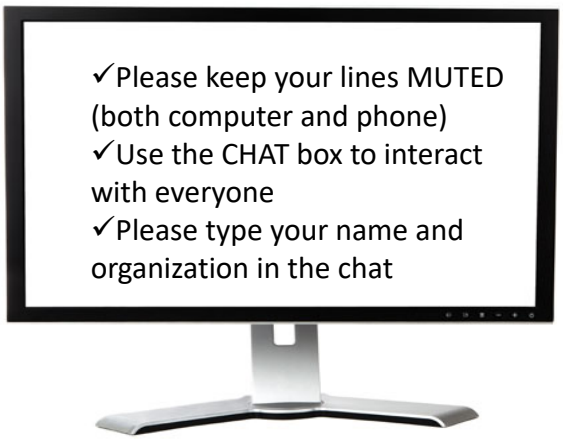

VIRGINIA DEPARTMENT OF
SOCIAL SERVICES
Child Welfare Advisory Committee
March 29, 2023

We are so glad you are here!



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AGENDA

- CWAC Charge
- CFSP History
- Problem Identification (large group discussion)
- Problem Exploration (breakout rooms)
- Safe and Sound Taskforce Update
- Family First Update
- Plus/Delta

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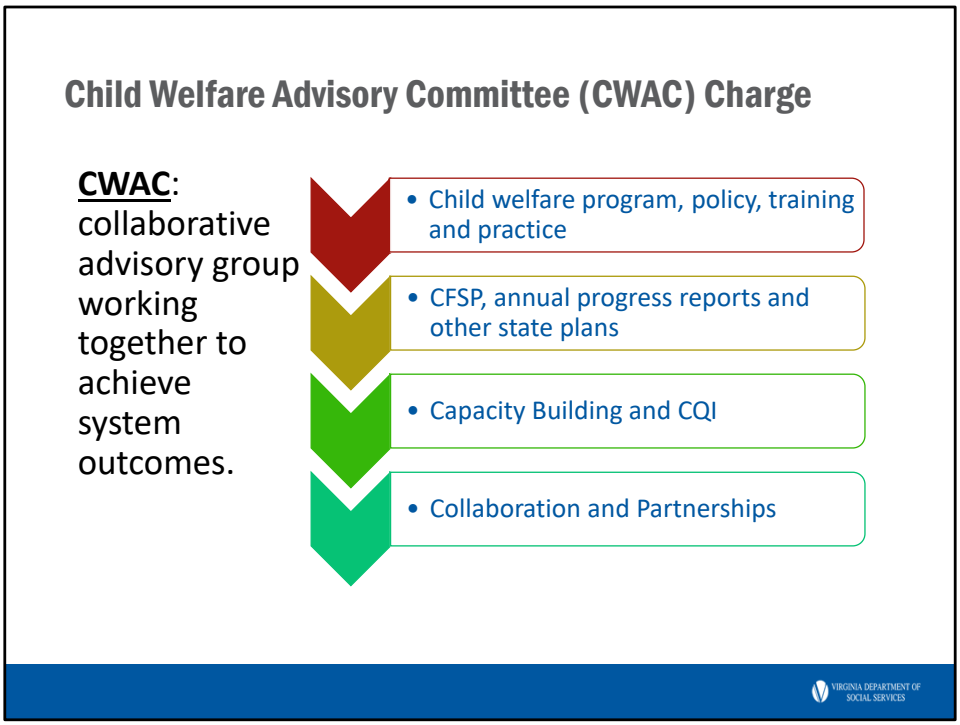
If you haven't done so already, please let us know you're here by writing your name and organization in the chat. Now that we have been holding these meetings virtual, we hope we are able to give more folks the ability to join our CWAC meeting from across the state. This is new sign-in sheet. But also, it gives everyone the opportunity to see the other partners involved in this work. If you are only participating via phone, please send me an email so I know you were here today and we can capture your attendance. And if this is your **first** CWAC meeting, please let us know in the chat.



You may recall this slide from our last meeting. CWAC is a collaborative advisory group whose charge is partner and advise how we get to our outcomes as a ***system***. We are working on developing our partnerships in meeting the outcomes.
The items we're working towards as a child welfare system include

- Child welfare program, policy, training and practice issues
- The development of the five-year Child and Family Services Plan and annual progress reports, as well as other state plans under the responsibility of Family Services including guiding the development and implementation of Virginia's Program Improvement Plan for any element that Virginia does not meet requirements of the Child and Family Services Review (CFSR)
- Ensuring that we build capacity and CQI efforts in achieving and improving all of our outcomes

Let's move to the next slide for a couple updates.

Division Updates

Welcome Traci Jones!
Assistant Director of Protection & Prevention

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We would like to welcome Traci to our CWAC team as the new Assistant Director of Protection & Prevention. Many may recognize Traci in her prior role as DFS' Adoption Program Manager. Traci became the Assistant Director of Protection/Prevention in November so this will be her first CWAC with us in her new role. Welcome Traci!!!!

Any additional updates:
February was the 5 year anniversary of FFPSA so we have been looking at where we started and where we are now as far as kin-first culture and a focus on prevention and looking at community pathways.
CCWIS replacement project moving forward with next steps

Child & Family Services Plan (CFSP)

The CFSP is a **five-year strategic plan** that sets forth the vision and the goals to be accomplished to **strengthen** the states' overall child welfare system.

The Annual Progress & Services Report (APSR) is the annual update on the progress the state has made on the goals & objectives in the CFSP.

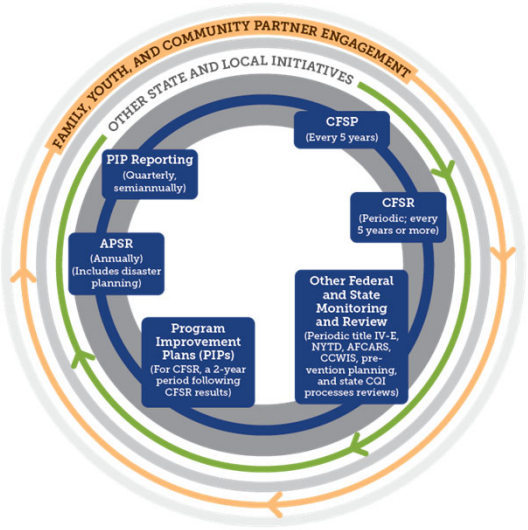

Image from Strategic Planning in Child Welfare (Child Welfare Capacity Building Collaborative)
https://capacity.childwelfare.gov/states/topics/cqi/strategic-planning

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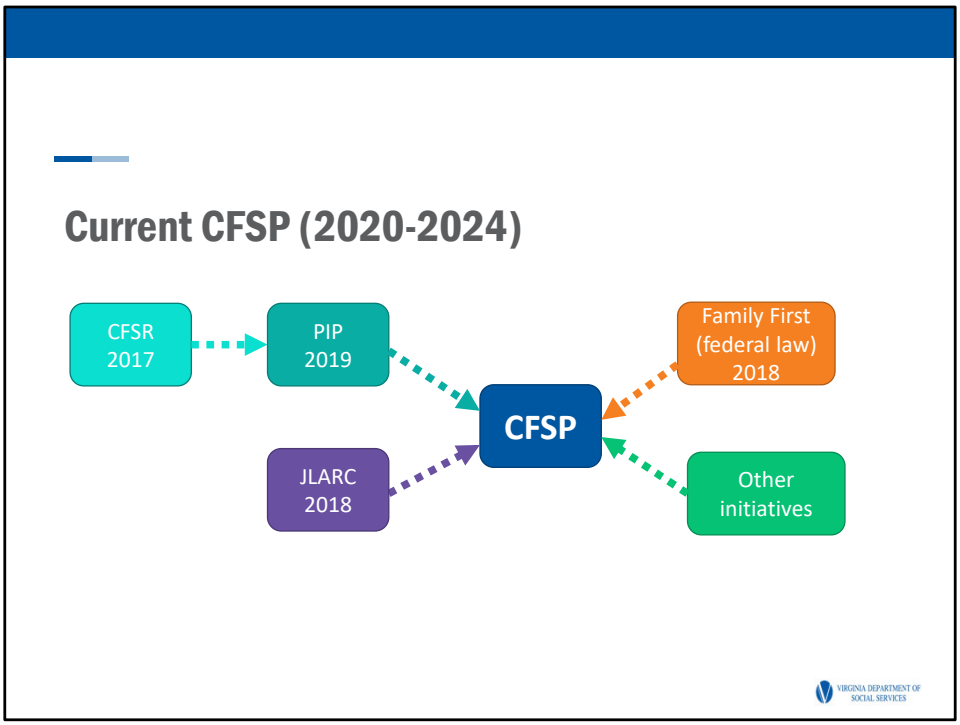
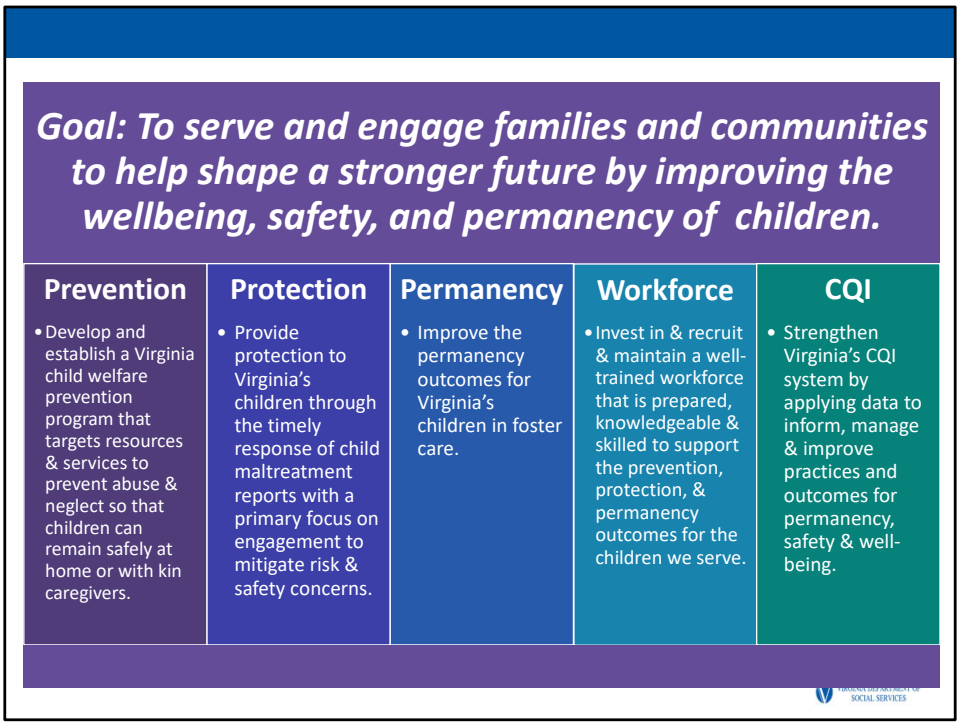
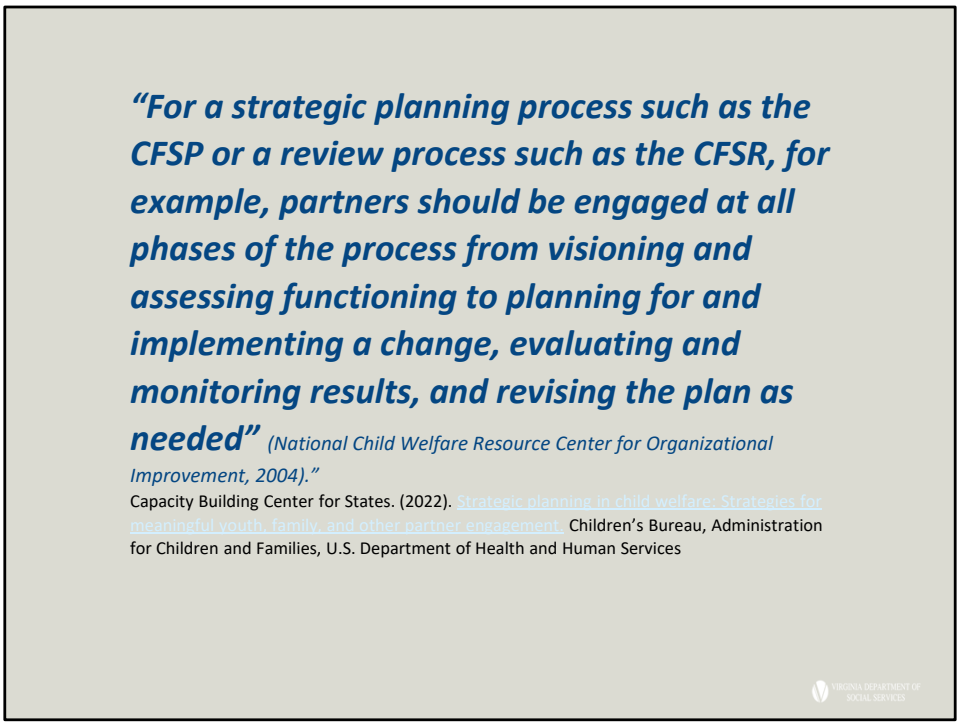
Our CWAC meetings this year will have a primary focus on developing our Child & Family Services Plan. Our Child & Family Services Plan or CFSP is a five year strategic plan that identifies our state's child welfare vision & goals.. The Annual Progress & Services Report (APSR) is the annual update we provide on the progress we made on our CFSP. The graphic on the slide shows the child welfare cycles of planning, monitoring, and reporting. VDSS works to align goals and implementation activities throughout these cycles. We will discuss this a little more in the next slide



Our Current CFSP was completed in 2019 and covers the 2020-2024 5 year cycle. As you can see, the CFSP focused on the alignment of several key areas into the plan. In 2017, Virginia underwent Round 3 of the Child & Family Services Review (CFSR) which are periodic federal reviews of state child welfare systems. As a result of the CFSR review, Virginia developed a Program Improvement Plan to address areas needing improvement in that review (PIP was approved beginning 2019). In addition, JLARC had released their report, Improving Virginia's Foster Care System, and Virginia was also focused on the implementation of the Family First Prevention Services Act. The CFSP ensured that the goals, strategies, and activities aligned with these items.

