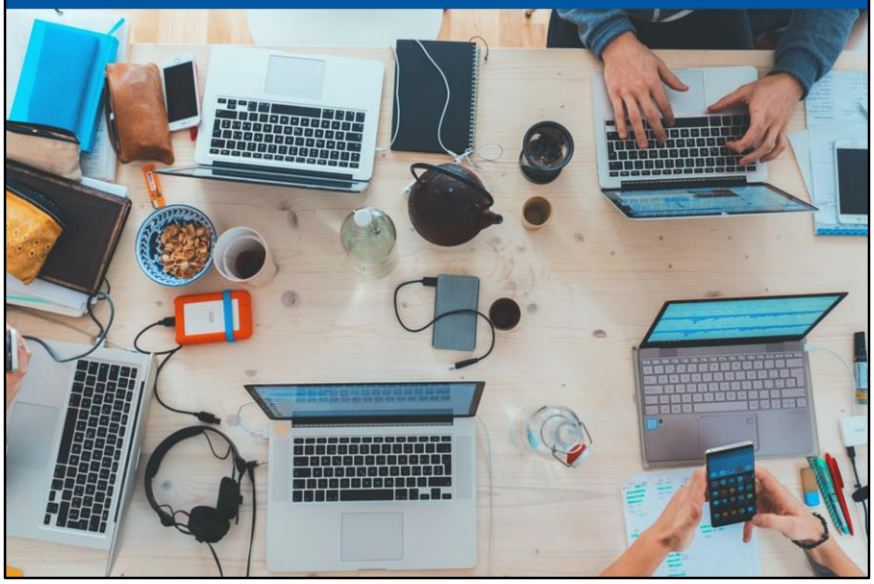

Virginia Department of Social Services
people helping people
CWAC
September 22, 2021

We're So Glad You're Here!

Who is Here?



CWAC September 22, 2021

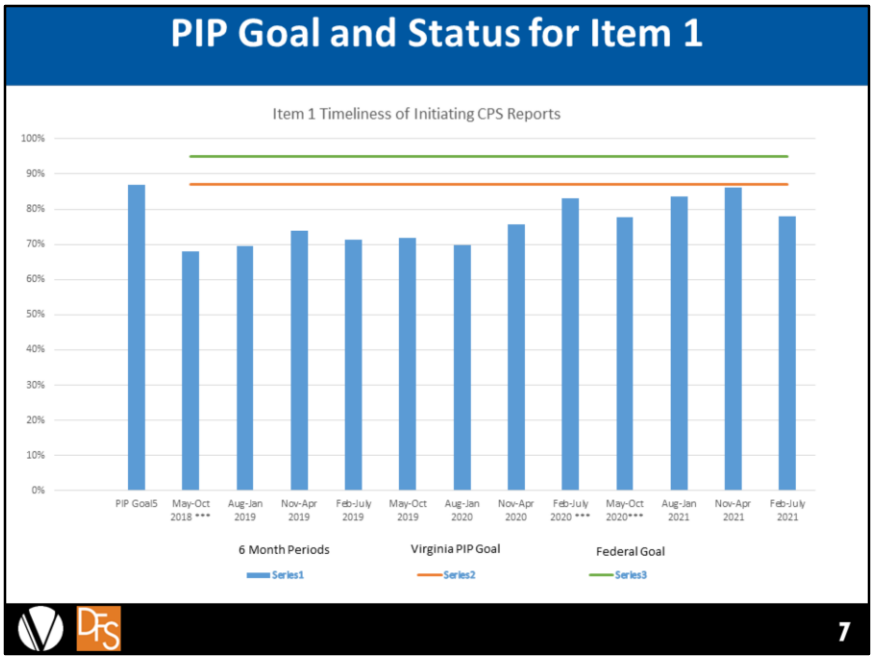
- CWAC Charge
- PIP Update
- Kin First Culture
- Family First Update: QRTP
- Children in Foster Care without Placement
- Plus/Delta

Child Welfare Advisory Committee (CWAC) Charge

CWAC: collaborative advisory group working together to achieve system outcomes.

- Child welfare program, policy, training and practice
- CFSP, annual progress reports and other state plans
- Capacity Building and CQI
- Collaboration and Partnerships

Em provided a welcome and an overview of CWAC and the charge of the committee. Reported the APSR was accepted by the Federal government. Announced parent advisory council is kicking off this week and thanked Brenda for her leadership in getting this program going. DFS is preparing for General Assembly and organizing around ideas for what the legislature may help us with. We spend a lot of time looking at the funding available and opportunities for program enhancements. Noted concern about youth in foster care who are eligible for the vaccine but haven't had the information available to them and their parents. They typically have worse health outcomes primarily because of consent and information sharing. We want to make sure kids in foster care have the opportunity to receive the vaccine. Urged those with access to foster children to make sure information is shared. It is an area of continued growth. The Office of the Children's Ombudsman is up and running. Eric Reynolds is the Director, and he is working with DFS around procedures he's setting up for his office. The office has a small staff, and they are beginning to take referrals and collect information. Three steps in their process: preliminary review of the complaint, preliminary assessment of the complaint, and opening an investigation when warranted, final report published on their website.



We continue to work towards achieving item 1 Timeliness of first contact with the victim child. The six month review period is represented in the blue lines, the orange line represents our PIP Goal 87.5%, the green line represents our federal goal 95%. Look how close we were in MP11. We were 1% away from passing our goal. There was updated CPS guidance released in July of 2020 and you can see an increase since the new guidance was released. Our regional consultants continue to work with LDSS regarding ensuring timeliness of first contact with victim child and we are committed and continue to focus on passing item 1.

Kin First Culture

- Approaches work as a learner and recognizes families as the experts
- Invests in discovery, which leads to engagement
- Maintains strong connections to families
- Includes families in decision-making
- Creates opportunities for families to rely on one another as natural supports

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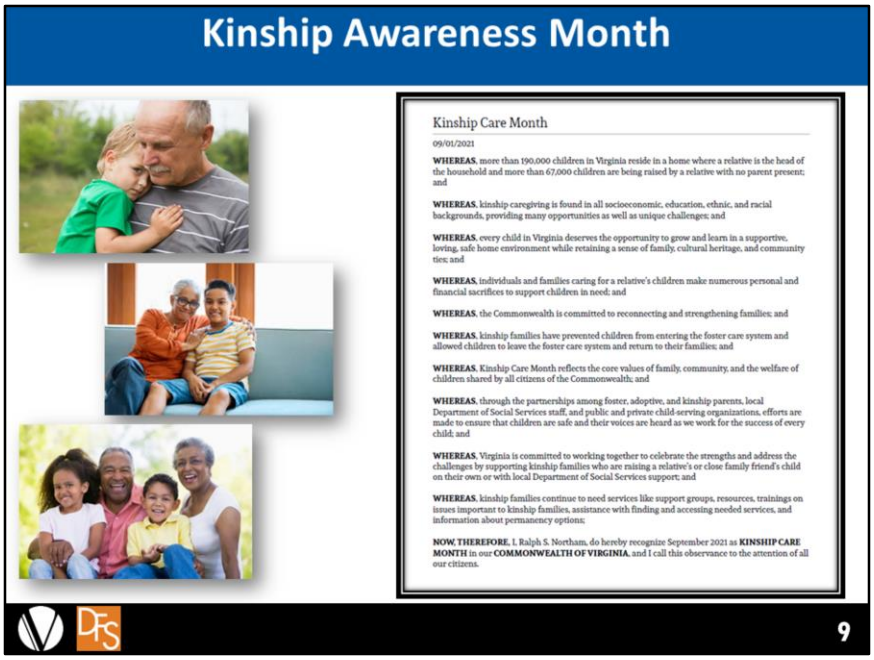
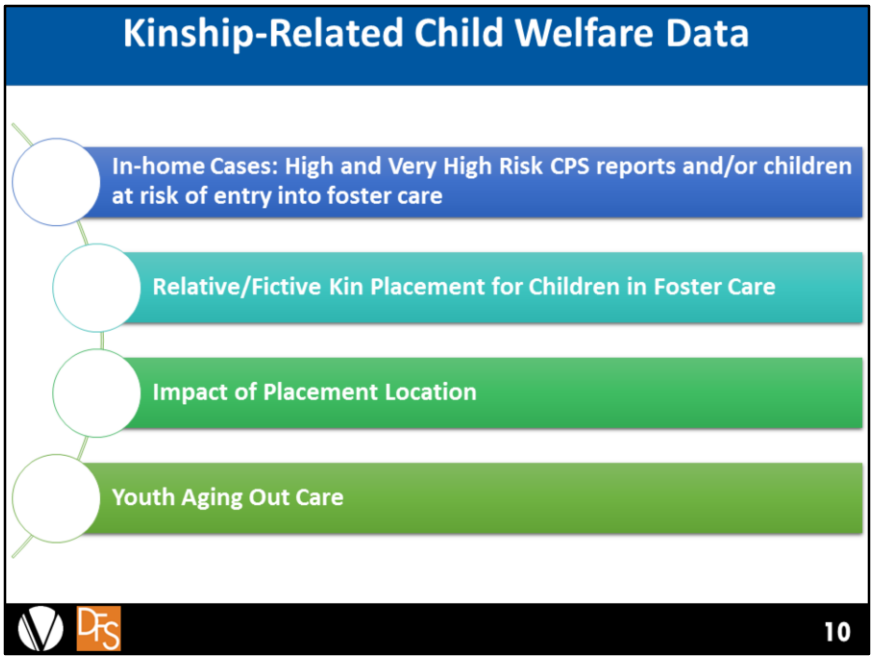
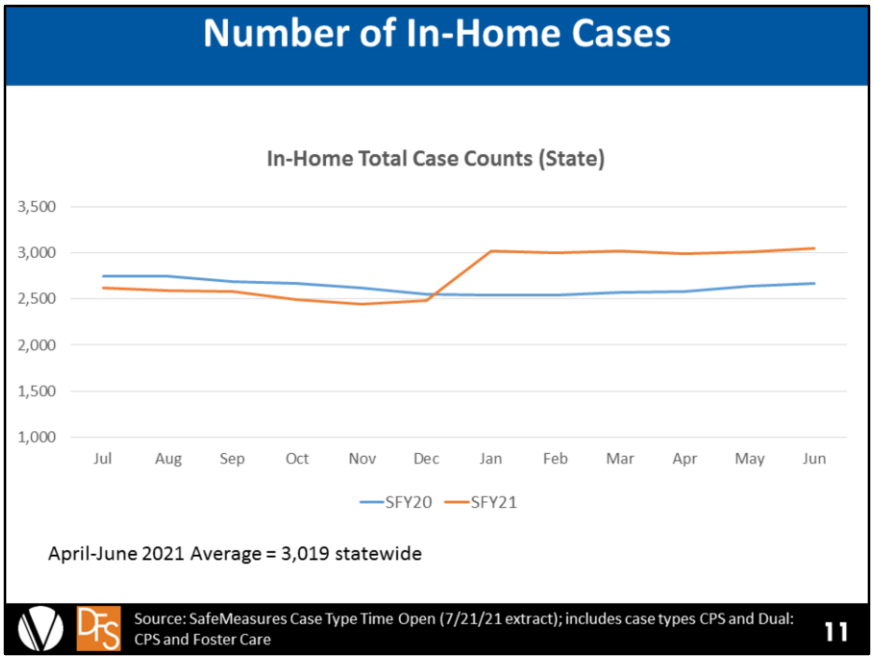
Garrett Jones discussed Kin First Culture and the importance of working with families as the experts in their own experiences and stories. We need to understand families and the connections to those around them. And how we can strengthen and facilitate family connections.



