



**Virginia Department of Social Services**

*people helping people*

CWAC

# AGENDA

- CWAC Charge
- PIP Update
- VDOE/VDSS Foster Care Project
- Youth Aging Out of Care
- Substance Use Disorder and Child Welfare
- Family First Update
- Plus/Delta

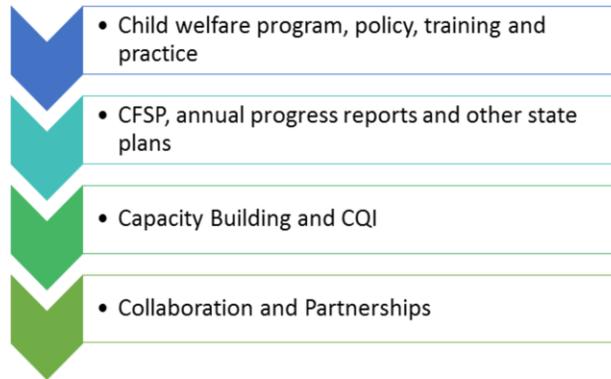


## Who is Here?



## Child Welfare Advisory Committee (CWAC) Charge

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



Em Parente, Acting Director: all of our partners are critical stakeholders in the work we do across the state, especially related to our Strategic Plan moving forwards as last year's APSR has been completed.



Kristin Zagar, Deputy Commissioner, Human Services, VDSS: Opportunities to work together in Benefit Programs, Child Support Enforcement and Child Care to support safety, permanency and well-being outcomes, creating a full child welfare community. Promising Initiatives: Thriving Families Safer Children (TFSC) <https://www.acf.hhs.gov/media/press/2020/first-its-kind-national-partnership-aims-redesign-child-welfare-child-and-family>; driven by Families Forward VA and in partnership with VDH and FACT; have support from Casey Family Programs, Children’s Bureau and Chapin Hall; it support VA’s Prevention Plan. NGA Learning Collaborative- Crossing the Aisles - takes a look at our ability to look upstream and address families all of the way upstream and bringing in a community approach to child welfare. Many calls to the hotline are due to a lack of families’ basic needs being met. Working within the community using CBCAP dollars in LDSS agencies.

Em: Today’s topics include maintaining a kin-first culture, focusing on youth aging out of foster care and substance use disorder and Family First.

Visualizing Equity:  
Virginia Longitudinal Data System Projects  
for Students in Foster Care

Prepared for the Child Welfare Advisory Committee

*June 2021*

Dr. Jen Piver-Renna, Director of the Office of Research, VDOE gave overview of two projects working in collaboration with several partners focusing on children in foster care.

## Overview of the Virginia Longitudinal Data System

- Designed to address cross-sector research questions pivotal to citizens and policymakers by merging data across partner agencies
  - Algorithm matches then de-identifies data across agencies
  - Data sharing agreement allow researchers access to data from the system
- Federated model with 11 participating agencies and non-profit organizations
- Operational since 2013
  - 44 active research projects
  - 131 researchers

# VLDS Agency Partners



State Council of  
Higher Education for Virginia



VIRGINIA DEPARTMENT OF  
SOCIAL SERVICES



Virginia's  
Community Colleges



Virginia Department of  
Health Professions



OCS

Office of Children's Services  
Empowering communities to serve youth



**dbvi** Department for  
the Blind and  
Vision Impaired  
Education • Employment • Independence

## New VLDS Projects through US Department of Education Grant Funds

- Vision:
  - Increase data transparency for a broader audience of stakeholders
  - Produce equity-centered data tools and research to influence Virginia policy and program delivery models
- Project deliverables focused on students in foster care:
  - Dashboard to visualize outcomes of students in foster care by locality
    - School division and locality program management
    - Promote practices and policy efforts to leverage strengths and address disparities
  - Query tool to provide on-demand access to complete student educational records
    - School-based practitioners
    - Facilitate timely and appropriate educational placements

## Outcomes Dashboard

- **Needs:**
  - Linked education and social service data within and across localities are not widely available
  - Difficult to quantify the outcomes of children in foster care by locality
- **Questions that could be answered:**
  - Relationship between type of placement, attendance, and achievement
  - Relationship between number of placements and on-time graduation
- **Timeline:**
  - Through December 2021: Complete development
  - Beginning in 2022: Pilot, refine, and publish

## Query Tool

- **Needs:**
  - Individuals placing students seek out and rely on information from multiple sources for educational placement decisions
  - Longitudinal educational records are often unavailable, delayed, or incomplete
- **Purpose:**
  - Provide on-demand access of longitudinal, individual student data to authorized users to inform appropriate placement of students
- **Timeline:**
  - Through April 2022: Development and testing
  - Beginning in May 2022: Soft launch, refine, and state-wide deployment

## Contact Us

- Interested in learning more, providing feedback during development, or helping to pilot test these tools?
- Jen Piver-Renna, PhD  
Director, Office of Research  
[Jennifer.Piver-Renna@doe.virginia.gov](mailto:Jennifer.Piver-Renna@doe.virginia.gov)
- Jamie Williams, MBA  
Data System Project Coordinator  
[Jamie.Williams@doe.virginia.gov](mailto:Jamie.Williams@doe.virginia.gov)

12

Please complete survey if you are interested in providing feedback during development of tools: [https://www.surveymonkey.com/r/VLDS\\_fostercare](https://www.surveymonkey.com/r/VLDS_fostercare)  
Question asked: **Does this research include DEI as it relates to outcomes?** Yes, the Federal grant prioritizes equity. Students in foster care are a priority group in this work and it is anticipated that a lot of projects being developed will be equity centered. Developed a research document that is equity centered with specific questions around DEI and outcomes that can be addressed by the LDSS.

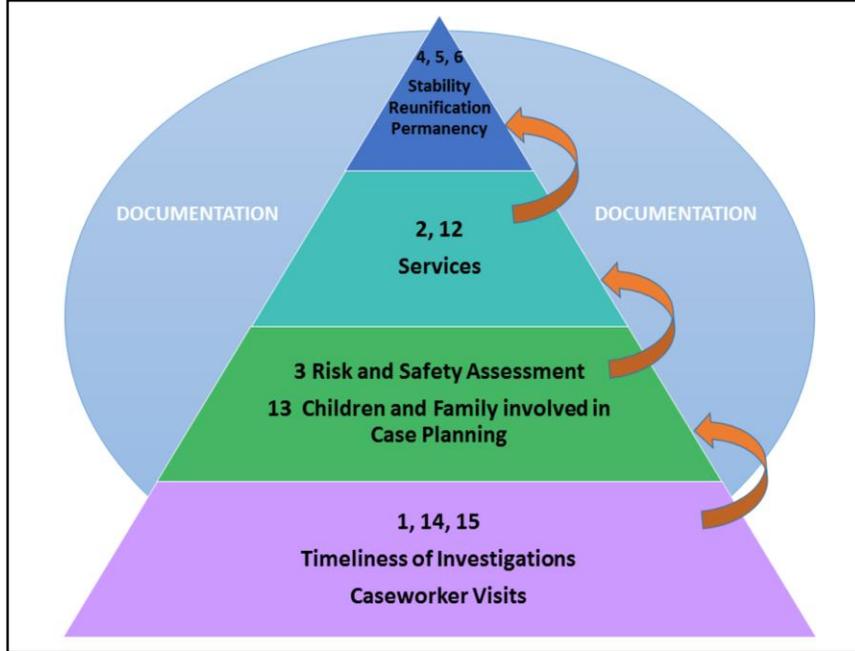
## PIP PIP Hurray

PIP  
PIP  
Hurray!!!



13

Deborah Eves, Federal Liaison: We have completed our PIP implementation timeline; very close to completing all items related to the 3<sup>rd</sup> round of the CFSR.



Deborah reviewed the taxonomy, where family engagement is the key.

The goals, strategies, and activities bring us to the taxonomy. Using the CFSR item numbers, which you see at each level of the taxonomy was created building upon the basis of engagement. We respond to and have quality, frequent visits with our families in a timely manner SO THAT we will be able to complete risk and safety assessments and engage children and families SO THAT we will be able to provide the most effective services SO THAT our children will achieve safety, stability, be reunified in a timely manner, and achieve permanency.

