

Achieving Permanence For
Children In the
Child Welfare System:
*Pioneering Possibilities Amidst
Daunting Challenges*

By

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PERMANENCE—A MUST FOR CHILDREN

Permanence—the word brings to mind thoughts of forever...safety...security. When the word permanence is integrated into child welfare policy language, it suggests long term and meaningful connections—an attachment—between a child and a caring adult. We have learned through research and study of human development that to evolve into a psychologically healthy human being, a child must have a relationship with at least one adult who is nurturing, protective, and fosters trust and security. We also know that optimal child development occurs when the spectrum of needs are consistently met over an extended period. When healthy attachment occurs, it forms the basis for all other long-term relationships between the child and other persons.¹

We also know that having this connection with an adult who is devoted to and loves a child unconditionally is key to helping a child overcome the stress and trauma of abuse and neglect. However, the reality is that children in foster care, who have been victims of abuse and neglect move—a lot. When this day-to-day consistency is lost, the emotional consequences of multiple placements or disruptions further impacts the child's ability to trust and love. Repeated moves compound the adverse consequences that stress and inadequate parenting have on the child's development and ability to cope. Adults cope with impermanence by building on an accrued sense of self-reliance and by anticipating and planning for a time of greater constancy. Children, however, especially when young, have limited life experience on which to establish their sense of self. In addition, their sense of time focuses exclusively on the present and precludes meaningful understanding of "temporary" versus "permanent" or anticipation of the future. For young children, periods of weeks or months are not comprehensible. Disruption in either place or with a caregiver for even one day may be stressful. The younger the child and the more extended the period of uncertainty or separation, the more detrimental it will be to the child's well-being.²

It has taken the child welfare system over three decades to fully comprehend and then implement key policy and practice reforms that emphasize permanence as a fundamental requirement for the healthy development of a child. Let's consider the background and history of child welfare services commitment to permanency and how this history is impacting our success in achieving permanent and stable placements.

¹ Lieberman, A.F., & Zeanah, C.H. (1995). Disorders of attachment in infancy. *Infant Psychiatry* 4 (3), 571-587.

² Werner, E.E., & Smith, R.S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York: Adams, Bannister, Cox.

THE POLICY AND PRACTICE JOURNEY TO PERMANENCY

The past 30 years have seen major changes in how child welfare professionals think about the needs of children and how children should be served. This evolution has resulted in refined definitions of best practice and a challenge to policy makers and practitioners to do a better job for children.

The child welfare system of the 1940s and 1950s primarily maintained children in foster care or institutions. The child advocacy movement that began in the 1960s and expanded in the 1970s—fueled by the groundbreaking publication *Children Without Homes*³—had a tremendous impact on the field of child welfare, and awoke professionals, advocates and the public to the what was happening to children in the child welfare system and specifically those residing in out of home care. While many knew that “temporary” arrangements were not always good for the children, it was not until this publication and other large scale research studies emerged that child welfare professionals had to face the stark reality that children were “drifting” in care, and that these multiple moves had a devastating impact on a child’s long term emotional health.⁴

During this period in the history of child welfare in this country, the family centered movement was gaining support. Family centered practice spoke to the importance of working to maintain relationships with a child and his/her biological family if possible, and if not possible, then to find a care situation as close in structure to a family as possible. This commitment to family became embodied in the permanency planning movement. “No child is unadoptable” became the call to action.⁵ When the landmark legislation P.L. 96-272 was enacted in 1980 it defined, for the first time in federal law, what best practice looked like in child welfare—including placing family centered practice and the focus on permanence at the center of sound child welfare practice.

The core elements of practice as defined in P.L. 96-272 as synthesized by Ann Hartman included:

- Intensive in-home services to maintain children in their homes and prevent placement.
- Reconceptualization of foster care as a temporary service to children and parents. This required that foster parents view themselves as a support to the visitation and ultimately the reunification process.
- Care assessment of every child who comes into care—and of the child’s family.
- A permanency plan with clearly defined time limits.
- A revised format for service planning that included defining every member of the service team, including the family, roles and responsibilities.⁶

³ Knitzer, J. & Allen, M.L. (1978) *Children without homes: An examination of public responsibility to children in out of home care*. Washington D.C.: Children’s Defense Fund.

⁴ Pine, B., Warsh, R. & Maluccio, A. (1993). *Together again: Family reunification in foster care*. Washington, D.C.: Child Welfare League of America.

⁵ Pine, Warsh, & Maluccio.

⁶ Pine, Warsh, & Maluccio, A.

Over the next two decades, while the definition of best practice was evolving, the needs of families grew more complex and the child welfare system was stretched thin—and not able to keep up with the multiple needs of children and families. It became clear to advocates and policy makers that more attention needed to be paid to the root causes of child abuse and neglect through active efforts aimed at prevention and early intervention with children and families. As a result in 1993 Congress passed the Family Preservation and Support Services program. This legislation increased the amount of funding available to states to provide a continuum of services to families beginning with community based family support opportunities and including family preservation, family reunification and adoption as appropriate.⁷

More than ever before in the history of child welfare practice—the emphasis is on maintaining or creating permanent relationships and connections between children and caring adults.

Finally in 1997, the Adoption and Safe Families Act (ASFA) was passed marking the culmination of more than two decades of reforms and practice evolution. The principles and key provisions and best practice implications of ASFA took us significantly farther than P.L. 96-272 and include:

- The safety of children is the paramount concern that must guide all child welfare services.
 - Children have a right to a fair chance in life and to the essentials of healthy development, including a sense of belonging, continuity of care, safety, nurturing and access to opportunities to acquire basic social competence.
- Foster Care is a temporary setting and not a place for children to grow up.
 - The best care and protection for children can be achieved when service delivery focuses on developing and using the strengths of nuclear and extended families and communities.
 - Foster families play a critical role in supporting biological families in their efforts to improve their parenting skills.
 - The values and customs of families from different cultures need to be acknowledged and valued, and service delivery, training, policy development and evaluation must be designed to be culturally competent and respectful.
- Permanency planning efforts should begin as soon as the child enters the child welfare system.
 - There is a sense of urgency in all child welfare services to ensure safety and a permanent placement for children.
- The child welfare system must focus on results and accountability.

⁷ U.S. Department of Health and Human Services. (2000). *Rethinking child welfare practice under the Adoption and Safe Families Act of 1997: A resource guide*. Washington, DC: US Government Printing Office.

- Training must provide information and direction regarding strategies and methods that promote high-quality service delivery to children and families.
- Family centered practice involves children, parents and extended family members as partners in all phases of assessment and case planning. This advances the overall objectives of establishing safe, stable and permanent families.
- Innovative approaches are needed to achieve the goals of safety, permanency and well-being.
 - A strong network of both informal and formal community based resources is necessary for prevention and early intervention in child abuse and neglect cases.
 - Strengths based practice emphasizes the strengths of the children, their biological and extended families and their communities. Tapping into these strengths in new ways is core to goal achievement.

The challenge of the child welfare system is to ensure that these principles and philosophical underpinnings of ASFA are institutionalized in child welfare practice, resulting in an improvement in the lives of children served by the child welfare system. Are we achieving the seemingly illusive goal of permanence for children? The next section addresses this question.

AN OVERVIEW OF THE CHILD AND FAMILY SERVICE REVIEW RESULTS AND THE MOST RECENT AFCARS DATA

The 1994 Amendments to the Social Security Act (SSA) authorize the U.S. Department of Health and Human Services (DHHS) to review State child and family service programs to ensure conformance with the requirements in titles IV-B and IV-E of the SSA. Traditionally, reviews have focused primarily on assessing State agencies' compliance with *procedural* requirements, as evidenced by case file documentation, rather than on the *results* of services and States' capacity to create positive outcomes for children and families. On January 25, 2000, DHHS published a final rule in the Federal Register to establish a new approach to monitoring State child welfare programs. By the end of March 2004 all States will have been assessed for substantial conformity with certain Federal requirements for child protective, foster care, adoption, family preservation and family support, and independent living services. The Children's Bureau, part of the Administration for Children and Families (ACF) within DHHS, is administering the review system. The Federal Government is conducting the reviews in partnership with State child welfare agency staff; peer consultants will supplement the Federal review team. The reviews are structured to help States identify strengths and areas for improvement within their agencies and programs.

The goal of the reviews is to help States improve child welfare services by ensuring that the best practices described in ASFA are operationalized at every level of the system. The expectation is that by honoring best practice principles the following will occur for children:

Safety

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their homes whenever possible and appropriate.

Permanency

- Children have permanency and stability in their living situations.
- The continuity of family relationships and connections is preserved for children.

Family and Child Well-Being

- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.
- Children receive adequate services to meet their physical and mental health needs.

States are being assessed in their conformity to seven outcomes and seven systemic factors (bolded outcomes relate to permanency).

Outcomes:

- Children are, first and foremost, protected from abuse and neglect
- Children are safely maintained in their own homes whenever possible and appropriate
- **Children have permanency and stability in their living arrangements**
- **The continuity of family relationships and connections is preserved for children**
- Families have enhanced capacity to provide for their children’s needs
- Children receive appropriate services to meet their educational needs
- Children receive adequate services to meet their physical and mental health needs