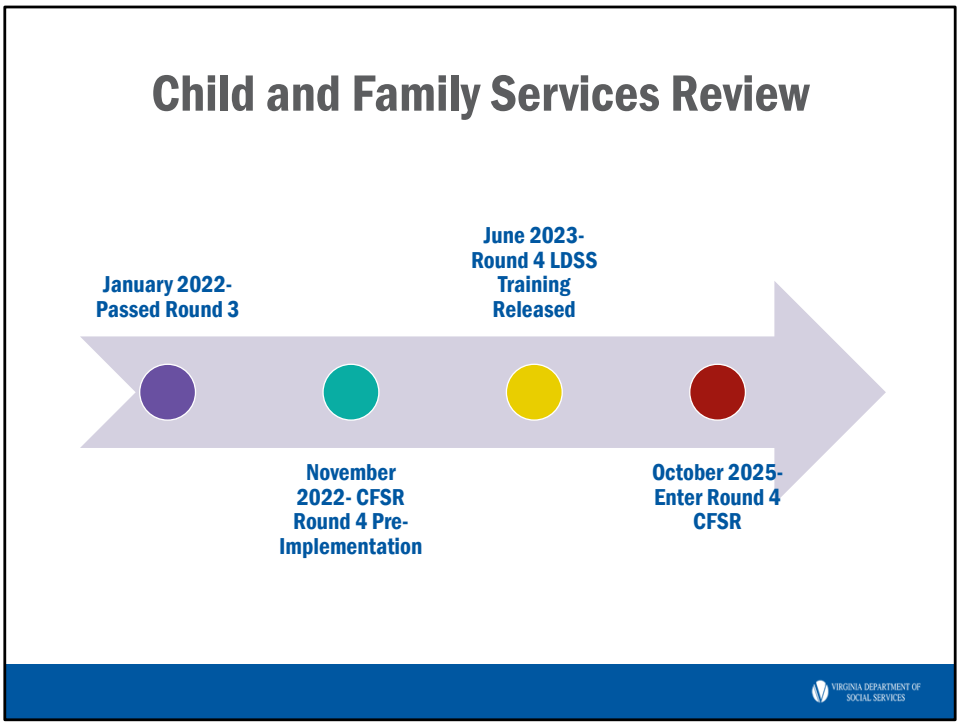


High-level overview of the goals of the current CFSP.



The next CFSP will be due in 2024. In order to ensure that our partners are involved in each phase the strategic planning process, we are purposely beginning this process now so that we can use the remaining CWAC meetings in this year to cover the next steps in the strategic planning process. On the slide is a quote from the National Child Welfare Resource for Organizational improvement "***For a strategic planning process such as the CFSP or a review process such as the CFSR, for example, partners should be engaged at all phases of the process from visioning and assessing functioning to planning for and implementing a change, evaluating and monitoring results, and revising the plan as needed "***

As part of our process to develop the next five year plan, we are moving through specific stages of the strategic planning process. As you can see on the slide, our focus in January through May will be on problem exploration to really identify our priority problems so that we can move into solutioning in June – September and make sure our plan strategies are aligned with all of our other requirements/priorities. October through February will be focused on ensuring our plan is complete and ready for leadership review beginning in March of 2024.

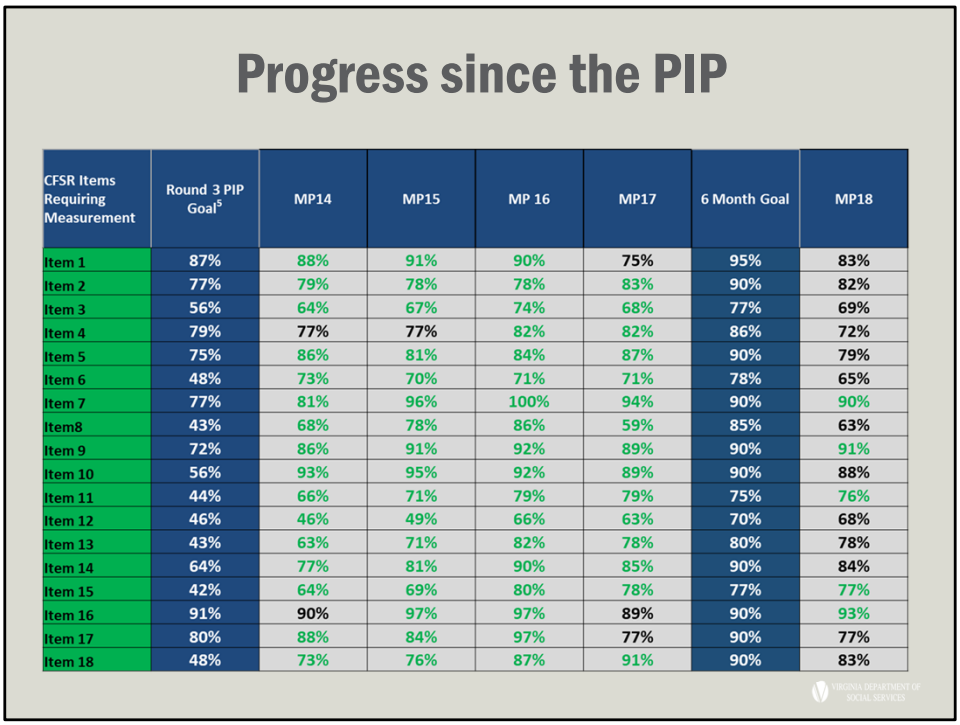


For those who may be less familiar with the CFSR, it is a federal review process that allows the Children's Bureau to ensure state's conformity with federal child welfare requirements, determine what is happening to children and families receiving child welfare services, and assist states in enhancing their capacity to help children and families achieve positive outcomes related to safety, permanency, and well-being. Although federal CFSRs are only held periodically, Virginia continues to conduct CFSRs on a regular basis as part of our CQI process.

This is a brief timeline that shows the recent progression of Virginia's CFSR. Our last federal review took place in 2017, and in January 2022, we passed our Round 3 CFSR PIP. Since that time, our team has continued to conduct regular CFSR reviews each quarter. We've also began CFSR Round 4 pre-implementation, to include a gradual increase in our benchmarks for each CFSR item so that we can incrementally move Virginia forward toward meeting the Round 4 federal standards. Our team is working collaboratively with our strategic consultants and other regional partners to support local agencies to progress in both practice and process.

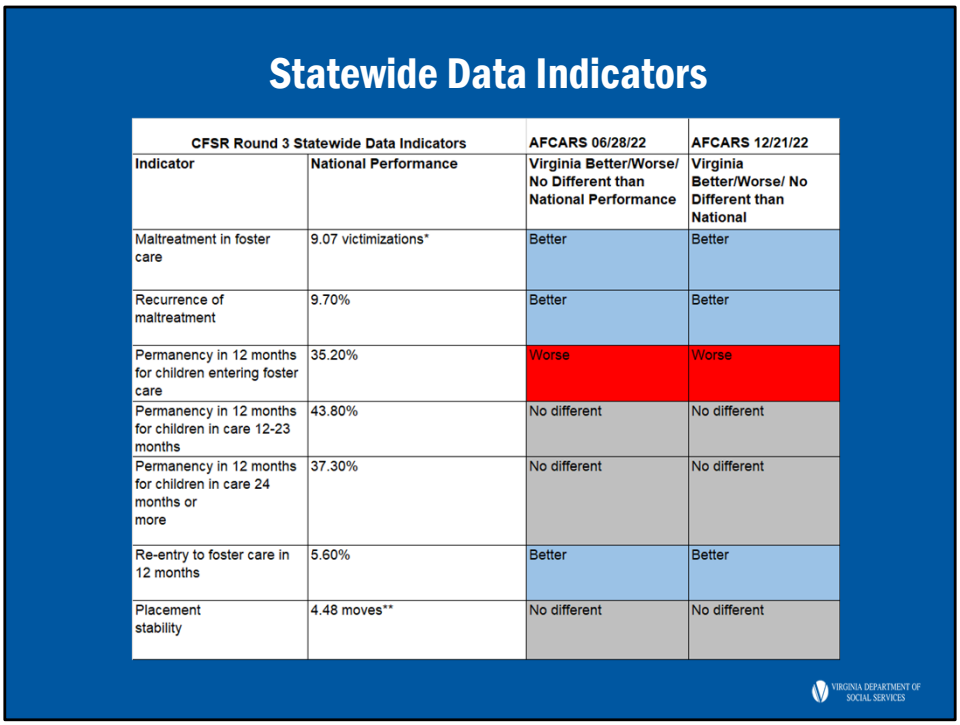
We anticipate the release of our round 4 LDSS training in June 2023, which will be a live virtual training offered on a quarterly basis to all LDSS staff. This training will focus on answering the questions of what is the CFSR? Why do we do it? And how to achieve a

strength rating in each item? The training will be offered through the start of the Round 4 CFSR, which is scheduled to begin in October 2025.

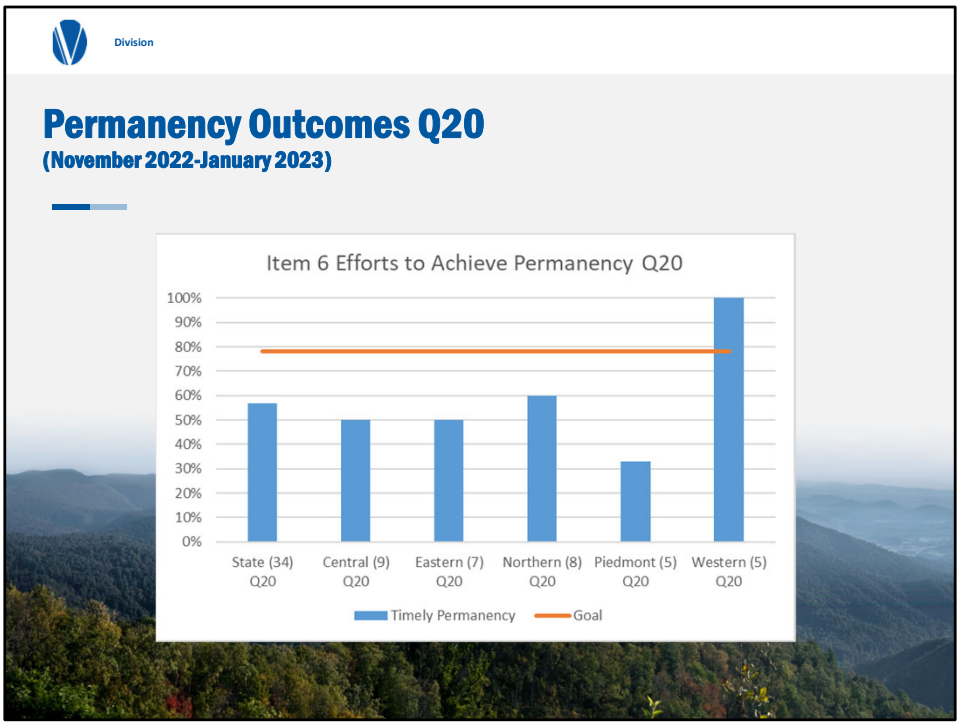


This chart demonstrated Virginia's progress in each CFSR item since we passed the PIP in MP 14, which was January 2022, and through the most recent MP 18, which ended in January 2023. Each MP represents a 6-month period of time that overlaps with our quarters. For the past year, we have been utilizing a different sampling method than was used during the PIP. We have focused on reviewing cases from agencies that had not experienced CFSR in the past, and that had historically had high IV-E error rates. Using this sampling method, we were able to ensure that every agency in the state had experience with the CFSR process, and in our current CFSR year we will continue to ensure that every agency has a review and receives preparation and support going into Round 4 CFSR.

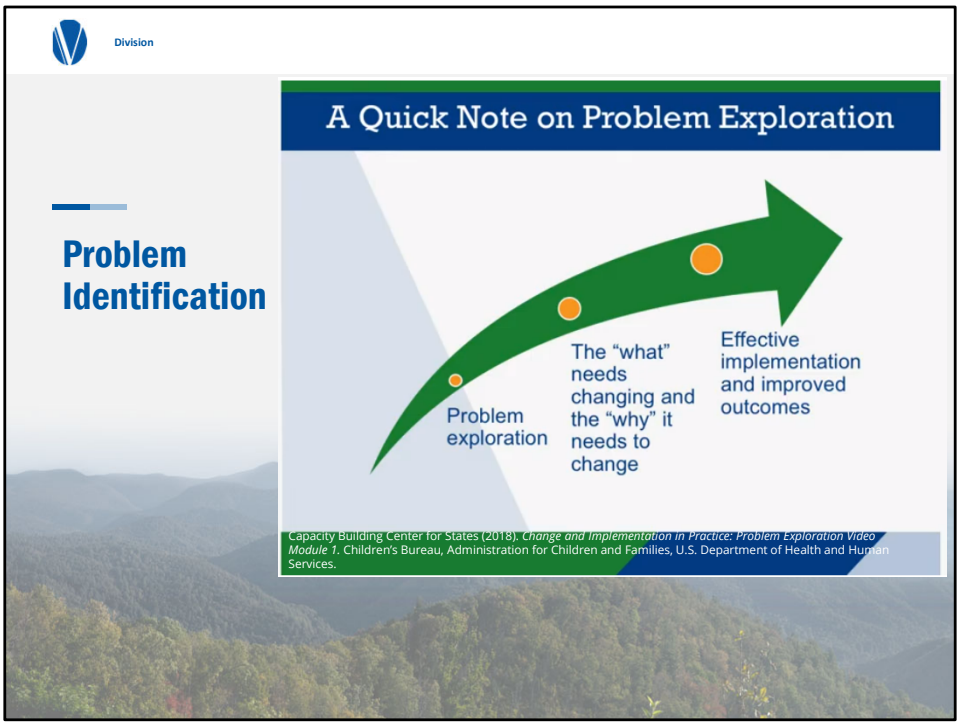
Although we had passed the PIP, MPs 14 through 17 continued to be measured against the Round 3 PIP Goals. In November of 2022, we established new 6-month goals in order to move Virginia forward toward the Round 4 Goal of 95% for Item 1 and 90% for Items 2-18. Items in GREEN reflect that we met or surpassed the identified goal for that item. While it may appear that we took a dip in our performance in MP 18, we have actually remained relatively stable in our numbers across MPs. The difference this MP being that we are measuring our agencies, many of which have never experienced the CFSR process before, against the higher Round 4 standards. Also keep in mind that our Period Under Review covers a 12-to-15-month period leading up to the review dates, and therefore some outcomes do not reflect agencies' more recent efforts to improve practice.