# PIP Installation Timeline

15



The PIP timeline, we had 4 over-arching, 12 strategies and 23 key activities.

## Collective Thinking

In your role, how can you support improvements with education, which is one of the CFSR outcomes



## Kin-First and Supporting Youth Aging Out

**Emancipation** is defined as youth who turn 18 while in Foster Care.

On average, 826 days in care (2.3 years)

Less than a quarter of these youth had a TPR finalized (24.3%)

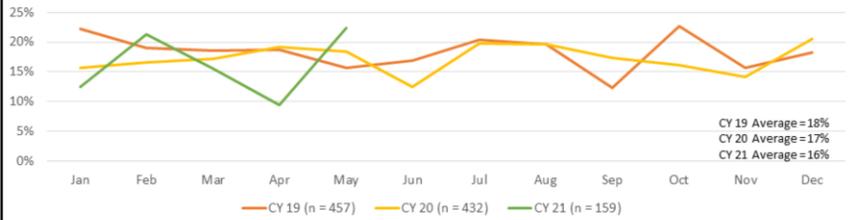
Only 10.9% had ever been placed with a relative or kin prior to emancipation.



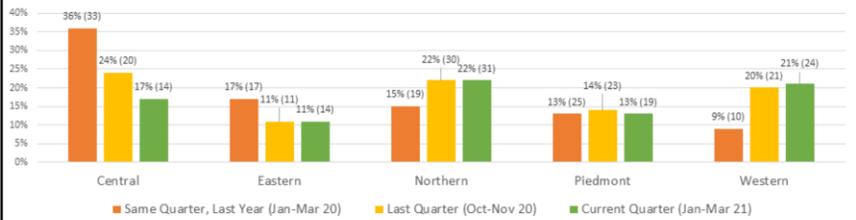
Claire Kimberly, Permanency Data Analyst.

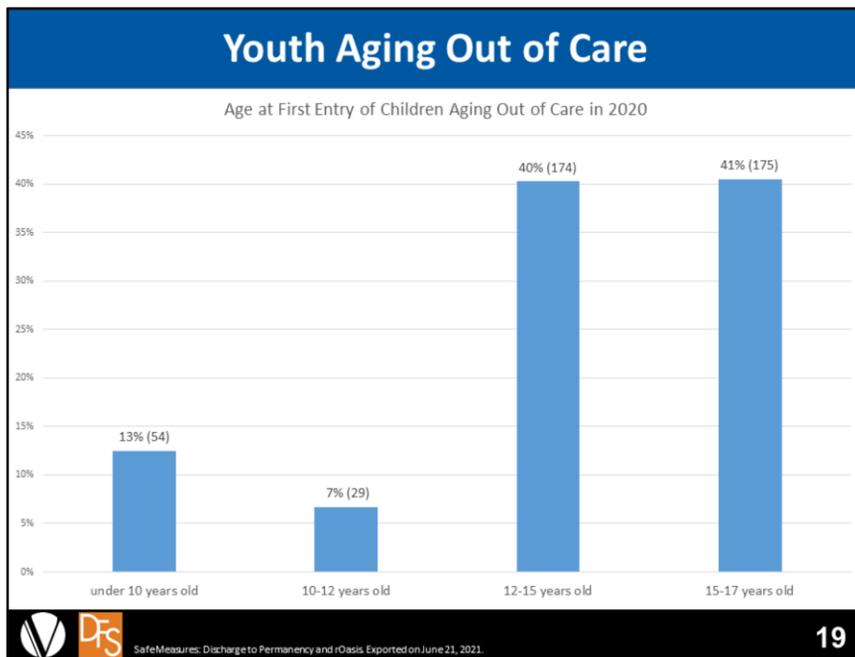
# Youth Aging Out of Care

Percentage of Children Aging Out (State)

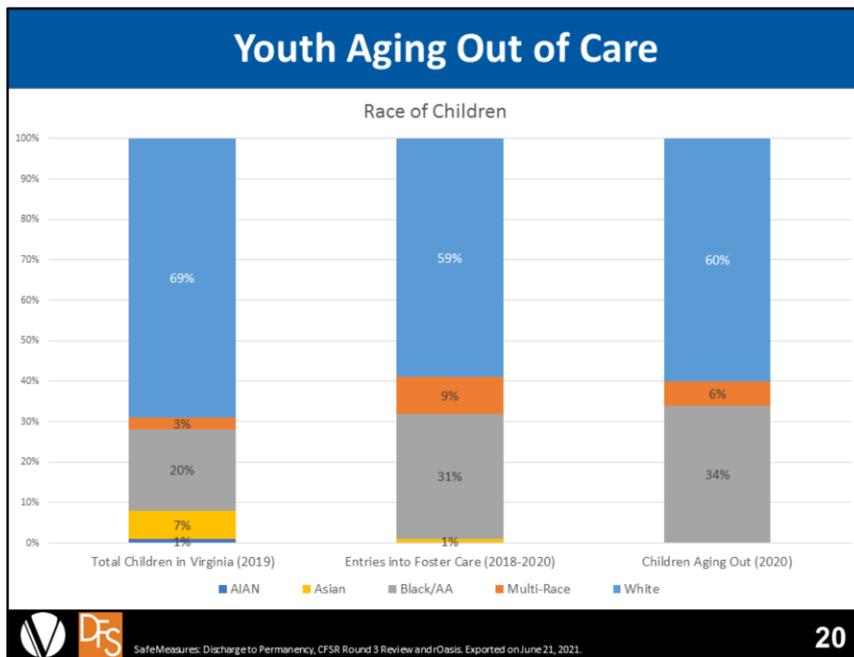


Percentage (#) of Children Aging Out (Region)

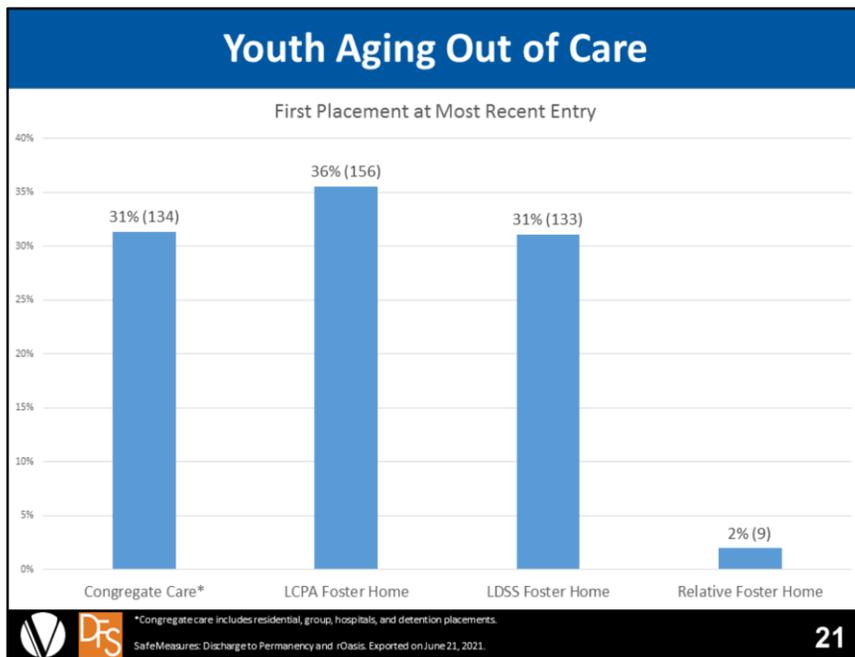




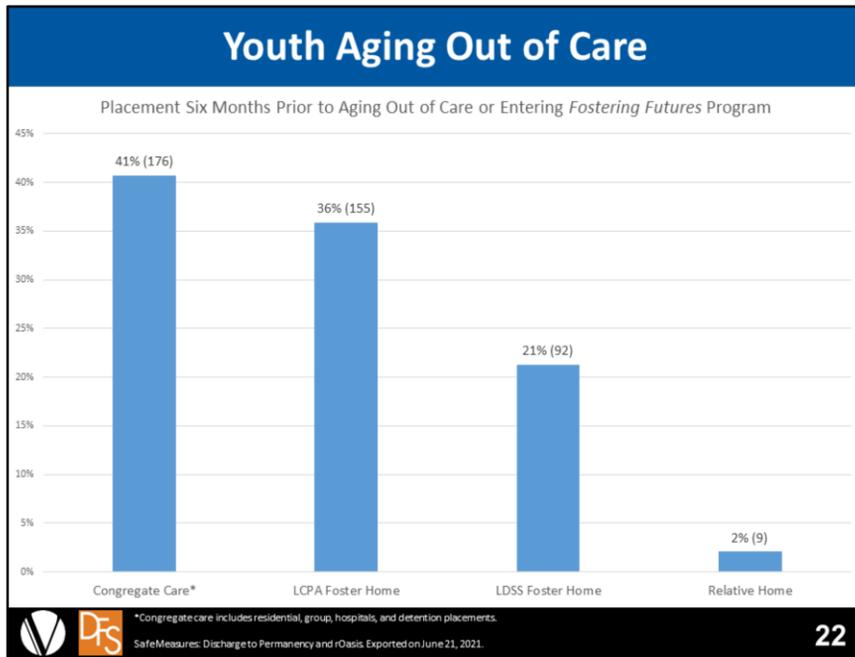
The data for this chart is based on children who emancipated during calendar year 2020. Overall, there were 432 children who aged out of care during this time period. Here we are specifically looking at the age of the children when they entered care. In parenthesis, you are seeing the number.