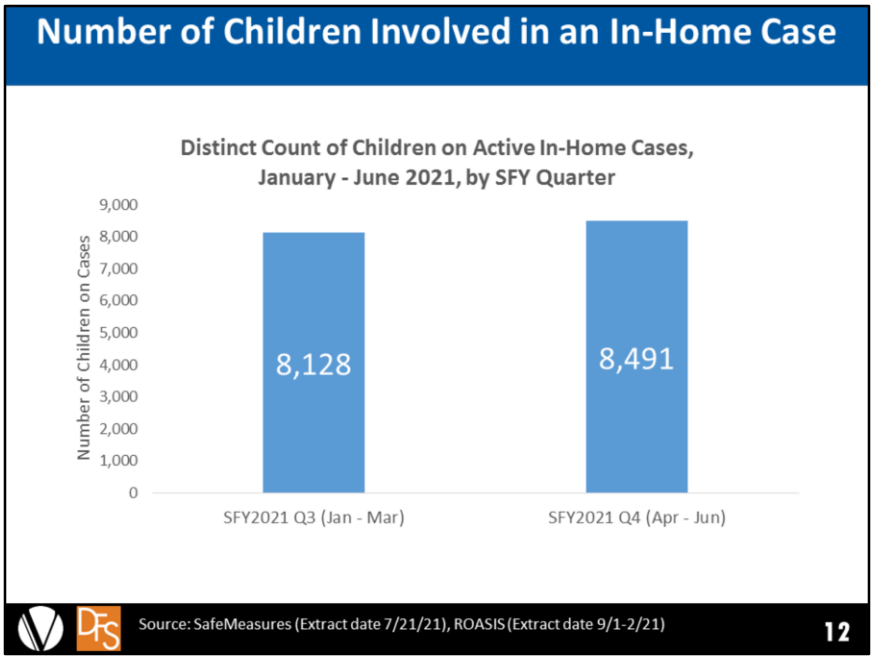
Acknowledged September as Kinship Care Month and reviewed the proclamation that can be found here:
https://www.governor.virginia.gov/newsroom/proclamations/proclamation/kinship-care-month.html



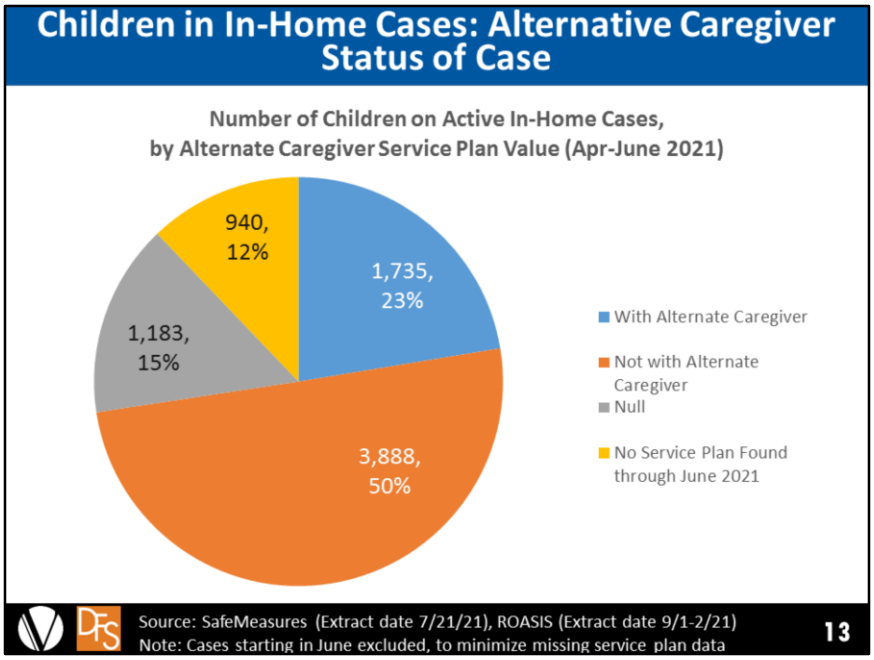
This is the data that will be reviewed over the next few slides.



Carrie Thompson, the Prevention/Family First data analyst reviewed In-Home case numbers before going into kinship specific data for in-home cases. The monthly average of In-Home cases between April and June was 3,019 statewide. This was similar to January through March's average, but an increase of 15% compared to the same period last year. This increase was even higher in Central, Piedmont and Western regions, due to decreased case counts in Eastern and Northern compared to April through June 2020. Please note that in January of 2021, a change was made in OASIS to consolidate case types to reflect the in-home case type, which likely caused the jump from last year to this year. An important thing to note about opening an in-home case: LDSS should open a case when there is a high/very high risk on the structured decision making tools. At this time, we know we really want to improve on the percentage of cases that are opened.



Unduplicated number of children on cases active between April and June 2021: 8,491 (4% increase from the count of children on cases between January and March of this year – 8,128)

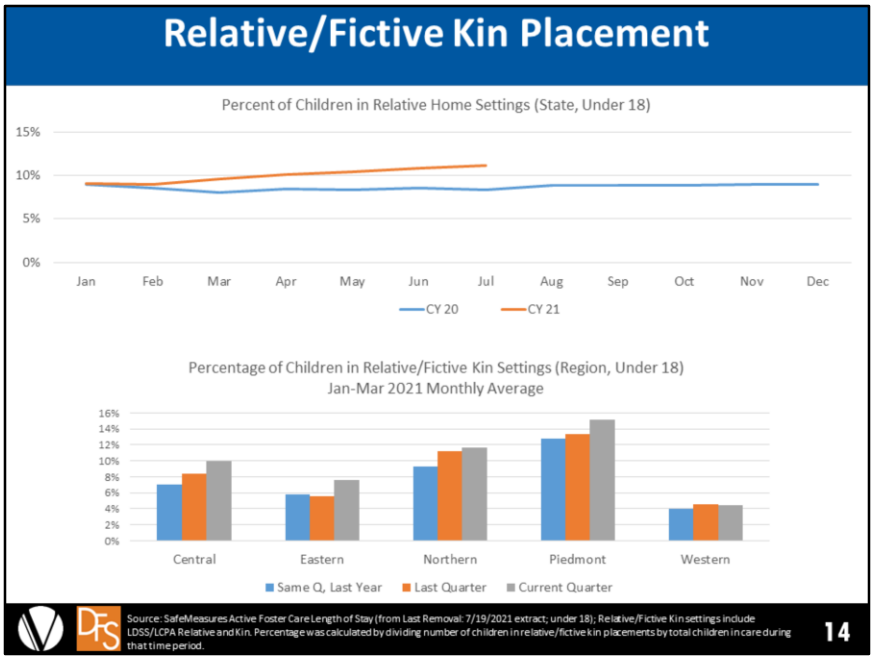


Kinship-specific data in in-home: In guidance, an alternate caregiver could be a relative or fictive kin. Because staff have up to 30 days to enter the service plan after opening a case, the numbers on the next two slides represent the cases that were active between April and June 2021, excluding cases that opened in June, to minimize missing service plan information. Documenting when a child in an In-Home Case is placed with an alternate caregiver is a new requirement in In-Home Guidance, and the capability to track was recently added to OASIS in January. This data shows us: Of the 7,746 children associated with In-Home cases active between April and June of 2021.