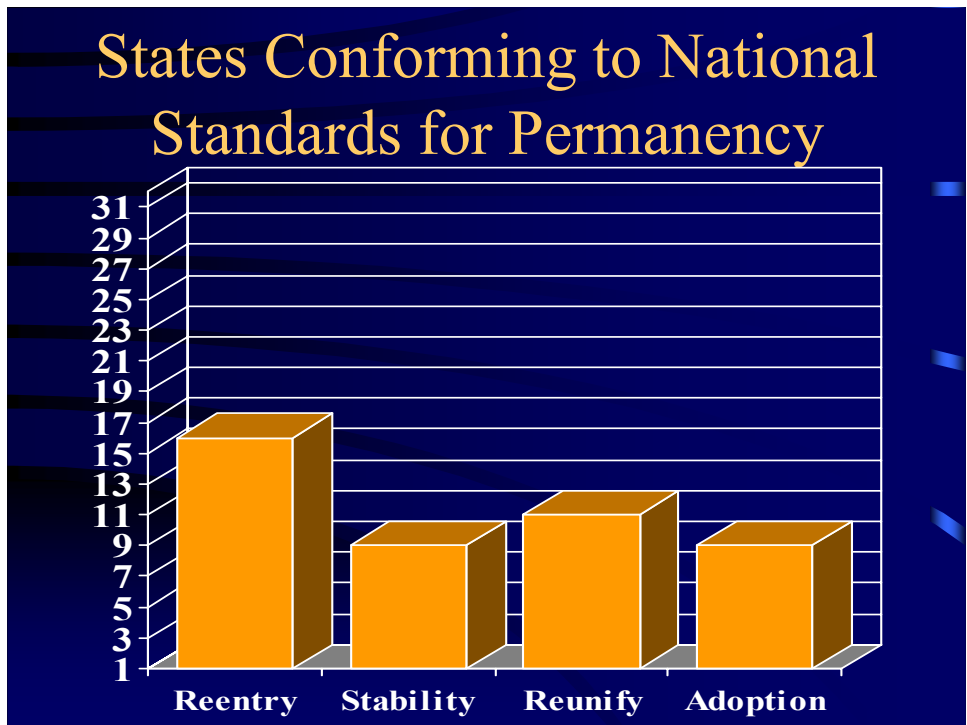
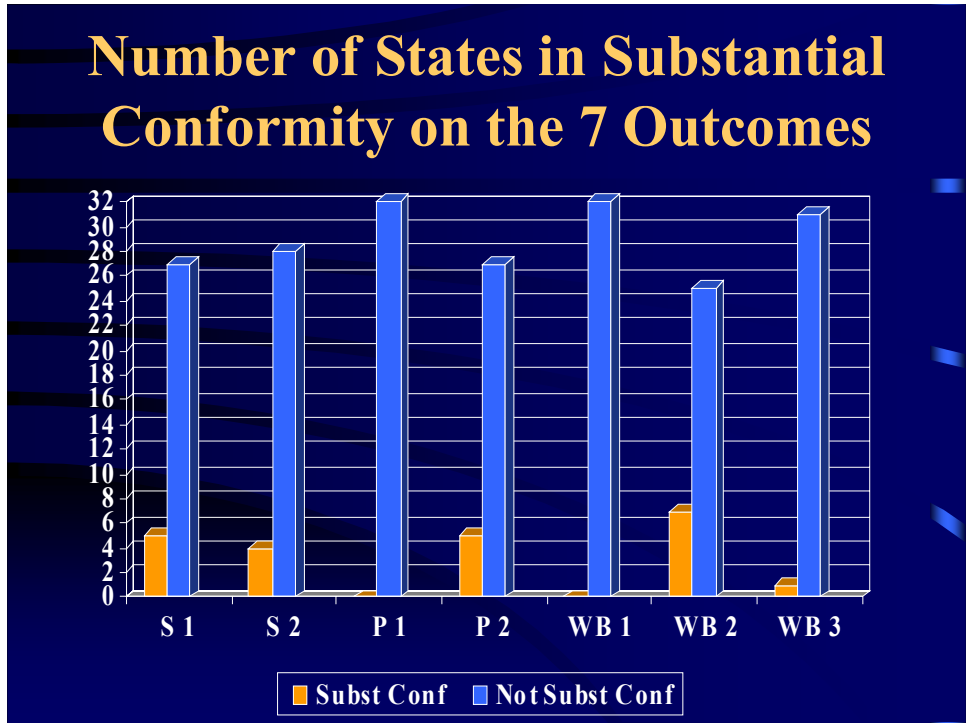
Systemic Factors

- Statewide Information System
- Case Review System
- Quality Assurance System
- Training
- Service Array
- Agency Responsiveness to the Community
- Foster & Adoptive Parent Licensing, Recruitment, & Retention

The indicators being used to assess a state's conformity to Permanency Outcome 1 are highlighted below:

Indicator	Data Source
Incidence of foster care re-entries	Onsite and statewide aggregate data
Stability of foster care placement	Onsite and statewide aggregate data
Permanency goal for child	Onsite data
Length of time to achieve adoption	Onsite data
Length of time to achieve reunification, guardianship, or permanent placement with relatives	Onsite and statewide aggregate data
Permanency goal of other planned living arrangement	Statewide aggregate data

The results of the Child and Family Service Reviews (CFSR) paint a rather dismal picture of the success of states in achieving permanence for children. The following slides depict the data from the reviews as of May 2003.⁸



⁸ Slides were downloaded from the Children's Bureau Website in May of 2003.
<http://www.acf.hhs.gov/programs/cb/cwrp/index.htm>

Some of the concerns identified in the CFSRs relating to child permanency include:

- The goal of long term foster care (LTFC) is often established without thorough consideration of adoption or guardianship (11 States)
- Appropriate concurrent planning efforts were not being implemented on a consistent basis (11 States)
- The goal of reunification was maintained for too long before reconsidering/ reviewing the goal (10 States)
- Agency did not routinely file for termination of parental rights (TPR) in a timely manner and reasons for not filing were often not documented in the case files (6 States)

This information is further broken down into concerns regarding adoption delays. Some of the common concerns regarding adoption delays include:

- Agencies did not consistently conduct home studies or complete adoption-related paperwork in a timely manner (9 States)
- Lengthy appeals of TPR (9 States)
- Agencies and/or courts were reluctant to establish a goal of adoption or seek TPR unless an adoptive family had been identified (6 States)

The national Adoption and Foster Care Analysis Reporting System (AFCARS) data from August of 2002 tells us more about the setting and the length of time that children are spending in foster care.

What were the placement settings of children in foster care?

Placement Setting	% of population in care	Number of children
Pre-Adoptive Home	4%	23,159
Foster Family Home (Relative)	25%	137,385
Foster Family Home (Non-Relative)	47%	260,636
Group Home	8%	43,893
Institution	10%	56,512
Supervised Independent Living	1%	5,108
Runaway	2%	9,964
Trial Home Visit	3%	19,343

What were the lengths of stay for the children in foster care?

Mean Months	33	
Median Months	20	
< 1 Month	4%	23,057
1 to 5 Months	16%	87,222
6 to 11 Months	15%	83,723
12 to 17 Months	12%	64,299
18 to 23 Mos	9%	47,742
24 to 29 Months	7%	41,101
30 to 35 Months	6%	32,799
3 to 4 Yrs	15%	82,784
5 Yrs or More	17%	93,274

What were the lengths of stay of the children who **exited** foster care during FY 2000?

Mean Months	22.7	
Median Months	12.0	
< 1 Month	19%	52,312
1 to 5 Months	17%	46,091
6 to 11 Months	14%	39,288
12 to 17 Months	11%	29,377
18 to 23 Months	8%	20,872
24 to 29 Months	6%	16,409
30 to 35 Months	5%	13,108
3 to 4 Yrs	11%	30,204
5 Yrs or More	10%	27,338

What were the outcomes for the children exiting foster care during FY 2000?

Reunification with Parent(s) or Primary Caretaker(s)	57%	157,712
Living with Other Relative(s)	10%	26,291
Adoption	17%	46,581
Emancipation	7%	19,895
Guardianship	4%	10,341
Transfer to Another Agency	3%	7,726
Runaway	2%	5,865
Death of Child	0%	589

These results confirmed the need to expand what states are doing to improve the continuity and permanency of relationships for children in care and to decrease the multiple moves.

A LOOK AT INNOVATIONS IN THE FIELD FOCUSED ON IMPROVING PERMANENCE FOR CHILDREN

In late 2002 the National Resource Center for Foster Care and Permanency Planning at the Hunter College School of Social Work was asked by the Children's Bureau to survey states, learn about barriers to placement stability and share the findings of promising practices that are occurring around the country. The hope is that by sharing ideas with one another, states will be able to systematically improve their outcomes for children.

The questions posed in the survey were as follows:

- Can you identify specific barriers that interfere with placement stability?
- Can you identify any outside resources that have been especially valuable in assisting your efforts to improve placement stability and ultimately permanency for children?
- Is there a population or target group where placement stability is harder to achieve?
- What strategies or innovations has your state developed to improve placement stability?

31 states responded to the survey. The themes from the survey are highlighted below:

• Can you identify the specific barriers that interfere with placement stability?

- Lack of sound assessment tool and uniform approach to child assessment.
- General lack of resource families.
- Selecting homes based on availability not skill level of resource family.
- Lack of understanding amongst line staff, community based providers and caregivers about the importance of permanence and permanent relationships in the life of a child.
- Lack of medical insurance when the child returns home to support ongoing mental health services for the child and family.
- Difficulty coordinating educational services with the rest of the service system—sometimes it is the educational needs of the child that force a move.
- Insufficient caregiver training and skill level in caring for older children with behavioral health needs—this results in families taking children for whom they are ill equipped to provide care.
- Caregivers with unrealistic expectations about the children placed in their homes.
- Infrequent contact between caregivers and case managers—resulting in caregivers leaving the system due to lack of support.
- Inadequate support services to care givers such as respite, intensive in-home, housing assistance, substance abuse services.
- Overloading care givers by placing too many children in the home.
- The current licensing process does not always effectively develop homes that are prepared for the types of children who enter state custody.
- Inadequate reimbursement rates.
- Inconsistent practice of concurrent planning including rigorous search for relative caregivers early in the process.

- Changes in a child’s level of care resulting in a forced move.

Author’s Note: Changes in a child’s level of care resulting in a forced move was a major theme for responding states that employed a level of care system. While level of care is a means to ensure that foster families and community based agencies are paid a fee that is commensurate to the child’s needs, it creates a disincentive for the foster families. In addition, in some states when a child moves down (or up) a level of care, this requires a move to a more “appropriate setting”. Such a child is “rewarded” for working hard and addressing personal struggles by leaving caregivers and friends and school ties that may have become very important and key to success. The system must address this ineffective approach to fee scales.

Options to consider:

- 1) Implementation of a case rate approach where the cost of providing care to a child is averaged over a period of time (that includes high need times and low need times) and the rate is established accordingly. In this approach a caregiver is paid for both the difficult and the less difficult times within a single fee. Rewards might be added to the mix for providers who consistently maintain a child in care until a permanent plan is implemented (reunification, adoption, independent living).
- 2) Payment based on age of child, not on severity of need. In this model we might assume that children 10 and older will have the greatest needs and pay accordingly.

• Can you identify any outside resources that have been especially helpful in improving placement stability and child permanency?

- Effective use of mentoring programs such as Big Brothers/Big Sisters
- CASA workers who have a strong family centered/strength focused orientation have been helpful in stabilizing placement (not all CASA workers are helpful but those who “get it” can be very helpful).
- Visitation Centers
- Home Based Services when available are very successful and supportive to families.
- When we have the time to closely interact with our community providers, work with them to understand the need for placement stability, and push them to serve the child even when they would rather have the child moved from their home/facility they usually respond well; we just don’t always take the time.
- The state’s Child Care Association, made up of community based providers of home based services, mental health services, substance abuse services, residential care, group home care, and parent aid services are an untapped resource for training.
- Foster parent to foster parent liaison system—very helpful especially during the early days of fostering.

- Mental Health system—but they are not always as well versed about the treatment needs (post-traumatic stress disorder (PTSD), reactive attachment disorder, loss and abandonment issues) as they could be.

- **Is there a population or target group where placement stability is harder to achieve?**

- Children age 10 and over who have emotional and behavioral health needs.
- All teens have their own struggles and developmental issues—but because they are in foster care they are judged and this further exacerbates an already difficult age. *“Sometimes we make them a lot ‘sicker’ than they really are.”*
- Teen parents.
- Sibling groups.
- Juvenile sex offenders.
- Children who are dually diagnosed mentally retarded and emotionally disturbed.
- Children who have been “kicked out” of programs for the very behavior that got them into the program in the first place pose a significant issue. Each time they “fail” their sense of self is further damaged—resulting in more acting out.