On the left side, you are seeing the racial identity of our children in Virginia based on the most recent Census Data report (2019). The middle chart looks at the racial identity of our children that entered foster care between 2018 and 2020. On the far right, you are seeing the racial breakdown of the 432 children that we have already discussed, that aged out of care during calendar year 2020.



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.



Now let us look at **where our children were prior to aging out of care** or entering our *Fostering Futures* program.

## Youth Aging Out of Care

	CY16	CY17	CY18	CY19	CY20
<b>Fostering Futures % of Entry</b>	32%	53%	50%	38%	58%
<b>Total Eligible FF Population</b>	534	567	641	656	510
<b>Total Participating FF Population</b>	170	303	317	247	294



23

In regards to our *Fostering Futures* program, we had 510 children turn 18 in calendar year 2020. **57.6%** of those children entered *Fostering Futures*. The average length of time children in our *Fostering Futures* program had participated during calendar year 2020 was 1.4 years.

## Breakout

What is your organization doing that is supporting children aging out of care? What do you need to do differently?



## Kin-First Culture and Substance Use Disorder

- Families are the experts on themselves
- Driving and included in decision-making
- Opportunity to rely on one another for support



25

Garrett Jones, Resource Family and Family Engagement Program Manager: Our kin-first work highlights engagement with families and letting families be the experts on themselves. However, we know that challenges exist as staff balance encouraging parents, and being an ally to parents but also having the charge of child protection and safety. This paradox is frequently encountered with cases involving substance use disorder and parents who are moving through recovery

# Substance Use Disorder Recovery Framework

## VDSS SUD Framework



Source: Stephen Wade, SUD Recovery Ally Presentation, 5/11/21

26

Stephen Wade is the Health Equity Project Manager with the Office of Community and Volunteer Services at VDSS. He recently presented on the SUD Ally work he and this team are heading up at VDSS. SUD is another area of focus we will work on this year due to the impact it has on our population. We want to do better in our work.

## DBHDS Partner: Julie Truitt

### **Julie Truitt, MPA, CSAC, CCJP**

Substance Use Disorder Quality Manager  
Regional Behavioral Health Consultant  
Division of Community Services  
Office of Adult Community Behavioral Health  
Email: Julie.Truitt@dbhds.virginia.gov



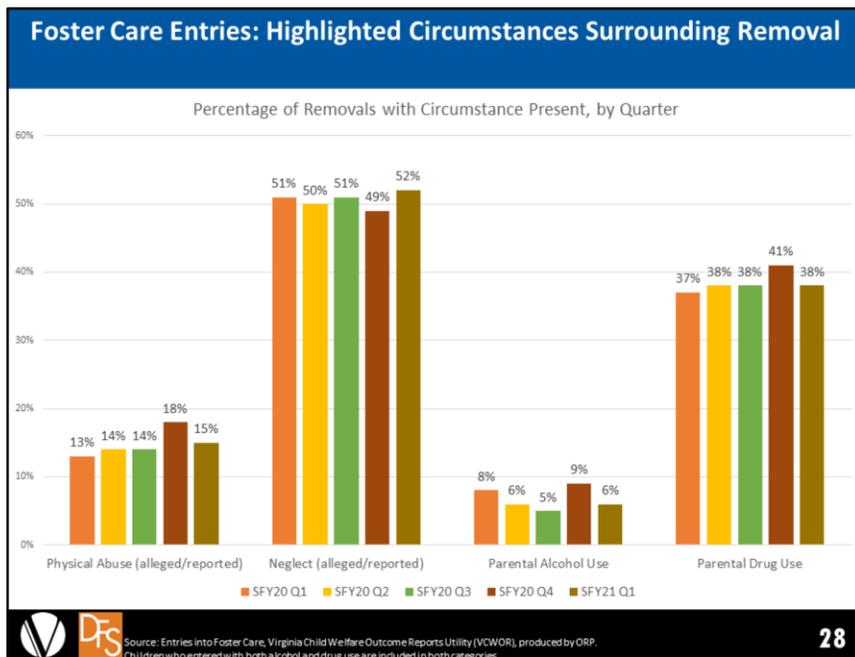
Virginia Department of  
Behavioral Health &  
Developmental Services



27

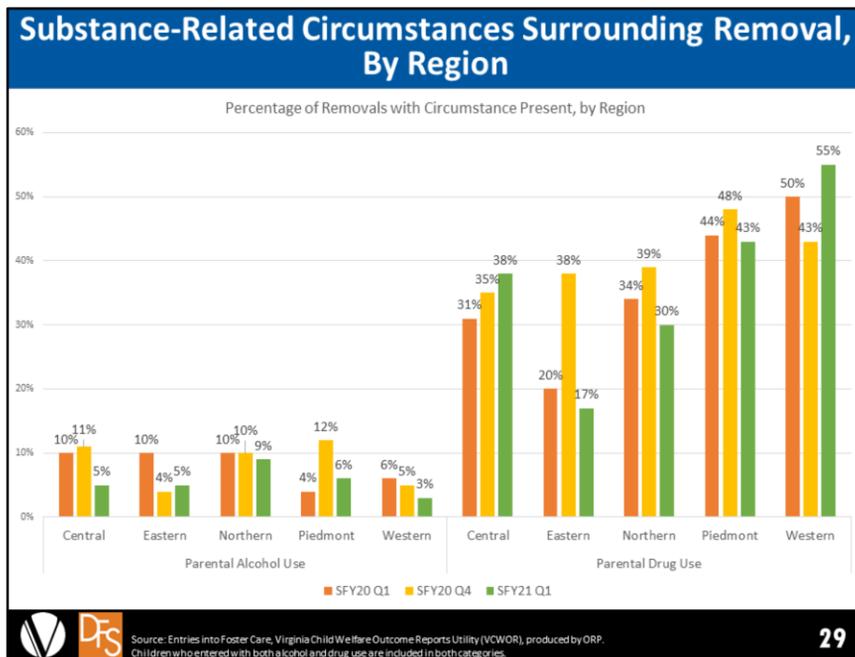
We asked Julie Truitt to give a high level overview of newer developments in SUD work. She is a subject matter expert and the Substance Use Disorder Quality Manager with the Department of Behavioral Health and Developmental Services in the Division of Community Services. Prior to that, Julie was a behavioral health regional consultant for the Coastal/Tidewater/Hampton Roads area, which is Region 5 health Planning region. Several years ago Julie worked with the CSBs in Northern Virginia as well. She also works closely with DARS regarding employment for individuals that have an SUD diagnosis and experience barriers to employment as result of their disability.