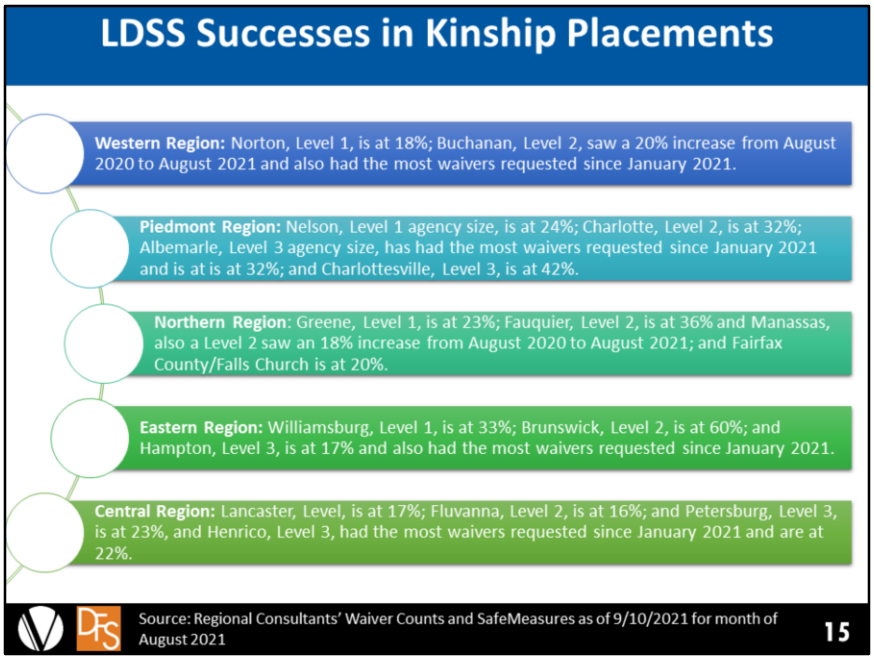
- Half of the children on In-Home cases between April and June did not have an alternative caregiver supporting their case, based on the most current service plan through June.
- Nearly one in four (23%) were on a case supported by an alternative caregiver. At least one child on each of these cases was placed with an alternative caregiver.

-We also recognize that 12% of In-Home cases do not have an active service plan for the time period reviewed and that Null means that a service plan was found for the cases of these children, but the alternate caregiver box was not selected. We will be developing some targeted assistance for LDSS to ensure accurate completion and documentation of service plans.

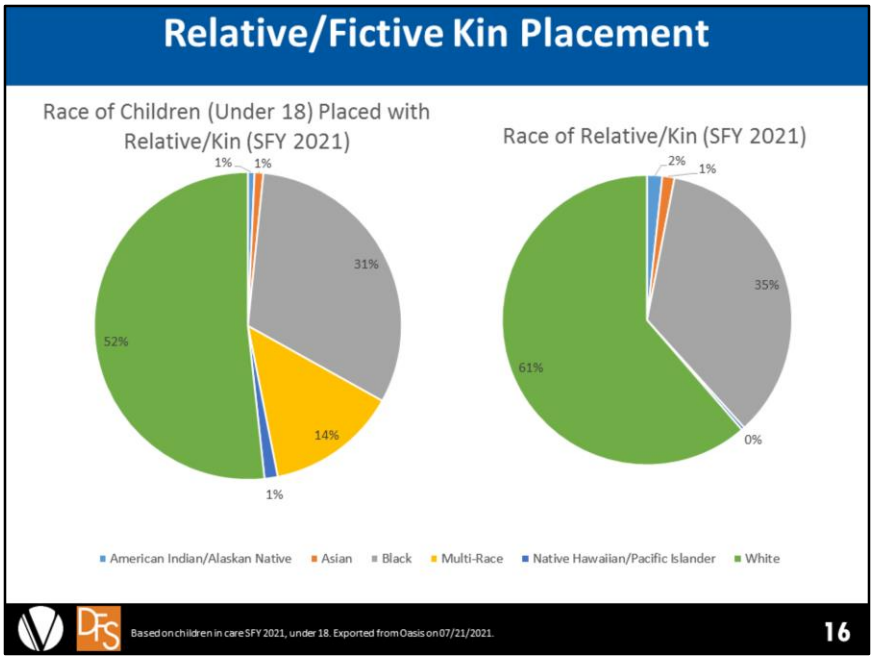
What might this data be telling us? Some responses: that's a higher % of kids with relatives than would have thought; looks like we're doing a lot of diversion from foster care with relatives; need for uniform policy as to how to serve alternate caregiver when they are not in locality of the parents.
Kristin notes: As we move further into our kinfirst culture, we are looking forward to focusing on shifting from thinking about "diverting" children from foster care to focusing on supporting children to live and thrive in their homes and communities. We can do this by opening very high/high risk cases, via following in home safety scenarios, utilizing FPMs, and providing EBS services to kin/fictive kin. If we can continue to focus on the front end of services, we should be able to reduce the need to focus so much on foster care in the future.



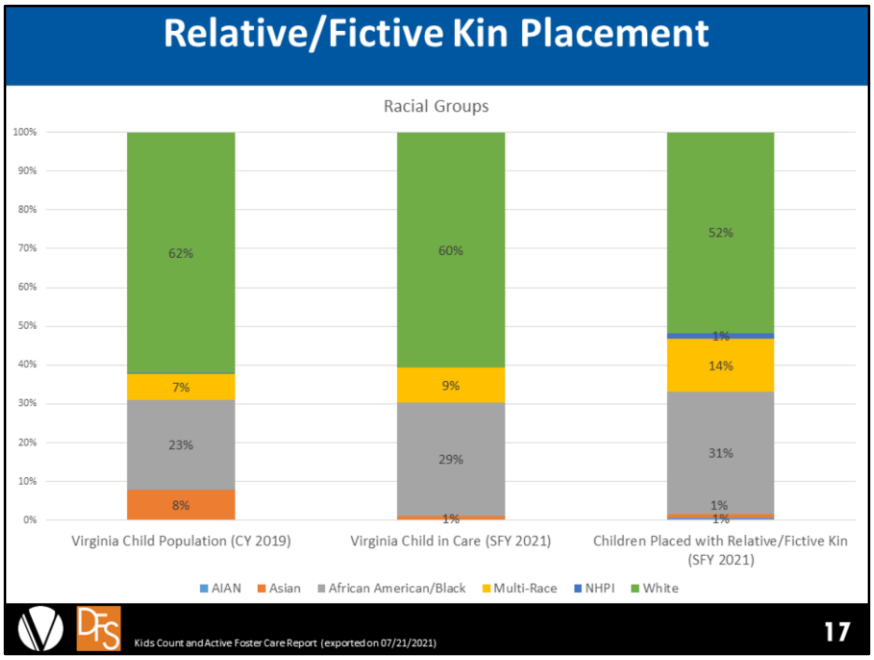
Here we are looking at the placement of children in relative/fictive kin homes. On the top, you are seeing the line graph for the state. We have been increasing since January of 2021 for those under 18 in relative/fictive kin homes. Below you will see a bar chart comparing regions by quarters. Overall, Piedmont has the highest percentage of children in relative/fictive kin homes. We want to reiterate that families are the experts on themselves and that families need to be given the information to be able to make the choices, such as becoming an approved relative/fictive kin foster parent.



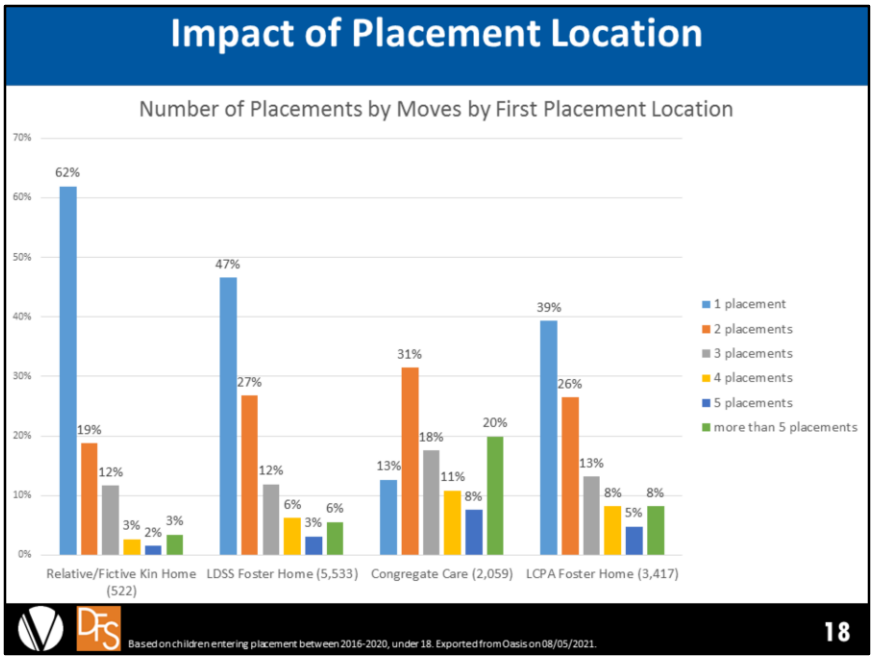
Garrett shared the successes in relative and fictive kin placements. VA had been stagnant or holding at 7-8% of children in foster care placed with relatives. He shared successes by region and by agency level. FYI, Level 1, 2 and 3 refers to the agency size with level 1 being the smallest and Level 3 being the largest. From chat: Alice asked if we could share how local agencies run report on relative placement so we can se how we are doing. Morgan responded that we are working with SafeMeasures to add the alternate living arrangement data to the reports.