- **What strategies or innovations has your state developed to improve placement stability?**

-

On the following pages are examples of innovations that are being implemented in states, counties and private provider agencies around the country to improve placement stability and permanency outcomes for children. Many of these innovations resulted from the Child and Family Service Reviews, where states were not found to be in substantial compliance with the permanency national standards. Other states have yet to go through the CF SR process, but know from their own self assessment that they struggle in the areas of placement stability and continuity of relationships for children and therefore have implemented new permanency strategies.

CONNECTICUT: COMPREHENSIVE ASSESSMENTS AND VISITATION CENTERS

The state of Connecticut was aware that it was struggling with placement stability prior to the CFSR. In April of 1999, in an effort to address their concerns, Connecticut implemented a “Safe Home” assessment program that provides a 45 day initial placement resource for children ages 3-12 who are experiencing their first out of home placement. The program was put into place in response to lack of foster homes, child deaths in the state that focused attention on the system, and a core commitment to learning more about children’s needs prior to placement in a foster home. There is a Safe Home located in every region of the state. These facilities are home to on average 15 children ranging in ages from 3-12 (although there are times when children younger than three are placed in the Safe Homes).

At the Safe Homes children are given a multi-disciplinary assessment that includes medical, dental and mental health needs. As of May 2003, an educational assessment is not a formal component of the assessment process. The purpose of the assessment is to assist staff members in determining the most beneficial placement resource *if* the child has to continue in placement past the 45 days. During the time the child spends in the Safe Home, extended family resources, unrelated families in the child’s community of origin, licensed foster families, and legal risk adoptive families are considered as potential placement resources. The goal of the program is to ensure that if the child has to stay in placement longer than 45 days, the placement will be stable, serve as the permanent home if reunification is not possible, and minimize the number of moves for the child. Concurrent Planning is a foundation for the case planning.

Addressing child behavior disruptions

If a child is placed in a licensed or adoptive family, the Department of Children and Families (DCF) has a social worker from the foster/adoptive services unit assigned to the family to serve as a supportive social worker for the family. The goal is that, with consistent and supportive communication, the offering of comprehensive post licensing training and the increased availability of contracted community services for the child and foster family, the placement will not disrupt. However, this is of course not successful in all circumstances. When it looks like a placement will disrupt the Department calls a Disruption Conference to discuss the child’s need for individual treatment and any other supports required by the foster family. These conferences occur within 3-5 days of the notification to the social worker that the placement is vulnerable.

About the Enhanced Community Supports

While every community has at least a minimal array of educational, medical, and psychological resources, DCF has specifically contracted with agencies to provide emergency mobile psychiatric units, which go to the foster home at any time to intervene in a crisis situation, and they have contracted with private agencies to provide respite services to foster parents in the foster home. These respite clinicians work with the child and help the foster parent develop ideas for managing child behaviors. Foster parents share that this service has been invaluable and has enabled them to continue to care for a child when they thought that they were at the end of their patience and abilities.

Are the Safe Homes Working?

As with all good ideas there are times when there is a gap between the purest of intention and the program implementation. Stakeholders interviewed expressed the following concerns about the success of the Safe Home model to date:

- There is not enough focus on reunification by the staff. The Safe Homes were historically residential care facilities and some of the same staff that worked in residential care work at the Safe Homes; as such their mindset may be more institutional than reunification focused.
- Having such a diverse age range may not be best for children; some of the younger children are exposed to some very disturbed behavior of adolescents in the Safe Home. Many stakeholders suggested that very young children and infants may not need to stay in care the full 45 days and that an alternative to the safe homes should be constructed for this younger age group.
- Children do not leave in 45 days—many are there much longer. This was mentioned by numerous stakeholders as an area of significant concern. It is a challenge for the child welfare system to place children in care for a short term comprehensive assessment and then have to leave them in this “short term” environment for a long period due to lack of appropriate caregiver options. Clearly this requires enhanced recruitment and retention efforts if this model is to truly function as short term assessment and not simply another kind of group care. State representatives agreed that this was a concern in the program and hope that improved efforts to find kin and a more comprehensive recruitment and retention plan will mitigate this issue.
- The quality of many of the assessments is such that they are not helpful in finding a more long term permanent placement for a child.

Most stakeholders felt that if these issues were addressed, additional staff training provided and the original goals revisited this model has tremendous potential to stop the multiple moves of the system’s most “hard to place” children and youth.

The data compiled by the state to date suggests that while there is not a direct correlation between the safe homes and improved child stability—yet—they are completing more comprehensive assessments for children, which is resulting in better, more effective and more timely services. The data also shows a greater success by the state in identifying kin, who can serve as permanent caregivers for children who cannot return home.

CONNECTICUT’S APPROACH TO VISITATION CENTERS

In the process of learning about the Safe Homes, the topic of visitation and Connecticut’s new model of visitation centers was raised. During these conversations it became clear that the state of Connecticut and its provider community are implementing very innovative practices within the regional visitation centers of the state. Lynn Gobbard, Clinical Coordinator of RKIDS—a visitation center in New Haven Connecticut— described their Center and its practices.

The RKIDS Visitation Center began to serve children and their families in late 2001. The regional visitation centers were to serve as a support to the visitation process between birth families (predominantly mothers) and their children. “When a family is referred to the RKIDS Visitation Center, I spend a significant amount of time in person and/or on the phone with the DCFS worker trying to understand the dynamics of the case.” Ms. Gobbard poses a series of questions that, when answered, serve as the foundation for the clinical work of the center:

- Where is the case in the permanency timeframe?
- Where is the case in the legal process?
- What is the history of the birth family with the agency?
- Are there any extended family members that have been involved or helpful?
- How many placements has the child had to date?
- What has been the role played by the foster family from the worker’s perspective?
- Is the foster family expecting to adopt this child if the child becomes free for adoption?
- Has the DCFS worker had the conversation with the foster family about the possibilities of adoption?
 - **Author’s Note:** According to Ms. Gobbard this question is very critical because if the foster family expects to adopt this child (possibly as a result of a premature conversation by the DCFS worker or a misunderstanding of the concurrent planning process) this makes the dynamics of visitation very complicated and the prognosis for successful reunification slim.

In turn, Ms. Gobbard has an in-depth conversation with the foster family, seeking to understand their perception of the case, their role to date, their attitude about the child and the birth family, their willingness to work with the birth family, and how they view their interaction with the visitation center.

These conversations allow us to better understand if the foster family will be a support or a potential hindrance to the reunification process, their commitment to the child, and their understanding of where this case is headed. There are many times when foster families tell us that they fully expect to adopt the child...that they were told that this child was most likely not going to go home. It is no wonder then that they are confused and frustrated by the efforts to involve the birth family and to support reunification activities. We have found that it is worth every minute to clarify misunderstandings early in the process.

Then staff from RKIDS schedules a meeting between the visitation center staff, DCFS social worker and the birth Mom. This meeting is used to plan for the visitation and to gain clarity from the social worker regarding what the birth Mom has to do to regain custody of her children.

It is critical to make it very clear what everyone expects of the birth Mom. In well over 95% of the families we serve, when we ask the birth Mom what needs to happen for her children to return home, she cannot clearly explain the behaviors or activities required. We ask the Mom to bring the “Court Steps” document with

her to the first visit. (This is the document where the court lays out expectations for reunification). We walk through this document with the Mom and help her plan her next week, month in small “doable” steps.”

According to Gobbard, over 90% of the birth families visit consistently, even if this means that they have to take three buses and/or walk 2 miles. In most instances, the parents are evidencing a true commitment to their children. Transportation to the visitation center is provided for the children.

RKIDS has established support groups for the birth families. These groups are incredibly powerful—with women supporting one another emotionally, giving each other rides to the center, and firmly confronting one another during the group sessions. According to Gobbard, “These women are strong and have life experiences that many of us have not had. They can say things to one another with an insight and passion that can be life changing.” In addition, during these sessions staff of the visitation center provide education to the birth families on developmental issues and parenting strategies and stress the importance of permanence in the life of a child. According to Ms. Gobbard, there have been times when birth Moms realize that they are not going to stop doing drugs and that their children need a more steady, reliable place to call home. When this occurs some Moms have proceeded with voluntary relinquishment.

However, there are times when the consistency of the visits is not enough. Possibly the Mom is steeped in the drug culture and is unable to stop using. In these instances, RKIDS helps the Mom see the needs of the children and how her patterns of behavior are destructive to her child/children’s long term happiness and health. According to Ms. Gobbard there have been several times when Moms have voluntarily relinquished their rights and in doing so put the best interests of their children first.

The dream of RKIDS staff is to bring services to the center forming a kind of one stop service center. They are already in conversations with mental health practitioners and staff from the housing office in an effort to get them to come to the center weekly.

SOUTH DAKOTA: ENHANCED FOSTER PARENT-SYSTEM INTERACTION

South Dakota did not achieve substantial conformity in their Permanency Outcomes. The state decided to address this result by starting at the core of placement stability—the quality of the relationship between the agency and its caregivers. The quality was of concern to policy makers, foster families and agency staff. In part the poor retention of foster families was attributed to the lack of meaningful and ongoing dialogue between agency staff and foster families. Poor retention means the disruption of child placements. While South Dakota always required foster families to provide monthly reports to the agency, all agreed that they were not viewed as important—not by the agency staff and not by the foster family. The information provided was cursory and upon receipt of the monthly data some workers might have quickly scanned the document, but most would simply file the reports in the child’s case record. The report did nothing to improve the communication and understanding between the staff and the foster families.

In an effort to improve communications and the agency’s understanding of the foster families’ perspectives, experiences and concerns, the monthly report form has undergone a major revision. The information being requested is more substantive, addresses both child well being and foster family stressors and provides opportunities for foster families to share their perceptions on the stability of the placement.

Once the revision of the new report is finalized (see Appendix A for a draft version) a series of training initiatives will occur across the state.

Foster families will be trained on the purpose and importance of the new reporting format, how to complete the form and what to do if the agency response is still not satisfactory.

Line staff will be trained on the steps that need to be taken upon receipt of the report including when a call to foster families is required, how to respond to foster family stressors, and the practice skills involved in stabilizing a placement that is about to disrupt.

Policy is also being crafted around the responsibilities of the staff and supervisors when the report indicates a potential disruption in a placement. The expectation is that *the social worker will visit the foster family within 24 hours* and seek to find ways to provide support, respite and encouragement, either through the social worker, a community based provider or another resource family. According to Duane Jenner, foster care specialist, “this innovative model of crisis innovation could result in fewer disruptions in placement and a more effective partnership between agency staff and foster families. We are hopeful that foster families will see this as a direct response to concerns they have voiced about our lack of responsiveness to their needs.”

