for resource caregivers is in progress. Last year, the State of Vermont and the University of Vermont wrapped up work on a 5-year grant with the Children's Bureau that developed a foundation for a research-based mentoring program. The sustainability plan for continuing this program included FSD assuming ongoing responsibility for the administration of this program beginning in the Fall of 2018.

An effective method to promote greater stability is providing resource parents with support and training in managing and understanding the trauma related behaviors of the children in their care (Price, Chamberlain, Landsverk, Reid, Leve, & Laurent, 2008), and the influence of peer support and training should not be underestimated. Another study by Hughes, Harbert, & Tucker-Tatlow (2015) found that "when resource parents are asked about what they need to feel supported, they often request support from other resource families, including support groups, mentoring from more-experienced families, a buddy system or a hotline staffed by experienced resource parents (p. 21)."

Research in Vermont found similar responses from caregivers citing a desire for additional opportunities to strengthen a caregiver's natural system of supports and help prevent placement disruption. Vermont's peer mentoring program is an ongoing mechanism for formally linking caregivers to one another, so they feel supported when facing challenging situations. The peer mentoring program will allow trained peers to support fellow resource parents during times of need/crisis while awaiting additional supports and training from the professional system.

Since kin caregiving brings unique dynamics, it has become clear through the development of our program, that we need to develop and implement kin-specific mentor recruitment, training, and support. Efforts are underway to enhance the kinship specific mentoring training and delivery.

Child Welfare Waiver Demonstration Activities

Vermont is not operating its IV-E program under a waiver.

Adoption and Legal Guardianship Incentive Payments

2016 Incentive (\$100,500) must be liquidated by 12/31/2019

- 1.) Amendment to Project Family grant \$79,398. (obligated 3/1/2019) - To support the additional home study work being done through Project Family.
- 2.) Lund Screeners Contract (31088) \$21,102:
 - a) The Lund Substance Abuse Screener/Case Manager will be assigned cases from the referring district supervisor or director. Services provided will be to screen for substance abuse, address barriers to treatment/services and make referrals as appropriate to support treatment for substance abuse. The Lund Substance Abuse Screener/Case Manager will work in collaboration with the Department for Children and Families Child Safety Intervention Social Worker.
 - b) Lund Substance Abuse Screener/Case Manager(s) will be provided with log-in rights to FSD Net and comply with the confidentiality agreement. The Lund Supervisor and Substance Abuse Screeners/Case Manager will be available to serve families from the designated Department for Children and Families District Office for investigation and assessment

The above spending obligates and will liquidate the entire \$100,500 adoption incentive allocation for 2016

2017 allocation (\$110,000) must be liquidated by 12/31/2020

- 1.) Amendment to Project Family Grant \$65,000: To support the addition of the following responsibilities:
 - a.) Permanency Improvement Project Administrator Lund will provide a Permanency Improvement Project Administrator for the data entry and management of the Permanency Improvement Project.
 - b) Post-Adoption Contact Agreement Worker. Lund will provide a Post-Adoption Contact Agreement (PACA) worker to work with prospective adoptive parents and all related parties, to develop a post-adoption contact agreement proposal on behalf of the prospective adoptive parents.

Additional conversation regarding Adoption Incentive Spending purposed to allocate an additional \$57,198 (from the 2017 award) to the Project Family Grant to ensure that the above two functions would be carried out by Lund for the remainder of their grant period.

2018 allocation (\$655,000) must be liquidated by 12/31/2021:

Planning to date includes:

Project Family Grant Allocation \$65,000 to support the following:

a.) Permanency Improvement Project Administrator will provide a Permanency Improvement Project Administrator for the data entry and management of the Permanency Improvement Project.

b) Post-Adoption Contact Agreement Worker: The subrecipient will a Post-Adoption Contact Agreement (PACA) worker to work with prospective adoptive parents and all related parties, to develop a post-adoption contact agreement proposal on behalf of the prospective adoptive parents.

Program Support

The following section describes what trainings and technical assistance has been provided to Vermont over the last year as well as the planned training and technical assistance for the upcoming year. This section also provides updates relating to research, evaluation, management information system, and/or Family Services quality assurance system.

Training and Technical Assistance to Districts:

SDM tools and Safety Organized Practice Implementation- The Children’s Research Center (CRC) has continued to provide technical assistance around the implementation of Vermont’s SDM tools which include the Safety Assessment, the Risk Assessment, the Risk Reassessment and the Reunification Assessment tool. In addition, they conducted a training on their quality assurance case read tool for directors and supervisors. Over the last year, the CRC has also facilitated monthly calls with the Safety Organized Practice core team to ensure that our planning and approach to training and coaching staff are aligned with best practice and implementation science (see **Appendix C-** CRC workplan).

Technical Assistance and Capacity Building Needs:

Data Analytics: Over the last year, Vermont continued its work with the Capacity Building Center for States to help strengthen the agency’s CQI infrastructure by focusing on the creation of an analytic framework to outline an approach for analyzing outcomes. The project came to an end in the summer of 2018 after presenting findings on Workforce Development, Foster Care Re-entry, and Foster Parent Diligent Recruitment. Moving forward, these skills will assist FSD to effectively “tell the story” of the agency with data and develop a stronger Continuous Quality Improvement feedback loop within the agency.

Foster Care Recruitment and Retention: Vermont continues to receive technical assistance from the Capacity Building Center for States (CBC) to support the agency’s work around foster recruitment and retention. Please refer to the Diligent Recruitment Plan for Foster and Adoptive Parents section of the APSR for more detail.

Strategic Planning- FSD contracted with a local organizational effectiveness consultant to develop a 3-year strategic plan which was completed in February of 2019. Please refer to the CFSP for more detail.

Research, Evaluation, and Management Information Systems, and QA systems:

ROM- Vermont continues to contract with the University of Kansas to implement the Results Oriented Management system over the next year.

Qualitative Case Review System- Vermont continues to work on improving its first robust qualitative case review system which was implemented effective spring 2016. As part of the PIP, the agency reviews a total of 130+ cases in the spring and fall utilizing the Onsite Review Instrument (OSRI) which is a web-based tool developed by the Children's Bureau. These reviews involve a review of the file and as well interviews with the family, social worker, foster parents and/or other key people in the child/youth's life. Vermont has received ongoing support and training from the Children's Bureau around the implementation of FSD's QCR system.