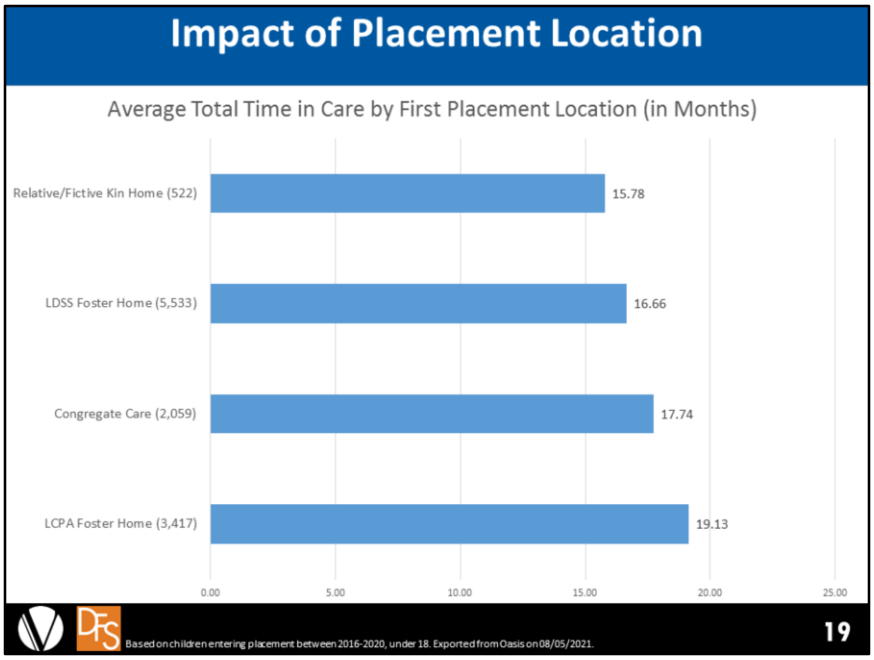
On the left, you will find the racial breakdown of children in relative/fictive kin homes during SFY 2021. On the right, you will see the racial breakdown of the head of the household for those relative/fictive kin homes during SFY 2021.



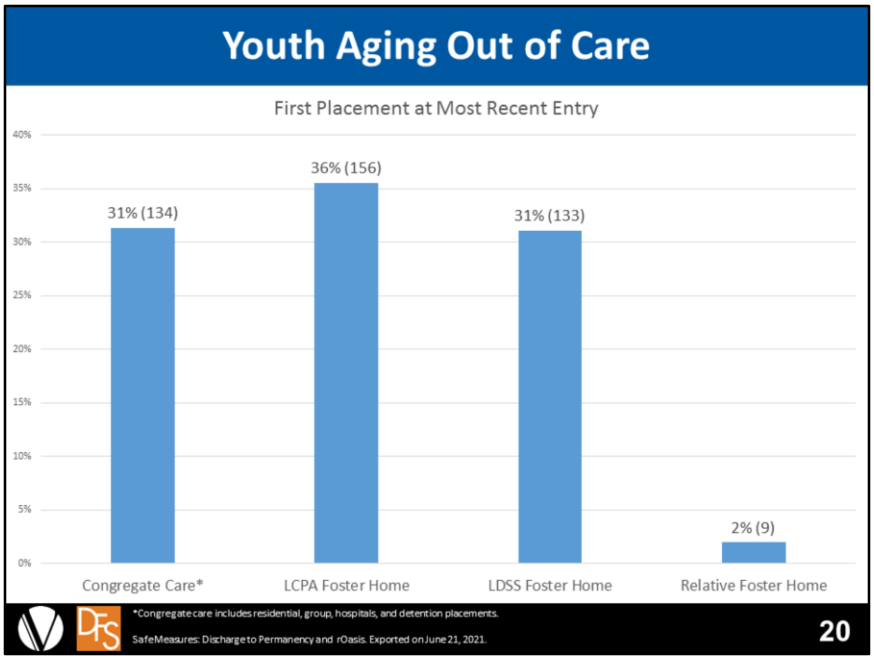
Here we are looking at the racial breakdown of different groups. On the far left, you see the racial breakdown of children in the state of Virginia. The next bar chart provides information about children who entered care. The chart on the far right represents the racial groups for children placed with relative/fictive kin.
We can see that White children (as shown in green) were less represented as being placed with relative/fictive kin. Multi racial and African American/Black were more represented for those placed with relative/fictive kin (as shown in yellow and light grey).



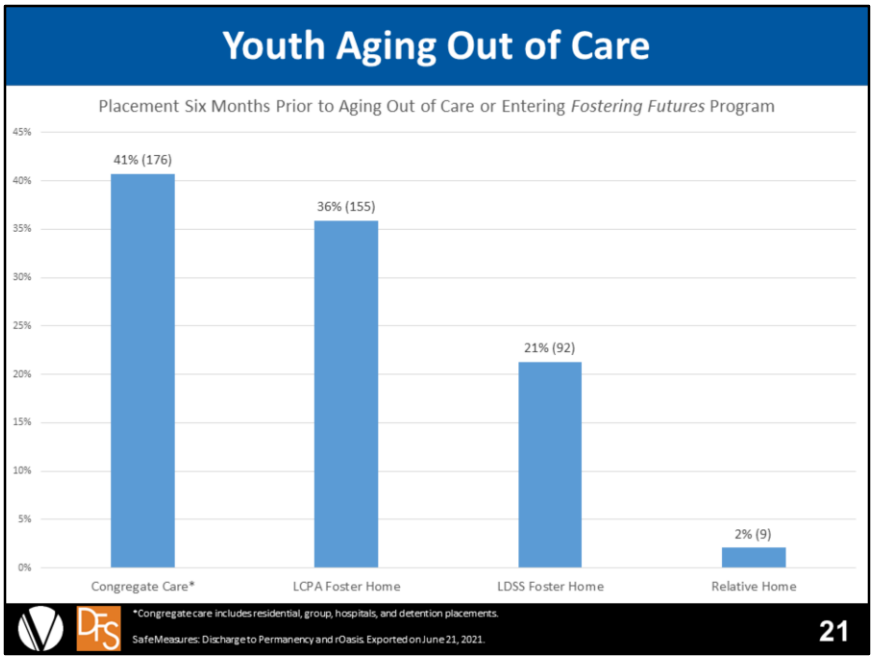
The decisions that are made when placing children in foster care are critical in providing stability that is critical to the ability of children to heal from the trauma related not only to abuse and neglect but the trauma of separation from their families. Here we are seeing how many times a child was moved based on their first placement location. Each location—or cluster of bars—includes all children that were first placed in that location so, for example, the cluster of bars on the far left for relative/fictive kin home includes all 522 children that were first placed in that location. We can see that 62% (or 324 children) remained in their original location. This is shown by looking at the light blue bar above "relative/fictive kin home" that represents only being in one placement. Reviewing the light blue bars for all placements (i.e., being in one placement), we see that children first placed with relative/fictive kin were more likely to remain in that placement at 62%, followed by children first placed in LDSS foster homes at 47% and LCPA foster homes at 39%. Children that had been in five or more placements—looking at the green bars—were more likely to be first placed in a congregate care setting.



Looking at the average amount of time in care based on where the child was first placed: If a child was first placed in Licensed Child Placing Agency foster home, they were in care the longest at 19.13 months (on average) followed by children first placed in congregate care settings (17.74 months). Being placed first in a relative/fictive kin home would result in the child spending the least amount of total time in care at 15.78 months. Comments in chat: Really interesting to see that kids first placed in LCPA homes have more placements and longer LOS than kids in any other first placement, including congregate care. I wonder if this is directly related to "where" geographically they were placed? It would be interesting to look at distance from removal home for this as well. I also wonder how this data relates to the age of the children. Typically older children are placed in LCPA foster homes as opposed to LDSS homes so they may be more likely to age out.



We shared this at our last meeting, but here we are looking at where our children were first placed that aged out of care during 2020. Just a reminder that the number you see in parenthesis is the number of children represented. Based on these 377 children, 36% were first placed in a LCPA foster home, while 31% were placed in congregate care and LDSS foster homes. Only 2% were first placed in a relative foster home placement. Comments in chat: I would want to know how the IL aged youth came into foster care and what placement they entered (i.e. Delinquency, CHINS, A/N). We have piloted 30 Days to Family with 2 children and had some great success. We are hoping to expand this. These data totally support that!!



Looking at where our children were prior to aging out of care or entering our *Fostering Futures* program. Based on our 432 children that aged out of care in 2020, a majority were in congregate care placements six months prior to aging out of care or entering *Fostering Futures.* 36% were in LCPA foster home, followed by 21% in a LDSS foster home. Only 2% were in a relative foster home placement.

Breakout

How does your agency/organization assist in identifying and supporting/addressing barriers to informal and formal kinship during an in-home or foster care case?