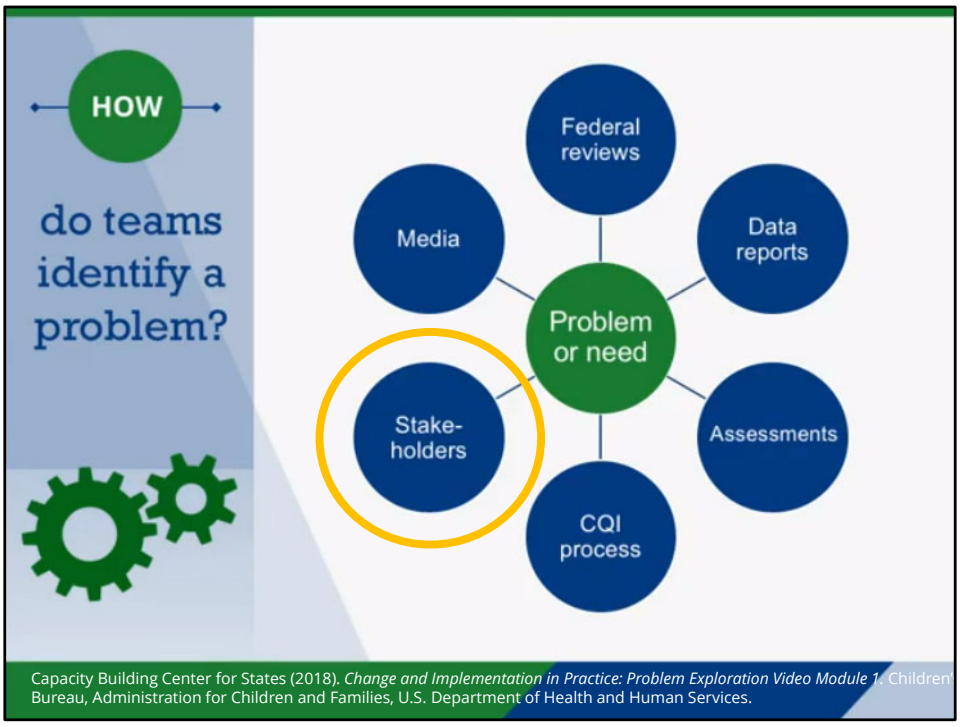
These are our most recent statewide data indicators, which measure how Virginia scores against the national average for maltreatment in FC, recurrence of maltreatment, achievement of permanency, re-entry into FC, and placement stability. As you can see, Virginia scores worse than the national average in the area of achieving permanency in 12 months for children entering FC. Virginia scores no different than the national average in other permanency data indicators, and in placement stability. The results of CFSR reviews support these findings.



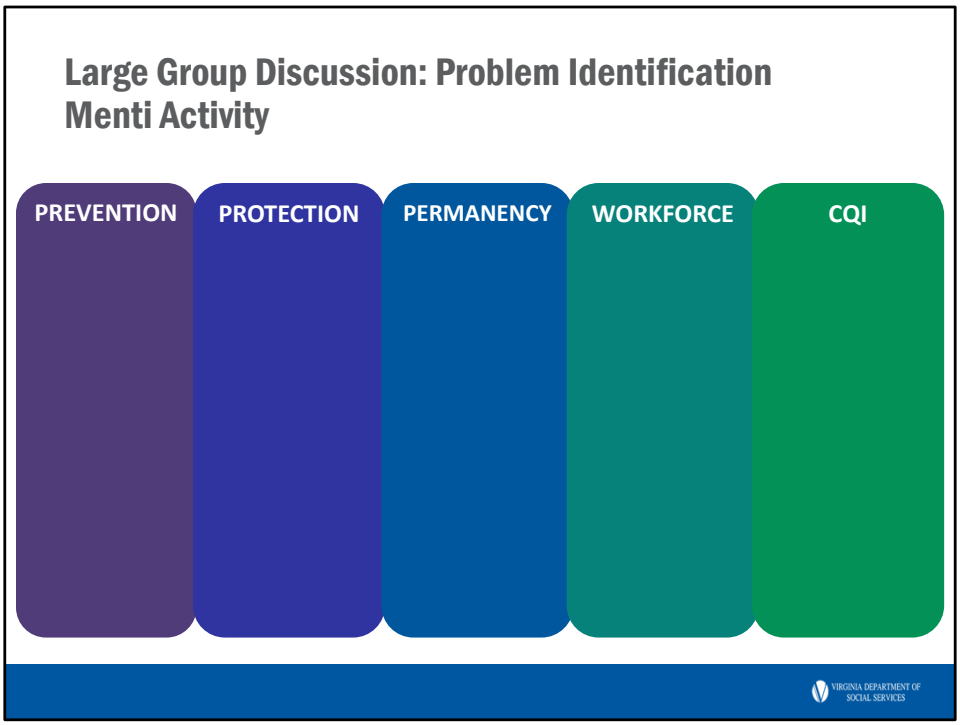
This chart shows our outcomes for CFSR Item 6, which measures agencies' efforts to achieve permanency, in the most recent quarter 20. The orange line represents the current 6-month goal for Item 6, at 78%. One region surpassed the 6-month goal, as well as the federal goal of 90%. However, as a state overall we continue to see achievement of timely permanency as an issue. Factors that we see impacting the timely achievement of permanency include insufficient visitation between children and parents, insufficient case planning efforts, infrequent or poor quality caseworker visits, and lack of concerted efforts to assess client needs and to provide appropriate services.



Now that we've had a chance to review some our performance and our outcomes, we are now going to move into our Problem Identification topic. On the slide is a graphic from the Capacity Building Center for States. It really provides an overview of why we are beginning with problem exploration. By really taking the time to fully understand our problems we can develop effective strategies for improved outcomes.

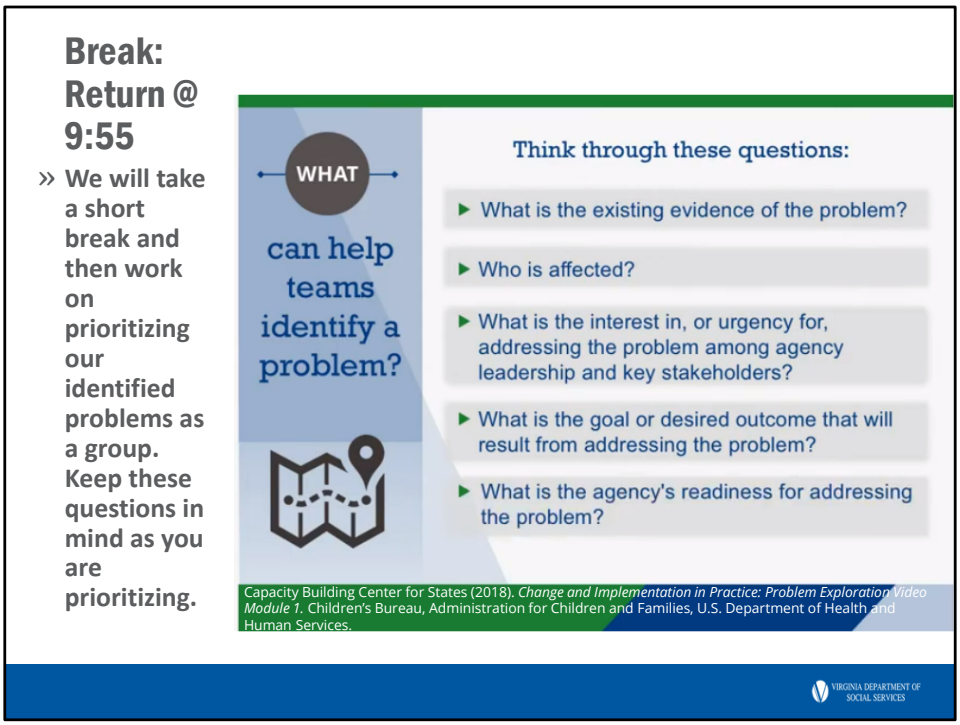


This slide is another graphic that shows what we are hoping to achieve in this meeting. CWAC is a diverse collection of our many stakeholders and by engaging in problem exploration with this group, we are provided with valuable perspectives and insight into assessing what needs to change.

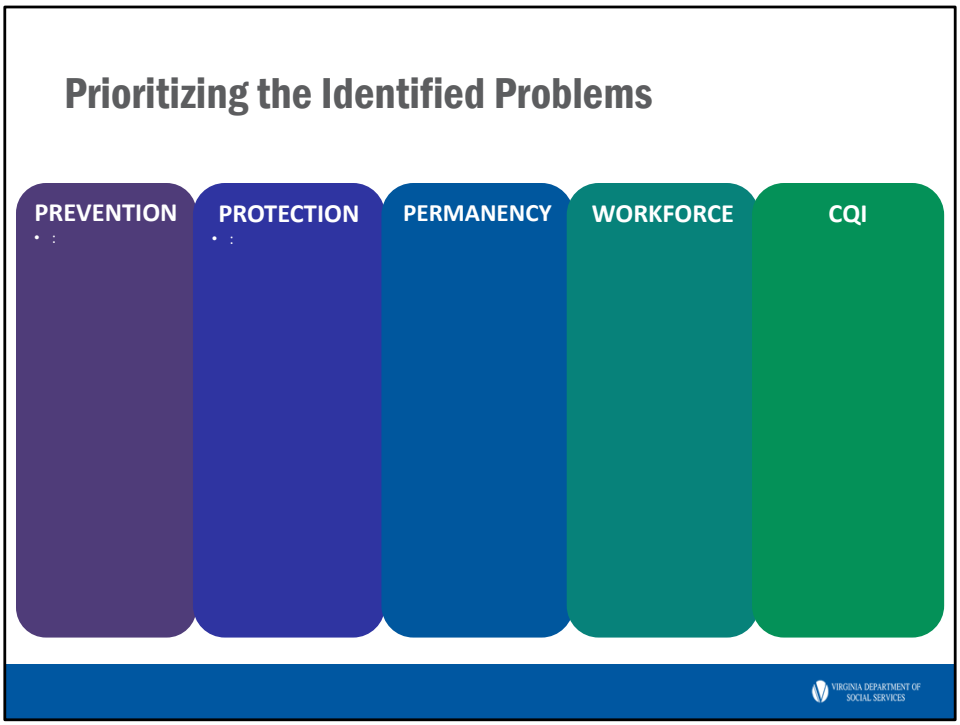


The large group discussion today will be on problem identification. While we have many opportunities to identify existing problems in child welfare, this activity is designed to really let us hear from you as a our stakeholders. We really want to prioritize hearing from those individuals from local departments, community stakeholders, other stage agencies, lived expertise partners, etc. For any VDSS folks, there will be additional opportunities to provide feedback on problem identification in later meeting this spring.

For this activity, we will be using a menti product to allow you to submit your identified problems directly to us and have it pop up on the screen. We will be moving category by category to help us organize the feedback we will get. I am going to be displaying the Menti poll as well as putting the link in the chat. Please try to use that link since it will be the most helpful but if you cannot get Menti to work for you, please feel free to raise your hand in Zoom and we can unmute you to share your feedback verbally.



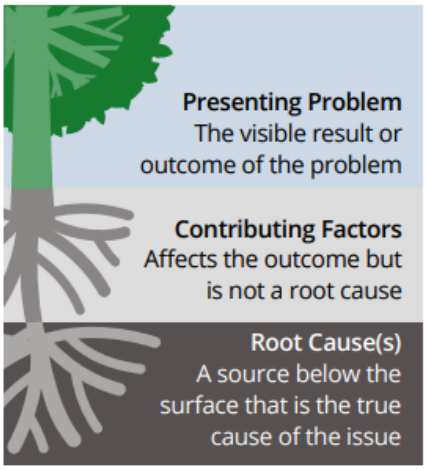
We will take a short break and then work on prioritizing our identified problems as a group. Keep these questions in mind as you are prioritizing.



Our next steps are to identify what this group sees as the problems needing the highest priority in terms of efforts, resources, strategies, etc to help address. We have a lot of different representation on this committee and it's fine if we don't agree on what a priority problem is but we'd love to hear from individuals in the group about what they see as a priority. We will again by walking through these category by category. If you thought of something else that's a priority that occurred in your mind while on break, feel free to put in the chat and we will capture that in our notes.