MISSISSIPPI: NO DECLINE/ NO DISMISS CONTRACT CLAUSE

Between 1995 and 1999 the state of Mississippi became increasingly interested in the idea of creating a contractual clause that eliminates the ability of certain providers to either refuse to take a child or reject a child based on the child's behavior. After numerous conversations with providers and line staff, in early 2002 the state implemented their NO Decline/NO Dismiss Policy for Therapeutic Foster Care or Therapeutic Group Homes. The contract stipulates that if a child is determined to be eligible for the designated NO Decline/NO Dismiss service, then the provider must take the child into care and they must maintain the care until it is determined that this level of care is no longer required. At this juncture no financial sanction has been employed to provide further incentive for providers to maintain children in care, but this is part of the near term planning.

Gail Young, Director of the Placement unit for the state suggests that one of the things that the state might have done better during the implementation phase of this contract was to provide training to these providers on ways to meet the needs of the very challenging children ending up in care. The child's complex needs in the areas of mental health and developmental disabilities are creating increased demands on providers. Previously these providers would have asked that the social worker remove the child from care. Today they are faced with the requirement to provide care without some of the skills necessary at the line staff level. Training would have assisted in the transition to this contractual arrangement.

Because only a few of the providers operate within the contractual arrangement, it is sometimes difficult for the social workers to remember which providers must take all eligible referrals and work to maintain the placement. According to Ms. Young this is an area where the state needs to communicate more frequently with staff.

While Ms. Young is the first to admit that there are loopholes in the policy and that it is by no means working perfectly, there have been some very important byproducts of this contracting model that all agree are improving stability of placements for children. (NOTE: At this point the Mississippi Statewide Automated Child Welfare Information System (SACWIS) has not been in operation for one full year and as such there is no data to verify these perceptions.)

Some of these healthy byproducts include:

- Monthly, the state staff and the providers meet individually to discuss every child in care, every child who was planfully discharged and every placement disruption. This frequent and consistent communication has resulted in the stabilization of placements that were very vulnerable, and opened up the communication between the state and providers so that there is a renewed commitment to partnership and problem resolution.

- Identification of the needs of the provider community if they are to be able to successfully meet the needs of the children in care.
- Triage prior to removal of a child in an effort to avert a placement disruption through respite, additional supports, and increased agency involvement. In those cases where the provider contacts the social worker and asks for help if the placement is very shaky (this “heads up” phone call is a vast improvement over the calls of the past where the provider simply said “come take this child”) there are often interventions and supports that can be put into place to save the placement. “Each time a provider contacts us with one of these very shaky placements we learn more about how to avert placement disruption and better support foster families” says Ms. Young.

Overall, the change in contracting is improving dialogue and increasing the quality of the working relationship between providers and the state. “I have to believe that this will in time impact the stability of placements” indicates Ms. Young.

VERMONT: SHINE THE SPOTLIGHT ON THE PROBLEM

Vermont's CFSR was held in April of 2001. Prior to the CFSR, staff from central office conducted an intensive and comprehensive statewide self audit. As such, they were well aware that when the CFSR team came on site they would most likely not achieve substantial compliance in the Permanence Outcome of placement stability.

They attacked the problem head on by communicating the results of the self assessment to the following key state stakeholders:

- Senior Leaders
- Social Work Supervisors
- Vermont's Foster and Adoptive Parent Association
- State Agency Partners
- Community Based Partners

By communicating the results of the self assessment early in the process, Vermont was able to capture the attention of those who had the opportunity and power to make a difference. According to Shaun Donahue, Community Services Unit Manager for the state, "The key to this phase of the change process was getting the support of the middle managers and the foster parents. Without either of those groups we were not going to impact our data." The state began this process by holding a mandatory meeting for their regional directors. Each director left that meeting understanding that they needed to improve performance in this area. Then they did the same thing with their supervisors from around the state. Supervisors met, discussed the issue and left the meeting with preliminary regional work plans. Donahue is convinced that key ingredients to system change have been: letting people know that the state had a problem in placement stability; bringing key leaders together to share ideas and to "own" the problem; bringing in supervisors to craft area specific plans; and letting staff know consistently and frequently how the changes made in practice are impacting outcomes.

As expected, the final results of the CFSR showed that In FY 1999, 587 children (69.96%) who had been in foster care less than 12 months had no more than two placement settings. The national standard is 86.7%.

Vermont drilled down their data analysis to learn that children who enter custody *before the age of five* are least likely to move. The State found that they do their best job with young children entering custody: 77% of children 0-5 had no more that two placements in 12 months. However, they found that children who stay in care for longer periods—and are not pre-school age—tend to move more frequently. The following were identified as the major reasons for placement disruptions:

- A high percentage of older children are entering care because they have exhausted the community services available to them or they have intensive needs that cannot be met through in-home services. Thus, meeting the increasingly more challenging needs of these older foster children is placing additional burdens on Vermont's substitute care system.

- Insufficient or lack of timely assessment of children's needs at the time of entry into care results in some children being placed in settings that fail to meet their needs. For example, stakeholders reported that children are sometimes placed in foster homes when a higher-level placement resource would be more appropriate. Reviewers found that once children received thorough assessments and were matched to the appropriate placement resource, stability and permanency goals were more likely to be achieved.
- All three sites where the CFSTRs were held described older youth in foster care as having more complex needs, such as behavioral problems, substance abuse issues, and/or severe mental health needs that are difficult for foster parents and group home staff to manage. Many foster parents reported that they struggle to meet the specialized needs of these children, often without supportive services to assist them. In addition, foster parents articulated a need for more information regarding children's special needs at the time of placement. Finally, foster parents indicated some confusion about the protocol for accessing services to assist them in coping with children's behaviors and issues. They sometimes found that they were "bounced" between Social and Rehabilitation Services (SRS) and the mental health provider. Foster parents saw a need for SRS staff to be more actively engaged with them and the children in their home to better assist them in addressing the children's problems.

Once the CFSTR data was in and thoroughly examined, the state evaluated what kind of goal was actually attainable. They negotiated with the representatives from the Children's Bureau to have as their goal to improve their placement stability percentage from 69% to 77%. This seemed much more doable than going from 69% to 86%, and did not set the state up to fail once again. Based on the examination of the data, they made a decision to focus on the 6-11 age group—where they believed they could make the strongest impact both from a child's best interest perspective and from a data/outcome perspective. They started by trying to learn why children in this age group move. However, when they attempted to compile the data they found that their management information system (MIS) did not code moves with any degree of sophistication. According to Donahue, "I sat down to review the data and found pages of 'behavioral problems' as the reason for the move. So the state worked with the MIS staff to revise the coding into the following categories:

- ◆ Planned Step Down
- ◆ Planned Step Up
- ◆ Other Planned Placement
- ◆ Trial Reunification
- ◆ Temporary Visit/Placement
- ◆ End Temporary Visit/Placement
- ◆ Provider Request
- ◆ Provider Moved
- ◆ Provider Issues
- ◆ Program Overpopulation
- ◆ Permanency Planning Needs
- ◆ Primary Parent Needs
- ◆ Aggressive/Threatening Behavior
- ◆ Fire Setting

- ◆ Medical Needs
- ◆ Medical/Developmental Issues
- ◆ Mental Health Emergency
- ◆ Runaway
- ◆ Return from Run
- ◆ Risk to foster family member
- ◆ School Issues
- ◆ Sexual/sexualized behaviors
- ◆ Stealing
- ◆ Substance Use/Abuse
- ◆ Other

The state then decided to provide more support to the field through some central office reorganization. Additionally, the state initiated sending quarterly reports describing success in placement stability—called *PIP Points*—to every staff member in the state. These reports provide a touchstone to staff about progress that has been made in stabilizing placements and ensuring permanence as much as possible in the life of a child. (See a sample of the *PIP Points* in Appendix B).

In addition, Vermont leaders felt that it was important that the field see the attention focused on this issue by central office staff. So Donahue and others from central office went on the road for 8 months, meeting with staff and foster parents, listening—really listening—and seeking to elicit support for making a change in practice.

Finally, the state implemented a caregiver responsibility contract. This new tool clarifies the role of the caregiver in ensuring stability for the child. (See Appendix C for a sample)

Since the CFSR, for three quarters in a row the state of Vermont has met their goals of placement stability. Clearly this multi-faceted approach has helped the state to move in the right direction.

GEORGIA: FIRST PLACEMENT BEST PLACEMENT

First Placement/Best Placement is a plan by the Department of Human Resources, Division of Family and Children Services (DFCS) to reform Georgia's foster care system. With First Placement/Best Placement, fewer children will enter foster care. They will stay in temporary custody for shorter periods of time before they can either return safely to their families or be placed in adoptive homes. First Placement/Best Placement assures every new child/family coming into care is fully assessed and that the first placement recommended is the best placement to provide the services that meet the needs of the child and family.

When children enter foster care, *both* the child and family receive a comprehensive assessment, including medical, psychological and educational evaluations. The standards for the critical assessments and levels of foster care services were developed with the help of the private sector in a inclusive planning process.

The assessments help caseworkers place children in the most appropriate setting. Through public/private partnerships, Georgia has been developing a pool of specialized homes that will be available for children who have mental, emotional or physical problems.

The Purpose Statement for First Placement Best Placement is as follows:

To improve services for children and families; to ensure appropriate placement, provide stability and expedite permanency for children in care; to promote parental involvement and responsibility; and to increase foster home capacity.

The Guiding Principles of First Placement Best Placement include:

- **Assessment Driven:** Comprehensive family focused, strength based assessments of every family and child in need of foster care.
- **Safety:** Strengthening risk/safety assessment process with children's safety the primary concern.
- **Integrated Services:** Demonstrated collaboration at all levels using Multi-Disciplinary Teams.
- **Partnership with Foster Families:** Foster Families are a crucial part of the interdisciplinary team.
- **Public/Private Partnership:** Demonstrated public/private partnerships.
- **Results Driven:** Efforts are driven by results and demonstrate creativity, innovation and flexibility.
- **Respectful of Culture:** Build on the culture of the children, families and communities served.
- **Systems Approach:** Utilization of a systems approach to working with the family in the community.
- **Participation:** Consumer input and parent's participation and involvement in foster parent/birth parent services.

The Goals include:

- Protect Children and Prevent Further Abuse
- Increase Permanency for Children
- Remove Placement Barriers
- Establish Standards for Serving Children
- Increase Foster Home Capacity Based on Children's Needs
- Achieve Compliance with Federal Law - Adoptions and Safe Families Act (ASFA) of 1997

The Expected Results include:

- Reduce the Number of Moves of Children in Out-of-Home Care
- Reduce the Numbers of Placements
- Increase Family Foster Care Resources
- Decrease the Length of Stay in Placement
- Increase Cost Effectiveness

Since March 1998, five counties have successfully implemented First Placement/Best Placement. The five demonstration sites include Bibb, Colquitt, DeKalb, Screven and Whitfield counties. In January 1999, two additional sites were added. During FY 1999, DFCS is contracting with other agencies that can provide specialized homes for the most troubled children. This expanded network of homes will provide placements for all types of children.