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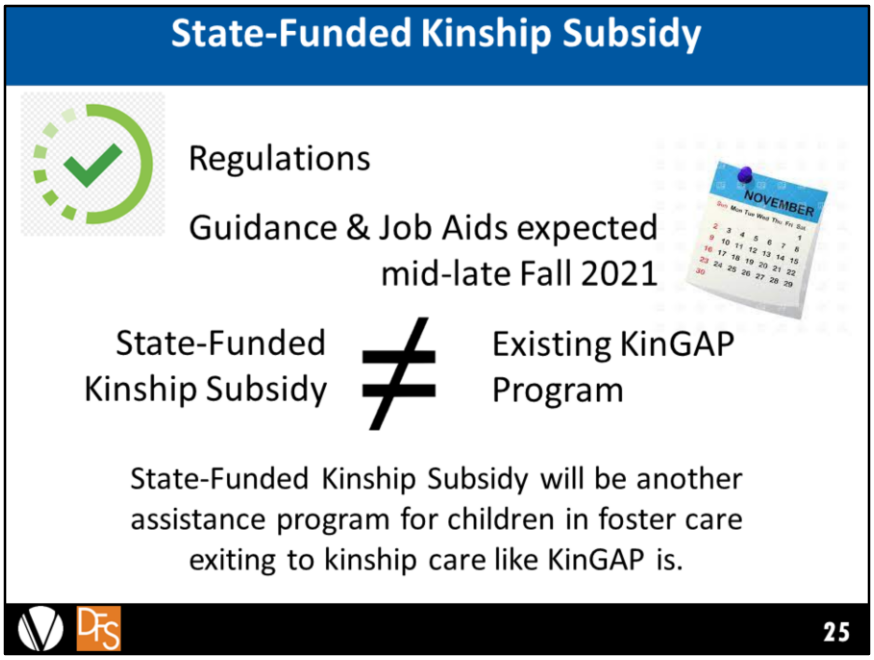
Report Out

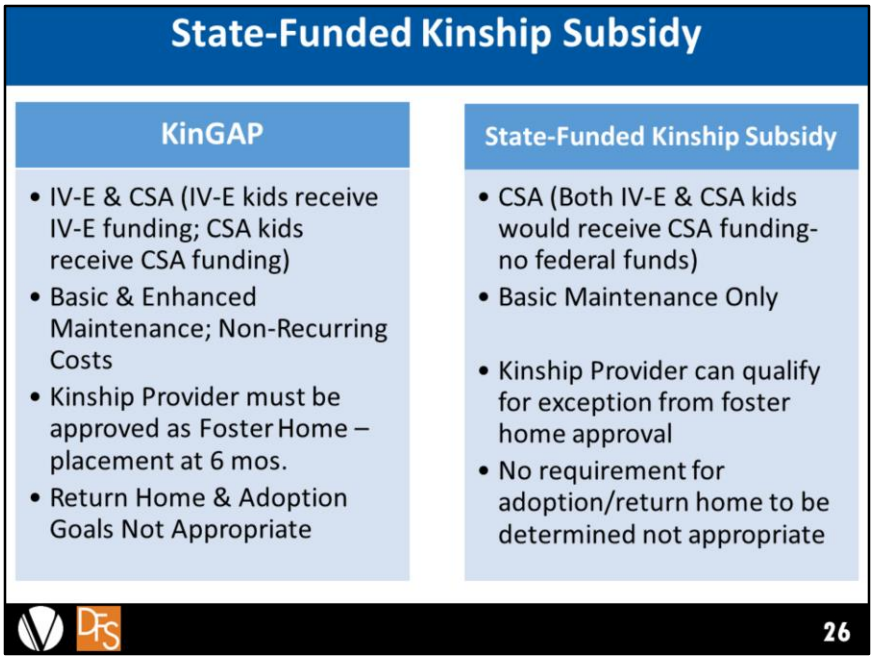
Brenda introduced Mary and Victoria, both previous kinship foster parents to share their individual stories.
Mary shared that three of her great nieces and nephews came into her care because of substance abuse in her family. She shared that it was a difficult time in her life, walking through the system with her family. The struggle for kinship is real and it is hard. Today, she has adopted one of the three children. For her, when the kids came into care, it was so confusing and she didn't know where to go. The relationship with that part of that family were broken, so she didn't know her place. She attended the five day hearing, it was really confusing and family wanted to be involved. She filed for custody. She wasn't contacted by any social worker. At the 30 day hearing, the judge ordered the agency to talk to her. Over the next 30 days, she was vetted and it became a smoother process. During that time, her great nephew suffered trauma and was emergently placed with her. Had he have been with her, she thinks it might be have been better and they could've walked through the process more easily. The unknown and being seen and considered was the hardest part of the process. This happened five years ago, and she recognizes the culture is changing.

Victoria became a kinship provider because of the death of a child in her family. She was called to the police station to voluntarily answer questions. She felt very

uncomfortable with the situation with the police questioning her and her family. She filled out the necessary paperwork to request custody of the surviving children. The two surviving children went into foster care for 30 days while she was vetted and the investigation into the child's death was completed. She feels there was limited communication between CPS and the foster care provider; everyone operated in silos. When the children were placed with her, the social worker didn't know anything about the case and circumstances and that made it awkward and made her relive the trauma she had been through. She feels the service lines need to communicate with each other and be as transparent as possible. In the end, she appreciated the family partnership meetings and the support of the social workers during that time. Ultimately the father took custody of the children and that was difficult because he had never had to step up as a parent. The children are doing really well and she has visitation with them every other weekend. During the process, she felt very scared that the kids would be separated or be taken away from family, but she's glad to share that they are doing really well now.



Lora Smith, Foster Care Program manager shared an update from recently legislation for the state-funded kinship subsidy. Regulations are currently in the approval process through town hall and are available for public comment. Guidance is expected mid to late Fall 2021 once the regulations are fully in effect. Foster Care shared information on this program to Permanency Advisory Committee last week and requested feedback on what types of job aids will be useful to the field. Currently in the works to support implementation will be a comparison chart of the different assistance programs as well as edits to our kinship brochure. Foster Care will incorporate any feedback we receive from our advisory committee as well as information gathered from the field to develop any additional job aids or resources. State Funded Kinship Subsidy Program is completely separate from the existing KinGAP Program and does not change a single thing about the existing KinGAP program and eligibility requirements for KinGAP. State Funded Kinship Subsidy is completely separate program. We are going to talk about some of the main differences next.

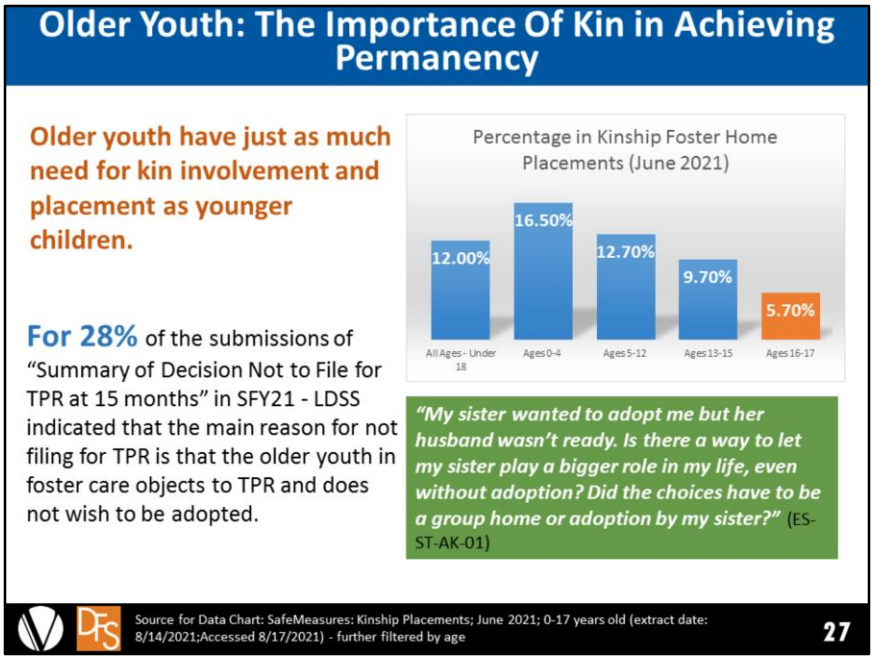


KinGAP contains both IV-E and CSA eligible kids and the way that is funded depends on the child's funding eligibility.
State-Funded Kinship Subsidy includes both IV-E and CSA eligible kids but only will be state-funded through CSA.
KinGAP agreements can provide for basic maintenance and enhanced maintenance as well as non-recurring costs.
Kinship Subsidy is basic maintenance only.
For KinGAP, kinship providers must be approved as a foster home and the child placed with them for 6 months.
For State-Funded Kinship Subsidy, the kinship provider can qualify for an exception from foster home approval. The kinship provider will still need to not have any federal barrier crimes to be approved for State-Funded Kinship Subsidy and under go a home visit.
For KinGAP, return home/adoption must be determined not appropriate goals.
For State–Funded Kinship Subsidy there is no requirement that return home/adoption are not appropriate.

Comments in chat: Lora, I'm so glad you are clarifying this information. There's confusion about Federal KinGap and "State Funded KinGap." CSA funds are used for

the Federal KinGap program if a child is not eligible for IV-E. And of course CSA funds are used for the state funded program. This is only available for children in foster care. Victoria, Kinship Foster Parent noted: I know for me I wanted to take the boys in but I felt adoption was too extreme because it would require the parents to terminate their rights. But adoption was the only option for me because I would've needed the assistance, especially with them being so young and not of school age.

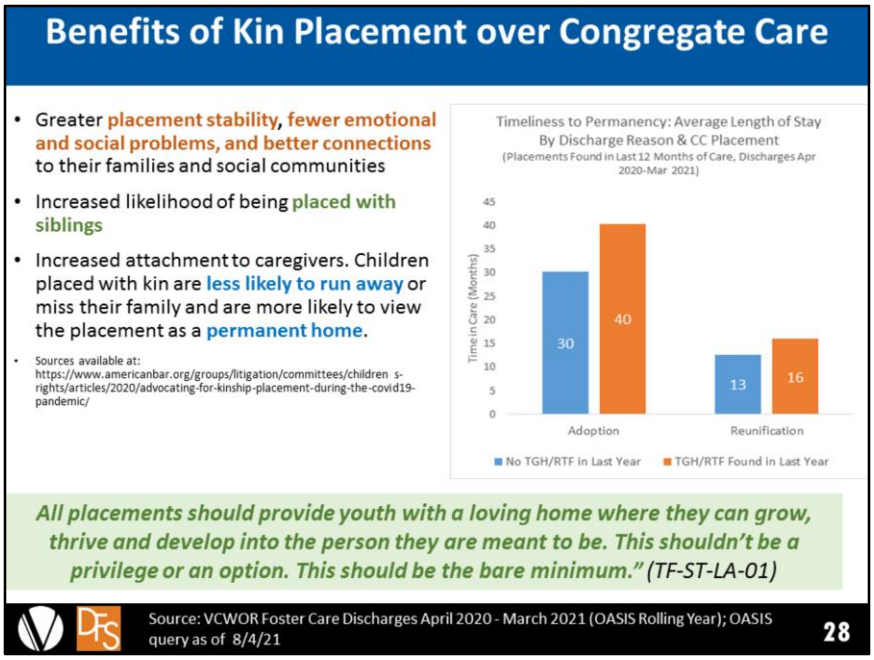
Sadie notes: KinGAP (federal program) is available to kinship families along with adoption. KinGAP agreement would be negotiated and signed prior to the custody transfer. There are certain requirements that have to be met for KinGAP.



