Winter/Spring 2000 Volume 1 No. 1

PERMANENCY PLANNING TODAY

The Semi-Annual Newsletter of the National Resource Center for Foster Care and Permanency Planning
Hunter College School of Social Work of the City University of New York
129 East 79th Street • New York, NY 10021

PHONE: 212-452-7053 • FAX: 212-452-7051 • E-MAIL: nrcfcpp@shiva.hunter.cuny.edu

A Note from the Director...

We welcome our readers to this edition of our semi-annual newsletter, "Permanency Planning Today" – the first supported by our new cooperative agreement with the Children's Bureau establishing the National Resource Center for Foster Care and Permanency Planning at the Hunter College School of Social Work in New York City. We are honored to have been refunded, allowing us the opportunity to continue providing training, technical assistance and information services to States, localities, Tribes and other federally administered or supported child welfare agencies. Our aim is to assist child welfare agencies to improve the quality of foster care services and renew staff commitment to permanence for children. Through our work, we are also able to assist child welfare agencies in the effective implementation of the Adoption and Safe Families Act of 1997 (ASFA) and existing MEPA and ICWA legislation, as well as provide assistance through other collaborative ancillary activities that support the efforts of training and technical assistance to sustain systems change efforts.

In This Issue

By changing our name to the National Resource Center for "Foster Care" and "Permanency Planning," the Children's Bureau acknowledges the complex reality that foster care as a service for vulnerable children should be temporary. It makes an explicit statement about the need to provide quality foster care services for children who can not remain safely with their parents or guardians, and the need to simultaneously - or concurrently - ensure that plans and decisions about children's timely permanence, stability, and continuity in family relationships are linked to safe, quality family-centered foster care services. We further believe that child welfare agency efforts to effectively implement new federal and state legislation must be linked to children's urgent developmental needs for emotional and legal permanence, and the collaborative planning processes needed to meet those needs.

And we know that permanency planning must begin when child welfare agencies first come in contact with families. Thus, we view permanency planning as a mix of efforts to safely limit entry into and reduce time children spend in out-of-home care, as it is widely acknowledged that the uncertain and long-term nature of the foster care experience has a negative impact on children's overall sense of belonging and emotional well-being (Sudia, C. 1986). Additionally, family, community, agency and judicial collaborations are needed to accomplish child welfare safety, permanency and well-being goals because more can be accomplished with the resources of many than any one entity can accomplish alone.

FUNDED BY THE Children's Bureau/ACF/DHHS

Over the course of the next five years we will creatively address emerging issues and concerns related to the provision of quality foster care services and effective permanency planning. We will disseminate information about model programs and innovative strategies to serve children and families. And we will convene opportunities for diverse perspectives to be heard.

In this issue of Permanency Planning Today, we highlight concern about the over-representation of poor children and families of color in our child welfare systems. The impact of a changing social, economic and political environment coupled with persistent poverty, alcoholism, easy access to highly addictive drugs, and pervasive racism has brought an over-representation of impoverished children and children of color into the public child welfare system. It is estimated that 65% of the foster care population is comprised of children of color who remain in care longer than any other group (Barbell, K. 1996). Factors that place children at risk of longer stays include residing in an urban area, being placed in kinship care, being placed as an infant, lack of services, and being African American (Wulczyn, F. Brunner, K, Goerge, R. 1999). Connect for Kids (Kellam, S. 1999) reports that while African American children constitute only 15 percent of the U.S. child population, they represent 49 percent of the foster care population nationwide – and a higher percentage in our large urban areas such as New York, Chicago, Baltimore or Washington, DC. Other research has found that poverty, single parenthood, and ethnic minority status are correlated with reports of child abuse and neglect and with entry into foster care (Lindsey, D. 1994; Waldfogel, J. 1998). In 1990, for the first time, there were more African American children in care than Caucasian. Latino children represent the fastest growing ethnic group in foster care–with a 172% increase from 1982-1990 (Tartara 1993). Indian children are also over-represented in the child welfare systems in many states and are more often placed in the most restrictive settings (National Indian Child Welfare Association, 1999).

A number of studies also indicate that as the percentage of children of color has increased dramatically in the past 30 years (Connect for Kids, 1999), they have received differential treatment in the foster care system – with African American children remaining longer in care and less likely to have service plans or regular contact with their families than other children; Latino children less likely than Caucasian children to have service plans and contact with their parents (Child Welfare League of America,1998); and Indian children more likely to experience termination of parental rights than other ethnic groups (National Indian Child Welfare Association, 1999).