Training to Support the First Placement/Best Placement Initiative

The state of Georgia is committed to training all providers and county staff in order to ensure the success of First Placement Best Placement. The following programs have been specifically designed for private providers and DFCS workers to receive the same technical information on all tools, standards, and policies of the First Placement, Best Placement program.

- ***Child and Adolescent Functional Assessment Scale (CAFAS)***_training for First Placement/Best Placement Providers who will have *direct* responsibility for administrating the CAFAS in their work with children in DFCS custody.
- ***Back to Basics***: This two-day presentation will be an overview of the basic requirements for foster care including the Foster Care service continuum, how to access funds appropriately and a complete review of the newly revised First Placement, Best Placement Manual.
- ***Advanced Training***: This 2-day program is designed to review assessment goals, tools, and standards. Model assessments will be utilized. The program will cover three components: (1) Infant and Child Psychological Assessment, (2) Transitional Youth Assessment, and (3) Family Assessment.

Wrap Around Support

Wrap Around services have recently been offered to assist the reunification process. The services include, but are not limited to, in-home intensive treatment, in-home case management, and crisis intervention. Wrap around service monies can be used to pay for counseling of the foster parent, for counseling of the parent who has a child in foster care and to pay for counseling of a parent and/or child when the child is in after care.

Some of the requirements of those select providers who are authorized to include First Placement Best Placement Wrap Around Supports include:

1. Contractor will make contact with each family referred for services within 3 days of the date of referral unless it is a Crisis Intervention Case, who will be contacted within 24 hours of receiving the referral.
2. Contractor will meet with the DFCS Case Manager within one week of the date of referral to obtain intake information, read family history, and review goals of the DFCS case plan.
3. Contractor will provide written reports of service activity on a monthly basis, and will meet with DFCS case managers as necessary for staffing purposes.
4. Contractor will ensure that clinical staff providing intensive treatment services have a course of study equivalent to a Master's degree in Psychology, Counseling, or Social Work with two years experience in direct provision of child welfare, social work, counseling or therapeutic services to families. Contractor will ensure that in-home staff providing case management services will have a Bachelor's degree in Social Work or a related field. Contractor will ensure that all staff providing any transportation services have valid Georgia Driver's Licenses and Liability Insurance. Contractor will ensure that all staff providing transportation are covered with additional liability coverage. Contractor will ensure that all staff providing transportation obey all traffic laws and practice safe driving, including using child safety seats for all children as covered by Georgia Law.

Focusing on Adolescents

The adolescent component of the First Placement, Best Placement assessment is part of the comprehensive assessment program to successfully guide young people (ages 14 to 21) from foster care to self-sufficiency. The observations and recommendations derived from the assessment are presented at the Multi-Disciplinary Team (MDT) staffings. The MDT explores options for an adolescent and makes suggestions/recommendations about youth moving from the foster care system into independent living. Adolescent assessments are used as a key component in the development of a transitional living plan. The assessment is *strength based, solution oriented and youth centered*. The assessment is designed to be completed in partnership with teens so they can identify areas of strength and challenges as they move toward transition. In addition, collateral interviews are completed with parents, caseworkers and/or teachers.

The assessment serves as a determinant for participation in the Transitional Living Program. The following areas and domains must be evaluated and included as an integral part of the assessment:

- Independent Living Skills
 - Daily Living Tasks
 - Self Care
 - Housing and Community Resources
 - Social Development
 - Money Management
- Family of Origin Strength and Issues
- Interpersonal Relationships and Social Support Networks
- Future Perspective
- Pre-Vocational and Vocational Goals
- Alcohol and Drug Use
- Coping Skills and Self Esteem
- Sensitive Issues
- Interviews with Youth, Caregivers, Caseworkers and Teachers
- Functioning

A report is generated from this assessment, which is used to help develop a Written Transitional Living Plan (WTLP). The WTLP directs the work of the Life Coach and Independent Living Coordinator with the adolescent. The youth receives a summary of the report and a copy of the WTLP.

Evaluation of First Placement Best Placement

DFCS is working with Emory University to evaluate the effectiveness of the plan. Preliminary data from the demonstration sites shows that children are spending less time in foster care, with fewer moves in the foster care system. One out of every four children is able to return to the birth family within 6 months. Of the children who have not returned to their families, almost eight out of ten remain stable in their first placement. The demonstration sites were able to develop 82 new foster homes.

Coupled with First Placement Best Placement, several new initiatives are helping to protect children in foster care. DFCS is using family conferences to speed up placement decisions. State DFCS officials and judges are reviewing the case of every child in state custody, and the University of Georgia is studying the impact of Senate Bill 611 passed in 1996, which frees more children for adoption.

COLORADO: EXPEDITED PERMANENCY PLANNING

The state of Colorado implemented their version of concurrent planning called Expedited Permanency Planning (EPP) in 1994. Colorado law requires that concurrent planning be used to expedite permanency for cases where there is a pattern of habitual abuse of a child. The statute also requires that “efforts to place a child for adoption or with a legal guardian be made *concurrently* with reasonable efforts to preserve or reunify the family.” In late 2001 the statewide implementation EPP was complete—a full three years ahead of schedule. All counties and their respective courts are functioning under the EPP requirements. This initiative continues to provide impetus for Colorado to transform its approach to permanency for the children under the age of six, as required by statute, and for older children as well.

Concurrent Planning as designed by Katz, et al⁹ supports intensifying and expediting efforts to achieve permanence for a child within one year—a timeframe that reflects a child’s sense of the passage of time. The National Resource Center for Foster Care and Permanency Planning defines concurrent planning as a process of:

working towards reunification while at the same time establishing an alternative or contingency back-up plan...concurrent rather than sequential planning efforts to more quickly move children from the uncertainty of foster care to the security of a safe and stable permanent family...¹⁰

Concurrent Planning as implemented in the state of Colorado under EPP offers caseworkers a structured approach to moving children more quickly from the uncertainty of foster care to the stability and security of a permanent family. It is consistent with a family-centered and community-based service orientation because it is rooted in the belief that children need stable families and supportive communities for their healthy growth and development.¹¹ Effective implementation of EPP includes the respectful involvement of parents and family members early in the planning process, as well as identification of “red flags” that might serve as barriers to timely reunification or another permanency outcome. When implemented effectively concurrent planning touches all parts of the child welfare system.

Colorado began their efforts in the pilot sites of Jefferson, Boulder and El Paso Counties in the summer of 1994. The core components of Colorado’s Expedited Permanency Planning at that time included:

⁹ Katz, L., Spoonemore, N., & Robinson, C. (1994). *Concurrent planning: From permanency planning to permanency action*. Mountlake Terrace, WA.: Lutheran Social Services of Washington and Idaho.

¹⁰ National Resource Center for Foster Care and Permanency Planning. (n.d.) Module 1: Nuts and bolts of concurrent planning. *Concurrent Planning Curriculum*. New York: Author. p. 14

¹¹ National Resource Center for Foster Care and Permanency Planning (1998). *Tools for permanency: Concurrent permanency Planning*. New York: Author.

- Early assessment of the core conditions that led to out of home placement, the strengths of the family and the likelihood of reunification within 12-15 months;
- Accelerated hearings—adjudication, disposition, permanency planning and court review processes for children under six (and their siblings when included in the same petition);
 - Reduction or elimination of delays or continuances of judicial hearings.
- Initial placement of a child with a resource family who can, if necessary, become the permanent home;
- Firm time lines for permanency decision-making—usually within 12 months unless there are extenuating circumstances—during which both reunification and alternative permanency options are pursued;
- Full disclosure to the parents and foster parents about these 12-month time lines, services, visitation, court actions and alternative permanency decisionmaking;
- Case planning that includes early and intensive service provision to parents, focusing on parental ability and willingness to make changes to undertake caretaking responsibilities;
- Involving extended families in decisionmaking and in providing care of children removed from their parents' homes;
- Regular visits;
 - While this is occurring in 64 different ways, it is clearly the job of the social worker to keep the family engaged. It is not acceptable to merely state that the family is not engaged so visitation does not need to occur.
- Regular review of progress; and
- When reunification is not possible within a reasonable timeframe, ongoing support to permanency resource parents through and *after* adoption.¹²

In Colorado when a county is moved to implement Expedited Permanency Planning, a comprehensive training for all judges, attorneys and county social work staff takes place. Trainings, such as the cross-systems and ASFA trainings delivered around the state, have helped all those involved with these cases realize the importance of meeting expedited time frames. Over the past several years training and support in the area of child development has been an emphasis. In FY 2003 the training will be looking at several issues, including visitation in regard to parents and children, minority over-representation in child welfare, adequate case planning, and timeline compliance versus the welfare of the family, among others. The training involves local departments of human services, the court, county attorneys, guardians ad litem, and respondent parents' counsel. In short, the training is designed to help the system, as a whole, improve. Additionally, judges and magistrates from around the state were involved in the annual Judicial Conference, which included many issues surrounding families and children. Increased training continues to raise judicial awareness of children's issues, and particularly EPP.

EPP forces the entire system: judicial officers, caseworkers, court appointed special advocates, attorneys, family court facilitators, and parents to be more accountable and responsible for their actions. State representatives are convinced that EPP has been so successful and met with so little resistance because of these ongoing and focused

¹² Schene, P. (2001). *Implementing concurrent planning: A handbook for child welfare administrators*. Portland, ME: National Child Welfare Resource Center for Organizational Improvement, pp. 1-2

trainings and opportunities for dialogue. This ensures that the entire service system is on board and committed prior to full implementation.

Outcomes to Date

Children continue to achieve permanency in shorter time frames through the EPP initiative. This year, of the 864 children reported who should have achieved a permanent placement, 82.9% or 717 children were residing in their permanent homes within one year of removal. Counties report anecdotally that many of the remaining 147 children were placed within a matter of a few months of the year's requirement and believe that although the letter of the law was not met for these children, the spirit of the law is definitely being met as these children also achieved early permanency. The rate of 82.9% is a marked increase in the success rate from only two years ago when counties reported that 72.5% of the children achieved a permanent placement within one year of removal from their homes. It is also an increase over last year's reported 79.5% of children who achieved permanency within one year.

The courts as a whole have improved their compliance with the EPP timelines from last year. Compliance with Adjudications has improved from 81% to 91% statewide. Compliance with Treatment Plan hearings has improved statewide from 84% to 91%, and timely Permanency Hearings have improved from 54% to 61%. Individual districts have also improved dramatically. Some districts have raised their compliance by more than 15%. Judicial officers developed an even greater awareness of the time frames and directed parties involved in the cases to adhere to the time frames. In the 4th Judicial District (El Paso/Teller Counties), for example, a case management document was prominently displayed and circulated in order to alert all parties to the mandate of the EPP time frames. Many family court facilitators closely monitor cases to ensure compliance. For example, as a part of their job, they alert the parties if a case is set outside of the time frames. They also review the cases before and after to alert all parties as to the time frames. The court clerks played a role in this as well. Training was given statewide, under the auspices of the Court Improvement Project,¹³ alerting clerks as to proper data entry with these cases, as well as the timelines to be followed in the cases. This training is cited by many individuals as a part of the awareness raising efforts seen in the trial courts.