- Recovery model vs medical model
- Peer recovery work
- Recovery is possible and relapse is part of recovery; looking at other social determinants
- Medication assistance treatment is evidence-based; opioid addiction affects the brain differently than other drugs
- STEP VA
- Recovery capital
- Treatment team

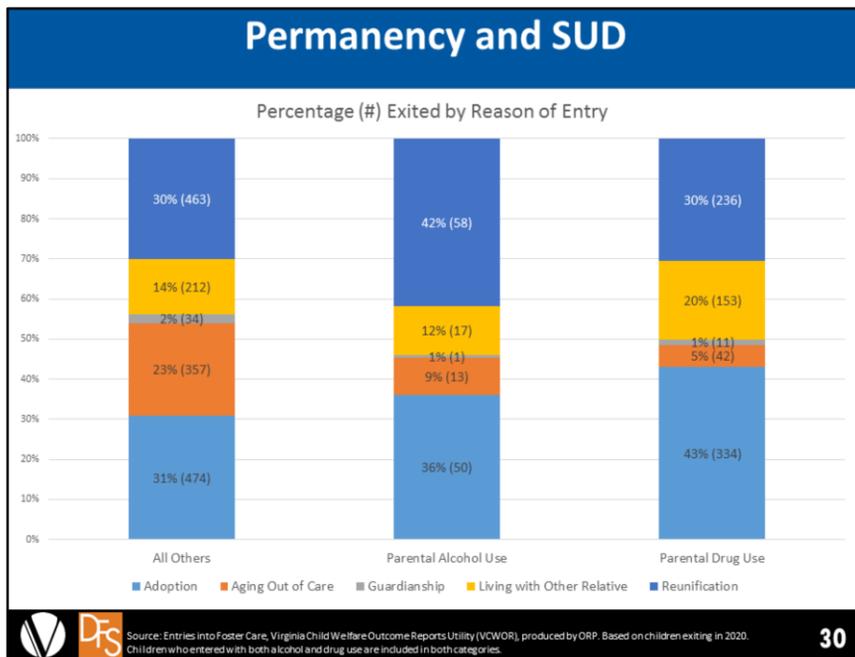


Claire Kimberly: This slide shows the percentage of removals with circumstance present by quarter. On the bars on the left, this represents the % of foster care entries where physical abuse was alleged/reported. We see that in state fiscal year 20 quarter 4 which is April 2020 to June 2020 had the highest percentage.

Neglect was at it's highest at 52% for state fiscal year 21 in the first quarter, that's July 2020 to September 2020. For parental alcohol use, we saw it's highest % in state fiscal year 20 quarter 4 and then for parental drug use, the farthest right hand side of this slide, we saw it's highest rate at state fiscal year quarter 4, which again is April 2020 to June 2020 right at the peak of the pandemic.

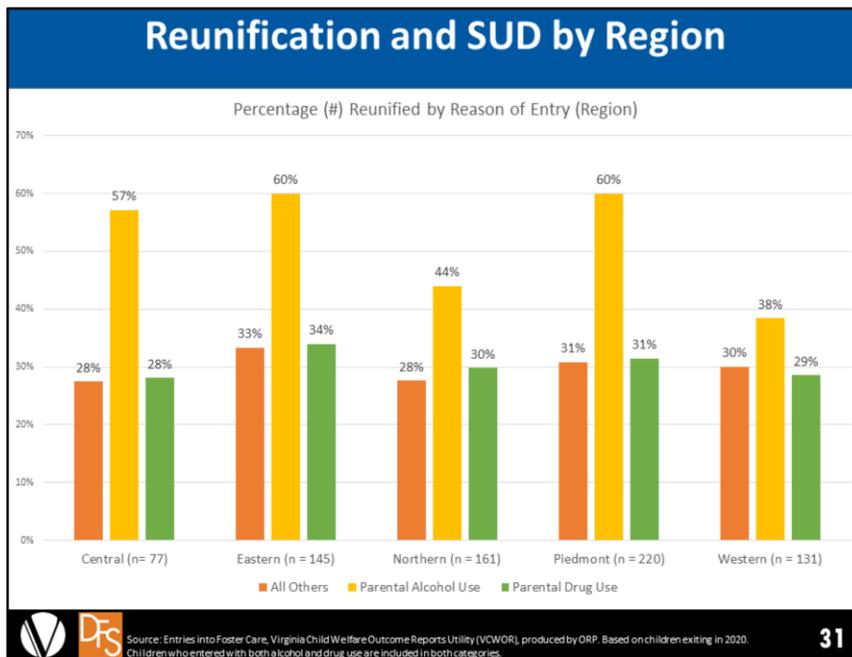


This slide is showing substance-related circumstances surrounding removal by region. On average about 38% of removals had parental substance abuse documented and around 7% of removals had parental alcohol abuse documented.

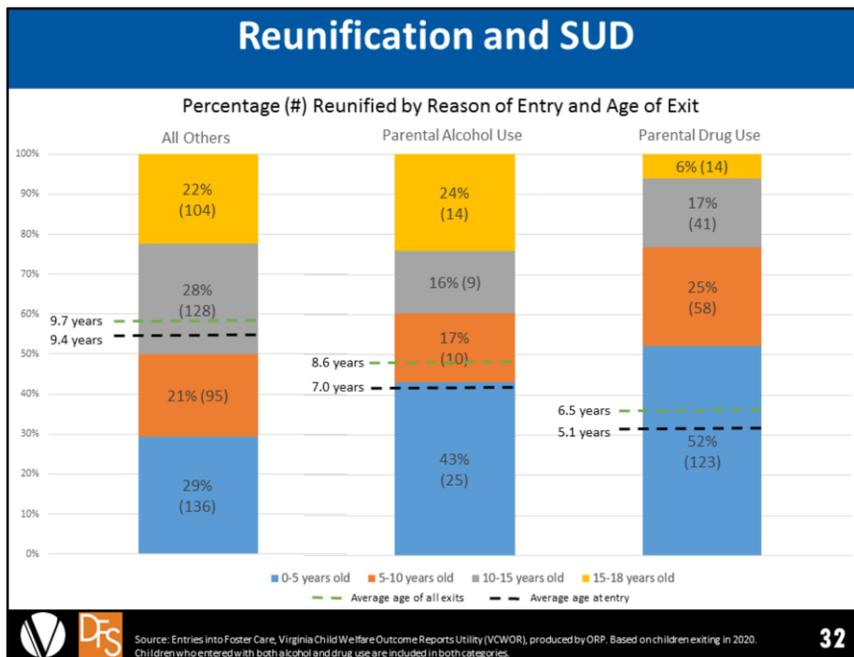


This slide provides information on children that exited in 2020 and is separated by the reason noted for entry. Starting at the bottom, we see that children who had parental drug use as a reason for why they were removed from home were most likely to exit by adoption at 43%. They were also more likely to be living with another relative at 20%. This can be seen by comparing the yellow bars on each bar graph. Now looking at the dark blue part of the charts on top, children removed from home due to parental alcohol use were more likely to be reunified at 42%.

Children removed from home with reasons other than alcohol or drug use were more represented with children aging out of care at 23%. This is seen by viewing the dark orange section of the charts.

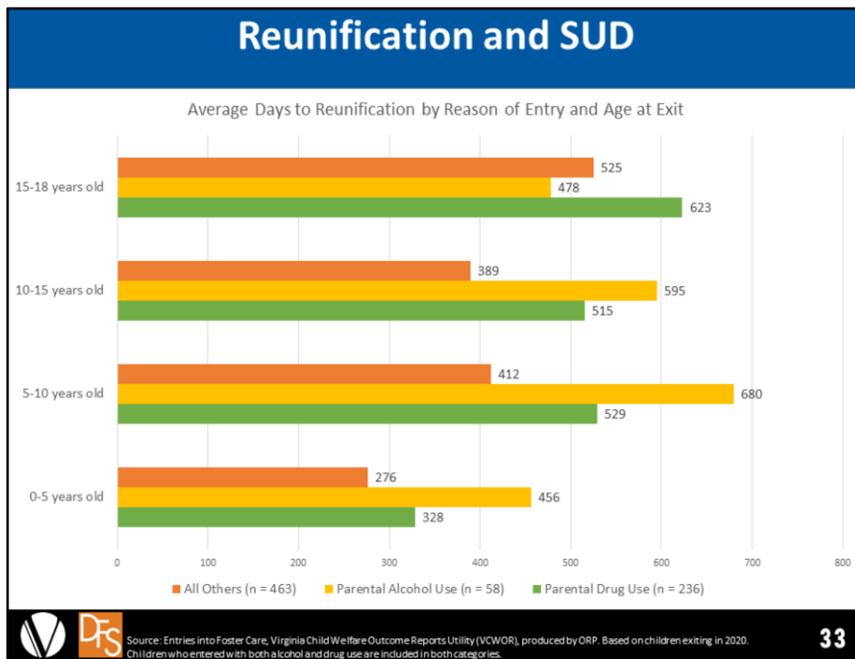


As June is reunification month, we dig a little deeper into differences with children who were reunified in 2020. Here you are looking at the comparison of children reunified to those that were not by region. To better understand data, let's take for example the Central region: 57% of children that entered care due to parental alcohol abuse exited by reunification. That means that 43% of children who entered in central reason due to parental alcohol abuse exited by another reason. Looking at the yellow bars, overall children that entered care due to parental alcohol abuse were more likely to exit to reunification regardless of region. Slightly more variation is found with the cases where parental drug use was referenced as a reason for entry.