Contributing Factors & Root Causes

- Critical to addressing the problems at the source
- Stakeholders provide valuable prospective on contributing factors & root causes



Capacity Building Center for States. (2018). Change and implementation in practice: Problem exploration. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services

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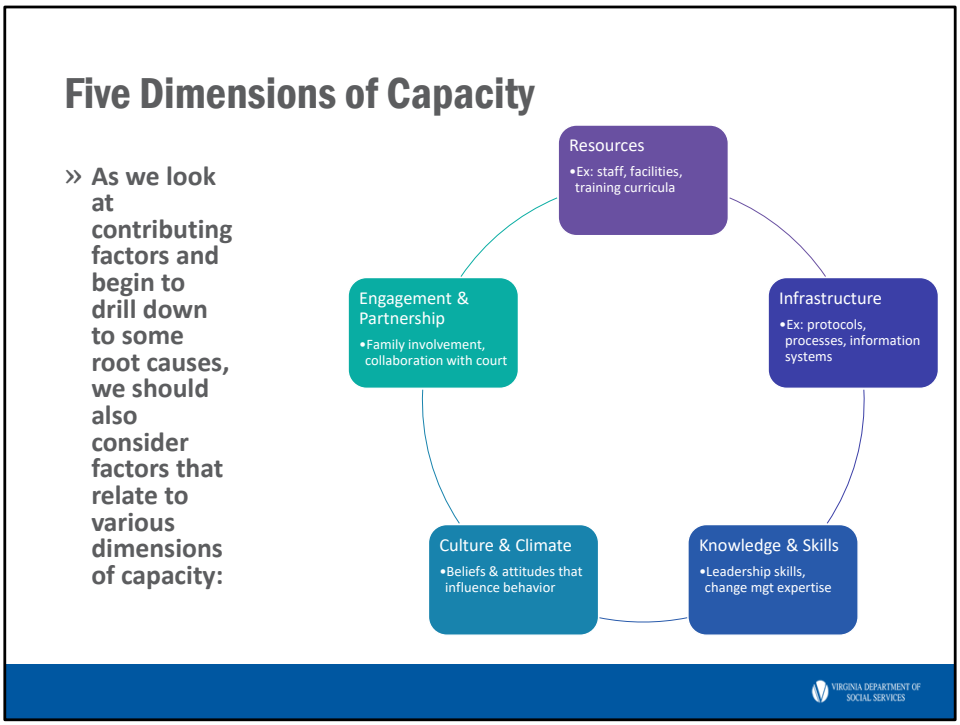
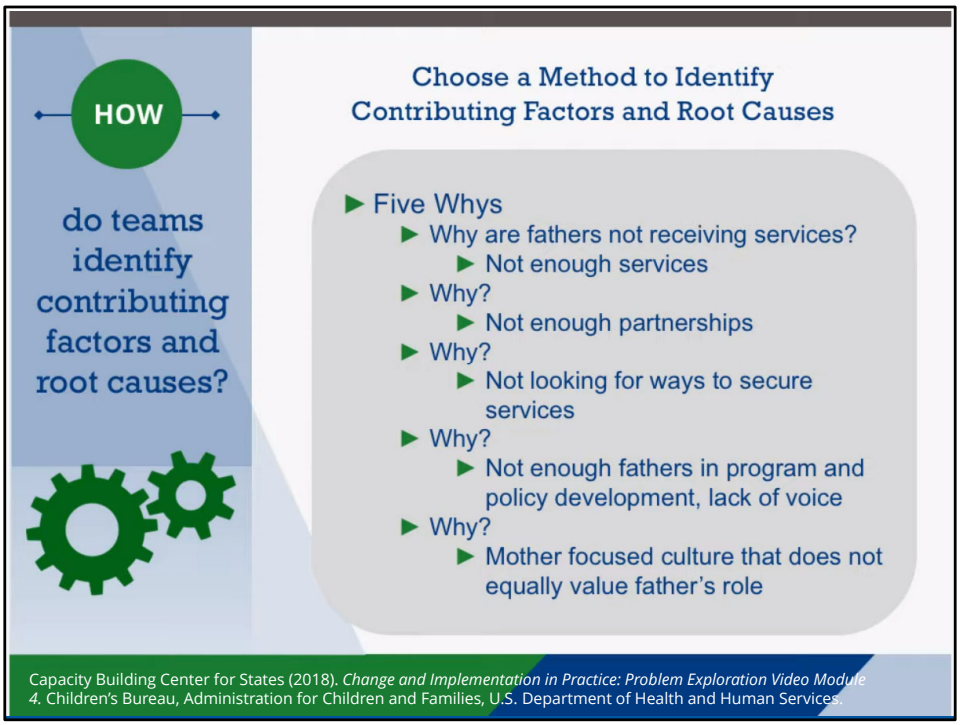
Now that we've spent some time on straight problem identification, we'd like to take a closer look at our problems, moving us into discussion of contributing factors and root causes. Like the graphic on the slide shows contributing factors affect the outcome of the problem but are not a root cause of the problem. A root cause of the problem is the true cause of the problem. Identifying these factors and root causes are critical to addressing problems at their source so that the solutions that are developed address the problem directly rather than mask symptoms of the problem. Stakeholders groups such as this one, provide a valuable perspective on contributing factors and root causes.



As we continue to look at these factors and start to drill down into some root causes, it's also helpful to consider the five dimensions of capacity in relation to those factors.



There are multiple ways to identify contributing factors and root causes but the method we will be focusing on today will be the 5 whys. This method has teams repeatedly asking why to drill down into a problem & contributing factors. This typically happens moving through 5 whys but you may need to ask more whys.

Breakout rooms

In your breakout room:

- **Each group will explore 3 problem areas:**
  - Workforce (includes information systems, training, recruitment/retention)
  - Family Engagement/Contact (across the continuum)
  - Placement/Living Arrangement Stability (across the continuum – kinship, parent, foster parent)
- **Each problem area will be allotted 20 mins with a 5 min break in between**
- **Explore the Five Whys on identified problems in your area**
- **After completing the Five Whys, ask:**
  - **What additional info is needed about this problem or contributing factors?**
  - **Who needs to be at the table?**

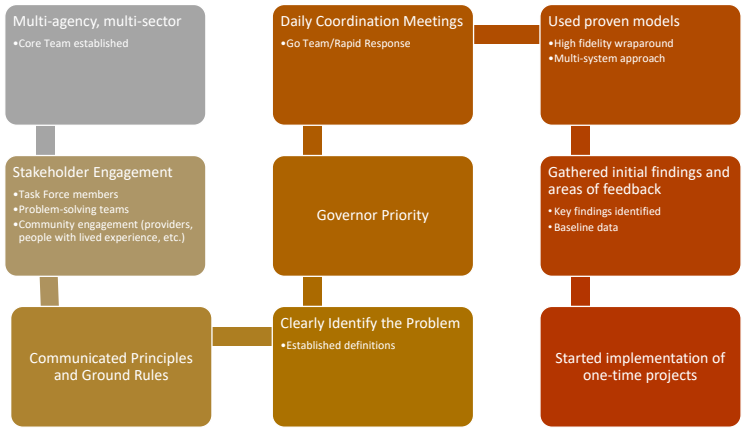
CWAC Update
March 29, 2023

Background

Launched April 1, 2022 by Governor Youngkin. Goals:

1) end the phenomenon of youth sleeping in local department of social services offices, hotels, or other unsuitable locations by identifying and securing safe placements for youth who are displaced;
2) develop a “reservoir” of safe and appropriate placements for youth who may need them in the future; and
3) enact policy and system changes in Virginia

Approach


Multi-agency, multi-sector
•Core Team established
Daily Coordination Meetings
•Go Team/Rapid Response
Used proven models
•High fidelity wraparound
•Multi-system approach
Stakeholder Engagement
•Task Force members
•Problem-solving teams
•Community engagement (providers, people with lived experience, etc.)
Governor Priority
Gathered initial findings and areas of feedback
• Key findings identified
• Baseline data
Communicated Principles and Ground Rules
Clearly Identify the Problem
•Established definitions
Started implementation of one-time projects

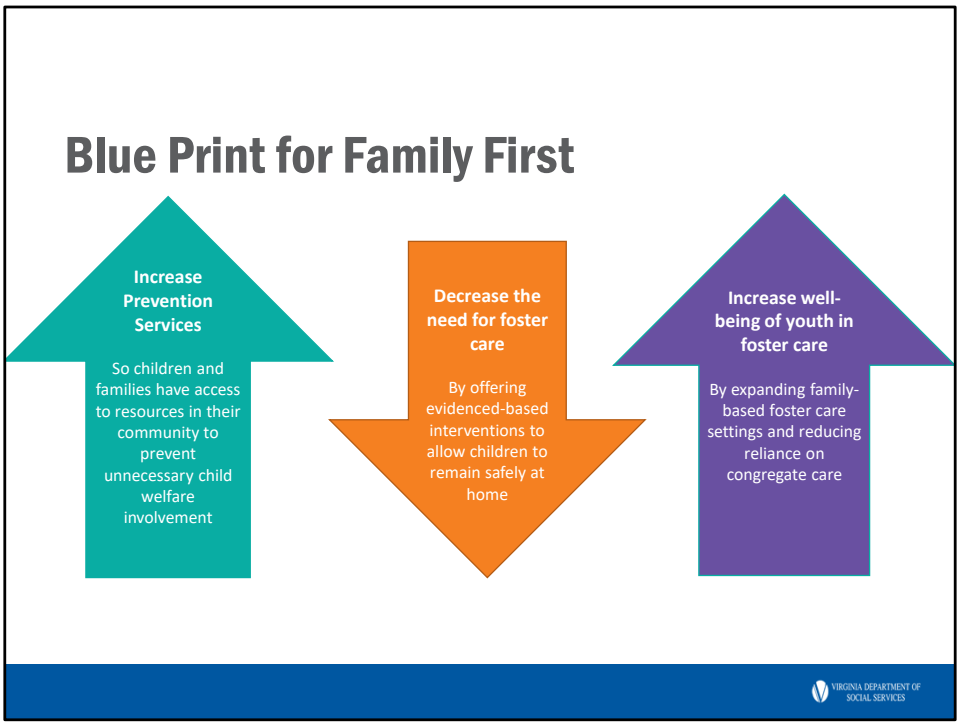
Recent Activities

- *Right Help, Right Now* Behavioral Health transformation plan launched - January
- High acuity placement coordinators hired (VDSS) – January
- Multi-agency coordination / Go Teams - Continue
- Listening Session with TFCs – January
- All Provider Check Ins – March
  - Local/regional convenings
  - Universal referral
- Launch of S&S one-time projects
- Next steps
  - Annual Update

Safe & Sound One-Time Initiatives

July 1, 2022 - June 30, 2023	**Exceptional Circumstances Pilot** for foster care families to provide care and supervision to children in foster care who have high needs and require an exceptional level of supervision for the child to be successful in a family setting
	Expansion of kinship care best practice by child welfare staff through Family Seeing Workshops conducted by Kevin Campbell (consultation, coaching, leader days, workshops)
	Child Abuse and Neglect Project ECHO (telehealth) for non-clinicians in behavioral health, schools/day cares, juvenile justice, and child welfare focusing on pediatric mental health, trauma-informed care, human trafficking, and child development
	Additional operational and systems capacity to address emergent placement disruptions or at-risk placements through two contract High Acuity Youth Placement Coordinators
	Psychiatric Residential Treatment Facilities Learning Collaborative to strengthen **evidence-based approaches in PRTFs** to prevent disruptions and enhance peer supervision
	Local resources to **increase access to community-based treatments**, expand support for kinship, foster, and adoptive families, and enhance trauma-informed care for children in foster care
	Family and community online training to **equip volunteers and communities** to support kinship, foster, and adoptive families

Thank you!


Blue Print for Family First
Increase Prevention Services
So children and families have access to resources in their community to prevent unnecessary child welfare involvement
Decrease the need for foster care
By offering evidenced-based interventions to allow children to remain safely at home
Increase well-being of youth in foster care
By expanding family-based foster care settings and reducing reliance on congregate care
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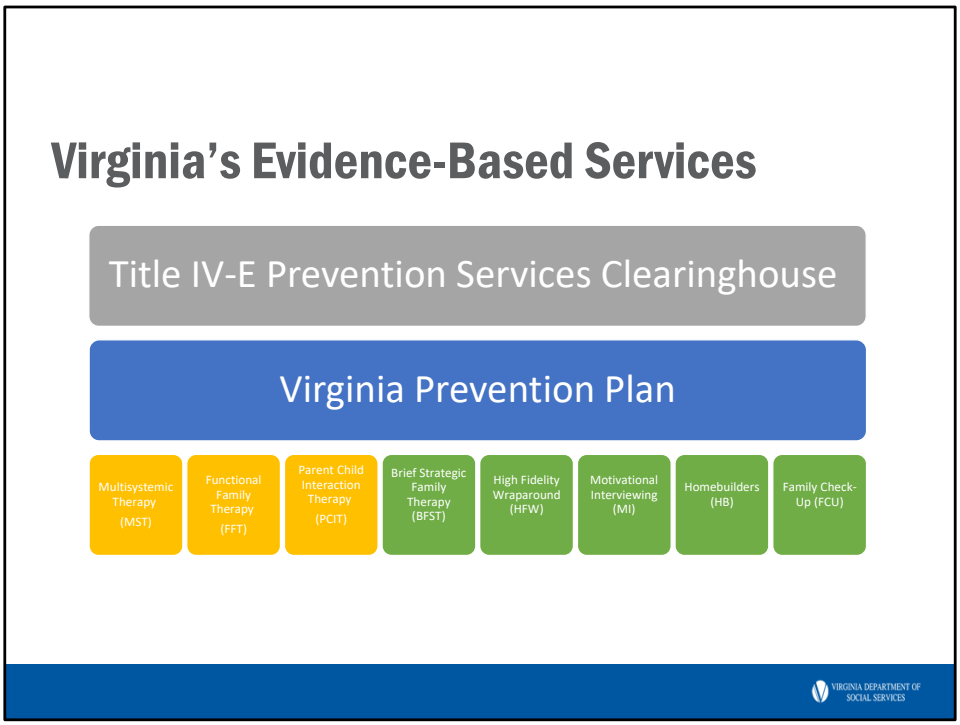
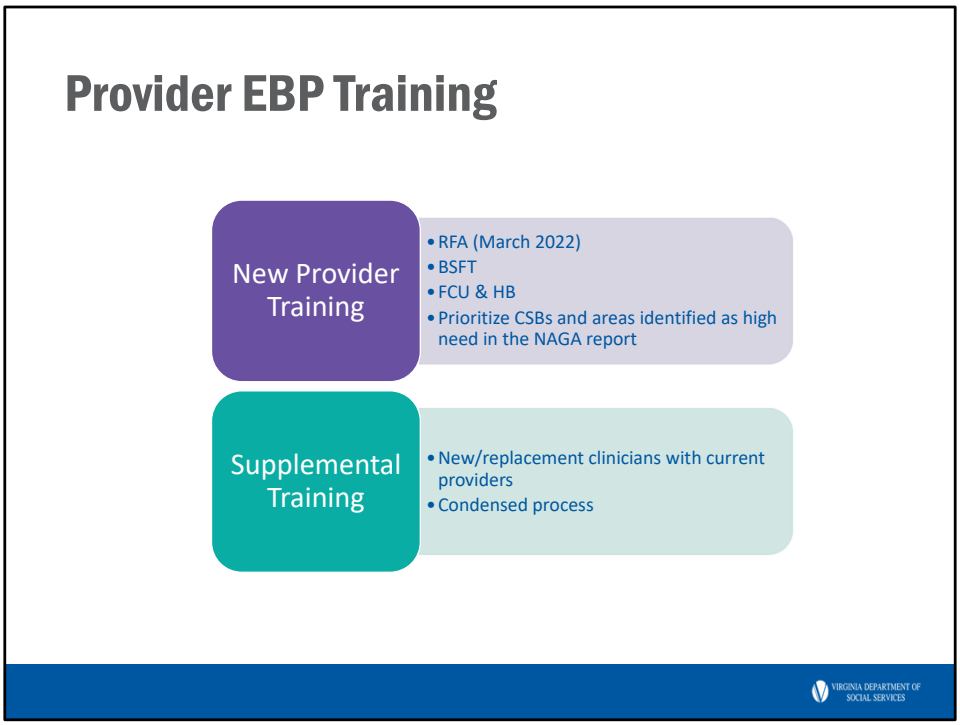