Comprehensive Child Welfare Information System- Over the last year FSD began exploring the possibilities of developing Comprehensive Child Welfare Information System (CCWIS) which to replace the division's existing databases SSMIS and FSDNET. Funding was not approved at this time, so the focus remains on improving our current databases.

NEICE:

Vermont is currently working towards implementing NEICE (National Electronic Interstate Compact Enterprise) which is a national electronic system for quickly and securely exchanging the data and documents required by the Interstate Compact on the Placement of Children (ICPC) to place children across state lines. The goal is to Go-Live by Fall 2019.

Consultant and Coordination between States and Tribes

There are no changes since our CFSP was submitted. Note that there are no federally recognized tribes within Vermont's borders. The St. Albans districts continues to work and collaborate with advocates in the Abenaki community when appropriate.

CAPTA Updates

Changes to State Law or Regulations Concerning Child Protection

There have been no substantive changes 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.

Significant Changes in CAPTA Plan

There were no significant changes from the states previously approved CAPTA plan, though the division did expand the funding of substance abuse screeners from 2 to all 12 districts over the last year. Vermont plans to continue to use CAPTA funds in the following manner:

- I. Utilize joint funding in partnership with VDH and UVM Medical Center (UVMMC) to provide consultation with medical professionals on complex child abuse/neglect investigations for \$50,000.
- II. To support the development and spread the model of joint investigation that includes the use of a forensic interviewer. \$20,000 has been used to pay for a part time forensic interviewer.
- III. To pay for investigations and assessment training for staff. These funds are used to finance foundation and core training related to child safety interventions provided by the University of Vermont Child Welfare Training Partnership. \$7,000 is spent to cover this cost.
- IV. Finance the activities of the Child Fatality Review Team and the Vermont Community Advisory Board (VCAB). CFRT meets monthly and reviews all child deaths in the state to understand the public health and system issues needing attention. VCAB meets 4 times a year and reviews policy and child welfare related issues. The team enhances interagency collaboration and information sharing. \$17,300 is spent to cover this cost annually (\$7300 for CFRT and \$10,000 for VCAB).
- V. To pay for a portion of Regional Partnership Program through LUND that is intended to screen caregivers for possible substance use disorders and connect them to assessment / treatment if indicated. This is intended to ensure early identification and intervention and to address needs related to Plans of Safe Care for infants. \$180,000 will be used to pay for this activity.
- VI. Other investigative related trainings.

Use of CAPTA Funds

DCF Family Services anticipates using CAPTA funds to address some or all of the following program areas:

	Program Area	Activity
	1. The intake, assessment, screening, and investigation of reports of child abuse or neglect;	
X	2. Creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations; and improving legal preparation and representation, including procedures for appealing and responding to appeals of substantiated reports of child abuse or neglect; and provisions for the appointment of an individual appointed to represent a child in judicial proceedings;	Utilize joint funding in partnership with VDH and UVM Medical Center (UVMCC) to provide consultation with medical professionals on complex child abuse/neglect investigations.
	3. Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families;	
X	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;	We are in the process of implementing revised safety and risk assessment tools and CAPTA funds may be used to further refine, train and automate these tools.
X	5. Developing and updating 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;	See #4.

	Program Area	Activity
X	<p>6. Developing, strengthening, and facilitating training including—</p> <ul style="list-style-type: none"> • training regarding research-based strategies, including the use of differential response, to promote collaboration with the families; • training regarding the legal duties of such individuals; • personal safety training for case workers; and • training in early childhood, child, and adolescent development; 	<p>Parts of our foundation and core training for social work staff is funded by CAPTA, when specific to training staff how to conduct child abuse and neglect assessments and investigations.</p> <p>Collaborate with UVM regarding RPC+ and some work they are interested in doing to create CPC (caregiver plus care) – a complimentary program that would be targeted at parents.</p> <p>Support the UVM CWTP agreement specifically for (1) Safety Organized Practice, (2) staff safety and (3) RPC+ training if the division doesn't get an increase in our CWTP funds in the next year.</p>
	<p>7. Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers;</p>	
X	<p>8. Developing, facilitating the use of, and implementing research-based strategies and training protocols for individuals mandated to report child abuse and neglect;</p>	<p>FSD continues to refine and improve training for mandated reporters. Funds may be used for consultation, the purchase of equipment needed for trainings, and for training and education materials.</p>
	<p>9. Developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions, including—</p> <ul style="list-style-type: none"> • existing social and health services; • financial assistance; • services necessary to facilitate adoptive placement of any such infants who have been relinquished for adoption; and 	

	Program Area	Activity
	<ul style="list-style-type: none"> the use of differential response in preventing child abuse and neglect. 	
X	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;	FSD continues to refine and improve training for the public and for non-mandated reporters. Funds may be used for consultation, the purchase of equipment needed for trainings, and for training and education materials.
X	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;	FSD is interested in doing some work to augment peer supports in our system to support recovery centers in some way to have a peer support component.
	12. Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems;	
X	13. Supporting and enhancing interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs— <ul style="list-style-type: none"> 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; or 	This includes our work with UVMCC providing consultation on complex cases.
	14. Developing and implementing procedures for collaboration among child protective services, domestic violence services, and other agencies in—	

	Program Area	Activity
	<ul style="list-style-type: none"> • investigations, interventions, and the delivery of services and treatment provided to children and families, including the use of differential response, where appropriate; and • the provision of services that assist children exposed to domestic violence, and that also support the caregiving role of their non-abusing parents. 	

Annual reports from VCAB

For a copy of the Vermont Citizen Advisory Boards report, please email Suzanne Shibley, Policy and Planning Manager at: suzanne.shibley@vermont.gov

Identification and Services to Substance-Exposed Newborns

Vermont is still in the implementation phase of the requirements outlined in the CAPTA and the Comprehensive Addiction and Recovery Act (CARA). Over the last year Vermont lost of couple of key partners who are no longer in their roles to assist with this work. However, there is a lot of energy to continue to move this work forward and weave it into other related projects. As of June 2019, Vermont is in the process of identifying who should be a part of this core team which will include partners from the Vermont Department of Health, the University of Vermont Medical Center (UVMCC), and Family Services.