To address these long-standing inequities, we have selected a mix of articles for this issue of "Permanency Planning Today" that in combination broaden our understanding of the experiences of poor and over-represented populations, as well as pose recommendations for improving services to vulnerable families and children involved in the child welfare system. Each article addresses a different issue or population of vulnerable and over-represented children. Pamela Walker helps us to confront assessment and decision-making biases; Juanita Milon suggests mentoring strategies to help parents navigate the system; Max Moran addresses the needs of immigrant youth aging out of the foster care system; Elysa Gordon and Sheryl Decker shed light on the unmet health care needs of poor children in foster care; and Terry Cross lends a view of the history of child welfare services with Indian children and families and the challenges of meeting the mandates of the Indian Child Welfare Act of 1978 in light of ASFA's new timeframes for permanency planning and decision-making.

We have taken just one step towards deepening our awareness and understanding of the issues that contribute to the over-representation of poor children and children and families of color in the child welfare system. This is a dialogue we plan to continue in our collaborative work throughout the country. We hope you will let us know what you think of this issue of our newsletter, and share with us ways you have addressed these complex and often difficult issues in your own agencies.

Sarah B. Greenblatt

BIBLIOGRAPHY

Barbell, K. 1996. Foster Care Today: National and South Carolina Perspective. Child Welfare League of America.

Child Welfare League of America.1998. Foster Care Fact Sheet.

Kellam, S. 1999. The Color of Care. Connect for Kids. Benton Foundation. www.connectforkids.org

Lindsey, D. 1994. The Welfare of Children. New York: Oxford University Press.

Tartara, T. 1998. "VCIS Research Notes, No. 14: Child Substitute Care Flow Data for FY 96, US Child Substitute Care Population Trends." Washington, DC: American Public Welfare Association–now American Public Human Services Association

Sudia, C. 1986. Preventing Out-of-Home Placement of Children: The First Step to Permanency Planning. Children Today. 15(6) 4.

Waldfogel, J. 1998. The Future of Child Protection: How to Break the Cycle of Abuse and Neglect. Cambridge, MA: Harvard University Press.

Wulczyn, F. Brunner, K, Goerge, R. 1999. Foster Care Dynamics 1983-1997. A Report from the Multistate Foster Care Data Archive. Chicago: The Chapin Hall Center for Children at the University of Chicago.

A Model for Examining Personal Biases

by Pamela J. Walker, M.S.W., L.M.F.T.
Trainer/Consultant with the Department of Social Work, Child Welfare Training Centre, California State University, Long Beach

Many of us who review characteristic data on children in out-of-home care are struck by the disproportionate percentage of vulnerable children (children of color, of poverty, of substance abusing families) compared to the percentage of these groups within the population as a whole. This concern with over-representation has led us to look for explanations. What's going on? Are some cultural groups less able to parent children safely than others? Does poverty prevent parents from providing adequate care for children? Does parental abuse of drugs or alcohol always signal high risk to children? As human services practitioners we know that these suppositions are general and mostly incorrect. But what then accounts for the discrepancy? From our personal experience in public child welfare, we believe that personal bias may influence decision-making. What are our individual, agency and professional beliefs about hitting children? What are our beliefs about substance use? Why isn't social cocaine use as permissible as social drinking? Is it okay for older siblings to care for younger ones and if so, at what age? Do the standards we apply in assessing child safety differ from family to family? Culture to culture? Who helps the worker evaluate risk to the child when the primary assessment process usually occurs behind closed doors in the family's home? A supervisor is only as effective as the information that is consciously or unconsciously filtered, edited, and shared by the worker. The information that workers give their supervisors is based on their own perspective and what they see, what they take to be important, what they determine to be risky depends in part on their personal belief system and may not be the same as what is objectively risky.

As a profession we are concerned with being objective and not allowing our biases to intrude on decision-making. We have trained on cultural awareness and sensitivity to cultural bias (culture not solely as ethnicity but as the integrated pattern of belief and behavior of any group). These sessions, usually conducted by outside "experts" who do not know the workers, are often less than successful, in part because the workers are not particularly willing to explore or to expose their own biases in this open setting. Although biases and personal beliefs are unlikely to change because they are so deeply rooted and long held, we believe they can be addressed and applied to casework issues. The unit or team setting is the best forum for this work as the supervisor and co-workers know each other, know their cases, have established confidentiality and a level of trust, and have learned how to support each other. Within a larger, three-day Case Conferencing Training for Child Welfare Supervisors, we have developed a model to facilitate workers looking at personal beliefs, or what we call "templates."