We wanted to review our current services and then the new services that we have added to Virginia's Prevention Plan. EBS have to be reviewed by the federally approved Title IV-E Prevention Clearinghouse. With the implementation of Family First, Virginia implemented three evidence based, trauma informed service models throughout the state. These models received a rating of Well-Supported from the Clearinghouse and include: Multisystemic Therapy (MST), Functional Family Therapy (FFT) and Parent Child Interaction Therapy (PCIT).

Over the past year VDSS has partnered with the Center for Evidence-Based Partnerships (CEP-VA) to determine how best to increase our access and availability of evidence-based services. CEP-Va completed a Needs Assessment and Gaps Analysis (post in chat) that identified areas of need in expanding services. The report provided several recommendations and highlighted opportunities for growth and areas in need of services. As we continue to expand our services eligibile for IV-E prevention funds, VDSS has added the following services to our prevention plan: Brief Strategic Family Therapy, Family Check-Up, Homebuilders, High Fidelity Wraparound, and Motivational Interviewing. We have submitted our request to add these EBPs and are waiting to hear back from our federal partners for final approval. In the meantime, we have offered a Request for Application (RFA) to identify providers to receive EBP training and certification. CEP-Va will continue to receive RFA's on a rolling basis as they work towards training providers.

We are prioritizing BSFT and High Fidelity Wraparound for community providers and creating a plan to train our In-Home staff in Motivational Interviewing. In looking at spending for EBS, over the past year 28 LDSS spent a total of $252,557 on the three EBS. We have highlighted which localities utilized the IV-E prevention funds. We do want to state that as of December. 2021 all three of the EBS that are eligible for IV-E prevention funds are covered by Medicaid and Medicaid is the payer of first resort. Our goal over the next year is to fill in some of the service needs gaps and provide services that are eligible for multiple funding sources. We want to make sure EBS are available to families regardless of the funding source.
We will now provide a brief overview of the services available for IV-E prevention funds

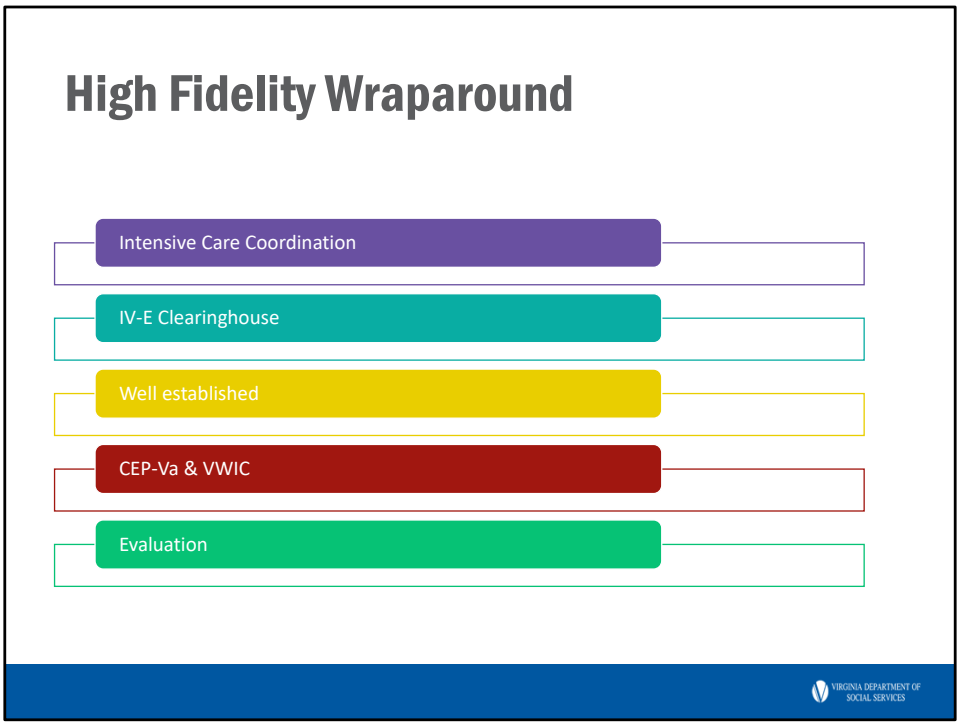
Another layer we have to work with in regards to what EBS we have in our prevention plan is based on whether they are deemed "well Supported", " Supported or Promising. At this time we only have the capacity and instructure to mainly only use well supported programs due to the fidelity monitoring and evaluation requirements. We currently do not have the system in place to evaluate different models. With that being said though we have included one "supported" service in our recent updated prevention plan that is currently with our federal partners for approval and that is High Fidelity Wraparound. This is an already established program in Va and has a strong evaluation method that we can adapt to our needs. In addition to High Fidelity We have added the following services to Virginia's Prevention Plan: Brief Strategic Family Therapy BSFT, Motivational Interviewing, Family Check up and Homebuilders. We are waiting to hear back from our federal partners for approval. In the meantime, with our partnership with the Center for Evidence-Based Partnership (CEPVa) for our training efforts in new EBS. A Request for Application was released this spring and we received lots of applications for
the new services. VDSS is prioritizing BSFT, High Fidelity Wrap Around and Motivational Interviewing. We are also providing some funding for training of MST, FFT and PCIT staff to assist some agencies who have experienced turnover during the past year. We currently have four agencies that have applied for training in PCIT with one that is a pre-existing site.



- New Provider Training
    - In the last CWAC meeting we informed the group that a request for applications was released by CEPVa earlier this spring for providers to be trained. Applications are accepted on a rolling basis with ongoing review.
    - Based on service need and provider interest, we prioritized BSFT training to start. We have one provider that began their training in September and just began with their first clients.
    - Family Check-up and Homebuilders will be offered next.
    - As many of you may recall, CEPVa provided VDSS with their first Needs Assessment and Gaps Analysis (or NAGA) report in October 2021. This report identified areas with the highest concentration of foster care entries. CEPVa found that 46% of all foster care entries are within the service areas of 13 CSBs. With that, we have prioritized CSBs in general but specifically targeted those 13 CSBs, as well as prioritizing private providers who serve those areas.
- Supplemental Training
    - When we released the RFA a number of current MST, FFT, and PCIT providers reached out to see if they could apply for training for an individual clinician to replace a clinician they have lost since implementation last year. Recognizing the mental health care workforce shortage being seen around the nation, we

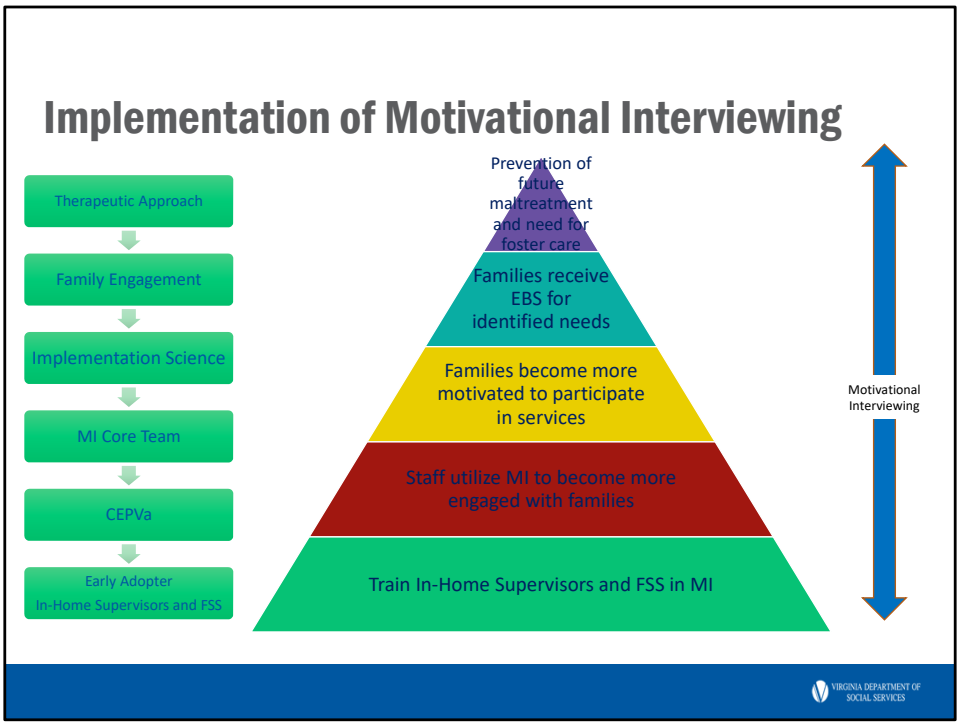
immediately agreed that we could do this and have worked with the purveys of MST, FFT, and PCIT to get trainings for these providers on an individual basis.

- Because BSFT, FCU, and HB are all new EBPs and require building a team, the RFA requires quite a bit of detail and documentation. We determined that we did not need that much information for current providers looking for supplemental training and have created a condensed application process that allows us to expedite those applications.



- HFW is a form of intensive care coordination, utilizing an individualized, team-based, collaborative process to provide a coordinated set of services and supports to youth and their families.
- It was added to the Title IV-E Prevention Services Clearinghouse this Spring with a rating of "promising" which means there is some evidence of success but not enough to be considered "supported" or "well supported". The rest of our EBPs are listed as "well-supported", having the highest ranking for an evidence base. This lower rating does not necessarily mean that its outcomes are weaker, it could simply be that the evidence base has not been built up with our population of children and families to show the strength of the program.
- We decided to add it to our Prevention Plan because it is already well established in Virginia. Since we already have a number of providers who are already trained and certified in HFW, we are not currently offering training for this EBP, though we may in the future.
- CEPVa is partnering with the Virginia Wraparound Implementation Center (a subsidiary of the National Wraparound Implementation Center) as we add HFW to our Prevention Plan
- States who chose to include a "promising" EBP in their Prevention Plan are required to evaluate the service and submit the findings to the Children's Bureau. This helps them determine if this is an appropriate EBP for the IV-E clearinghouse and whether or not

the rating should be increased. CEPVa will be responsible for this evaluation and is currently building out that plan.



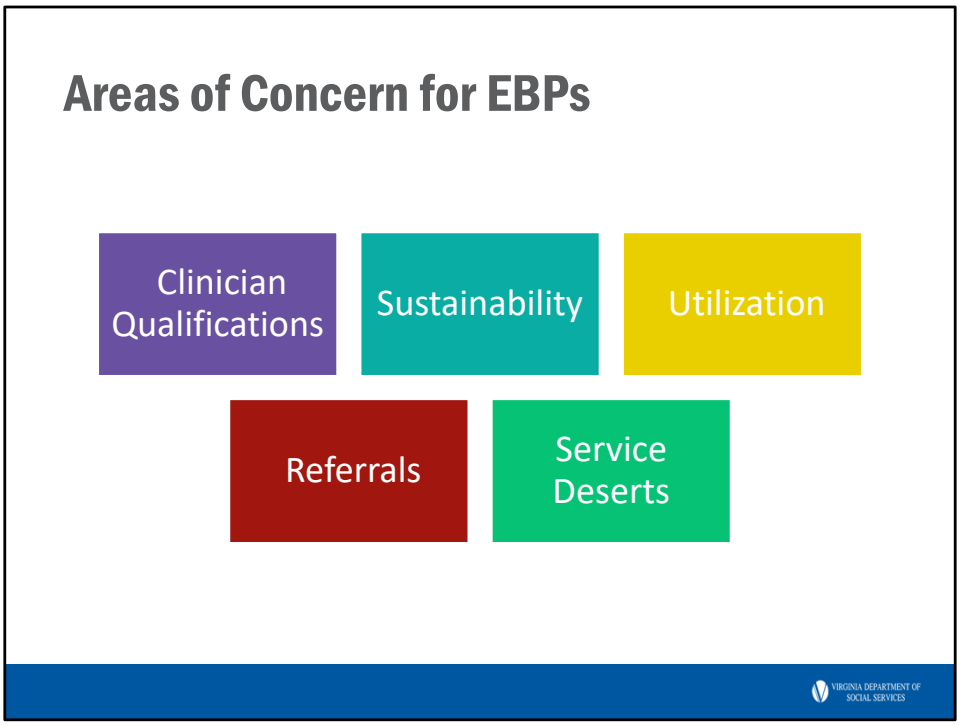
- Motivational Interviewing (MI) is a therapeutic approach that differs from other models that target personal change because it requires a shift in how care is typically provided. MI requires a partnership that honors and respects the other's autonomy, and a practitioner who is continuously seeking to understand the patient's internal frame of reference. MI enhances patient engagement by creating an environment of trust and eliciting the patient's own motivations for change and personal goals. The spirit of MI can be combined with other treatment modalities, because its practice is less of a set of skills and more of a philosophy to care. Many clinicians already incorporate motivational interviewing into their practice. So our goal with adding MI to our list of EBPs is not really for providers but for our LDSS workers. We believe that if Family Services Specialists embrace MI, become competent in utilizing MI, and have regular supervision and coaching around MI, that they will have improved engagement with their families and make better referrals for services, which will lead to better outcomes.
- We are utilizing implementation science to help guide our MI implementation within the In-Home services program
- We have developed a MI core team to assist with guiding this process
- CEPVa is a part of that core team and will play an instrumental role in creating the MI training plan.
- We are looking at a phased in approach, starting with pilot or initial sites. We are glad to say that there has already been interest from LDSS in moving forward with MI.