There have been several lessons learned over the last year that is helping Vermont improve the work in this area. First, it became apparent that the lack of a standardize process was causing confusion and inconsistencies at our largest hospital, UVMCC. They now have a protocol in place to fax the Plan of Safe Care (POSC) to the infant's primary care provider (PCP) and scan the POSC into the infant's chart. The hospital staff also give a copy to the mother and let them know that if they wish to get another copy to simply call medical records and get it from the infant's chart. UVMCC is also working to have the POSC started prior to birth hospitalization which is an exciting next step.

As for the rest of the birth hospitals it is understood that Vermont needs to get a better understanding of who is responsible for completing the POSC at each hospital to improve communication and better support implementation challenges. Efforts are being made to make assure there is appropriate representation at the quarterly statewide nurse manager meetings who have familiarity with the Vermont's protocols related to POSC. Those involved in the coordination of this meeting are feeling that they have a solid collaborative team to move this coordination forward. The next meeting is set for fall of 2019.

This past April, during the Improving Care for Opioid-exposed Newborns (ICON) annual conference, Vermont's work related to POSC was reviewed which generated some great questions and feedback, and highlighted some needed next steps. Over the next year, ICON will develop a survey to assess the POSC implementation and target not only the birth hospital teams (nurse managers/care coordinators and hospital social workers) but also infant primary care providers.

Vermont also spoke at the recent NNEPQIN spring conference on the POSC with representatives from New Hampshire presenting their work in this arena. The question of sharing information about the mother with the infant's PCP (or in the infant's chart) continues to be a topic of debate and the concern for those caring for women with opioid use disorder. This will need further exploration and Vermont is interested in collecting information from other states on how they handle this issue.

The following is a summary of the protocols developed in collaboration:

FSD will continue developed a plan of safe care for all substance exposed newborns and their parent/caretaker(s) when it meets the agency's acceptance criteria and monitor those cases as outlined in policy 51: *Screening Reports of Child Abuse and Neglect*, <https://dcf.vermont.gov/sites/dcf/files/FSD/Policies/51.pdf> .

Hospitals are now responsible for developing a Plan of Safe Care for substance exposed newborns and parent/caretaker(s) who meet the criteria listed below when there are no child protection concerns and FSD is not involved. The hospital will forward the Plans of Safe Care to the newborn's primary care provider for further monitoring.

Hospitals are also required to fax or email a non-identifying notification form to FSD which addresses the data requirements that will be provided to the Children's Bureau annually.

Criteria for when hospitals develop a Plan of Safe Care and send a notification to FSD before newborn discharge:

- Mother is stable and engaged in medication-assisted treatment with methadone or buprenorphine
- Mother is being treated for chronic pain by a physician
- Mother is taking benzodiazepines as prescribed by her physician
- Newborn was prenatally exposed to marijuana

To help medical and substance use providers working with pregnant women explain the new requirements, Vermont also developed a handout for providers to give to women. The handout explains under what circumstances a Plan of Safe Care will be developed, what will be in the plan, who keeps the plan, what information the hospitals provide FSD, and when the hospitals need to make a child protection report.

There is a section on FSD's public website, *Substance-Exposed Newborns* on the Resources for Partners page that has all the up-to-date Plans of Safe Care, Hospital notification form, FAQs, and flowchart:

<http://dcf.vermont.gov/fsd/partners>

Data

- FSD has received over 310 notifications from hospitals since Vermont began rolling out this process back in November of 2017
- Of the total # of notifications received from hospitals since November 1, 2017- June 1, 2019:
 - 87 % of mothers agreed to complete a POSC
 - 42% were mothers who were stable and engaged in medication-assisted treatment with methadone or buprenorphine
 - 42 % had newborns prenatally exposed to marijuana
 - 15% were mothers who were stable and engaged in medication-assisted treatment **and** had newborns prenatally exposed to marijuana
 - > 1% fell into one of the following categories:
 - Mother was being treated for chronic pain by a physician
 - Mother was being treated for chronic pain by a physician **and** newborn was prenatally exposed to marijuana
 - Mother was taking benzodiazepines as prescribed by her physician **and** newborn was prenatally exposed to marijuana
 - Mother was stable and engaged in medication-assisted treatment **and** mother was taking benzodiazepines as prescribed by her physician **and** newborn was prenatally exposed to marijuana

CAPTA coordinator

If there are any questions or comments, Suzanne Shibley, Policy and Planning Manager, is the CAPTA coordinator for Family Services and can be reached at 802-241-0905 or suzanne.shibley@vermont.gov.

Children's Justice Act

The Children's Justice Act (CJA) funds are federally required to be used for programs that reform state systems and improve the process by which Vermont identifies, investigates and prosecutes cases of child abuse and neglect, including child sexual abuse and exploitation and cases of suspected child abuse or neglect related fatalities. Projects should focus on creating more effective responses for both the child victim and the offender and to limit additional trauma to the child victim. The Federal Program Instruction states that CJA funds cannot be allocated for prevention or direct service activities.

The Vermont CJA Task Force Three Year Assessment Plan is Federally mandated to include a comprehensive review and evaluation of the investigative, administrative and judicial handling of cases of child abuse and neglect and to make training and policy recommendations that focus efforts on improving the system wide response to child maltreatment. The Task Force projects and focus areas are:

- Assisting in maintaining and further developing the Vermont Sexual Assault Nurse Examiner Program. Emphasis continues to be placed on the Pediatric SANE Program.
- Supporting the existence of statewide Children's Advocacy Centers (CACs) and Special Investigation Units (SIUs). Currently a strong focus is on sex trafficking of minors, strengthening statewide, department and division policy and response systems.
- Making recommendations to strengthen the Vermont Department for Children and Families (DCF) procedures for reviewing reported abuse and neglect as well as examine treatment service access and delivery.
- Maintaining and further developing the Vermont Children's Justice Act Task Force and to ensure participation in the Annual Meetings.
- Assisting in strengthening the Vermont's Guardian ad Litem (GAL) Program through funding regular training and increased outreach for active volunteers.
- Providing professional development training, support for research or model project testing to determine best practice standards for professionals who work with child abuse and neglect cases and acquisition of associated technical equipment.