Of concern to some state representatives is the fact that 36% were returned this year to the parent from whom they were removed, a drop of 7% from 43% last year. While there may be many reasons for this drop, Carol Wahlgren, Child Protection Treatment Program Supervisor for the state stated

The exceptionally tight timeframes—where we require that a child be in their permanent home within 12 months—places a tremendous amount of pressure on the workers that they may not be conducting as comprehensive up-front assessments and developing as carefully crafted individualized service plans that provide maximum opportunity for family reunification. We need to always monitor and support workers in doing the most thorough job possible.

¹³ The Court Improvement Project is a federal grant received by the Colorado Supreme Court to improve the courts' handling of cases involving children.

ARIZONA: A COMMUNITY RESPITE NETWORK

Respite care—temporary relief for primary caregivers to reduce stress, support family stability, prevent abuse and neglect, and minimize the need for out-of-home placement—is nothing new. Rooted in the deinstitutionalization movement of the late 1960s, during which families became primary caregivers for loved ones previously cared for in hospitals or other facilities, the concept took hold in the '70s as awareness of child abuse and neglect increased and "crisis nurseries" were formed. In the '80s, respite care met the needs of medically fragile infants with HIV/AIDS and prenatal drug exposure; in the '90s, children with serious emotional disturbances and adults with conditions such as Alzheimer's became candidates for respite care.

With each new development, human service agencies retooled to provide temporary safe havens for children and the families who cared for them by expanding existing services or coordinating with other groups to provide respite care. Local networks sprang up as providers sought ways to meet the needs of their clients and to better coordinate funding and access to care. Local initiatives evolved into what has become a national movement to create "cradle to grave" respite networks...Momentum for planned and crisis respite care is rising. But in most communities, such care is a patchwork of formal and informal arrangements that may consist of in-home babysitting by a volunteer or trained service provider, drop-in visits to a day care or therapeutic child development center, short-term stays in a residential facility, child enrollment in a camp or recreational program, or foster parents providing respite for one another. From community to community, the quality and availability of family respite services varies widely in type, scope, duration, cost, staffing, and ease of access...¹⁴

But what is unequivocally clear is the compelling need for such services. According to Susan Abagnale of Casey Family Programs in Tucson Arizona

The need is so great—our clients show us this everyday. We completed many surveys of nearly every population to include adoption, guardianship, foster care, and we reviewed the surveys of caregivers of individuals with mental health issues and those who have developmental disabilities, and in every one of these surveys respite is at the top of list. Caregivers tell us that it is "respite that makes the difference," "respite is what has made it possible for us to continue."

The National Child Abuse Coalition and the Child Welfare League of America support Ms. Abagnale's position. "Planned and crisis respite care prevents child abuse by increasing parents' ability to cope with the pressures of child care, enhancing parent-child communications, and improving family access to health and social services, among other factors."¹⁵ "Foster care managers have been telling us in clear terms 'We need

¹⁴ Green, M.Y. (2002, May). Care for the caregivers. *Children's Voice*, 11(3). p. 8.

¹⁵ National Child Abuse Coalition Quarterly. (June 2002).

respite care for the caregivers," says Pamela Day, CWLA's Director of Child Welfare Services. ¹⁶

However, in spite of the overwhelming support of respite care as a critical component of the continuum of care, the use of respite as a child abuse/placement stability preventive measure for families involved with the child welfare system is not a program currently supported in any great degree by state programs.

In Tucson, Arizona a group attempted to raise the bar on the availability, quality and visibility of respite care. In Tucson approximately 15 agencies offer respite services. Each runs a program that serves a particular population, and services are dependent on whatever regulations and policies may be required by its funding source(s). Approximately two years ago this group came together and formed the Community Respite Care Network. According to Ms. Abagnale they were able to attract quite a few community provider agencies, as well as representatives from the Department of Economic Services, Developmental Disabilities, Mental Health Adoption subsidy and Elder Care, and started to identify barriers and try to assess if there was any commitment to improve the entire system of care. It turned out that there was tremendous energy. They were able to benefit from the National Foster Parent Association (NFPA), who facilitated a two day intense strategic planning process. This very helpful workshop focused on community organizing as a key component of effective respite. They have approached the effort systematically, meeting monthly to address specific issues and determine action steps. The agencies have taken particular care to identify both practice and policy challenges that they face in developing a program that will effectively meet the needs of their community.

The list of challenges to be addressed may be instructive to other groups working toward community collaboration in the provision of respite services. Identified challenges include:

- Defining what respite is;
- Funding;
- Building a sufficient quality pool of providers;
- Sharing information, providers, or resources;
- Meeting the needs of diverse client populations;
- Requiring different skill requirements of providers depending on the clients served;
- Resolving insurance liability issues (such as child safety, loss and damage, provider protection, and agency protection);
- Changing community perception that families are doing well enough on their own;
- Overcoming family reluctance to use respite services; building a confidence in the respite pool;
- Setting standards for quality respite training –thus allowing for the interchange of training resource between providers;
- Improving provider to client ratios; and
- Providing sibling care.¹⁷

¹⁶ Green, M.Y. (2002, May). Care for the caregivers. *Children's Voice*, 11(3). p. 9.

¹⁷ Dougherty, S. (with Yu, E., Edgar, M., Day, P., & Wade, C.). (2002). *Planned and crisis respite for families with children..* Washington, D.C.: CWLA Press.

According to Ms. Abagnal:

We have had tangible results ...with little to no money. We identified cross training opportunities so that a respite provider of an elderly individual could serve as a respite provider for a child with a disability—and the parents could proceed with confidence and a good reference. We have found families who wanted to be respite care providers...and because our training was two months away, we were able to send the family to another provider who had a training in the next week...knowing that the quality of the training was the same as ours. This meant that a family under stress had a respite option much earlier than they might have..

The Community Respite Care Network is seeking to raise the bar on the quality of respite throughout the entire community. They are working on a standard of excellence that can serve as the foundation for all respite care providers. It is a significant challenge for families to recruit, interview and recognize the skill set required to be good respite caregivers. This is a vulnerable situation for families. If their child has been through trauma such as abuse or neglect situation it is all the more fear-provoking. If there are health issues—these require special skill sets. “We want to help alleviate the stress of these choices and to enable families to have tested options...thus minimizing the number of child placement disruptions.”¹⁸

Recently there was an increase in Mental Health respite dollars in the Tucson area. An area provider who has a history of providing foster care respite services bid on the contract and won the award. This event created significant excitement in the network because it started to actually operationalized the vision—where any provider of respite services could provide services to a variety of populations through a cross- fertilization of information and skill set. The Community Respite Care Network hopes to see this evolve in upcoming months and years—resulting in referrals to one another—thus increasing the numbers of providers, the ability to better match respite caregivers and families’ needs.

The other efforts of the Network include:

- Work toward common minimal standards of care for the community;
- Pursue collaborative funding opportunities;
- Explore ways for the agency representatives and family members to work together (including marketing, recruitment, training, and shared families);
- Promote cooperation and coordination of services; and
- Reduce duplication of efforts.

¹⁸ Personal communication with Susan Abagnale. (February 2003).

CALIFORNIA: KINSHIP CAREGIVERS SUPPORT

California's Kinship Support Services Program (KSSP) provides community-based family support services to relative caregivers and the dependent children placed in their homes by the juvenile court and to those who are at risk of dependency or delinquency. The KSSP also provides post-permanency services to relative caregivers who have become the legal guardian or adoptive parent of formerly dependent children. The program aims to help relatives do the best job they can in raising these children so the family can remain together. The program allocates funds to create these services in many communities throughout the state; services can include support groups; respite care; information and referral; recreation mentoring/tutoring; provision of furniture, clothing, and food; transportation; legal assistance; and many other support services needed by kin families.

The facts about Kinship Caregiving

The past three decades have seen a tremendous growth in the number of children living in households maintained by their grandparents, with or without parents present. According to the Census Bureau, this number has increased from 2.2 million in 1970 to 3.9 million in 1997, and over 5 million in 2000.¹⁹ This figure represents 7.7% of all children under 18 living in the United States. A reliance on relatives as caregivers is a practice with a strong historical precedent across many cultures, particularly during times of social and economic upheaval. While various factors have spurred the use of this informal network in recent years, the growth in kin caregivers can also be attributed to the fact that kinship placements have become a formal strategy of overwhelmed child welfare agencies with increasingly limited options. Though a growing proportion of children are becoming the responsibility of relative caregivers (usually grandparents) the public system has not focused on these caregiver needs. A review of 32 state's policies for kinship care strongly indicates that the government's response has been reactive as opposed to planful and proactive.²⁰

However, providing care for Grandmothers and other relatives is critical to child permanency in San Francisco County California. In San Francisco, 1 out of every 6 children is being raised by their grandparents or other relatives. Without supportive services, as many as 22 percent of these fragile families will break apart-placing the child in foster care. One grandmother said:

It's not my choice, it's just something you have to do, and I don't see it any other way. One of my friends said to me once that she thought that maybe I should have let the baby go into a foster home, that maybe it was too much for me. I

¹⁹ Cohon, D. Hines, L., Cooper, B. Packman, W., & Siggins, E. (2000). *Stuart Foundation kin caregiver study*. San Francisco, CA: Edgewood Center for Children and Families.

²⁰ Gleeson, J. & Craig, L. (1994). Kinship care in child welfare: An analysis of states' policies. *Children and Youth Services Review*, 16 (112), 731.

don't feel the same way about that person anymore, because I don't see a choice. It's not a choice, it is something I had to do.

California's Kinship Support Services Program is a public private partnership that was originally launched when the Kinship Support Network (KSN) of the Edgewood Center for Children and Families located in San Francisco, California won a competitive bid from San Francisco's Department of Human Services. Founded in 1851 as a refuge for Gold Rush orphans, Edgewood Center for Children and Families is a not-for-profit social service agency that provides an array of services in homes, schools and neighborhoods. Started over 12 years ago, KSN was developed to meet the growing and unmet needs of grandmothers attending support groups who were caring for their grandchildren. Over 90% of these grandmother caregivers were African American. Early in the program development, it was clear that a traditional bureaucratic response was not going to be effective. These grandmothers were unfamiliar and untrusting of the public social service system. To bridge this gap, The Kinship Network decided to hire elderly African American and Latino grandparents from the communities where the caregivers lived. With training and supervision these paraprofessional community workers effectively link, monitor and provide advice to caregivers, assuming the role of the second and third generations in the informal extended family support group system. Full time community workers carry a caseload of 20 families. They have direct contact with caregivers, visit their homes at least monthly and make at least weekly phone calls. They accompany caregivers to school meetings, doctor appointments, provide transportation for purchasing groceries or other tasks, and generally serve as the support in times of need.