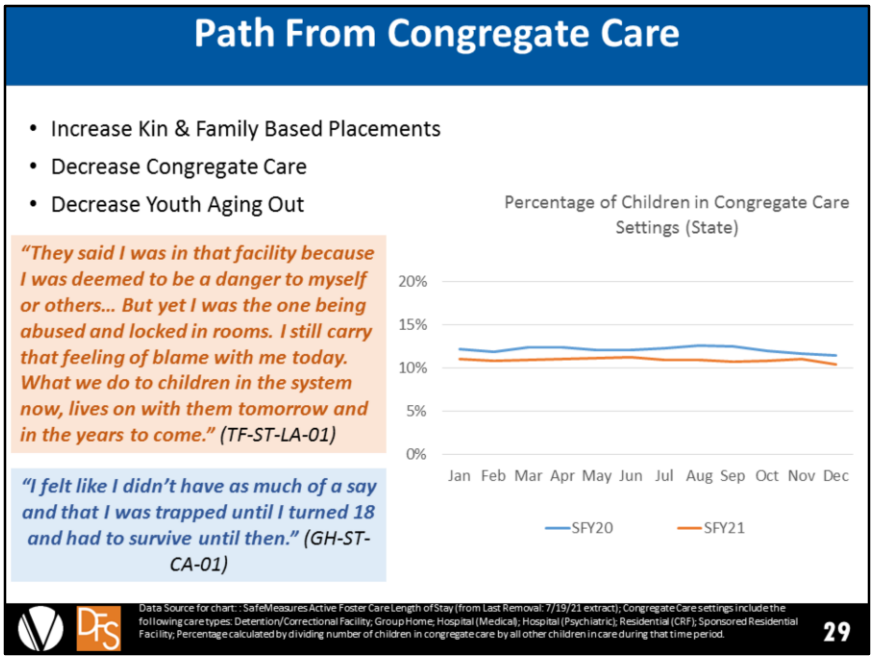
Kinship placements are most prevalent in our youngest ages decreasing each older age range until our age range of 16-17 year olds who are only at 5.7% being in kinship placements. Conversely they are at approximately 25% for institutionalized settings such as congregate care. Over the last year we have been collecting and reviewing LDSS submissions of the "Summary of Decision Not to File for TPR at 15 months". These are the reports that LDSS complete when the child has been in care for 15 out of the most recent 22 months and the agency has determined they will not file for termination of parental rights (TPR). 28% of the submission, LDSS indicated that the main reason for not filing for TPR is that the older youth in foster care objects to TPR and does not wish to be adopted. None of these youth were in kin placements and the majority did not have kin involvement. While the agency will still work to "unpack the no" regarding the youth's desires around adoption, having kin involvement could drastically change that youth's ability to achieve permanency and exit from foster care more timely, especially as we have additional ways we can support kinship caregivers through our guardianship assistance program(s).

The quotes on this slide (and following slides) are from a powerful report published by the non profit "Think of Us" titled "Away From Home" detailing research their team had conducted on youth experiences with congregate care. Youth voice is elevated throughout this report. What is so critical about this report is it highlights

the severe impact congregate care has on youth even years later. Hearing directly from youth the impact that congregate care has had on their life and what they experienced is critical as we work to improve our system.
Link to the report: https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf
National readout video: https://www.youtube.com/watch?v=zCW8nyXlWjs



The graph on the right shows the impact of congregate care on length of stay for children who discharged care within the period of a year (Apr 2020 – Mar 2021). The children with a therapeutic group home (TGH) or residential treatment facility (RTF) placement within a year of discharge were more likely to spend a longer time in care while waiting to be adopted or reunified. There was a difference of 10 months in length of stay for adoption discharges and 3 months in length of stay for reunification discharges.



Primary permanency goals are to increase kin & family based placements & decrease congregate care placements which will help us get to our main goal of ensuring every child/youth reaches permanency and does not age out of foster care. The chart on the right shows the comparison of SFY20 and SFY21. While we saw some decrease in care in SFY21 we still have a lot of work to do to continue to decrease our congregate care placements. The implementation of Qualified Residential Treatment Programs (QRTP) is one small piece of our much larger work to decrease congregate care & increase family based placements. This work includes our Kin-First efforts, our efforts to support kinship guardians, and our congregate care reviews.

Discovery Leads to Engagement

Discovery means learning who the families we serve are and understanding existing relationships.

Discovery maximizes the likelihood that children will maintain connections with their family and natural supports.

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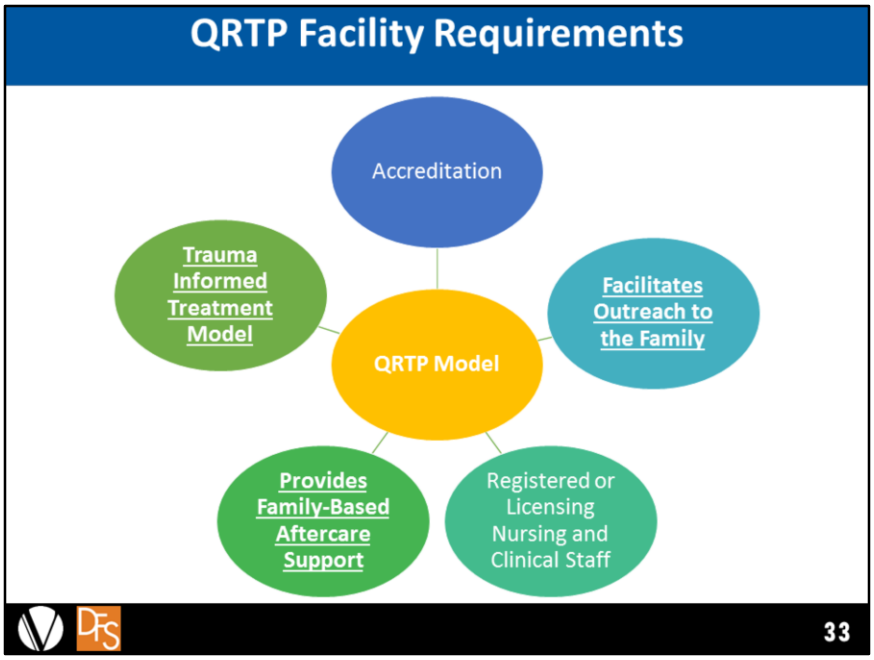
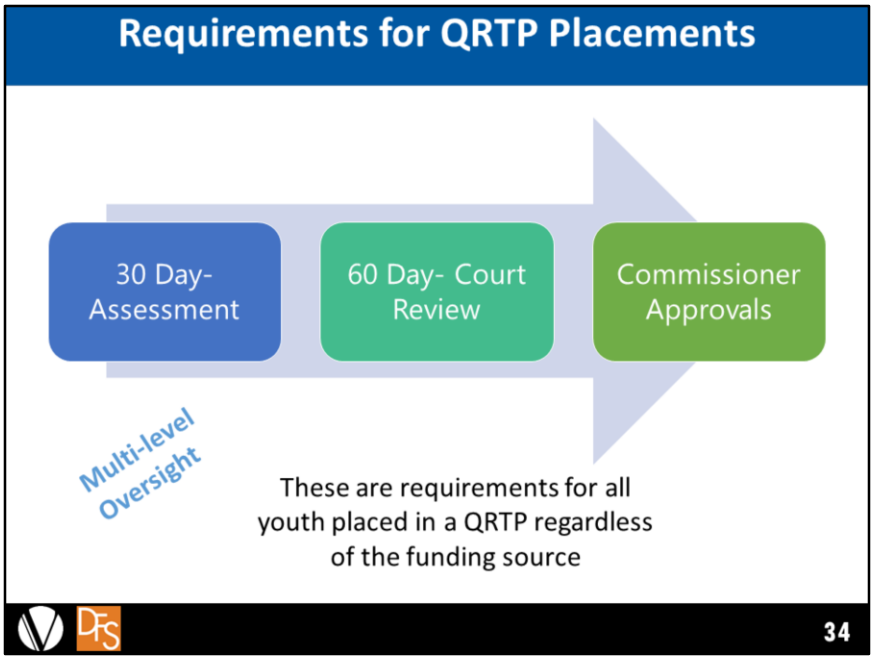
Discovery is a practice that's been identified as a need in our system. Discovery is the foundation of the work – this is where the kin first work starts. It's not just about finding the relatives but it's understanding the dynamics of the relationships, the strengths and the challenging. The assumption here is by engaging in discovery and understanding family systems more comprehensively we will identify relatives with functional strengths who may not be intimately involved with families experiences the crisis but may possess the willingness and given the opportunity to help.