For any questions related to accessing CJA funds, please contact Priscilla White, the State CJA Coordinator and Child Victim Treatment Director, at Priscilla.White@vermont.gov

Statistical and Supporting Information

CAPTA Annual State Data Report

Child Protective Service Workforce Overview

Vermont provides child welfare and youth justice services in an integrated system. Professionals are in one of three job titles:

- Family Services Workers– Family Services Workers typically specialized in one of four areas of focus:
 - Centralized intake and emergency (after hours) services
 - Child safety interventions
 - Ongoing work with families in child protection, child welfare and/or youth justice. This may include child protective services cases, children in foster care, and/or supervision of youth on juvenile probation
 - Foster and residential licensing and special investigations
- Senior Family Services Workers – Senior Family Services Workers also perform in one of the four areas of specialty listed above. They also supervise one to three Family Services Workers as part of their duties.
- Domestic Violence Specialists- Regionally based DV Specialists team with Social Workers on co-occurring child maltreatment and intimate partner violence case situations. DV Specialists screen all new reports of child maltreatment that are flagged with domestic violence, assist with background checks, safety planning and assessments with Family Services Workers on making engagement with families safer and for more accurately assessing the dangers to children caused by the pattern of coercive control by the perpetrating parent. DV Specialists when appropriate provide direct services to both victim and perpetrator parents to assist with assessment and appropriate case planning and services. The Safe and Together Model of Perpetrator focused, pattern based tools and training are utilized in consultation: <https://safeandtogetherinstitute.com/>.

DV Specialists also team with Family Services Workers on home visits and family safety meetings. In court involved cases, DV Specialists are often called to provide expert testimony on the impact to children due to exposure to domestic violence as well as appropriate service referrals for the parent using coercive control. These positions play a key role in coordination of services for families with the criminal justice system as well as the domestic and sexual advocacy service system.

Qualifications for Child Welfare and Youth Justice Staff

There are no new updates around the education and qualifications requirements for Family Services Workers staff. The minimum qualifications for Family Services worker Trainees are:

- Bachelor’s degree with no experience; or
- High school graduation or GED with 4 years in human services at or above a paraprofessional or technician level.

The minimum qualifications for Family Services Workers are:

- Master’s degree in social work with no experience: or
- Bachelor’s degree with 18 months of human services casework, including at least six months with a child or youth services caseload.

The minimum qualifications for Family Services Supervisors are as follows:

- Master’s Degree in social work with one year of casework experience with a child protective or juvenile services caseload; or
- Bachelor's degree with three years of casework experience with a child protective or juvenile services caseload; or
- Bachelor's degree with two years of casework experience with a child protective or juvenile services caseload PLUS one year of supervisory experience; or
- Completion of a Family Services worker Traineeship in Children and Families and 3 years of casework experience with a child protective or juvenile services caseload.

All Family Services Workers complete the Foundations training which is described in our Annual Progress and Services Report, regardless of what kind of job duties they will perform.

Demographic Information for Child Welfare and Youth Justice Staff

The division continues to be challenged around collecting demographic information on the workforce. The information provided below came from a Staff Retention survey administered in November 2018 where 89 Family Services worker responded.

Q28 - Age range

#	Answer	%	Count
1	Under age 30	12%	11
2	Over age 30 to age 40	40%	36
3	Over age 40 to age 50	26%	23
4	Over age 50 and over	22%	19
	Total	100%	89

Q29 - Gender

#	Answer	%	Count
1	Female	82%	73
2	Male	15%	13
3	Other	3%	3
	Total	100%	89

Q30 - Education

#	Question	I do not have this degree		Degree in Social Work		Degree in Sociology		Degree in Psychology		Degree in other field		Total
1	Undergraduate degree	2.44%	2	24.39%	20	7.32%	6	26.83%	22	39.02%	32	82
2	Graduate degree	35.82%	24	37.31%	25	1.49%	1	4.48%	3	20.90%	14	67
3	Associate degree	66.67%	34	1.96%	1	0.00%	0	5.88%	3	25.49%	13	51

Caseload Size

Caseload is measured in different ways depending on the duties of the Family Services Worker (FSW). Family Services Workers who conduct child safety interventions (investigations and assessment) are expected to conduct 100 interventions per year.

The caseloads of ongoing Family Services Workers are measured by the number of families per worker, regardless of the type of case. FSD calculates district capacity by using the following equation:

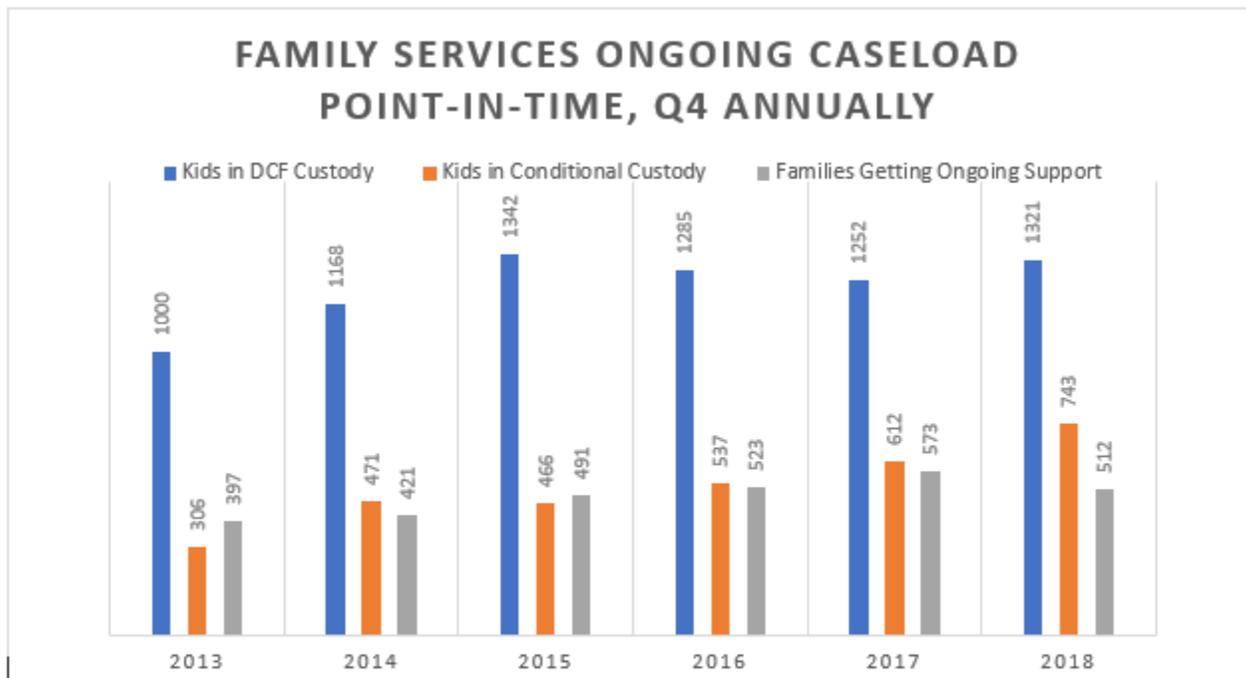
of on-going FSW (-) vacant positions (-) 0.5 FSW with > 6 months experience
(÷) by the family caseload