- The implementation of MI will begin with In-Home Services supervisors and family services specialists. Eventually we would like to train other program staff to include permanency, protection and benefits staff.

We created a taxonomy for the Motivational Interviewing Training for In-Home Staff. This taxonomy is a similar format to the one that was used for the PIP, it explains how the use of MI can assist In-Home staff and the families they serve:

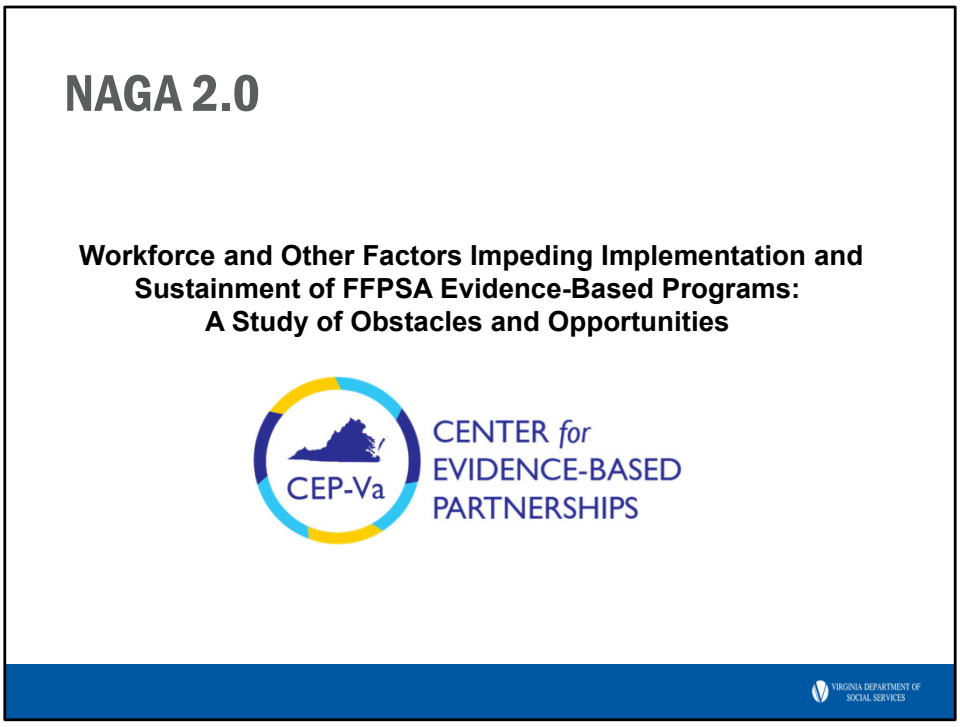
In-Home supervisors and Family Services Specialists will be trained in MI
So that
Staff will utilize MI to become more engaged with families
So that
Families become more motivated to participate in services
So that
Families receive evidence based services that align with their identified needs
So that
We can increase the prevention of future maltreatment and the need for foster care.

The arrow to the right shows that MI will be used throughout the case life and assist both families and In-Home workers in connecting the family to the services they need.



- One barrier that we have experienced in our initial implementation of Family First is Virginia's uniquely stringent clinician qualification. While most of the EBPs we have implemented allow for some members of the team to be bachelor's level clinicians, Virginia regulations require master's level licensed clinicians for the same role.
- Due to the current mental health care workforce shortage, some providers are having difficulty maintain qualified clinicians and/or hiring new or replacement clinicians with the proper qualifications. We have seen multiple providers from our first go round of EBP trainings that have been unable to sustain the EBP because they do no longer have the qualified staff so they have had to dissolve those EBP teams. VDSS and CEPVa are looking further into this.
- EBP utilization by the LDSSs has been slower than hoped. We recognize that change is hard and learning when to refer families to EBPs does take time. We believe that it has also been difficult because there is no one comprehensive resource list of certified EBP providers. Individual EBP purveyor websites have lists of providers that are searchable by state, but LDSS appear to have difficulty using these lists and some are unreliable because they are out-of-date.
- We have heard from some providers that they are not receiving enough referrals while also hearing from some LDSS that wait lists are too long for some EBPs. We believe both can be true.
- Finally, and as always, there continue to be service deserts where some of our families

cannot receive the services they need. We are working to incentivize providers who are willing to cover areas that do not have adequate coverage but we know this will not solve all of the problems.



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QRTP Designation Pause

- Temporary suspension of QRTP designations
- Areas of concern
- Funding during pause
- Plan for QRTP return

What's Next?

NAGA 2.0 Priorities

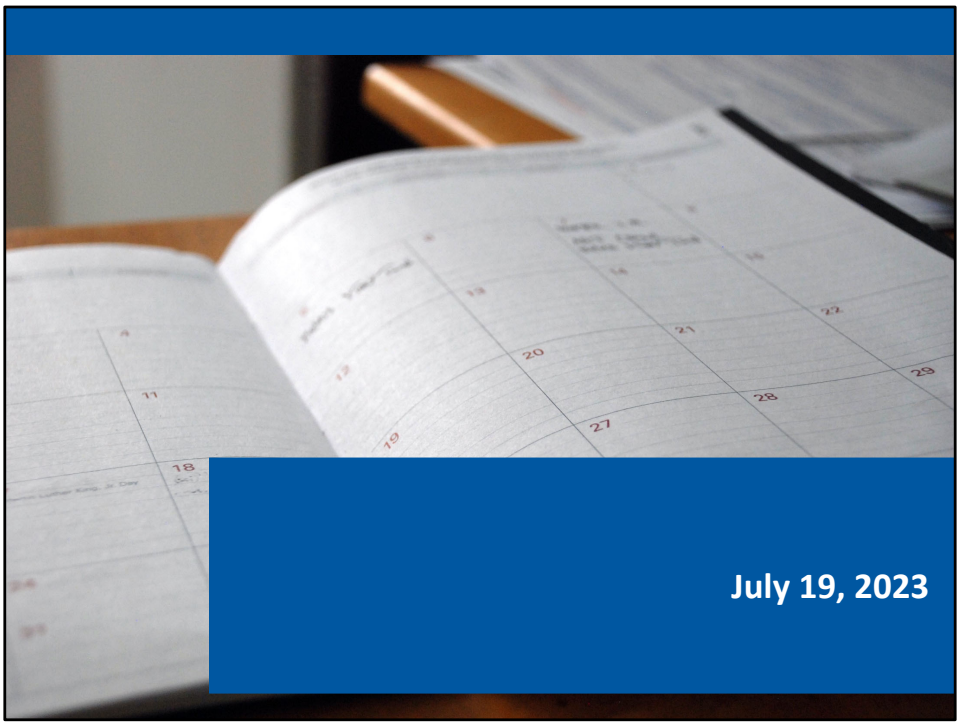
Kin First

QRTP

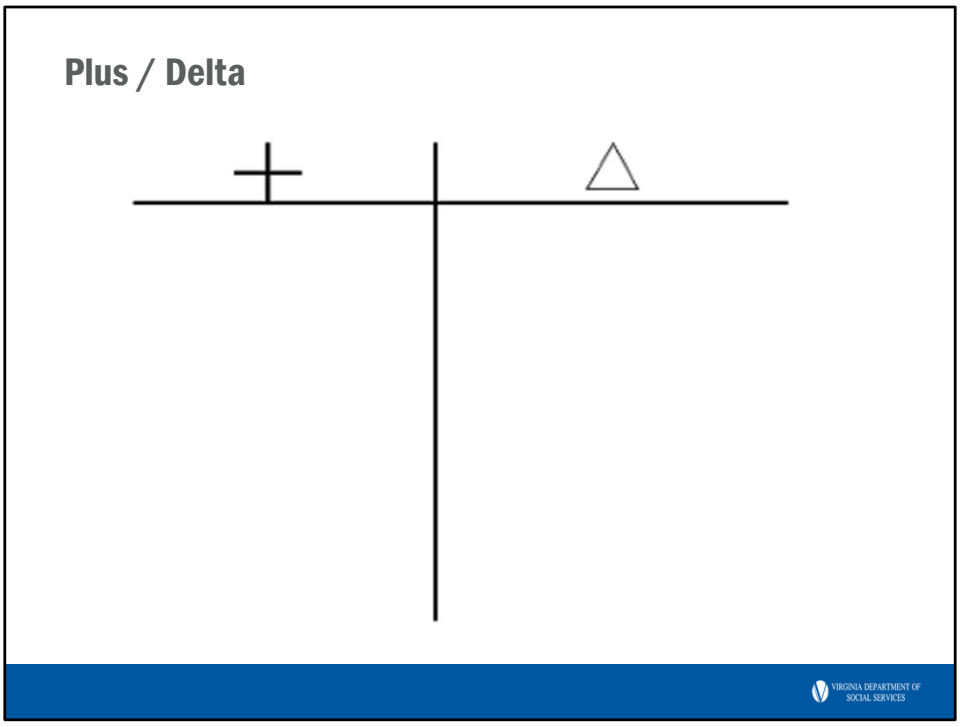
MI

Evaluation

VIRGINIA DEPARTMENT OF SOCIAL SERVICES



Next meeting, July 19, 2023



For those who are new to this meeting: plusses what went well and we should consider continuing on for future meetings. For deltas, what we should consider changing for our next meeting . Start with plusses. Write in the chat:


THANK
YOU
VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

Compiled Responses from Large Group Discussion: Problem Exploration

Prevention:

- No enough staff, not reaching families with young children sooner
- accurate assessment of needs, timely risk/safety assessments, inappropriate safety plans/lack of monitoring of safety plans, recidivism
- staff retention
- A lack of understanding of the process and criticalness - workforce
- Lack of funding
- Families not having a voice in services
- Lack of a system of care mental health, social services and and juvenile justice programs do not work together well
- Staffing shortages
- Identifying family/kin earlier in the prevention process.
- Lack of agency ownership of the Prevention Plan
- Need a brochure to explain services
- Lack of good assessments on the front end of a case.
- Leadership is investing in tax cuts for corporations and wealthy people.
- retention of workers, remaining workers overwhelmed, engagement and assessment suffers
- community-wide initiative, not just a DSS effort
- Lack of housing
- high needs exist beyond prevention phase and current problems get the most attention
- justifying prevention can be hard - proving effectiveness
- often too late, we need to be intervening earlier-before abuse/neglect
- need a stronger system of care and breaking down silos among state/local/community programs
- pulling together the natural supports of families
- Trustworthiness of resources/services, fears about reporting
- We need policy language embedded in legislation
- Not enough prevention services broadly available.
- prevention is often a collaboration among local govt and nonprofits; partnerships can be complicated
- Judgmental attitude towards certain culture norms. Misunderstood culture of historical poverty.
- Lack of consistency in how prevention services are administered across the state
- lack of trauma informed placements
- No real priority for prevention services or funding
- Political leadership doesn't want to invest in families.
- Where should prevention programs live? govt or community agencies?
- Not enough providers for needed services
- Lack of definition of Prevention in VA
- Values differs statewide around the value of engaging fully with families
- Lack of Prevention Services and workers in LDSS
- limited resources to support families
- our director has 'threatened' to pull prevention and shift resources to CPS
- Prevention - Creating a non-CPS pathway to access prevention services.
- Lack of services. This has been an overarching concern since prior to the pandemic.
- The best needs of children are grossly overlooked. Much better planning and focus should be implemented when working with families with children.
- Resource scarcity, ongoing engagement and assessment skill building

- Lack of pre-petition parent advocates
- Family finding and engagement of outside support for families isn't being utilized in timely manners- seems like it waits until there's an emergency.
- prev often 'pushed aside' when mandated programs need help
- disentangling the issues of poverty and maltreatment - particularly neglect
- cost of starting and maintaining a sustainable evidenced based program
- lack of family engagement
- Lack of services that clients find valuable and willing to engage in
- lack of workforce = lack of services
- Inability to expand prevention plan programs to include more that are not already well-supported due to limited capacity for evaluation.
- sufficiently engaging and partnering with families
- Lack of trust of LDSSs for families to want or ask for services.
- More robust coordination with community based partners to move resources more upstream to families before crisis
- Shifting child welfare from a punitive system to a support system for families is very difficult after so many years of only being reactive
- public cw is historically reactive, we are not staffed or trained for early intervention & primary prevention BEFORE things happen....no dedicated staff at DSS - needs to be a community approach
- Inequity of resources and supports to communities specifically related to race and ethnicity
- Lack of funds that can be used, Workforce,What is being asked of the Worker to complete.
- workforce: not enough staff/not retaining talented front line staff to actually coordinate and ensure prevention.
- Lack of desire to shift to a Prevention framework - reactive vs. proactive
- Lack of funding for prevention programming or services.
- Perception of gov cps as punitive and adversarial. Not trauma informed or people first
- lack of funding for primary and secondary prevention
- Access to services- long wait lists, providers are understaffed and unable to meet demand for services due to staffing
- Lack of consistency in how prevention services are administered locally
- Total buy in
- Services available timely
- workforce lack of training
- family engagement