The Templates model leads workers through three stages. The first is to discuss within the group personal childhood experiences on a selected topic; for example, poverty, alcohol or drug use, discipline, cleanliness, working mothers. The second step is to articulate as adults what sense was made out of these experiences and what generalizations we might make from these experiences. This adult generalization is the template or filter through which we view the world. The third step is to discuss how these generalizations might impact our work with families. For example, two workers might share with their co-workers that they grew up in homes with alcoholic fathers. In one family the father came home from work and drank consistently until he was ready to pass out at which time he excused himself and went to bed. There was never any yelling, nastiness, or violence, just a quiet receding from the family. The first worker's adult generalization might be that alcoholic fathers are distant, withdrawn, unapproachable but basically not angry or dangerous. In the second family the father drank daily, was routinely fired from jobs due to his drinking, and was loud, violent and destructive around his wife and children. The second worker may have made the adult generalization that alcoholic fathers are abusive and dangerous. If both these workers receive the same case of an alcoholic father it is likely that they would see different families, collect different evidence and most importantly they might make quite different decisions concerning detention and placement. One worker might minimize signs of risk in the client family while the other worker might view the case through a filter of his/her own nega-

tive experience with alcohol and collect risk factors that show the children at extremely high risk.

Obviously workers do not act solely through their templates. Workers interview, assess, and make decisions on the information they obtain from and about the individual family in consultation with their supervisor. However, the real danger of operating from templates (and we all do!) is that workers may be unaware that these filters exist and they believe that they are always objectively gathering information. For example, a cleanliness template may prevent a worker from accurately assessing the safety of a living situation. What is the risk versus what is the worker's template about people who aren't clean? A worker, whose template is that there is never a need for corporeal punishment, may honestly see higher risk to a child who has been hit (with no physical harm to the child) than actually exists. Once a template is in play it is difficult, if not impossible, to take in any information other than that which fits the template. Templates do not change very much: they are part of who we are. Our best hope is to be aware of them when we are making decisions about other people's lives.

The Templates model provides an easy way for workers to talk about their beliefs and assumptions in a non-judgmental way. It also gives supervisors important and useful information on where workers may have particular difficulty in being as objective as possible. How do supervisors find the time to do this exercise? Perhaps the only absolute truth about child welfare practice is that workers, supervisors and administrators are extremely busy. Simply meeting regulatory mandates is more than a full time job. Adding a new activity, no matter how worthy, means that some other activity will not be done, or done as well. In our overloaded child protective system, prioritized and monitored activities that have consequences are what get done; what isn't, doesn't happen. Our experience is when management commits to unit-based professional staff development, including discussion of cultural bias, it works and works well. Without this support, supervisors respond to other important administrative demands. Once begun, however, supervisors and workers alike rely on this time and format to consult, learn and develop professionally.

To incorporate unit-based professional development in the unit's schedule, note the existing frequency of unit meetings (usually weekly or bi-weekly). Dedicate every other meeting to new information, compliance issues, and other policy and procedures issues. This frees up half the currently scheduled unit meeting time for professional development. This will require the supervisor to structure the compliance unit meetings more carefully, deciding what must be discussed and what can be handled in other ways. This planning initially takes more time but the rewards are immense. Workers feel validated and supported in their professional work, supervisors have more direct connection to their workers and their professional and personal issues, and the unit acquires and maintains commitment to the work we do.

Pamela Walker and her husband, Michael Walker, an administrator with Los Angeles County Department of Children and Family Services, developed and train Case Conferencing for Child Welfare Supervisors.

SELECTED RECOMMENDATIONS TO IMPROVE CHILD WELFARE SERVICES TO OVER-REPRESENTED POPULATIONS

by Sarah B. Greenblatt
Director, NRCFCPP
(Adapted from "Necessary Components of Effective Foster Care and Adoption Recruitment" developed by the National Resource Centers for Permanency Planning and Special Needs Adoption 1997)

- *Talk about race, class and culture at all levels of staff within your agency and address issues of assessment and decision-bias.*
- *Assess the prevalence of over-represented populations and determine a mix of agency-specific strategies to address the special needs of minority as well as other families and children.*
- *Assess and determine the need in your locality to improve cultural competence and utilize the natural community mechanisms to provide services and recruit families for children.*
- *Recognize that all kinds of families can change with the right education and supports.*