This was the first program in the nation to provide comprehensive, private-sector support services to relative caregiver families. Today for kin caregivers the program provides an array of services including but in no way limited to:

- Respite and Recreation
- Emergency Response
- One-on-one Peer Mentoring
- Parenting Education
- Advocacy
- Clothes Closet
- Health Care Services and Referrals
- Summer Camping Programs for Youth
- Computer Lab
- Housing Assistance
- Long Term Planning for Children

One year after the award of the contract, the Stuart Foundation of San Francisco funded Edgewood's Institute for the Study of Community Based Services to collect descriptive data on the caregivers served by the program and to evaluate the efficacy of services provided. Due to space this paper only contains a sampling of the data available. For a more comprehensive review see the contact list at the end of this paper for Donald Cohon, Institute Director. While it is clear from the extensive research of the Institute that caregivers experience financial and emotional strain and role confusion, and struggle in dealing with the behavioral, health and educational needs of their children, it is also readily apparent that children in the Kinship Support Network homes experience placement stability. While not all of the children are adopted, and as such may not

experience the legal definition of permanence, the data clearly shows that children in this program see themselves part of an extended family. A most interesting figure reported by the caregivers is that only two children out of 725 cases studied in 1999 were involved with the juvenile justice system.

In light of the growing trends in kinship care, community and faith-based organizations can expect to see a growing demand for them to provide services needed by kin caregivers. Some ways in which they can meet this demand include:

Training and supervising paraprofessional “community workers.”: The shift from professional case workers in public agencies to paraprofessional staff managed by private agencies is consistent with widely accepted recommendations to provide outreach services to families through indigenous workers who can collaborate with community organizations, offer transportation, and coordinate multiple service needs.

Offering support groups: Caregivers greatly benefited from access to organized support groups, which supplement the informal support networks these women typically rely on. In addition to serving as a safe place for emotional catharsis, the support groups allowed the women in this study to improve their coping skills through “reframing” —i.e., thinking about their role as surrogate parents in a new, more acceptable way—and “social comparison,” in which they compare their own situation to that of others in similar circumstances.

Providing education and guidance: KSN staff try to teach caregivers about current theories related to child development and how they can incorporate these ideas into their day-to-day parenting. However, while many of the younger caregivers have welcomed this kind of advice, a number of older caregivers have been reluctant to accept new ideas about raising children. KSN’s Community Workers also offer guidance in navigating the school system as well as other public agencies.

Offering opportunities for respite and recreation: Throughout the year, KSN offers a variety of activities for kin caregivers and their children that allow them to get a break from each other. For example, the program sponsors outings for caregivers only as well as supervised activities for both older and younger children, which free their caregivers to pursue their own agenda.

Meeting the children’s needs for medical and dental care, tutoring, and counseling: KSN has teams of professional staff who offer tutoring and counseling for the children in the program. Community Workers and a nurse on staff also refer families to specialty clinics and physicians when needed.

CONCLUSION

Children need permanent caring relationships with adults who love them. The challenge of public child welfare systems is to find innovative ways to achieve this permanence. Barriers of limited flexibility in funding streams, mistrust and poor communications between foster parents and child welfare social workers, lack of available options for children, lack of respite options, and the increasing number of children with significant emotional and behavioral health issues make achieving permanence a daunting challenge. Yet there have been states and providers throughout the country who have found ways to be innovative and creative, and change the patterns of instability and lack of permanence for children. These sites provide hope and encouragement that as a system we can do better for those children and families we serve.

The top recommendations coming out of this paper include:

- Make permanence a high priority! Provide data to staff regularly to let them know the results of their efforts. Celebrate improvements in permanency outcomes.
- Find one way—just one way—to improve the communication and relationships between foster families and social workers. This relationship is key to improved placement stability!
- Change the conversation about the purpose of foster care—ensure that all foster families understand Concurrent Planning and their role in reunification.
- Change the focus of the assessment—safety and risk are just the first steps. What do children and families really need to stay together safely? Train staff on how to conduct good family centered assessments that inform foster care placement.
- Provide respite—just do it!
- Modify contract language, and train providers on the importance of permanence—they must be part of the solution.
- Search for relatives—as if they were your own—and then support them in the task of caring for their kin. Honestly evaluate how the role of paraprofessionals can assist this process!

Contact List

State	Contact	Contact Information
Arizona	Susan Abagnale, Division Director	Casey Family Programs- Tucson 1600 North Country Club Road Tucson, AZ 85716 520/323-0886 X 231
California	Ken Epstein, Director of Programs J. Donald Cohon, Director Institute for Study of Community Based Services	Edgewood Center for Children and Families Kinship Support Services Program Grandparents Who Care 1801 Vicente Street San Francisco, California 94116 415-661-8560
Colorado	Carol Wahlgren Child Protection Treatment Program Supervisor	State Department of Human Services 1575 Sherman Street, 2nd Floor Denver Colorado 80112 303-866-3796
Connecticut	Derith McGann Foster Care Specialist	Department of Children and Families 505 Hudson Street Hartford, Connecticut 06106 860-550-6463
Connecticut	Lynn Gobbard Clinical Director, Foster Mom and Adoptive Mom	KIDSR US New Haven, Connecticut 203-865-5437
Mississippi	Gayle Young Placement Unit Director	Department of Human Services Division of Family & Children's Services 750 N. State Street P.O. Box 352 Jackson Mississippi 39205 601-359-4995

State	Contact	Contact Information
South Dakota	Duane Jenner Foster Care Specialist	South Dakota Department of Social Services Child Protection Division 700 Governors Drive Pierre, South Dakota 57501 605-773-3227
Vermont	Shaun Donahue Community Resources Unit Manager	Social and Rehabilitative Services 103 South Main Street Osgood Building Waterbury, VT 05671 802-241-2259

Appendices

Supervisor _____
Worker _____
Licensing Worker _____

PLACEMENT RESOURCE MONTHLY REPORTING FORM

Child's Name: _____

Report for the Month of: _____

Please note significant happenings during the month

1. **At School:** (IEP's, grade reports, conferences, awards, behavioral issues, etc.)

2. **Medical, Dental, :** (Dates, cost, and type of services—name of doctors)
Are there any health issues that need further attention?

3. **Special Events:** (Activities and achievements)

4. **Clothing:** (List clothing items and costs)

5. **Behaviors:** (as it related to separation, attachment, and loss)

6. **Mental Health:** (issues being working on with therapist) (issues you have been asked to work on by the therapist) How much time have you spent discussing issue, strengths, techniques with the therapist on parenting the child?

7. **Connections:**
 - Visits with parents, date, where visit was held, and behaviors prior and after visits.

 - Visits with siblings, date, where visits were held, and behaviors prior and after visits.

 - Attachment, separation, loss issues observed

 - Cultural connections

 - Life Book (worker involvement, child involvement, your involvement)?

Appendix A: South Dakota Draft Monthly Reporting Form

8. Were you informed about permanency, review, other court hearings, and PPRT's that were scheduled this month? If so, were you given the opportunity to attend?

9. What is the child's permanent plan?

10. Concerns/assessment/support services needed or provided:

11. Agency contact (when, with who, what type)

12. Would you like more contact?

Return to the office with your billing forms at the end of each month.

Signature Date _____

ASSESSMENT/NEEDS RESULTS

- 1.) **Identified needs of the child?**

- 2.) **Identified needs of the foster parent?**

- 3.) **List the support services: (ie. Childcare issues, respite care, etc.)**
 - a.) **already in place**

 - b.) **still needed**

- 5.) **For those support services still needed, what is the plan to put these in place?**

- 6.) **Concerns/issues**

- 7.) **How will these concerns/issues be addressed?**

- 8.) **Legal status of case**

Social Worker

Supervisor

Date

Social Worker _____
Supervisor _____
Licensing Worker _____
Licensing Worker Supervisor _____



PIP Points

Quality Assurance: District Reviews

What is our Quality Assurance System?

Our newly adopted quality assurance system will monitor, evaluate and provide feedback to the Division on the performance of the system of care and whether services provided are of sufficient intensity, scope and quality to meet the individual needs of children and their families. It will confirm strengths, identify successful strategies and recommend ways in which effective practice and system performance can be replicated or improved. The QA system consists of two phases. Phase I focuses on a new district review that mirrors the Child and Family Services Review.

What is a District Review?

The District Reviews are an important tool that will enable the Division to accomplish the following: (1) ensure conformity with Federal and State child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; (3) identify strengths; and (4) assist districts and communities to enhance their capacity to help children and families achieve positive outcomes in the areas of safety, permanency and well-being.

What is the District Review Process?

Each district review is a two-stage process that consists of a District Self-Assessment and an Onsite Review of the Division outcomes and systemic factors. The entire process takes 28 weeks. The Self-Assessment provides districts with the opportunity to examine data relating to their practice and programs and to consider the data on light of programmatic goals and outcomes for children and families served by them. The self-assessment process leads to identification of areas where the district is performing well and those areas that need further examination through community discussion and the onsite review.

After the District Self-Assessment, a review team consisting of SRS staff from other districts and community representatives conduct the onsite review. The onsite review is an examination of ten cases and interviews with key participants in each case. This portion of the review is primarily designed to gather qualitative information to evaluate services and outcome achievement.

At the end of the review, each district will be required to develop a District Plan addressing areas identified as needing improvement as well as other issues. The quality assurance unit will support districts with technical assistance throughout the review process and field service managers will support and monitor implementation of the district plans.

What is the Schedule for District Reviews?

Currently there are four reviews scheduled. The process for the first review has already begun, with the onsite review scheduled for the week of May 5, 2003. An onsite review will follow every other month until all 4 are completed at which time we will have a schedule for the remaining districts. As we proceed we will be evaluating the process and making adjustments as necessary to ensure the reviews are a meaningful tool for districts and communities to enhance their capacity to help children and families achieve positive outcomes.

How Can You be Involved?

There are several ways to participate in a review. You may be invited to participate in a survey or a focus group addressing a particular issue or outcome. You may be interested in being on a review team, in which case you will be required to attend a daylong training in April (more information at a later date). Districts under review may need volunteers to help with planning and scheduling. Finally, if you are involved in direct services you may be asked to participate in an interview. Contact the SRS director in your community to see if they are scheduled for a review and express your interest.

Want to Learn More About District Reviews?

Contact your local SRS director or Sheila Duranleau at 241-2669 or sduranleau@srs.state.vt.us.