Some responses in the chat: Uplift youth voice. They are the experts and we have so much we can learn from them! Ensure to always include the youth in the process to include allowing them to identify people. Provide access to services and resources to support the placement. Wrap-around services. Be very available for questions from relatives; be creative in meeting their needs; and be flexible wherever possible. Do you ask schools if they know of family?- esp students who've been in the same school awhile. Loved the idea of one local agency that talked to the youth and explored their contacts with social media....that opens up fictive kin because the child may not understand the term "fictive kin" and who could be considered. Debrief when placements break down and ensure we are appropriately assessing what sort of supports the relative may need to be successful. Make sure they get paid timely and if they need support before that payment, use PSSF funds to purchase items. Start FPM and visitation/visits earlier in a youth's group Home/PRTF placement. Offer the same supports to the kinship placement as a foster care placement. Send out notifications (placement change) to all known relatives.

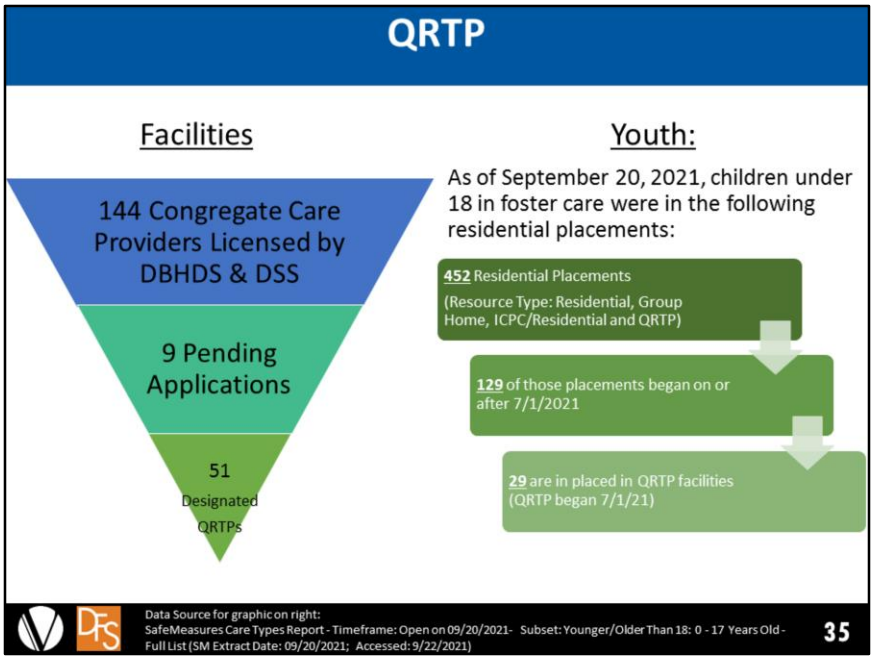
Aaran Kelley, Family First Project Manager: Family First went live July 1 and we want to thank everyone on this call who assisted with its successful implementation.



Update on the implementation of QRTP. QRTP is not an addition of a funding stream. It's a further restriction of a funding stream that already exists for kids in foster care. Family First focuses on investing on the front end (through title IV-E prevention services) versus the back end. QRTPs were implemented on July 1, 2021. The goal for our youth in care is to prevent congregate care placement and if it is absolutely needed, the goal is for kids to get a better quality of care - and for families to be served too- for a shorter period of time. There are several requirements for QRTP facilities that help support this goal.



In addition to the requirements for the facilities there are also requirements for the youth placed in these facilities. These requirements comprise a multi-level oversight system that engages an independent assessor (provided by the state), the courts, and state approval for long-stayers. All kids in foster care placed in a QRTP beginning 7/1/21 or later must have a 30 day assessment. We have a state employee who completes these assessments using components of our existing congregate care placement process. Youth placed in QRTPs must also have a 60-day court review with judicial approval of placement. Just a note: This must happen by the 60th day (the first day of placement counts as day 1). Additionally, LDSS must submit documentation at every subsequent foster care court hearing for continuation of the QRTP placement. The 3rd practice requirement for any child placed in a QRTP is Commissioner approval for long-stayers (i.e. state approval). This depends on the age of the child as well as if they have been placed for a certain amount of consecutive or nonconsecutive months.



Out of 144 congregate care providers that are licensed by DBHDS and DSS we currently have 9 pending applications for facilities to become approved as a QRTP and have 51 facilities that have been designated as a QRTP. As of today, we have completed 47 QRTP referrals.

Lora Smith: An informal poll of local departments showed that there were approximately 160 children total over a span of about 6 months who spend at least one night in the ER, DSS office or hotel. Local departments are forced to supervise kids in non-placement settings, which is not therapeutic; this is a significant challenge. These are Virginia's children and together we can figure out how to do better for our children.

Characteristics of Children in Foster Care without Placement

- Have experienced TRAUMA before entry into foster care; receive subsequent diagnoses and identified treatment needs; experience more trauma via placement disruptions
- Some history included 20+ placements and acute psychiatric hospital admissions
- Diagnoses such as: ADHD, PTSD, ODD, Anxiety and Depression, Conduct Disorder, Disruptive Mood Dysregulation Disorder (TRAUMA)
- Behaviors include: aggression, poor impulse control/risky behaviors, self-harming, and disruptive behaviors

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Every child who comes into foster has a traumatic background which leads to more diagnosis and then further traumatizing kids because our providers cannot serve them or won't serve them. Some of these kids have had multiple placements but some agencies cannot even find placement when child first enters care.

Reasons for Denial / Discharge

In May 2021, a survey of Treatment Foster Care agencies and congregate care facilities indicated that they had **350 available beds** for placement of unaccompanied minors, if needed.

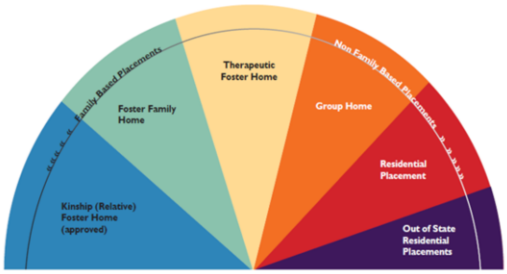
However, these same providers are not accepting referrals for youth in foster care:

- They are unwilling to take youth with difficult behaviors such as verbal and physical aggression, sexual exploration, criminal charges, etc.
- If intensive 1:1 is needed, service providers are not willing to travel; foster parents are unwilling to accept that level of 1:1 support
- Some characteristics (e.g. ID or Autism Spectrum) or behavioral issues (e.g. youth with sexually offending history, fire-setting, or previous mental health diagnoses to include suicidal statements) are exclusionary for many providers.

Long-term solutions: Build capacity at local departments to place with kin; look at creating No Eject/No Reject policies. We've heard from providers that licensing may be an issue for them not taking kids. We need to look at how we license congregate care facilities here in VA, are they licensed so that they can be effective and agile in servicing our kids who are hard to place? In addition to licensing congregate care facilities, we want to look at how we license a higher level of care of treatment foster homes. How can we create a supportive virtual residential model to support a higher level of treatment foster care and increase capacity of these homes in the communities that need them thereby eliminating the need for placing our kids in congregate care.

Continuum of Placements

- ✓Increase kin/fictive kin placements
- ✓Increase family-based placements
- ✓Increase quality of congregate care (QRTP)
- ✓Decrease use of congregate care



Breakout – Brainstorming Session

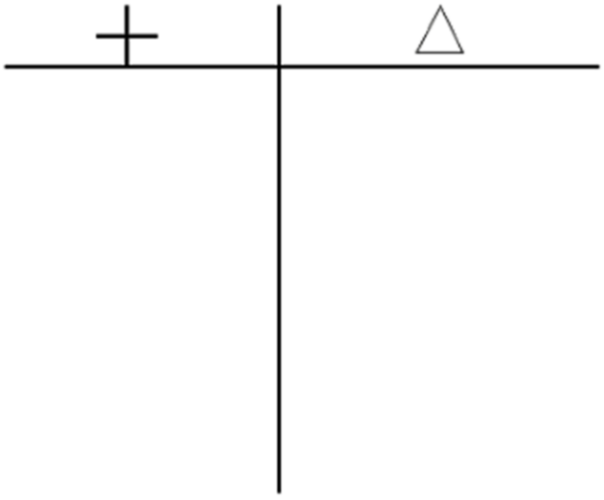
What more can be done to ensure that all kids in foster care have immediate access to a placement that meets their needs?

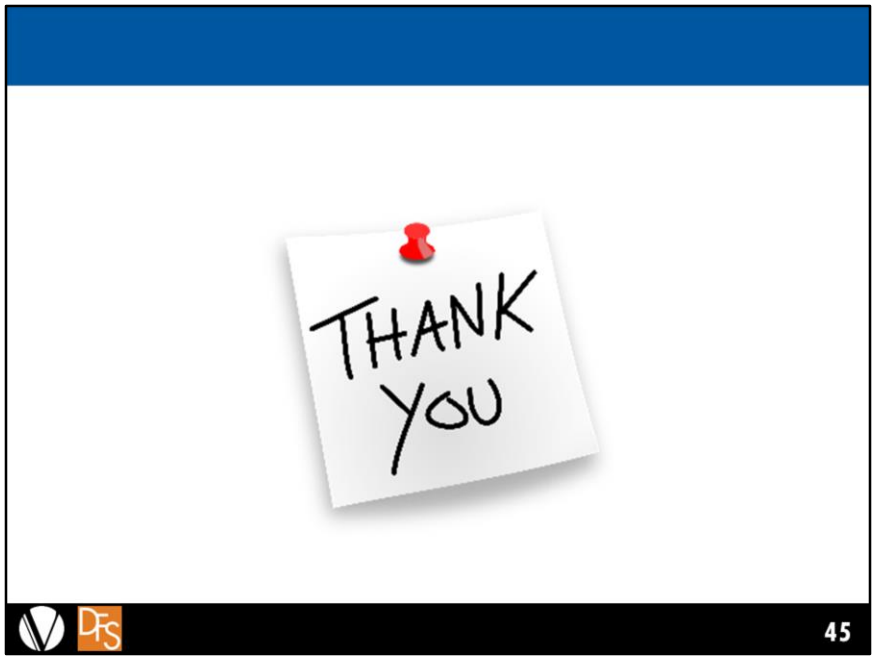
Could a change to the way enhanced maintenance or VEMAT is calculated make a difference?