- *Acknowledge that children need information about who they are, where they have come from and where they are going.*
- *Consider the potential of diverse families as resources for children in need of permanent placements.*
- *Recruit and support staff from the same cultural/racial heritage as the children and families.*
- *Offer a welcoming approach to all families, children and prospective foster/adoptive families to minimize negative effects of bureaucratic procedures and as a means of reaching out to minority families.*
- *Locate offices so they are readily accessible to members of the community and are located in the community.*
- *Have persons who are culturally competent and sensitive in key placement and permanency planning decision-making positions in the agency.*
- *Have written materials in the language of the community served and staff able to communicate in the language and dialect of the community.*
- *Seek blood and non-blood kin as potential resource families to preserve cultural continuity.*
- *Seek other families in the community who are comfortable with diversity and help children remain connected to their culture of origin.*
- *Encourage and support foster parent adoptions (relatives or non-relatives) to maintain continuity in children's care when they cannot return to birth parents.*

From Within the System: A Parent's Point of View

by Juanita Lynne Milon, MSW
Program Supervisor,
Adult and Adolescent Partial Services,
South Jersey Behavioral Health Resources
Member of the NRCFCPP Advisors Group

The issue of minority over-representation in the foster care system has been long documented. We know that children of color enter and remain in the foster care system at rates significantly higher than those of white children. We know that factors such as income, employment, education, culture and living environment contribute to the rate of placement. We know that cultural misunderstanding about issues such as teenage pregnancy, drug and alcohol use, and parenting skills also play a role in placement of children of color. There are numerous articles and studies that speak to the positive impact of early interventions, such as parenting education, in-home and out-of-home services, how they are rendered and what impact they have. Yet still we are faced with increasing numbers of children, especially those of color, entering and remaining in the foster care system. While we lament why services seem to be minimally effective, why caseworkers may have negligible effects on reducing the incidences of child abuse and the resulting placement, and why the fostering system has not become the temporary respite it was designed to be, children continue to be "placed."

They are "placed" in the middle of an overwhelmed, understaffed child welfare system. "Placed" in foster homes whose parents are overwhelmed by the complex issues they present. Children continue to be "placed" in homes that often re-victimize them; and are "placed" away from their cultural and biological roots. "Placed" in the dilemma of wanting to belong when few connections are available to them. Children, who want to be loved, nurtured and have a sense of security about the present and future are "placed" without answers to basic questions about who they are. Most alarmingly, four and five generations of family histories have been "placed" in the archives of child welfare agencies.

Biological parents, while not experiencing placement in the physical sense as their children do, are also "placed" in many ways. They are "placed" in the midst of changing policies and rules about how they can discipline their children. They are "placed" in front of caseworkers that don't look like them and/or understand their family history and way of life. They are "placed" in the presence of judgements and indictments about what they've done without necessarily understanding the ones who are judging them or the language they speak. This presentation may be biased because I was a foster child and am a parent who experienced being "placed" on both levels. I am also a person who is of color, but unclear as to my ancestry because I was "placed" at birth.

I could tell you stories of my personal experiences. They would be numerous and traumatic, but also there would be moments of tremendous joy and fulfillment. I would prefer, however, to present some suggestions based on these experiences that may be more helpful towards contributing to improved services to children and families of color and there-

fore more positive outcomes for those whose experiences of being "placed" I share.

Mentoring

First let me suggest mentoring as an option. Not just mentoring for children at-risk of placement or in placement but mentors as an option for birth families, parents and guardians. We know that mentors for youth both as a preventive and intervening method have produced enough positive outcomes that a national movement was constructed and led by the President and Colin Powell. What if parents who evidenced a need for systemic involvement were introduced to an advocate/mentor who, like themselves, had faced similar obstacles? This type of mentoring from those who had developed the skills necessary to produce a successful resolution for their families could be effective for many reasons. While caseworkers are most often well intended and possess the requisite educational skill base to intervene with families at risk, they often do not or cannot relate to a family in the same way as a person who has been involved with the child welfare system. Barriers that social workers are trained to overcome, such as culture, language and understanding the impact of socioeconomic stressors could be addressed through simply relating from an "I've been there" perspective. We support and advance the notion that recovering drug addicts are best able to assist other addicts. Would the same rationale not apply to at least some of these child welfare cases? Mentoring from someone who looked liked me, spoke in a manner that I could understand and could relate to but not support my inadequacies, may have produced more meaningful results.