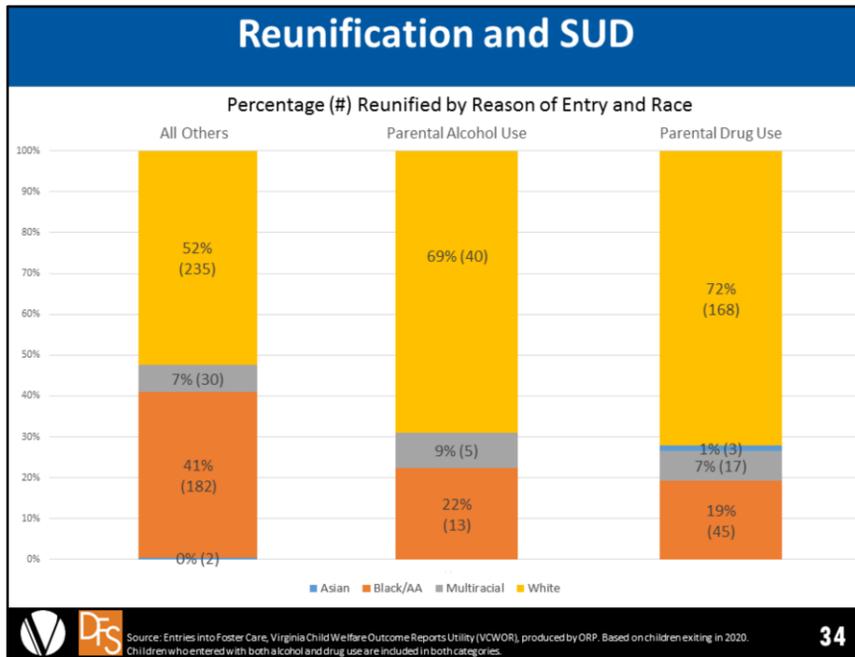


Now let us look at differences in age. Here we are seeing the children who reunified in 2020 separated by reason for entry and age of exit. Let's point out the dotted lines. You are looking at two averages based on the reason the child entered care. The black lines are the average age at removal for those children that entered care. This average includes all children regardless of how they exited and gives us an idea of how old are children are when they enter care compared to each reason. So, for example, children who enter care with parental drug use as a reason are lower than those that enter care for the other two reasons. The green dotted line is the average age of children when they exited care regardless of how they exited. So, for example, children who entered due to parental drug use and exited in 2020 were, on average, 6.5 years of age. These lines provide context for the bar charts behind them. Each bar chart is giving the % of children who exited to reunification based on their reason for entry and age of exit. If something besides parental alcohol or drug use was referenced as a reason for being removed from home, age did not vary much for children who were reunified in 2020. This can be seen by looking at the left bar chart and how each color (or age group) is about the same percentage. For children who entered due to parental alcohol or drug use, younger children were more likely to be reunified. This is shown by how the largest section on the right bar charts are the light blue, representing our younger children. Looking at the yellow sections on top, our older

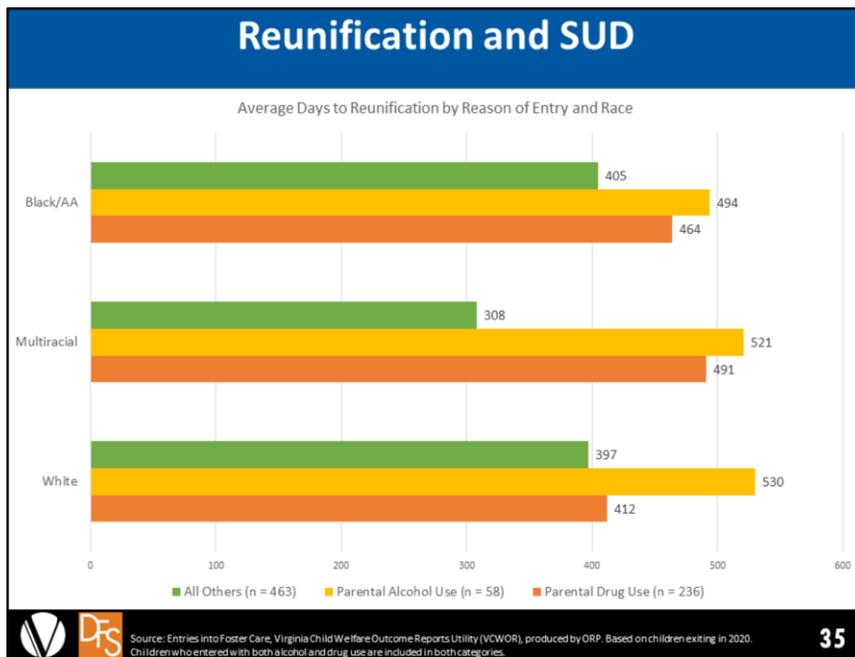
children were less likely to return to home if parental drug use was referenced when compared to the other categories (at 6% compared to 22 and 24%).



This chart gives us additional insight into the amount of time the reunification took to occur by age groups and reason for entry. Overall, it took longer for children to be reunified in all age groups when alcohol use was present, with the exception of our 15-18 year olds. For this group, it took longer to be reunified if there was drug use. If drug or alcohol use was not the reason for entry, it took the least amount of time to be reunified with the exception, again, of our older children.



Now let us look at differences in race. Here we are seeing the children who reunified in 2020 separated by reason for entry and race. Overall, our White/Caucasian children were more likely to be reunified regardless of reason for entry. If parental alcohol or drug use was not referenced as the reason for removal, Black/African American children were more likely to be reunified. You can see this by looking at the dark orange sections from left to right.



Now let us look at the average amount of time to reunification based on race and reason for entry. Overall, if parental alcohol or drug use was not referenced as a reason for removal, it took less time to be reunified. This can be seen by looking at the green bars from top down. Looking at the yellow bars for each racial group, we see that children who were removed due to alcohol abuse took longer to be reunified if they were White/Caucasian at an average of 530 days. Looking at the orange bars which represent drug use, children that were Multiracial took the longest time to be reunified at 491 days.

## Kin-First Culture and Substance Use Disorder

- Families are the experts on themselves
- Driving and included in decision-making
- Opportunity to rely on one another for support



Garrett Jones: We've state that in the kin-first culture families are the experts on themselves, are driving the decision-making and are given opportunities to rely on one another for support. We know that sometimes this paradox exists in child welfare when we are working with parents supporting their recovery but also having to ensure child safety and protection.

## Breakout

What do you need to support a recovery model when working with families with SUD?



## Family First Prevention Services Act – July 1<sup>st</sup>!

The **vision** for Family First is to **keep children safe, strengthen families** and **reduce the need for foster care** whenever it is safe to do so.



38

As we prepare to implement fiscal components of Family First on July 1<sup>st</sup>, we're reminded of the alignment of the federal goals of Family First with our child welfare system goals – keeping children safe, strengthening families, and reducing the need for foster care.

## IV-E Funding for Evidence Based Services

Children (and their caregivers) who are at risk of out of home placement, including adoption dissolution, and a pregnant/parenting teen in foster care, are eligible to receive IV-E funding to pay for **evidence based services**.