Report Out

Next meeting, date TBD, will be in March 2022.

Plus / Delta




THANK
YOU
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Child Welfare Advisory Committee (CWAC) Meeting Minutes
September 22, 2021

New members of CWAC introduced themselves in the chat:
Haley Tiller, Pittsylvania DSS
Victoria Davis, Previous Kinship Foster Parent
Christine Minnick, DMAS Child Welfare Program Specialist
Emily McGarrity, In Home Services Practice Consultant, Northern Region

First Breakout Session, CWAC Members were asked: **How does your agency/organization assist in identifying and supporting/addressing barriers to informal and formal kinship during an in-home or foster care case?**

Group 1:

- CASA - Recognizing the importance of children staying with family; strengthening families; in our guiding principles and standards; training on Kin First culture and the importance of family and the importance of maintaining those connections
- Northampton – Utilizing FPMs; run searches early to invite family members to participate as supports or potential placements; FPMs has been wonderful
- Permanency Consultant – focusing a lot of our conversations with a Kin First lens; talking with LDSS about their practices around family engagement; building their capacity to engage family; encouraging the use of waivers to place with kin;
- Newport News – Utilize our eligibility staff to find who may have been in the home previously; ensuring Accurint searches completed; ensuring family is at the FPM
- Northampton – ensuring that workers know the importance (training/education) and being constantly aware that family needs to be involved
- LDSS Richmond County – historically have not had many kids in care; it starts at the very beginning; we ask that in our interview process to find where they stand on their outlook of child welfare to ensure that we are hiring workers with a Kin First approach
- Ombudsman – identifying agencies that are engaging families well and those who are struggling

Group 2:

- Build on staffing momentum; train and educate individual staff and the whole agency; look outside of just the agency to include training judges, CSA, community supports etc.
- Every child does better with family, private agency trains staff as a "family worker" - UMFS
    - Helps LDSS to locate family and asks the LDSS the tough questions
    - Asks the children/youth about relatives
    - Creates life books when kids come into care to find out more about kin and relatives
    - Do the work with or for the LDSS
- Vamping the treatment team meetings
    - Making sure the child's voice is heard; family time and holding connections during meetings between the child and kin/family
    - Identify barriers to why family is not participating in meetings, don't just send a letter, maybe call or stop by

- The pressure of finding a placement can outweigh the need for engaging with family/kin, change that mindset and discover families right away rather than waiting

Group 3:

- Permanency Practice Consultant - Throughout the life of the case ask, relatives said no a year ago then circle back and engage them and keep them informed has something changed, or be a support for the child in any way. Do meaningful diligence search and having conversations and work through the barriers.
- Permanency Practice Consultant - Asking the question "why not"; ask what would you need to see differently. Don't stop at the first challenge- see if there is a bias and unpacking those.
- Louisa - Constantly checking in with the family and seeing what the concerns are. Match those concerns with resource and wrap-around services. Our families are often scared of bringing a child into their home that is in foster care, assume it is the child's fault why the child came into care. Do everything we can to support them, our children have better outcomes when with relatives.
- How do we start with yes, how do we get to yes. Are these truly barriers that we cannot overcome.
- Resource Family Practice Consultant - Piedmont region working with LDSS to reach out to community partners ie: CASA, why kinship works. Show how it is better for children and families we serve. Listening to what the LDSS are barriers creating job aids to assist them. Change is hard but when we look at outcomes for children and families. Working with CSA partners and some of the barriers regarding crib and being creative with space. Find interventions that work for the family and try different things.
- An example, having a parent coach for our kinship providers, you would usually have for a parent but did for kinship.
- Lack of familiarity with kinship process. Crisis and trying to find a placement, might take longer but ultimately get us there. Not harder work but different work, do a time analysis for referrals to different TFC/Congregate care and spent it on relative searches.
- PSSF funding is a great resource to support families.

Group 4:

- Use nondiscretionary funds to support kinship placements. This could include donations; LDSS worked with stakeholders to come up with ideas on how to better support their kinship families.
- PSSF - promoting safe and stable families, communicating with local agencies in reference to how they can support relative placements; listening to their concerns and barriers. Helping LDSS brainstorm through some of those barriers. If there is an unhealthy relationship between family members, could they assist with providing supervised visits. Would the family benefit from TANF to assist with additional financial support. PSSF Coordinator helps them through their different scenarios to see what funding is available that could help support them.
- VHBG - Oversees program development and admissions, request contact logs from other agencies to see who has been involved and who they may no longer have contact with due to moves or transition. During interviews with youth, asks them about their social media and their friends they keep up with and who is considered family. If a child was on the run for several months where were they and who were they with? Family? Friends? Know who the people are who support them and keep them safe. Then talk to the social worker about including some of these people and how they can get them approved to be involved in services.

- Relative identification form as part of the PIP, incorporating VHBG's questions into this form to help us to identify fictive kin.
- Who do the children go to? Who do the adults go to? Identifying the natural supports. The challenge is that they are not related, but we need to educate the systems to include the court system that these people are still important to the case and to support the family during this difficult time. These natural supports could be an alternate to foster care or be used for respite/or temporary care.
- Norfolk DSS - partner with community partners to help identify supports

Group 5 NOTE: due to technical issue, Group 5's notes were not available for the meeting minutes.

Second Breakout Session, CWAC Members were asked: **What more can be done to ensure that all kids in foster care have immediate access to a placement that meets their needs? And, could a change to the way enhanced maintenance or VEMAT is calculated make a difference?**

Group 1:

- Resource Family Consultant – conversations with our private partners about barriers and ensuring that we are on the same page; these are VA's kids and already dealing with so much; being denied is another form of trauma, especially over and over and over again; consider changes to licensing regs
- LDSS – Trying to do more better matching of children and foster families; will try to do more targeted recruitment to get more families who can meet the needs of the children we have coming into care
- Permanency Consultant – denials are based on physical aggression, fire setting, sexual acting out; a lot of these teens are coming into care with the court focused on congregate care, or even already in a congregate care setting; need conversations with CIP regarding foster care and whether or not the LDSS can produce a better outcome than a parental placement
- Permanency Consultant – CSA to support wrap-around services for kids and their families during a congregate care setting; LCPAs regarding holding a foster family while a child/youth is in residential to return to the same foster family upon discharge
- CASA – bring along partners in this process; collaboration, trainings, etc; how do we really get to meeting the needs = collaboration
- Resource Family Consultant – it is not extra work, it is the work; reframe how the work is done; put more energy into the front end and it will improve outcomes on the back end

Group 2:

- Foster families are working towards reunification with families and are collaborating with birth relatives and the foster parents are actively involved helping to make reunification occur
    - Create a partnership between the foster parents and relatives
    - Enable Foster parents to work with families
- Enhance training for foster parent and provide them with training that will enhance the family's capacity
    - Using CRAFFT for more specific in-service training
    - Maximize training on an ongoing basis and utilize services

- More Resources for families and have increased supports for foster parents
    - Look at things differently not just funding for training but having it more individualized

Group 3:

- Resource Family Consultant - Oversight of LCPAs; look at how parents are being trained and way information is being shared with them. Improve data on LCPA to have better understanding
- Permanency Family Consultant - Encourage agencies to look at the data, prior to the child coming into care- who has the child been placed before, what family, track the data and discover more relatives
- Look at why relative placements are not working and why the kids keeps having to leave. Make sure we are providing appropriate supports. Can they become an approved foster parent and get additional support?
- Assist LDSS to increase their local foster parent homes so we don't rely on LCPA homes.
- Better training for LDSS with mental health needs; children have trauma and need more training for local foster homes and to maintain children in their community.
- LCPA- therapeutic foster care should be a higher level of need. LCPA are not equipped to meet needs of our children. More training to address and cope with behaviors with children with mental health needs or autism.
- Children do not want to be in these homes, need kin in these placements.
- Relative feels they cannot support the children, even after the agency offers support; under the assumption relatives have more specialized training.

Group 4:

- Create a subcommittee of CSA, Human Rights and other community providers etc; have a discussion of the fears of accepting some of these children and talking through the barriers.
- Emergency foster homes/Respite similar to an emergency shelter. These people could be trained for this and serve as a buffer. Trained professional parents that can assist in de-escalating behaviors
- Identify specific individuals that work with specific behaviors and have increased recruitment efforts. Looking outside traditional recruitment efforts.
- An increase in this payment could assist with some parents taking on youth with higher needs.
- Matching the needs to the child and not so much the parent's ability.
- Maybe a refresher on VEMAT training would help and not all local agencies are utilizing the VEMAT. Should be required for all local homes.

Plus/Delta:
Plus: family voices/lived experience shared at the meeting from Victoria and Mary, great pacing, variety of ways to participate, breaks, breakout conversations, enjoyed hearing the discovery efforts of other agencies, kinship data and agency successes

Delta: mix up or rotate the breakout rooms, have more private providers participate, hear about Family First and IVE component for in-home cases, have youth who have aged out attend and provide their voice, ensure breakouts aren't too VDSS heavy