Calculated variance with a 15:1 Family Services Workers to family ratio

As of 5/28/2019, caseload per district were as follows:

District	Ongoing FSW FTEs	# Vacant Positions	# Less Staff (count @ .5 reduction)	Total FTE Capacity Reduction	Adjusted Ongoing FSW Count	FAMILY Caseload Avg Per Auth FSW	CHILD/FAMILY Avg Per Auth FSW	Adjusted Family Caseload Average	FSW Capacity
ADO-St Albans	18	0.0	3.0	1.5	16.5	17.4	23.4	19.0	79.07%
BDO-Burlington	22	2.0	0.0	2.0	20	18.9	27.8	20.8	72.12%
HDO-Hartford	9	0.0	2.0	1.0	8	10.4	13.6	11.8	127.66%
JDO-St Johnsbury	5	0.0	1.0	0.5	4.5	17.8	28.6	19.8	75.84%
LDO-Brattleboro	10	0.0	0.0	0.0	10	16.7	26.2	16.7	89.82%
MDO-Barre	13	2.0	1.0	2.5	10.5	18.2	25.9	22.5	66.74%
NDO-Newport	6	1.0	1.0	1.5	4.5	22.3	29.3	29.8	50.37%
RDO-Rutland	13.5	0.0	2.0	1.0	12.5	16.0	20.1	17.3	86.81%
SDO-Springfield	9	0.0	4.0	2.0	7	10.3	13.1	13.3	112.90%
TDO-Bennington	8	1.0	0.0	1.0	7	21.3	28.6	24.3	61.76%
V-Morrisville	4.5	0.0	1.0	0.5	4	16.9	21.1	19.0	78.95%
YDO-Middlebury	8	0.0	1.0	0.5	7.5	13.6	19.8	14.5	103.21%
Total	126	6.0	16.0	14.0	112	16.8	23.4	18.9	83.77%

The following point-in-time graph reflects the caseloads as of 12/31/2018.



Data Source: FSD Quarterly Management Reports-last day of Q4 for custody cases; FSD Conditional Custody Report. FSD Full Caseload Report for family support cases.

Data Note: Conditional Custody Report & Full Caseload Report are point-in-time and may not be the last day of Q4.

Juvenile Justice Transfers

Reporting Year (CY)	New DC Case Type	Juvenile Justice Transfer (prior custody)
2014	33	8
2015	49	9
2016	32	4
2017	43	6
2018	49	15

Education and Training Vouchers

The following table provides historical data about the disbursement of Chafee ETV funds through VSAC.

	Total ETVs Awarded	Number of New ETVs
<u>Final Number: 2017-2018 School Year</u> (July 1, 2017 to June 30, 2018)	26	13
2018-2019 School Year* (July 1, 2018 to June 30, 2019)	31	21

Inter-Country Adoptions

Vermont had 1 child who was adopted from other country and who entered into state custody in FY 2018 as a result of the disruption of a placement for adoption or the dissolution of an adoption.

Agency: Private Non-Profit Adoption Agency (agency name not known)

Reason for disruption/dissolution of adoption: Youth came into custody as an unmanageable youth. The mother stated she was ready to 'relinquish' because she was experiencing daily abuse from the youth and is afraid to be at home alone with them.

Case plan goal for child: The case plan goal is reunification, but youth stated in court earlier this year that they does not wish to be reunified with their adoptive parents.

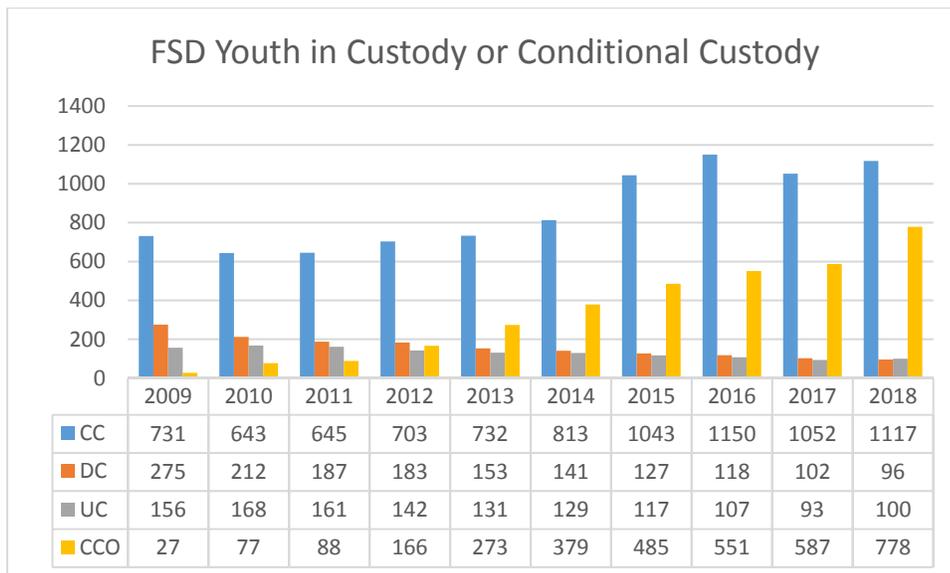
Monthly Caseworker Visits

Vermont's monthly face-to-face contact data is at 91 %, which is an increase from the 88.60% from the before though still below the national standard of 95%. The division continues to focus on this practice area and identify potential strategies to make improvements. The division however achieved a 55% rate of visits occurring in the placement setting which is a positive highlight. The division supports the districts and workers to meet the monthly contact requirements by employing a multi-pronged approach that addresses caseload as well as efficiency and effectiveness of our interventions:

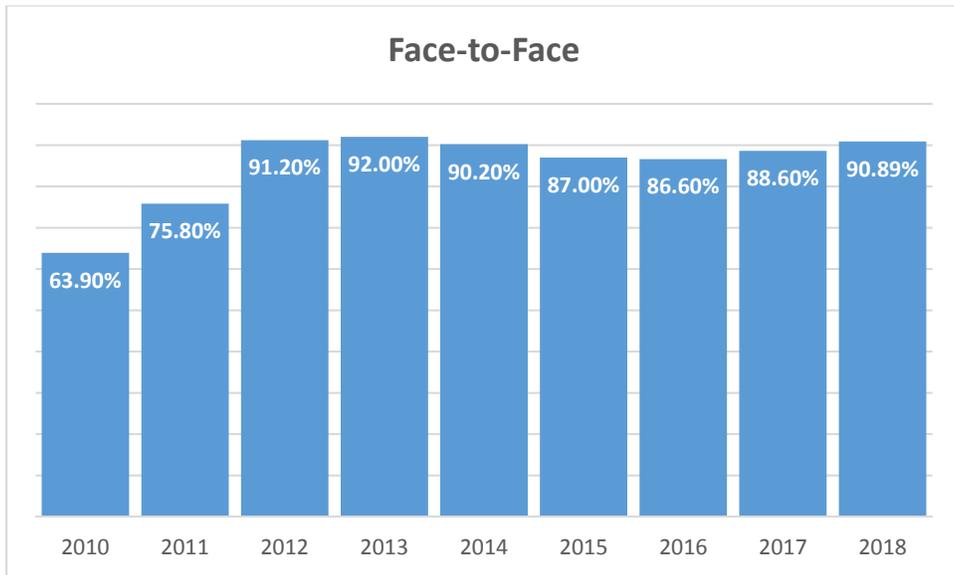
- All Family Services workers are equipped with I-phones (with telephone, e-mail, scheduling and wireless modem capacity) and laptop computers. This combination enables them to access division computer applications from remote locations, including from client homes.

- The division continues to promote teaming and group supervision models, to increase the number of social workers who have a relationship with a family and can assist in times of intense service need.
- A report is sent weekly to districts, which assists them in tracking which children and youth have not yet been seen during the month.
- Case aides have added to all districts to assist with certain tasks to help support Family Services Workers.
- Staff have been provided with the SafeSignal app for their I-phones and bright yellow tethers that attach to their phones. This technology is downloaded on state issued phones and gives staff to the ability to signal for help 24/7/365 if they are faced with an unsafe situation.

In examining Vermont’s QCR results, we know that staff turnover has contributed to item 14- caseworker visits with child in many cases being an ‘area needing improvement’. In 2018, our Quality Assurance team worked with the Capacity Building Center for States on a data analytic project focused on staff retention. The data showed that FSD had a 25% turnover rate (which includes internal transfers and promotions). FSD will continue to review our qualitative case review data to identify strategies to achieve the federal standard. Lastly, Family Services was recently allocated 9 additional FSW positions this past legislative session which will help address some of the challenges, including high caseloads.



Face-to-Face



Family Time Coordination

The purpose of this document is to provide guidance for family time coordination. When a child enters DCF custody, the family services worker will likely make a referral for this service that will clarify the danger and risk items present in this case. Given this information the coordinator will coordinate the appropriate support needed for family time and will develop a family time plan within 60 days. There may be multiple options for family time utilized at the same time. Specifically, the coordinator will:

- Use information available, including results of family finding, and consider options for family time;
- Address financial challenges including transportation that may be a barrier;
- Identify community-based options to support family time and help connect families to these resources; and
- Conduct a meeting to formalize a plan for the most appropriate option for family time, including location, and how that may change over time.
- This family time plan should include benchmarks for the family to move from one form of support to another.

The goals of family time coordination are to:

- Use the results of family finding efforts to identify natural supports which may directly support the plan for safe and the most appropriate form of contact;
- Determine the most natural, safe setting in which contact may occur. This process shall include the consideration of alternatives to family time coaching; and
- Formulate a family time plan that outlines the most appropriate form of contact, and how the form of contact may change over time.

Please see the Family Services Division's Initial Caregiver Meeting, Shared Parenting Meeting, and Family Time Guidelines Practice Guidance for additional information.

Options for Family Time

Natural Supports – These are people who have a caring connection with the child and parent, are willing to meet with family services staff and contracted providers, understand the harm/danger concerns that exist, and are willing to take action that supports the family and helps keep the child safe. It is important to meet with natural supports and parents to be clear about boundaries, expectations, and detailed logistics about family time. Family and friends can support a parent to participate in community activities. It is important that they have information about any specific needs or other work the parent is doing in family time. Family finding may be an important activity to identify natural supports.

Foster Parent/Kin Caregiver Support – Family time with the foster parent should only occur after a thoughtful process of has occurred. There must be a belief that it can occur safely based on the caregiver having a clear understanding of what is being asked of them and positive regard between the parent and foster parent/kin caregiver. There should be a meeting with the caregiver and family services worker, resource coordinator and/or CFS staff to discuss specific danger and risk factors, abilities, availability, expectations, and boundaries. Following this, there should be a meeting with the parent, caregiver, family services worker, and others if necessary to discuss expectations and logistics for family time. There needs to be confidence that supporting family time will not destabilize the child’s placement. Shared Parenting Meetings are a useful tool to facilitate the development of relationships between caregivers and parents and can be used to prepare a caregiver to support family time in some way. This option should not be put in place with a new caregiver until a meeting with the caregiver occurs to establish role clarity, clear boundaries and appropriate supports.