Title IV-E Prevention Services  
Clearinghouse

Virginia Prevention Plan

Multisystemic Therapy  
(MST)

Functional Family  
Therapy  
(FFT)

Parent Child Interaction  
Therapy  
(PCIT)



# Team Virginia!

## LDSS

- Provide In-Home Services Support/Management
- Identify Child as Candidate for Foster Care

## Providers

- Provide EBS for Families
- Communicate Capacity to LDSS
- Certified to Deliver EBS

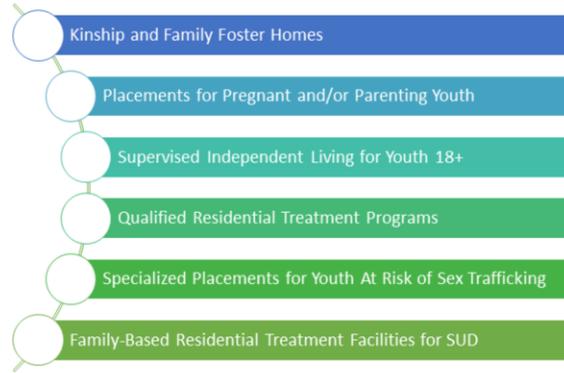
## Communities/Advocates/Partners

- Assess community needs for additional EBS
- Wrap families with support to ensure all their needs are met

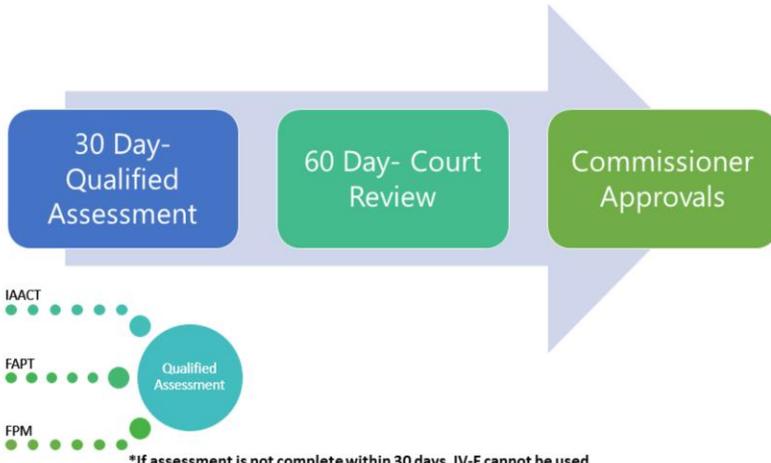




## IV-E Funding for Congregate Care



# QRTP Placements

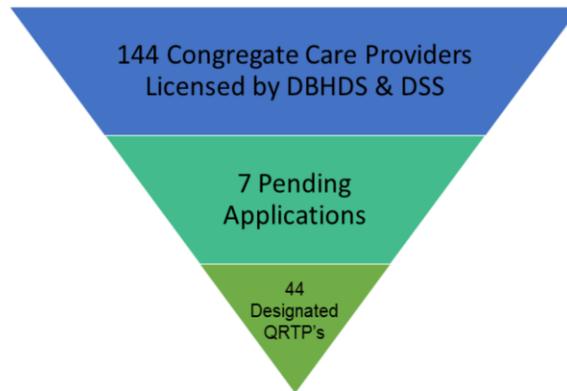


\*If assessment is not complete within 30 days, IV-E cannot be used

\*If assessment determines QRTP is not appropriate, IV-E can be used for 30 days to transition child



## Qualified Residential Treatment Programs (QRTP)



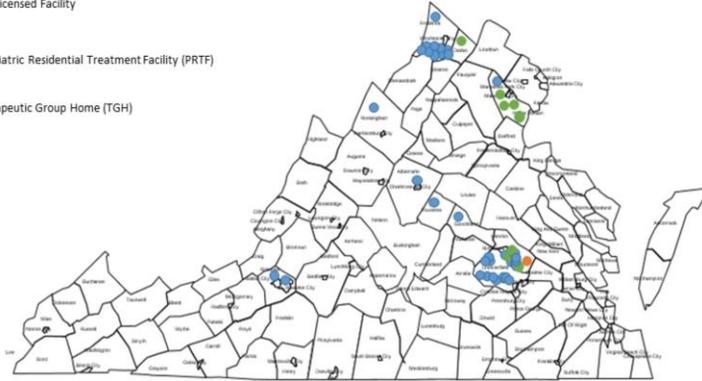
[https://familyfirstvirginia.com/foster\\_care/qrtip\\_applicants.html](https://familyfirstvirginia.com/foster_care/qrtip_applicants.html)

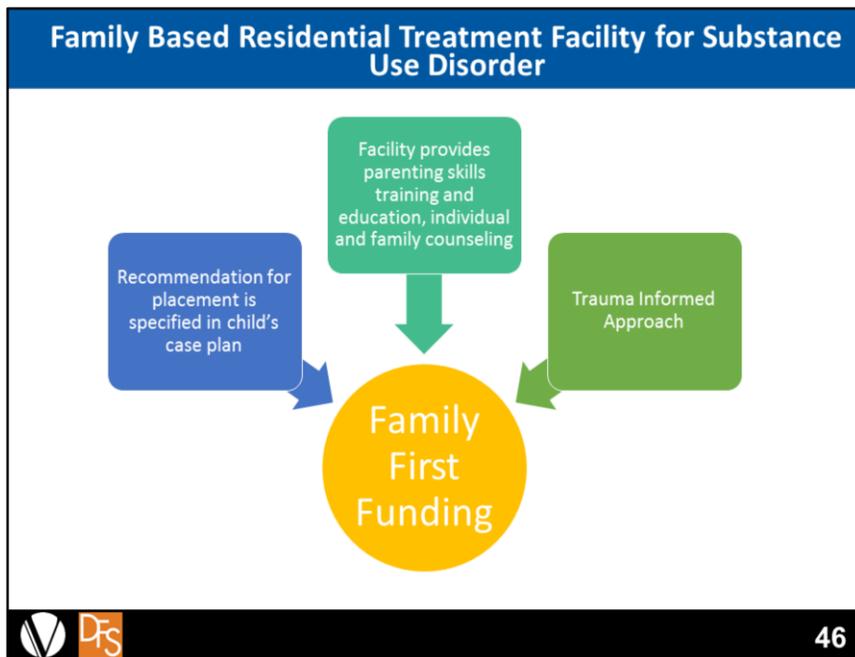


We now have 44 designated QRTP's and 7 pending applications for QRTP's. As we continue to see more providers come onboard with the QRTP requirements, we'll be able to continue our focus towards more short term placements meeting the specific needs of our youth to ensure youth are placed with families.

# QRTP Designation Map

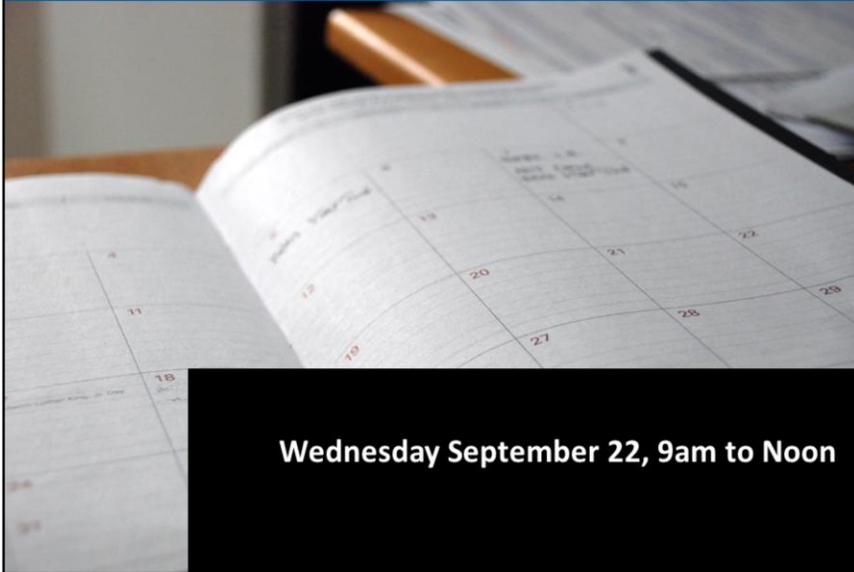
-  DSS Licensed Facility
-  Psychiatric Residential Treatment Facility (PRTF)
-  Therapeutic Group Home (TGH)





The other service that it is available to support families experience SUD is when a child is in foster care, title IV-E funds may be used for the placement of a child to remain with their parent at a family based residential treatment facility for SUD.