Protection:

- LACK OF STAFF
- Lack of training of addressing systemic racism within the system that affects BIPOC
- Lack of family engagement / discovery - or buy in of
- don't have good systems to 'quickly' prepare new staff to do the job, and then they leave sooner than before. and we're hiring new staff with less education and experience, so they need MORE training
- Jurisdictional wars
- Inability to access protective services on the front end and then sustaining those services to keep the child and family safe. Again, a lack of services.
- cultural awareness/competency/sensitivity

- There are disparities with who is protected and who is not… BIPOC communities are negatively impacted
- Training
- a long history of child welfare acting like police instead of supporting families
- Meaningful family finding
- Insufficient resources and training around alternatives to removal
- Gov seems to be concerned about protecting children “from” families as opposed to protecting children “with “ families!
- Inconsistent follow up and support from LDSS worker from LDSS worker
- The use of repeated safety plans
- Engagement
- anecdotally we're seeing greater trauma and severity of abuse and neglect in CPS lately compared to before
- Lack of a true uniformed approach across the Commonwealth
- Safety Plans
- leadership demonizing marginalized children and families instead of actually investing in more services
- inconsistent services across local LDSS
- How to ensure these services are truly interventions and not just transactions
- staff turnover
- Not leveraging kinship care resources
- Creating appropriate safety plans
- There has been a shift in the attitude of the public participants.
- Lack of compassion and family understanding from those who are in the position to make decisions (seemingly).
- Varies by worker with approach is partnering/supportive versus punitive approach with families
- not enough early exposure in school curriculum
- over-investigation of families leading to some children falling through the cracks
- A true career path
- can't attract and retain enough staff to do the work
- Is there a paraprofessional tract for early entrance in the field
- lack of transparency for fear of repercussion
- Inadequate pay for quality staff
- Child welfare stipend students need to be hired to be able to do CPS
- Who is actually held accountable for outcomes?
- Keeping up with training with frequent turnover of staff.
- building trust with families/collaborating
- family by in
- We are protecting the system and not really the families
- Lack of consistency in response - policing vs. supporting - across the state
- Intentional feed back and communication loops
- Recruitment and retention, lack of use of trauma informed approaches with families
- Staffing and pay. Safety of staff,
- workforce: not retaining talented front-line staff to actually ensure protection.
- Secondary trauma - lack of resources to address
- High caseloads don't allow workers to spend sufficient time with families to build trust, engage them, and identify family-centered interventions
- What do you mean “protection?
- Time frames of completing the work
- systemic racism and bias in our systems, especially police
- Inconsistency in what is validated in some localities vs others
- Creating appropriate feedback loops to include lived expertise to inform

sustainable change and process improvement
- Turnover in staff
- Stereotype about role of protection
- Substance use and safety
- lack of skills/knowledge in the workforce
- Lack of strong assessment of core safety needs versus canned safety plans
- Community support
- Not making response times, training on making accurate risk/safety assessments, providing appropriate services, implementing and monitoring appropriate safety plans
- staffing shortage
- Training or Lack of training
- We need to over hall the hiring, retention, and retirement program for CPS. We should look at the law enforcement model for recruitment, retention, professional development, and retirement.
- Alternate temporary placement WITH family during the "protection" process
- Alternative placement arrangements

Permanency

- Foster families lack of understanding of trauma behaviors.
- Lack of clear ICPC policy manual/misconceptions and confusion about ICPC, issues with court system delays/court not following best practices, lack of case planning efforts and service provision
- Lack of available placement options that are trauma-informed in Virginia
- Barrier crimes with possible kinship placements
- staffing shortages
- Strong/quality supervision of new workers
- Family Engagement
- lack of a system of care that prevents out of home placements for children with developmental and behavioral health challenges
- Lack of emphasis on recruiting foster homes & family finding.
- Congregate Care issues
- services not initiated in a timely manner due to high staff turnover
- need to do better recruiting and retaining resource families that meet the needs of the children we have
- foster families need to have some rights to have say in the courts, etc if you want to retain them and have them work for kinship placements - they know more about the child than anyone
- Focusing on retaining foster families instead of cultivating birth families
- Inconsistency in service planning- not facilitating FPMs or TDMs consistently across the state
- DJJ
- Supervision issues
- Timelines for SA treatment vs FC timeline
- Kinship placement
- Lack of engagement with incarcerated parents.
- Lack of support to biological parents while foster care parents are showered in services and supports- best needs of child is decided and not considered by family.
- More resource families needed that understand the value and goal of reunification
- Terminating parental rights when we DO NOT have a permanent placement identified. Results in children aging out of foster care as legal orphans.
- Kinship understanding

- Court system is NOT trauma informed, judges largely ignorant of child development, trauma etc
- Families are not provided with sufficient resource (training, funding, support, etc.) to care for children with special needs or exposed to trauma
- Lack of services/resources for relatives who take in children
- workforce training and compensation, burnout
- Lack of (active) concurrent planning
- "hit and miss
- family driven decisions"
- Inconsistent funding / resources
- A lack of services prevents permanency goals from moving forward.
- Best needs of children are NOT considered. Cultural awareness and family trauma is NOT considered.
- Retention of workers
- bio family supports and services
- Poor legal representation for parents
- There's no accountability for judges to follow timelines or policy. Caseworkers gets held accountable for following timelines that aren't always in their control.
- need better programs and services to place children quickly with relatives
- Over utilization of congregate care and underutiization of kinship care
- need reasonable caseload standards and adequate staffing
- staff recruitment and retention, informal kinship placements not being able to access the same financial supports as foster families, lack of foster homes
- Asking more and more of the staff.
- barrier crimes preventing family permanency
- Need professional foster parents to keep children out of residential facilities
- Lack of community awareness, buy-in, and preparedness for kinship care
- Foster care is not a trauma informed intervention. Yet we hang our collective hats on it!
- Lack of knowledge about attachment, especially with very young children
- Some courts do not prioritize return home goals and reunification when it is safe.
- Lack of compassion for children and families
- Lack of youth voice on their case plan
- Not listening to parents about what they need, distrust of families
- Policy continuing to add expectations of staff, but caseload caps remain the same and resources and support are not added in proportion.
- we only bring children into care when there are no other options; this means they often come with the most challenges; hard to achieve permanency
- Training
- the war on drugs has created HUGE incarceration problem for families leading to lack of permanency
- juvenile court needs to be a court of record
- Families are not well-prepared to provide care for children who have experienced trauma
- Support for kin providers- LDSS is often unable to provide the level of support kin caregivers need
- Lack of foster homes
- placements with family members without permanency
- Relief of custody / Chins and not A/N
- Staffing shortages
- lack of family engagement, children languishing in congregate care
- Lack of foster homes

Workforce

- Too much responsibility for any one person! No shared support.
- NOT ENOUGH LINE WORKERS, LOW PAY, INADEQUATE TRAINING, NOT ENOUGH SUPERVISORS
- Lack of support/supervision
- Direct staff must have adequate training
- Worker burnout
- lack of understanding of what the career entails
- people leaving due to problems with supervisor/manager; these are hard to address - how to strengthen these leaders - in such demanding times
- lack of respect for our work
- Limited or no workers applying for child welfare position posted multiple times
- Not feeling heard by the state VDSS
- Lack of training on the front end leads to potentially negative outcomes for families.
- Health care for the workers
- Trauma
- Not being able to feel successful because being so overwhelmed by workload and needs of the population served
- we aren't using best practices in how we hire, so we sometimes hire people who aren't a good fit
- Need funding to hire and retain the right workers BSW/MSW
- Potential to be part of the problem by nature of the system.
- need to strengthen pipeline from universities
- The work is traumatic by nature. No real help available.
- Lack of mental health support to prevent burnout
- turnover and lack of training
- Lack of supervision / coaching
- Lack of value placed in workforce development/ retention
- Secondary trauma
- $$$$$$
- Salary, lack of training, management, high turn over, lack of collaboration with providers that support bio families.
- major wage disparities statewide
- Our approach. This is not the job people signed up for.
- You can't have people doing this job for under $40k, which many localities still start in the 30's, and expect the best and brightest to stay.
- fewer applicants for our positions
- Caseloads, pay, lack of support, work morale
- Unrealistic expectations
- Not enough support for supervisors
- A starting salary for some CPS workers is still under $40k.
- Agency culture, morale, leadership
- Not all jurisdictions provide quality healthcare for their workers
- effective training and streamlined/efficient processes
- people leaving for more money
- Insufficient time off to recover from secondary trauma.
- Under trained/educated - need ability to hire more BSW/MSW (inlcuding but not limited to stipend students) across the continuum.
- lack of work/life balance
- Secondary trauma
- Pay, Safety, Staffing
- Lack of funding has created an awful culture of exploitation of workers
- Not enough recruitment efforts for staff -
- Lack of support and protections for staff

- Emphasis importance of supportive supervision.
- feel a loss of team cohesion, staff supporting each other. need to rebuild that
- high turnover; difficult to determine if a result of the current economy or the high-stress nature of the job
- High turnover
- on-call/after hours responsibilities
- lack of understanding of what the career entails
- Recruitment, retention, adequate training
- Salary
- Problems are overlooked until they become major issues
- Not utilizing professional social workers.
- high caseload
- this work relies on expertise of LINE WORKERS. They need to be given dramatic raises in salary and a complete overhaul of retention and career growth for them
- Workers have incredibly stressful jobs; need built-in support and recognition
- Not hiring the right people for positions due to desperation
- High stress/Secondary Trauma
- Dangers of the job
- Lack of support
- We need a new system for recruitment, training and professional development
- Limited support and training
- Not getting the training they need before they are given FULL or OVER FULL case loads

Continuous Quality Improvement (CQI)

- there are many things that we do that relies on community partners that LDSS has little control, but we are responsible
- Data does not necessary tell us an accurate story. Example- Length of stay is NOT an indicator of care.
- Disconnect between data outcomes and support provided to agencies to make meaningful change at the local and regional level. More collab between regional staff and agencies on targeted issues
- There does not appear to be an improvement with quality of services and workforce. There appears to be the same heart breaking cocnerns
- OASIS is woefully inadequate in providing data; lots of extra time needed to get useful data
- Being realistic about interventions based on staffing and service availability
- need to have expertise in CQI on staff to manage these efforts
- How reliable is the data being collected?
- follow-through is hard for program staff - they move on to other 'fires' and we just go back to what we did before
- Do local agencies value the need for CQI
- LACK OF EQUITY DATA AVAILABLE FOR LOCAL AGENCIES TO USE
- accountability for data and implementing change base don the data
- Lack of common statewide definition of what is Prevention
- need foundational orientation to framework and clarity in how it is used and how it fits in with existing efforts.
- Disconnect between understanding/utilization of data at the macro, mezzo, and micro levels
- None of this will be addressed until staff turnover and professional development is solved
- Family needs are not heard. There is a gross disconnect with what families are

experiencing and what implementations are put in place.
- Root issues of workforce need to be addressed first. Stressed out, overworked, and under funded positions do not have capacity for CQI
- program staff don't have the bandwidth or patience to go through a CQI process; they want quick hits, but these don't bring lasting change
- Documentation lags
- jargon is inaccessible to external stakeholders
- Historic trauma and on-going trauma is not considered. The problems families have are not met with real solutions. Problems are met with continuing challenges.
- good CQI methods include thorough understanding of the problem before identifying strategies, then continuous monitoring to ensure results. it's a lot on top of the work
- "Constant shift of process
- Turnover of CQI staff"
- can the CQI process incorporate feedback about how dire the lack of funding is and how that contributes to the problems CQI is finding? can we do this in a systemic way?
- community-level feedback and lived experience not included in the evaluation process
- Getting feedback that comes from families
- More transparency needed on what data is being collected and where/how it is being collected
- Problems are identified by QAA after they occur
- Impersonal, over focused at times
- Are localities doing comprehensive debriefings or root cause analysis following cases of high acuity or serious incidents
- Issues in our systems impact data available

CWAC Breakout Room Notes, 3/29/23
Small Group Discussion – Problem Exploration

Workforce

Breakout Room:

- Retention, how to keep good people in the positions
- Why?
    - Capacity issue- staff are given cases before fully trained
    - Work is very emotional and we don't implement self care
    - Salary,
    - Some agencies are always struggling with their budget and provide limited career paths,- we don't have a state mandated budget or a career plan to be implemented at the local level.
- Why?
    - No incentives for people to come do this work, especially CPS, recommends switching to a law enforcement career plan, a way for people to advance
- Noted the Stipend program should cover more program areas.
- As a commonwealth it is hard to mandate localities to confirm to just one way
- Root: conform to better practices across the state, fair salary range, training

Breakout Room:

- Hard work
    - Dealing with families in the middle of a crisis
    - Workers experience secondary trauma.
        - Struggle with mental health after encountering the maltreatments they are introduced to.
    - Competing Salary
    - Lack of worker safety
    - No standard training across the board to give workers a realistic understanding of the actual field work.
    - Workforce support and supervision
        - Staff burnout due to unrealistic amount of cases
        - Inadequate supervision by supervisor/leadership
        - Supervisors are promoted based on who stays around long enough instead of who has the adequate skillset to lead like problem solving and critical thinking.
        - Too many new best and required practices mandated by state and federal governments
        - Local staff need to be more involved in their local and state legislative processes

Breakout Room:

- High vacancy & turnover rates, as well as concerns around quality training
    - Root cause/Contributing Factors:

        - Compensation- pay people at the level of difficulty of the task/job they are doing. Even looking at benefits package at various locality, considering cost of living as well as benefits needed for a family, it various. PTO vs private sector. It is compensation that you may not get in salary.
        - Difficult nature of the work- Low agency morale, lack of support within the agency.
        - Insufficient training- Smaller supervisor to worker ratios. The trainings do not appear to be preparing the workers for the actual work that needs to be done.
        - Caseloads too large- the suitable number that is currently accepted are too high, the number needs to lower. We are working folks at their max capacity at all times.
        - Covid-19
        - Limited networking opportunities with virtual training; impacts to engagement during training
        - Critical incident response that is widely across the state. We can do better at local and state level for providing tools to workforce and needed support
    - Decreased quality in FSS visits due to high caseloads
- Uneven caseloads lead to processing errors and delays (no CPS caseload standard) - this can also go back to training, and inexperience, build a routine, cannot build a routine if you are leaving the field, or jumping from agency to agency

Breakout Room:

Why:

- Low salaries
- Work is hard, burnout is high, turnover is high, lack of support for staff
- Hard to prepare new staff for the reality of the work and what they will encounter in the field
- Caseloads are high
- Can't partner with families because the caseload is too high and time is limited
- Lack of training, not just among front line staff, but supervisors and directors too
- Supervisors are carrying cases, which prevents them from working with staff
- Staff don't have time to research and implement new practices
- Staff don't feel fulfilled
- Stipend students unable to do CPS
- Accuity of kids served
- Barriers to service access or lack of services
- The pandemic allowed us to be flexible but now that it has abated, things have returned to previous conditions and lost that acceptance of flexibility

*** Described as an interconnected and interwoven predicament of issues with recruitment, training, support and retention

What:

- Comprehensive data on how long FSS stay in positions now as compared to 5-10 years ago
- Exit interviews – are they done and if so, what does that tell us
- Recruitment efforts – where do we recruit, do we partner with universities
- Knowledge gap between the front line workers and state level expectations
- Gaps in institutional self care
- Think we have the information we need based on the Menti answers, now we just need to put a plan into action and include in that recruitment, training, retention plan a plan to reduce caseloads and plan on including supervisors in that plan (salary and training)
- 3rd party salary study

Who:

- Front line staff
- Supervisors, directors
- HR
- Universities
- Students
- Lived experience

Breakout Room:

Agencies are not getting applicants/low pool of applicants applying in general, very unusual to see, recruiting challenges for those qualified or otherwise

Why do we have a lack of applicants?

- Since COVID, people want to work more remotely and not have to go out in the field
- At the state level and local agencies, there can be a lack of clarity in what you are applying for, the job postings are very generic. Changing how they are posted and advertised

Why are we not advertising in a way that is getting the applicants?

- Supervisors and leadership are overwhelmed
- Even though they may come into a specific position they may need to move them later, so hiring managers are trying to cover their bases
- When you are overwhelmed and need to fill a position, you may not have the time to change the job description and it will stay the way it is
- Recruitment is not prioritized

Why don't we prioritize recruitment?

- There are too many fires and things that you need to pay attention to
- Internship program: workforce that we have now and the age group we have now is wanting a level of flexibility that has not been known before. They want to be able to telework and have flexible hours. We need to better understand the culture of our workforce in order to post better positions and engage with

the workforce. What is the workforce that is interested in this position and what drew them in, how can we meet their needs?

Why don't we understand our potential workforce, if it is not working why do we keep doing things the way it has always been done?

- Some agencies do not know that they have positions and there is no one evaluating at the HR level to help consolidate or edit the positions. Why are we not evaluating our positions within the organization and addressing if we need more/less/edits within the system.
- We are not evaluating positions, not considering staff and their needs, and not willing to change. When you are in crisis, this is not a priority.
- The demands of the job itself are hard on workers and they lack support and supervision. There is a lack of innovation in this work and that does not excite new workers. There is a risk aversion that exists in child welfare work which leads to always doing the same thing without opportunities to be innovative.
- Leadership is built on people that have survived the system; this leads to doing things the way that they have always been done. People get promoted out of necessity, but that does not mean that they will be good supervisors. What supports are we giving to new supervisors? Everyone is working in crisis and when you are in crisis you can't think straight or creatively.
- You have to take something away if you want people do new things. Also, do we need to look at caseloads and revaluate how much is on people's plate.
- It is difficult to get boards and other entities to support growing government even though we are in need of more positions.
- State has a lot of innovative ideas but they take years to implement and sometimes they don't see them through and then go back to an old way of doing things.
- Workforce is disempowered because they have to listen to the court or therapist or another entity. The perception is that the child welfare worker refers to services, but they have expertise and should be empowered to act on behalf of their cases.
- Foster care workers are tasked with many decisions and the wellbeing of the child. The workers are not always trained or provided with opportunities to learn expertise. Due to people working in crisis, they are putting workers places that they are not ready to in.
- The child welfare system is not always family friendly, the worker has to take on the wellbeing of children and families to ensure they are not harmed by the child welfare system.
- High expectations of our workers to ensure that they can keep families safe, but they are not empowered, and then they are held responsible for their cases.

Placement Stability

Breakout Room:

trauma informed care; support of foster parents, why FPs aren't coming to support groups; maybe can get points for showing up? Just not feeling as supported; workers are busy, maybe workers and foster parents are not trauma or attached-informed. Little kids and their attachment issues; don't think foster parents are trauma informed; workers are somewhat trauma informed but haven't lived it. Empower To Connect – watch that several times; going to a conference is not enough

Why is there is lack of trauma-informed care? Need more resources.

Why don't we have more resources

Touching back to the workforce piece – going in and out of the work; dedicated to the recruitment of foster parents; have mandated programs – juggling act; some other pieces don't get fully supported as they need to be

Lack of resources?

It's the practice that is the problem; need to have your own trauma under control - https://www.nctsn.org/resources/child-welfare-trauma-training-toolkit

It (trauma informed care) has to be fully integrated into our system – time and effort to tack onto supervision; has to be integrated and have to have the time

Other Problem: lack of support of foster parents. Why?

You have to have the ability to get the real-life experience to have skills; can't hold onto people long enough, it snowballs into one overarching problem

TFC families have the case mgmt. component; most children in local homes don't have the case mgmt. component – maybe that's the barrier

Resource family staff are extremely limited in their power

Support of foster parent, no support groups, workers are not able to support foster parents

- Need to have experience to provide others with skills and feedback
- Expectations of the role of the foster parent, the default goal should be reunification, how involved are foster parents with the goal planning and o they understand their role.

Breakout Room:

- Kin, Fictive Kin compared to Foster Parents
    - Family lack of knowledge about services
        - In-home services should be tried, and staff supposed to be informing families, but it is not the experience in all areas.
    - Bio parents, kin, fictive kin do not receive the same support as foster parents.
        - Not given information about services
        - Families and parents do not receive financial help like foster parents.
            - Funding is a legislative issue because there is an ideology that families should be able to take care of their children/relatives.
            - Funding streams and budgets lines are to restrictive

- Families have an ideology that the "state" will take their children away for lack of funds and resources but give the funds and resources to foster parents to take care of their children.
- Guidance and laws are not being followed
- There is no one coming forward during legislative sessions/General Assembly to advocate for families. Many families don't know they can advocate for themselves in these avenues.

Breakout Room:

Why:

- Lack of preparation of kin providers about the level of care required for the children placed in their care
- Lack of community understanding of kinship care
- Code of VA does not require public schools to enroll children who are in informal custody arrangements

What:

- Full picture of what is lacking in kinship placements vs foster care (such as the education laws) that make it more difficult to place and sustain kin placements
- Engage families earlier – CPS
- Perspective of LCPA, partner agencies, front line staff on recruiting kin placements
- Managing family relationships after one member steps up to care for a child, i.e. conflict, emotions

Who:

- Educators
- CASA
- Lived experience
- Youth
- LCPA
- Front line staff

***Fairfax mentioned the 30 Days to Family model has amazing results, they utilized this some but not fully

Breakout Room:

- At all levels we need more placement options.
- Children also enter care and do not have family in the state of Virginia.
- Not enough resources- when you do not have enough resources, you start trying placements etc that do not work out.
- The higher the needs of the child, the harder it is to find placement. It is a challenge to stabilize higher needs children.
- Barrier crimes becoming a problem for placement

- Increasing behaviors we are seeing because all of our systems are breaking down.
- Need to invest in our communities where children can be raised and access services and supports they need.
- One Home Initiative-
- Children going into the system due to their instability and behaviors and being placed in unstable environments. Those having a harder time with placement we are seeing with more delinquent behaviors vs mental health. - part of the solution if we are disruptive in their lives, where is the harm in putting the responsibility back on the family and offering services. Look at the root of the issue. Why are we surprised when the disruptive behaviors continue
- Placement specialist being helpful – that is something the state could do for localities. If localities could connect to placement specialist.

Breakout Room:

- Placements stability is an issue, but how can we fix that when we are not doing that with our workforce?
- Foster families cannot handle the level of need for children and there is a lack of homes to support these children. Some LDSS to not have any foster homes to place children in.
- Foster families were not expecting to deal with the bio families for the length of time that they are and do not have the supports in order to do so. It is important to understand the family dynamics and culture.
- Workforce is working so hard to place children with kin and once they are placed they are not being supported because the worker has to put out another fire.
- Kinship families should dictate what kind of supports they need instead of just giving them what we think they need. The impact of trauma and placing children with strangers is very real. Once children lose their relationships with their families due to their system involvement it is very hard to get it back. The family should be presented with options in order to make their decision based on what is best of their family.

Why are we not prioritizing family and kinship placements?

- Relatives might not always know what they need. If they are adding additional children to their family, it can be a very stressful situation. It takes a skilled worker to look at what the needs are and help.
- If the family has never experienced the situation before they don't know what they need. The worker needs to engage with the family and provide different options for the family to choose from.
- The staff at LDSS do not have much experience, sometimes the veteran worker only has a year of experience
- They have limited experience and have not had a chance to learn complex engagement techniques. The workforce is very inexperienced.
- Reinstituting the academy model in order to allow workers to test out their skills and provide opportunities for improvement.
- Authentic power sharing with families
- Recruitment, the way we recruit and the skills we are looking for all related to proficiency in systems related items. We need to understand the way that the

workforce feels about the people that they work with – if they do not have empathy for the people that they work with they are not going to be able to properly engage.

- The way we ask questions during interviewing does not always capture the skills that we need the workers to have.

Family Engagement & Contract between Family & Child

Breakout Room:

Lack of parents legal representation, parents are more engaged when they feel they have someone in their corner. – federal funds to draw down for this

- Why don't draw down funds for this
- Parents attorneys do not always receive the proper training, regular salaried lawyers spend more time with the parents
    - Why are lawyers capped, they are not compensated to work with the families
        - Bills were proposed in the GA to increase the cap, but they were not passed
    - Lack of training and support for attorneys
    - Long list of families that need a court appointed lawyer

*Why don't we prioritize the child welfare system when it comes to the law and having lawyers support our families?

Parent may have had a previous negative experience in working with the system, mistrust of DSS

- Not positive social media presence. Social media and social networking groups that ban together to hate on a worker or LDSS
    - Lack of safeguards for LDSS to protect themselves

Hard for parents to build relationships with their children when they are working through their own trauma. Sometimes the therapy or services they need are not always funded

Breakout Room:

Why:

- Opiates and other drugs and how they impact the visits (quality, interruption)
- Lack of time to build rapport, workers too busy, cases too high
- Lack of trust of DSS
- Visitations often don't happen or frequency isn't adequate due to workforce issues

What:

- Perspective of courts
- Where are we successful, how do we institutionalize that
- Resourcing out visitation services

Who:

- Lived experience

- Courts
- Private agencies
- Parents
- Youth
- Community advocates
- Community leaders

*** Using those with lived experience is important but equally important is ensuring they have policy knowledge and authority – don't tokenize them

Breakout Room:

- Parent visitations and sibling visitations
    - Staff do not have the resources to do the best they can do. They want to do good work and provide quality services, but the resources are scarce.
        - Not feeling accomplished leads to lack of retention, amongst other variables
    - Not enough resources to help supervise visitation within the required timeframes for the number of children the state supervise.
        - Struggle with transportation, strangers having to help with transporting to and from visits.
        - Visitation centers lack of staff, causing waiting lists.
    - The need for a Community Engagement Model
        - Entities to the table such as school officials, community program leaders, families that have successfully navigated the system.

Breakout Room:

- Transportation and worker capacity: one FSS is supervising and transporting and does not have enough time. Regional visitation sites would be helpful.
- Too often, LDSS may assume kinship providers are comfortable supervising visits. This can create additional stress for kin placements.
- Consider getting supervised visitation services funded through FAPT
- Providers have waitlists (months long)
- Family are not included in case planning like they should be
- Localities differ in how they "encourage" parents to participate in service planning. Variation in parent engagement and involvement in CSA and DSS services (seconded).
- We need to use foster families to foster the family and not just parenting the youth/child in foster care. Need to encourage more engagement communication between foster parents and parents.

Breakout Room:

- Children in foster care are not visiting their families often enough. This goes back to capacity issues, they are not able to work around the family's needs.
- When children are put with strangers, they need to have much more contact with their families.

- Engagement, historical legacies, centralized government. We are not embedded in the communities that we serve and we do not understand what the communities need.
- There are stigmas and stereotypes that we need to work through and breakdown in order to engage authentically with families.
- There are community leaders that are not being included in the conversations.
- Community support is how children will engage with their community when they leave the system.

Why don't we trust community and extended families?

- Is our first thought to call CPS or do we think through how to engage with the family and support.
- Sometimes families and community partners minimize abuse and neglect, and children are not valued in everyone's eyes in the same way.
- There are a lot of control issues and fear of liability.
- Inability to assess the community supports often leads to excluding these people.
- We pass up better on our way to best, what is best is debatable. We are mitigating trauma by not removing children and placing them with strangers. Foster families are NOT always the best option.
- Workers are working in crisis and they do not have the experience to engage the families.
- VDSS needs to be better at responding to agencies. The LDSS is making the best decision they can with the information that they have. VDSS needs to support the locals so that they can continue to think creatively about their work instead of being scared to take risks.