Community Activities – The CFS contractor that is helping coordinate and plan family time should have knowledge of community activities that are available and appropriate to support parent child contact. They may include playgroups, library activities, community events such as fairs or holiday celebrations, and/or activities specific to the child – sporting events, extracurricular activities, school events, or appointments. The parent may or may not need support to attend these activities or events with their child. These may present opportunities for unsupported yet structured time.

Monitored – When safety cannot be assured in any other way, a family time monitor that is a paid staff person of either the division or a contractor is present for family time. This staff member is there to make sure that the time is safe for the child. Monitoring is also used when natural supports, the foster parent, or kin caregiver are not available to support family time. Efforts should still be made for the environment to be natural and least restrictive. The parent may have been the subject of an FS-110 and consultation with Staff Safety Manager. This information must be shared with any contracted partner being asked to assist with family time.

Supported – The word “supported” is used in a broad manner throughout this document to mean the many ways that an individual such as a coach, foster parent, natural support, case aide, worker or others might deliver parent child contact.

Supervised Visitation Center – This is a community agency (sometimes the domestic and sexual violence agency or other local providers) that adheres to specific guidelines to promote safe family time or exchange of a child when there is a history of violence perpetrated on one parent, usually the mother, by the other. In some parts of the state, the division has contracts with these centers and family time occurs there when this level of safety and security is necessary.

Court/DCF-FSD Office – There are times when family time needs to be held in these locations due to safety concerns. The parent may have been the subject of an FS-110 and consultation with Staff Safety Manager. This information must be shared with any contracted partner being asked to assist with family time. These are the least desirable locations for family time.

Family Time Coaching (FTC) – This is a highly skilled, primary intervention service designed to help the parent learn to identify and meet their children’s needs. Family time coaches develop, through training and practice, a set of parenting coaching skills. There is clinical oversight of the coaches that supports the identification of a child’s needs and intervention with the parent aimed at helping them learn how to meet their child’s needs. A parent must be ready to engage and benefit from this intervention. This is a time limited service. If a parent is demonstrating new skills, they move beyond this primary intervention. If they are not demonstrating new skills, the service is not having the desired outcome and is discontinued. FTC is not necessary or appropriate for all family time – for instance, if family time is happening 5 days per week, it is not appropriate for all of that time to be coached. Natural supports and foster parent/kin caregiver support may augment the parent-child contact plan, and the family time plan should encompass all aspects of contact. Please refer to the Family Time Guidelines for more in-depth guidance regarding the Family Time Coaching model.

OPTIONS FOR FAMILY TIME

	GREEN – Unsupported	YELLOW – Natural supports; community activities	ORANGE – Supported through coaching	RED – Most restrictive
Level of Collaboration	<ul style="list-style-type: none"> Parent demonstrates willingness and ability to consistently follow the safety plan, work with DCF-FSD, foster parents, and natural supports to ensure child safety 	<ul style="list-style-type: none"> Natural supports have been identified and are willing to support parent/child contact; the parent is willing to work with natural supports and, if applicable, challenging dynamics have been addressed 	<ul style="list-style-type: none"> Relationship dynamics between parents and natural supports may impact reunification efforts Parent demonstrates willingness to engage with coach and develop capacity to safely parent child. 	<ol style="list-style-type: none"> No contact (typically court ordered); or Monitored via visitation center, court, therapeutic setting, or DCF-FSD office <ul style="list-style-type: none"> Parent openly refuses, has demonstrated refusal in the past, or is unable to work safely with the Family Time Coach, natural supports, DCF-FSD, or court partners demonstrated by a staff safety incident with the parent requiring an FS-110 and consultation with the Staff Safety Manager
DANGER CATEGORY				
Substance Use	<ul style="list-style-type: none"> Parent is committed to recovery as demonstrated by sustained sobriety/successful MAT, development of a support system in recovery, distance from those engaged in substance misuse, and success in coaching/with natural supports 	<ul style="list-style-type: none"> Parent is not engaged in treatment or there is denial of substance use as an issue Parent is new to treatment and sobriety Natural supports have been (or are willing to be) an active part of supporting safe family time and the FSW has met with the support and the parent to establish clear expectations for safe contact 	<ul style="list-style-type: none"> Parent substance use is primary factor in custody status and parent is actively engaged in treatment and open to working with a coach 	<ul style="list-style-type: none"> Parent is actively using, has attended family time under the influence and impaired, which has had a negative impact on the child Other supportive interventions have not been successful in mitigating this
Domestic Violence (DV) / Intimate Partner Violence (IPV)	<ul style="list-style-type: none"> Parent who is a perpetrator of domestic violence has successfully completed certified Domestic Violence Accountability Program (DVAP) or DV specific parenting program (Caring Dads, Parenting with Respect, etc.) and engaged successfully in coaching where they have done reparative work with the child Parent who is a perpetrator of domestic violence owns the impact of the behavior and demonstrates respect for non-offending parent and the ability to 	<ul style="list-style-type: none"> Parent who is a perpetrator of domestic violence has natural supports that hold him/her accountable for his/her coercive or controlling behavior and are willing to be an active part of supporting contact that is safe for both the child and non-offending parent Natural support has met with FSW and DV Specialist to develop a plan regarding what the above bullet entails 	<ul style="list-style-type: none"> Parent who is a perpetrator of domestic violence has successfully completed certified DV Accountability Program and DV Specialist recommends the parent is ready to engage in the coaching model Parent demonstrates a focus on child well-being and restoring a relationship without undermining the other parent 	<ul style="list-style-type: none"> Parent who is a perpetrator of domestic violence denies harmful impact on the child and family; or has used family time to intimidate the non-offending parent; or has attempted to involve child in controlling the non-offending parent Child is fearful of the perpetrator parent and the child's therapeutic needs indicate that contact is not warranted Parent has criminal court order conditions, RFAs, or other previous