## Next CWAC Meeting





**Child Welfare Advisory Committee (CWAC) Meeting Minutes  
June 23, 2021**

New members of CWAC introduced themselves in the chat:

Kimberly Ayers, Wythe DSS Director, Child and Family Committee Chair

Cassidy White, Project Manager, VDSS

Christine Minnick, Child Welfare Program Specialist, DMAS

Kim Baskerville, Adoption Supervisor, VDSS

Chanda Yarbrough, ICPC Program Consultant, VDSS

Latasha Jones-Patterson, Intern, VDSS

Alisha Hunt, Permanency Practice Consultant (Central Region), VDSS

Thriving Families Information: <https://www.acf.hhs.gov/media/press/2020/first-its-kind-national-partnership-aims-redesign-child-welfare-child-and-family>

VDOE/VDSS Foster Care Project (VLDS Grant), link to sign-up for more information and/or to provide input: [https://www.surveymonkey.com/r/VLDS\\_fostercare](https://www.surveymonkey.com/r/VLDS_fostercare)

Deborah Eves, Federal Liaison, asked: **In your role, how can you support improvements with education, which is one of the CFSR outcomes?** Feedback from CWAC included:

- Secondary oversight (from federal partners); look at case review summaries for areas where improvements could be made, looking for trends in casework that might impact this item
- Placing children in their communities so that they do not have to change schools
- Using our suite of tools in In-Home casework to ensure it is part of our assessment and work and looking at supportive funds such as PSSF to provide services and supports once identified
- Ensuring we address education as part of our CPS assessment process on the front end
- Supporting locals to approve kin so that children can stay in their communities and not move schools
- We can red flag this item as part of our CC reviews
- By getting students in our Private Day School BACK to their Home Public Schools as soon as possible
- We're designing an internal database that will help us track changes in school placements and educational outcomes for children aging out of care
- Pursuing research and grant and/or TA opportunities to look systemically at outcomes and accessibility to data to align education and FC - like the VLDS grant project Dr. Piver-Renna spoke to
- VDSS is going to be getting information out to the LDSS about the new G3 program which makes assistance for vocational training available in the community colleges
- Ensuring follow-up for specific educational needs for youth we serve
- Doing a better job transitioning kids back to their home schools
- FPM and CFTM can inform active case management around this item
- Getting families the supports they need earlier so we can prevent further trauma/cycles of neglect
- Screen for mental health issues early
- Training stakeholders on the educational stability requirements and processes and improving collaboration with everyone who is a part of the child/youth's team
- CASA volunteers routinely are focused on educational needs of children assigned
- Added supports to expedite BID process when children move placements

Kristin Zagar, Deputy Commissioner, Human Services, VDSS notes: This collective Team VA response is how we will be the first state to pass the next CFSR; we are striving to get to 90-95% on all outcomes via our CQI processes and focusing on the areas that need to be improved and on the areas that we need to sustain the improvements.

First Breakout Session: CWAC members were asked: **What is your organization doing that is supporting children aging out of care? What do you need to do differently?**

### **Group #1:**

- Preventative services
- Reunify with birth families and set the youth up for success early
- Supporting youth who do age out
- Better engagement with joint conversations with family
- Collaborate with programs specifically for employment/vocation and matching youth to vocational opportunities
- Facilitate natural support connections
- Question “good enough” parenting knowing that youth do best in families and focusing on “safety” knowing youth frequently return home when they age out.
- Keep youth connected to family even if NOT a placement option since nothing replaces family
- Revisit family over time and get onboard with THEIR plan with safety in mind
- Lean on network of family and invest in learning about family
- We need to ASK youth about their plan and work to implement it.
- VDSS needs to promote and develop relationships with LDSS and connect with programs and TFC agencies who can develop wraparound services to support relatives. Also VDSS needs to understand when families aren’t being approved as kinship so they can address challenges
- Family Forward: Grappling with biases with diversity of frontline workers but need diversity in leadership so they reflect diversity of population worked with. They are having difficult conversations to address biases. Focusing on treating families with more respect and questioning assumptions, leaning on strengths and networks.

### **Group #2:**

- Supporting local agencies to encourage their agencies to have youth remain in Fostering Futures. Supporting locals to think outside of the box, consider placement back with parents after 18, how do we support youth in making decisions about their lives.
- Lifting up youth voice.
- Working to ensure Resource Families are educated about the options that youth have at 18.
- Private providers are supporting youth voice and choice. Working with local DSS to navigate kinship options for the child. Educating youth about what to expect when returning to family at 18, including assessing potential safety issues.
- TPR doesn’t mean termination of parental relationship.
- Exploring relatives, even those who can’t be placement options, for what supports they can offer the youth.
- COY is working on a study re: workforce development for youth aging out of care. Meaningful employment is key for our youth aging out of care.
- People’s lives change while kids are in foster care; revisiting relatives/parents as supports/placements for youth with time.
- Identifying and assessing potential supports; include youth voice in decision-making. Educating youth on potential support systems that might be available.
- TFC Home or CC setting, get them involved in activities in their home communities, making those connections socially.
- Make sure everyone is at the table and involved in planning and decision-making.
- Think differently—what are we protecting youth from? And at what costs?
- Listen to the youth.
- Challenge agencies on term “appropriate.” It varies case by case. Check our own biases. Is there a true safety concern. Engage entire support system.
- Have conversations during the entire life of the case.

### **Group #3:**

- CASA has ability to work with youth beyond the age of 18- policy developed several years ago that allows CASA volunteers maintain their appointments beyond 18- guidance gives structure and parameters for the volunteers

and shift to youth lead advocacy-- move toward working with young person as they move into being a young adult- Fostering Futures was passed- aligned nicely with our programs to continue in relationship with the young person. Want the young person to have their own voice and lead their way. Excited to see the number of young people in Fostering Futures programs.

- Children's Home Society has a program called My Path Forward that supports youth as they transition to independence between the ages of 17 and 26
- UMFS - Kinship care process for each regional center. Chief performance indicators that speak to permanency each program has a goal. Importance of connecting with kin. Initially collecting specific information regarding background and kin and do more of a search on. This is during the intake process-- treatment foster care program automatically does the process of searching for relatives- goal is always permanency with relatives or adoption. It is becoming a part of our language and culture. Evaluating them on their permanency goal each year; what can we do to make this process better and achieve permanency for all children
- C2Adopt - Adoption through collaborative grant- working with LDSS for children that are at risk for aging out of care. Still use principal looking at relatives over and over again- things can change in three/six months or years. There is no reason not to keep searching. Children do return to their families once they age out-- Private providers are trying to help get permanency for all children.
- Would like to see private providers have greater collaboration with LDSS/VDSS and private providers to support connecting and family finding. What is available for kin?
- Wonder if kinship numbers are not really reflective of the accurate number of kinship families that stepped up.
- LDSS example of a 17 1/2 year old who had been well and with the Uncle in kinship placement for months- Uncle heard it would be better to come into foster care so the child can get Fostering Futures funding

#### **Group #4:**

- Support meaningful family engagement and kin-first culture
- Focus on front-end interventions
- QAA lens - exit interview process - engage local departments in Assessments & Investigations - root cause considerations and what today's data highlighted
- Congregate care reviews - strategic efforts around recruitment and approaches to step-down; connectedness to family and community; constant communication to address bottlenecks and barriers to disruptions and delays in permanency
- DSS shared - Best Practice committee has developed an exit survey for youth; 3 months prior to exiting; adjacent to the FPM process; leveraging readily available data to identify improvement opportunities; incentive - \$25 gift card when completing the survey
- Resource Family Consultants - shifting practice to approve more kin caregivers - which aligns with emphasizing the connection to existing and natural supports; supporting local departments to lift child and family voice; ensure that permanency discussions are happening - disclosure of available options to families
- Expand knowledge base and not being beholden to the way that things have always been done - case mining and creativity
- Using SPEAKOUT and Youth Welfare Approach workgroup - to bolster lived experience and peer support; requires a culture shift to ensure that children and caregivers are prepared in this regard

#### **Group #5:**

- LDSS-IL Coordinator now supervises two staff who specialize in working with the IL populations, 'micro-team' within Permanency Team; High-Risk staffing cases with FAPT/CSA-youth at risk of aging out, youth in congregate care. Expand team to get different perspectives; Exploring ways to work with family members who have barrier crimes, but have a connection with the youth. How can we support these relationships
- Older teens-removal-'abandonment of youth at psychiatric facility'. Three youth in past few months; working on dissecting this data now
- New QA team that will be diving deeper into the numbers
- Family Preservation Unit-court ordered prevention cases-has helped reduce truancy cases