VERMONT SOCIAL AND REHABILITATION SERVICES
CAREGIVER RESPONSIBILITIES

Child's Name: _____ **Child's Case #:** _____

District: _____

Caregiver: _____ **Worker:** _____

Date: _____

LOC1 Medical/ Physical Health & Well-Being		
L1	Caregiver provides routine medical or physical treatment, or personal care management including the management of prescribed medications.	<input type="checkbox"/>
L2	Caregiver required to make accommodations to monitor and manage condition in the home AND arranges and participates with additional visits to specialists or other related services.	<input type="checkbox"/>
L3	Child or youth requires total assistance and is dependant on the caregiver. Caregiver required to vigilantly monitor and manage interventions.	<input type="checkbox"/>
	Outline the caregiver responsibilities:	
LOC2 Family Relationships/Cultural Identity		
L1	Caregiver supports efforts to maintain and develop positive family relationships, healthy attachments and cultural identity.	<input type="checkbox"/>
L2	Caregiver arranges and supervises visits and other activities to maintain and develop positive family relationships, healthy attachments, and cultural identity.	<input type="checkbox"/>
L3	Caregiver works with the primary family to co-parent child, sharing parenting responsibilities	<input type="checkbox"/>
	Outline the caregiver responsibilities:	
LOC3 Supervision/Structure/ & Behavioral		
L1	Caregiver provides structure and supervision to assist child in learning appropriate self-control and problem solving skills.	<input type="checkbox"/>
L2	Caregiver required to monitor child closely and work with others to develop, implement, and monitor specialized behavior management or intervention strategies	<input type="checkbox"/>
L3	Child/Youth has severe or chronic behavioral needs that seriously interfere with functioning in home, school, and community. One caregiver required to be available at all times to provide structure and supervision as needed.	<input type="checkbox"/>
	Outline the caregiver responsibilities:	

Appendix C: Vermont Caregiver Responsibilities

LOC4 Education/Cognitive Development		
L1	Caregiver supports educational activities, helps with homework, and communicates with the school and other providers as needed. Child/youth is not enrolled in an educational program, and is pursuing GED, job training, or some other alternative outlined in the case plan.	<input type="checkbox"/>
L2	Caregiver required to maintain formal communication with educators and participate in special meetings or to provide early educational services in the home.	<input type="checkbox"/>
L3	Caregiver works with school to carry out a comprehensive home/school program requiring daily communication.	<input type="checkbox"/>
	Outline the caregiver responsibilities:	
LOC5 Socialization/Age-Appropriate Expectations		
L1	Caregiver provides and arranges for child's participation in appropriate community/enrichment activities to encourage interaction and healthy relationships with peers and other community members.	<input type="checkbox"/>
L2	Caregiver required to monitor interactions and adapt activities to promote age-appropriate peer interaction and relationship with other community members.	<input type="checkbox"/>
L3	Caregiver required to provide ongoing, one-to-one supervision and instruction for the child to participate in community/enrichment activities.	<input type="checkbox"/>
	Outline the caregiver responsibilities:	
LOC6 Support/Nurturance/Emotional Well-Being		
L1	Caregiver provides a safe, stable, supportive and nurturing home environment that meets the child's day-to-day needs. Caregiver arranges for counseling or other mental health services as needed.	<input type="checkbox"/>
L2	Caregiver consults and shares information with other professionals to address identified on-going mental health issues and follows through with a specific intervention strategy to promote emotional well-being.	<input type="checkbox"/>
L3	Caregiver works with mental health professionals to implement and coordinate intervention strategy to assist child/youth and community in managing serious emotional difficulties and crises.	<input type="checkbox"/>
	Outline the caregiver responsibilities:	

Appendix C: Vermont Caregiver Responsibilities

LOC7 Transportation		
L1	Caregiver(s) provides or arranges for transportation for child to attend school, child care, community activities, family visits and scheduled appointments as defined in the case plan	<input type="checkbox"/>
L2	Child/Youth has needs requiring caregiver(s) assistance with and/or provision of transportation at least eight times per week in order for the child to receive necessary services as defined in the case plan, in addition to routine transportation needs.	<input type="checkbox"/>
L3	Child/Youth has needs requiring caregiver(s) assistance with and/or provision of transportation more than eight times per week in order for the child to receive necessary services as defined in the case plan, in addition to routine transportation needs.	<input type="checkbox"/>
	Outline the caregiver responsibilities:	
LOC8 Case Plan Participation		
L1	Caregiver(s) maintains open communication with SRS about child's progress and adjustment to placement as necessary, and is available to attend periodic meetings or court hearings as requested.	<input type="checkbox"/>
L2	Child/Youth's needs requires monthly involvement/participation by the caregiver(s) in activities such as case planning, attending case reviews, court hearings, and monthly multi-disciplinary team meetings, coordination and communication with treatment team members.	<input type="checkbox"/>
L3	Child/Youth's needs requires weekly involvement/participation by the caregiver(s) in activities such as case planning, attending case reviews, court hearings, and multi-disciplinary team meetings, coordination and communication with treatment team members.	<input type="checkbox"/>
	Outline the caregiver responsibilities:	
<hr/> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Caregiver Signature/Date</p> </div> <div style="text-align: center;"> <p>Social Worker Signature/Date</p> </div> </div> <p>Final/Assigned Level of Care: <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2: <input type="checkbox"/> Level 3:</p> <hr/> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Supervisor Signature/Date</p> </div> <div style="text-align: center;"> <p>District Director Signature/Date</p> </div> </div>		

**LEVEL OF CARE ASSESSMENT/REASSESSMENT ITEM
DEFINITIONS & FOSTER PARENT EXPECTATIONS**

LOC1. Medical/Physical Health & Well-Being

- L1: Caregiver (s) arranges and participates, as appropriate in routine medical and dental appointments; provides basic health care and responds to illness or injury; administers prescribed medications; maintains health records; shares developmentally appropriate health information, including sexuality education, with the child.
- L2: Caregiver(s) arranges and participates with additional visits with medical specialists, assists with the treatment and monitoring of specific health concerns, and provides periodic management of personal care needs. Examples may include treating and monitoring severe cases of asthma, physical disabilities, and pregnant/parenting teens.
- L3: Caregiver(s) provides hands-on specialized interventions to manage the child's chronic health and/or personal care needs. Examples include using feeding tubes, physical therapy, or managing HIV/Aids.

LOC2. Family Relationships

- L1: Caregiver(s) supports efforts to maintain connections to primary family, including siblings and extended family, and/or other significant people as outlined in the case plan; prepares and helps child with visits and other contacts; shares information and pictures as appropriate; helps the child to form a healthy view of his/her primary family.
- L2: Caregiver(s) arranges and supervises ongoing contact between child and primary family and/or other significant people or teaches parenting strategies to other caregivers as outlined in the case plan
- L3: Caregiver(s) works with primary family to co-parent child, sharing parenting responsibilities, OR supports parent who is caring for child AND works with parent to coordinate attending meetings and appointments together. Examples include co-parenting, primary family lives with caregiver, attending meetings with doctor, educations, therapist together.

LOC3. Supervision/Structure/Emotional & Behavioral

- L1: Caregiver(s) provides routine direct care and supervision of the child; assists child in learning appropriate self-control and problem solving strategies; utilizes constructive discipline practices that are fair and reasonable and are logically connected to the behavior in need of change, adapts schedule or home environment to accommodate or redirect occasional outbursts
- L2: Caregiver(s) works with other professionals to develop, implement and monitor specialized behavior management or interventions strategies to address ongoing behaviors that interfere with successful living.
- L3: Caregiver(s) provides direct care and supervision that involves the provision of highly structured interventions such as using specialized equipment and/or techniques and treatment regimens on a constant basis. Examples of specialized equipment include using alarms, single bedrooms modified for treatment purposes, or using adaptive communication systems, etc.; works with other professionals to develop, implement and monitor strategies to intervene with behaviors that put the child or others in imminent danger or at immediate risk of serious harm.

LOC4. Education/Cognitive Development

Appendix C: Vermont Caregiver Responsibilities

- L1: Caregiver(s) provides developmentally appropriate learning experiences for the child noting progress and special needs; assures school or early education intervention participation as appropriate; supports the child's educational activities; addresses cognitive and other educational concerns as they arise.
- L2: Caregiver(s) maintains increased involvement with school staff to address specific educational needs that require close home/school communication for the child to make progress AND responds to educational personnel to provide at-home supervision when necessary; or works with other to implement program to assist youth in learning life skills or job training.
- L3: Caregiver(s) works with school staff to administer a specialized educational program AND carries out a comprehensive home/school program (more than helping with homework) during or after school hours.

LOC5. Socialization/Age-Appropriate Expectations

- L1: Caregiver(s) works with others to ensure child's successful participation in community activities; ensures opportunities for child to form healthy, developmentally appropriate relationships with peers and other community members, and uses every day experiences to help the child learn and develop appropriate living skills.
- L2: Caregiver(s) provides additional guidance to the child to enable the child's successful participation in community and enrichment activities AND provides assistance with planning and adapting activities AND participates with child when needed. Examples include shadowing, coaching social skills, sharing specific intervention strategies with other responsible adults, etc.
- L3: Caregiver(s) provides ongoing, one-to-one supervision and instruction (beyond what would be age appropriate) to ensure the child's participation in community and enrichment activities AND caregiver is required to participate in or attend most community activities with the child.

LOC6. Support/Nurturance/Well-Being

- L1: Caregiver(s) provides nurturing and caring to build the child's self-esteem; engages the child in constructive, positive family living experiences; maintains a safe home environment with developmentally appropriate toys and activities; provides for the child's basic needs, and arranges for counseling or other mental health services as needed.
- L2: Caregiver consults with mental health professionals to implement specific strategies of interacting with the child in a therapeutic manner to promote emotional well-being, healing, and understanding, and sense of safety on a daily basis.
- L3: Caregiver(s) works with services and programs to implement intensive child-specific in-home strategies of interacting in a therapeutic manner to promote emotional well-being, healing, and understanding, and sense of safety on a constant basis.

LOC7. Transportation

- L1: Caregiver(s) provides or arranges for transportation to attend school, childcare, community activities, family visits and scheduled appointments as defined in the case plan.
- L2: In addition to routine transportation needs, the caregiver(s) provides assistance with and/or provision of transportations at least eight times per week in order for the child to receive necessary services as defined in the case plan to address various needs.
- L3: In addition to routine transportation needs, the caregiver(s) provides assistance with and/or provision of transportations more than eight times per week in order for the child to receive necessary services as defined in the case plan to address various needs.

Appendix C: Vermont Caregiver Responsibilities

LOC8. Case Plan Participation

- L1: Caregiver(s) keeps SRS social worker and other service providers informed about the child's progress and problems; is available to attend meetings or make court appearances as requested; discusses and cooperates in the case plan development.
- L2: Caregiver(s) maintains frequent (bi-weekly) and close communication with SRS social worker and/or other service providers AND participates at least monthly in scheduled multi-disciplinary treatment meets AND provides reports as requested in the treatment plan; assists in developing and monitoring intervention strategies as outlined in the case plan.
- L3: Caregiver(s) collaborates with SRS social worker and other providers to implement the treatment plan AND communicates the child's status at least weekly AND provides written reports regarding agreed upon areas as outlined in the treatment plan; works with SRS and other treatment team members, in conjunction with the case plan such as facilitating discussions between service providers, arranging and coordinate education, treatment, and health services, etc.