	<p>co-parent in a way that is devoid of coercive or controlling behavior</p> <ul style="list-style-type: none"> Note: Initial consult with DV Specialist should occur 			<p>contact restrictions prior to custody should be considered</p>
Serious Physical Injury	<ul style="list-style-type: none"> If the parent is the perpetrator, successful period in coaching demonstrating safe parenting strategies while parenting under stress/in situation that simulates when the abuse occurred 	<ul style="list-style-type: none"> During CSI phase and parent is alleged perpetrator of serious physical injury Natural supports understand the danger and are a safety 	<ul style="list-style-type: none"> Admission/cause of injury is known, and parent demonstrates willingness to engaging educational model 	<ul style="list-style-type: none"> Denied child abuse Parent that perpetrated the abuse continues to pose a physical and/or emotional threat to the child
Physical & Mental Health	<ul style="list-style-type: none"> Parent has no significant health concerns that impact the ability to care for a child Parent has no significant mental health concerns that impact the ability to care for a child Any health or mental health concerns of parent are adequately managed with recommended treatment 	<ul style="list-style-type: none"> Parent has diagnosed disability with an evaluation that has determined the individual is unable to care for children (for example a seizure disorder that is not managed by medication). Parent has physical limitations associated with meeting the age and developmental needs of the child 	<ul style="list-style-type: none"> Parent has mental health diagnosis of a mood disorder, psychotic disorder, or dissociative disorder (i.e., major depression, bipolar disorder, schizophrenia, dissociative identity disorder) requires third-party verification of treatment and ability to meet child's needs 	<ul style="list-style-type: none"> Parent has a serious, untreated disorder that leads them to be volatile, verbally or physically aggressive, or out of touch with reality; and therefore, presents a danger to the child or others that support family time
Sexual Abuse	<ul style="list-style-type: none"> Parent that perpetrated sexual abuse has successfully completed treatment for sexually harmful behaviors, has done therapeutic reparative work with victim and non-offending parent, and is deemed to be a low risk to reoffend by an expert Protective parent and child have safety plan in place Child is in treatment where disclosures could occur 	<ul style="list-style-type: none"> Parent that perpetrated sexual abuse is actively engaged in treatment to address offending behavior, natural supports have been trained as family time monitors specific to sexual abuse, victim wants contact and reparative work with victim is ongoing (overseen by treatment provider), and victim has safety plan Child is in treatment where disclosures could occur 	<ul style="list-style-type: none"> Child is requesting contact, the treatment provider supports this, and is working with the parent and child to ensure contact can occur in safe and healthy manner 	<ul style="list-style-type: none"> Parent that perpetrated sexual abuse denies child sexual abuse Parent that perpetrated sexual abuse has tried to get the child to recant or re-victimized the child in some way Child does not want contact Child's therapeutic needs indicate that contact is not warranted
Neglect	<ul style="list-style-type: none"> Parent has mitigated the situation that created neglect, understands the risk factors, and has demonstrated an ability to meet child's needs over time 	<ul style="list-style-type: none"> Parent is actively working to address concerns and has demonstrated some new skills in understanding and meeting the child's needs 	<ul style="list-style-type: none"> Parent is ready to engage in parenting skill development, learn about the developmental needs of their child, and engage in the coaching model 	<ul style="list-style-type: none"> Parent is not meeting the needs of the child in family time Parent has demonstrated an inability to develop skills through other interventions
Risk of Harm	<ul style="list-style-type: none"> Parent clearly understands what caused the risk of harm and has mitigated that situation 	<ul style="list-style-type: none"> Parent has awareness of what created the risk of harm, is working towards resolution, and continues to need support to address the risk 	<ul style="list-style-type: none"> Parent is ready to engage in parenting skill development / education to understand and remedy the circumstances that created the risk 	<ul style="list-style-type: none"> Parent does not believe that there is a risk Parent has not benefitted from other interventions

UNIVERSAL
HOME VISITS

RESPONSIVE
HOME VISITS

SUSTAINED
HOME VISITING

SUSTAINED
HOME VISITING

Nurse Home Visiting Program

Registered nurses from home health agencies deliver a long-term, structured, evidence-based home visiting program for families including at least 25 visits during pregnancy up to age two. The program improves maternal and child health and family economic self-sufficiency, promotes optimal child development, prevents child abuse and neglect, and coordinates referrals to community resources.

Family Support Home Visiting Program

Trained professionals from CIS partner agencies deliver a long-term, evidence-informed home visiting program for families through regular visits up to age five. The program strengthens the parent-child relationship, builds social connections, prevents child abuse and neglect, and promotes optimal child development and school readiness.

RESPONSIVE
HOME VISITS

Children's Integrated Services teams work together to connect families with Maternal and Child Health nurses and/or Family Support Workers to provide regular home visits in response to time-limited needs. These visits support and strengthen families' health, wellbeing, parenting skills, social connections and ability to address stressors.

UNIVERSAL
HOME VISITS

Many communities in Vermont offer universal home visits through a range of community partners working together to ensure every family receives 1-3 visits during pregnancy and in the first months of parenting. These visits take many forms to provide a warm welcome and promote social connections, check in on the health and wellbeing of parents and baby, and share information about community resources to meet their needs.

Delivered in partnership with Children's Integrated Services, Vermont Department of Health Division of Maternal and Child Health, and your local community.

Activity	Audience	Where	By whom	When
Post PIP QA Consultation	Directors and Supervisors	18 th ½ day – Mt. Ash 19 th Waterbury Fire Dept.	CRC	March 18-19
Practice Case Reads	Leadership Teams Mandatory Activity	Districts	T/C Collaborative Learning Agreements	
Learning and Coaching on talking points for FSW to describe tools	Supervisors District staff	Monthly supervisors meeting Districts	*Co-leaders T/C Collaborative Learning Agreements	April ongoing
Learning and Coaching on quality home visits	Supervisors District staff	Monthly supervisors meeting Districts	*Co-leaders T/C Collaborative Learning Agreements	June ongoing
Learning and Coaching on Cultural Context	Supervisors District staff	Monthly supervisors meeting Districts	*Co-leaders T/C Collaborative Learning Agreements	Aug