- Seeing increase in delinquency cases-safety issues with staff-being at office, trying to find placements, difficult to find with number of charges
- CIP - Train judges and lawyers regarding participation of youth in court hearings. Engaging youth in effective ways in the court process. Unpacking the no, making sure their voice is heard and incorporated into the court process
- Kinship Project-engaging youth and families in identifying supports in relatives and fictive kin and incorporating them into the youth's plan
- Children's Bureau - Push to incorporate views of those with lived experience with the foster care system to have input into programs and policies
- Hiring those with lived experience to participate in conferences and policy development

**Group #6:**

- Looking at data to see those youth who are close to aging out monthly
- Extending Fostering Futures during COVID
- Encouraging agencies and workers to revisit kin, or relatives again
- Keeping up open communication with family/kin as child gets closer to aging out
- Use state contractors to help find families if youth want to be adopted
- Make workers experts with this age group to help them find resources and supports  
Re-engage youth to look for kin; Talk to youth about relatives, and fictive kin
- Work on transition plans early
- Target Recruitment
- Have all levels in the agency be involved, i.e., Directors, Consultants, etc.
- Kids that have been successfully with fostering futures come back and talk to the youth
- Looking at more than just parents/grandparents, but looking at 2<sup>nd</sup> cousins, great aunts/uncles, etc.

Second Breakout Session. CWAC members were asked: **What do you need to support a recovery model when working with families with SUD?**

**Group #1:**

- Focus on promoting recovery framework and support local practices
- Acknowledge generational SUD
- Assess relative capacity and keep connected
- Ask individual what recovery looks like to THEM in order to increase buy in
- Recognize family as experts on their needs
- CASA: orientation and training on SUD/recovery is being done but need on-going training and a better understanding of services/supports
- DBHDS: need peer support person at the table for policy development and support services. If LDSS doesn't have a peer support to turn to, they need to ask around to borrow someone else's peer resources
- Address fears of LDSSs re: using peer supports
- Increase wrap-around supports
- Share success stories
- Acknowledge drug screening is NOT an assessment, but take the time to understand the client comprehensively (Foster Care guidance addresses not using drug screens and visits punitively and instead address treatment and support needs)
- Increase communication and dialogue to include everyone across the state including private programs to set up for success

**Group #2:**

- Understanding of safety planning with families with SUD. How to keep kids safe and get folks to recovery?
- Parent support services that have a clinical component
- Service providers with clinical backgrounds

- Collaboration between service providers regarding SUD
- Availability of treatment services
- Strengthen relapse prevention and maintenance services
- Peer recovery positions at local departments. Or, utilize peer recovery specialists at CSBs
- Work with extended families, not just the parent/caregiver with the SUD, to provide support and build up the recovery capital they can offer to the parent/caregiver
- Permanency timeline doesn't align with recovery trajectory
- Not holding SUD history against parents/caregivers when working with them
- Educating courts and child welfare staff on recovery processes and trajectories
- Using post-reunification prevention services. Wrap around services
- Appropriate use of supportive trial home visits
- Recognize that relapse is a normal part of recovery

**Group #3:**

- Have a Family drug court- timelines are difficult when dealing with Substance Use- wait time for treatment -- Align our timeline with treatment timeline ability to continue to visit. Visitation is based on results of drug screens
- Tools and resources to use with our community partners as local agency's we are more understanding than community partners may not feel the same way. Trying to reunify community partners need to be aware of the challenges that parents are facing with substance use
- Piedmont joined one of the CASA meetings to help them understand the shift to kin first culture; PC would be happy to provide trainings. Keep the language of hope- we are part of a culture change- we have to remain hopeful- If we give up on our families then our community partners will too
- Need to help the shift with timeline-- what supports need to be put in place for the child to reunify with supports in place
- Older youth specifically say- time needs to be longer for parents to change- parents don't change that fast.
- Not every relative can be a placement option- but pull in the rest of the family and have family support them by driving them to appointments. Family engagement is at the forefront. Build a trampoline of support so family helps them bounce back up.
- We could not juggle all the things that we request parents to complete. Barriers such as transportation, work and stress. We set people up for failure from the beginning. How can we get other support in there to help the families?
- Engage our parents that have struggled and were successfully reunified to work with families that are struggling now. If we truly engage parents, then they will be willing to reach out to other parents that are struggling
- Smaller agencies need help to find creative solutions to access resources
- Commitment to the work and time to get it done, make sure our staff are trained and have supports in place. If staff are not equipped then we really can't help parents the way we should. Need to start from the top.

**Group #4:**

- Framing: mindfulness and intentionality around the language we use in engaging children and families; challenging our own biases - and doing some myth busting - prevailing myths and stereotypes
- Supporting staff in navigating the dynamic of being an ally - while also being attentive to safety & protection; humility - shifting to a learning orientation; our work with children and families in this lane is not a zero sum treatment and recovery truly go hand-in-hand and work with respect to our child welfare timelines
- Continuum and service array - collaboration within local departments (i.e., Benefit Programs); providing stability and permanency for older youth; broader social determinants (as Julie touched on) - economic stability and social risk factors (food and housing insecurity)
- Drug testing procedures and processes - intentionality and approach
- Leveraging a broader range of available funding sources and tangible resources; blended funding

**Group #5:**

- Hopetree - Assumption that substance use automatically means 'unsafe' it doesn't necessarily. Families can still be in treatment and still be parents to their children
- VHBG- Review European models. Know that it can be generational, hereditary. Can be powerful to have a child witness recovery.
- Get to root of substance use - are they self-medicating, how can we provide supports and reduce stressors
- Can't just provide treatment to the parent, need to provide treatment to the entire family unit.
- How can we engage family members, SU can strain familial relationships
- How can we align foster care timelines with SU treatment and recovery?
- Cultural Use-relatives-relative has hx or current use-how does it impact safety? Shouldn't automatically rule out relatives
- Capitalize on expertise, include SU disorder specialists into treatment plan
- Work with CSBs—ie: automatic referral for SE infants
- Need more family recovery treatment options-parents able to attend treatment with their children
- Need knowledge of family centered treatment providers.
- Shortage of service providers in general, especially post pandemic. Tremendous waitlists
- VDSS-has implemented multiple requirements to access Family First funding for services, can be burdensome. Other State Departments do not have as many requirements to access services. Continue to review policies and procedures related to FF.

#### Group #6:

- Need more resources so difficult to support this model – CSB is great, but swamped
- Need actual treatment/prevention programs – behavioral health and substance use
- Need affordable housing – lack of exacerbates family stress, increases use, prevents ability to get to treatment
- Need wraparound services AND think about all the systems at play (look at SES factors and how these impact different responses to families with substance use issues)
- The way we think can change – how to keep children safe and support parent/guardian, maintaining family integrity
- CW timeline needs to match recovery timeline – court / judge support needed to support recovery model
  - Some jurisdictions still preventing contact when parent has one positive drug screen
  - Quickly change goal to adoption when there is a relapse b/c this isn't a well-understand part of recovery
- Realize not all treatment is the same – be creative in thinking in what type of services the family really needs, not just cookie cutter referrals – hard with limited resources
  - Tailor referral to family – they may need 1:1 treatment vs. group; difference between working recovery and being in treatment
- Home visiting programs more on prevention side – we see families who if they could get support in early stages, it wouldn't get worse – a complete lack of this option unless families have really good health insurance coverage which most don't.
  - Some affiliates have peer support programs which IS helpful.
- Explore natural supports in addition to professional support – leverage strengths/supports/relationships family has
- Guidance changes can support recovery model – will help shift operation as a system
- Piedmont – courts need to support families through recovery – still have courts ordering no contact w/kids w/one positive screen even while participating in screen – hard for parents to focus and recover when can't see their children

Family First QRTP app link: [https://familyfirstvirginia.com/foster\\_care/qrtp\\_applicants.html](https://familyfirstvirginia.com/foster_care/qrtp_applicants.html)

Plus/Delta from the meeting:

Plus:

- Appreciated the breaks; Breakout sessions; Great information and discussion; Guest speakers