When a family is in crisis, children and foster parents receive supports. The adults in the family of origin have no one who is there just to support, educate and acknowledge them and their struggle. They are often left feeling attacked, judged and abandoned, especially if the child is removed from the home. They are then expected to do the things the case plan requires with little to no intensive assistance. Having the assistance and support of a mentor could make a difference in both how receptive they are to initial interventions and how productive they are in following through with the recommendations for reunification. If we supported the parents differently at the initial point of intervention and in subsequent interventions, would not more responsive and productive outcomes, i.e. fewer placements, result? Might parents be less resistant and more accepting of the "help" offered to them and their children? From my personal and professional experience, the answer is yes. I once acted in a role similar to this and can personally attest to the difference in reaction and response when I presented myself as a parent who had experience with the child welfare system and workers.

Non-Judgmental Approaches

Second, how do we remove the harsh and negative judgements, often directed at parents deemed to be "abusive"? Parents who have never physically disciplined their children would concur that there have been moments when their patience was tested. While acknowledging that there are cases of abuse and neglect that few of us can comprehend or identify with, in most cases simply approaching the family from a more human and humane perspective could have produced far different results. While this includes and

embraces the need for a more culturally responsive system of care, it also speaks to being able to understand and communicate "there but by the grace of God, go I," to families who are troubled and struggling. Indicting them–if only in our minds and therefore our behavior–creates a dissonance that is difficult if not impossible to overcome. Identifying people as "bad parents" without acknowledging that most of us truly strive to be "good parents" can create negative worker bias that in turn creates a barrier to positive and effective work with the family.

Often the child is not the only victim. The parents are often victims themselves who, with proper treatment and support can begin to lead their families in a healthier direction. Overemphasizing the attention to the child, while isolating and ignoring the presenting factors that contributed to the parents' ineffective and/or harmful behavior cannot always be fixed with "parenting education." What is needed is support of parents and therefore their children, from a nurturing, non-judgmental change agent; providing the opportunity for them to develop insight into who they are as parents and where they developed the concepts and beliefs they practice. This supportive, educative and structured approach is likely to benefit everyone invested in producing a functioning, productive family unit.

Front line workers typically are those who have the least amount of knowledge and experience, have the least amount of ability to make decisions, and at the same time are the ones with the first and most direct contact with families. Their judgements have proven to be the ones that impact whether children stay with their parents or are "placed." They also are the ones who decide which services and how long services are rendered to families before placement decisions are made. Therefore the perspective they have, based on their own personal experiences and biases are tantamount to what eventually happens to families who come to the attention of the child welfare system.

Interventions at Point of Removal

Last, attention to the impact of initial removal on familial bonds should be given. Often once the child is removed, family members may reject the child and the system associated with removing the child. I can still go back to the moment and feeling when my son was first removed. I remember telling the worker that she was doing something that I thought only God could do. This concept is based emotionally both from being a mother and a parent, but also based on the influence of my culture. Prior to the removal of my son, I felt I had done everything possible to carry out the terms and conditions placed upon me by my caseworker. After my son was removed, something changed inside me and I was left feeling that no matter what I did or didn't do, "they" had still taken my child. The emptiness I felt in my soul has yet to subside. While I continued to make every conceivable effort after my child was removed to regain my son and the hope for my family that existed prior to the "placement" - and have been successful in many ways - the feelings of detachment that occurred that day remain. When removal of a child occurs, first recognize the impact from the emotional, "umbilical" standpoint, but also recognize the impact of culture on how a family may respond to the removal. With greater understanding and awareness of how various cultures see a "washing of the hands" once a child is taken, the child welfare system might respond with more effort to keep that child in his or her biological home. If an understanding of various cultures reveals a "washing of the hands," once a child is taken, the system might respond with more effort to keep that child in place. Understanding that cultural lenses impact the decision of whether a child is removed, child welfare agencies must clear their lenses to understand the writing on the wall – that if you take them, they might be yours to keep.

While acknowledging that the issues contributing to over-representation of children of color in the foster care system are multifaceted and problematic, we also must acknowledge that the prevailing methods of intervention are not having the intended impact. Often simpler solutions are far more effective, producing more efficient results:

- *Use parents who have benefited successfully from child welfare services as mentors to parents currently receiving interventions.*
- *Place more emphasis on culturally responsive case management and decision making.*
- *View victimization as affecting both children and parents.*
- *Consider changing the paradigm of who delivers services and the qualities and outcomes required of services to families.*
- *Increase attention and emphasis on the impact of the "first removal."*

As a consumer of foster care services, I am committed to assuring that families who are faced with issues of being "placed" within the system fully understand what is excepted of them, and why and what will happen if changes within the families do not occur. Understanding that some children must be placed, suggests that this occurs only when all other avenues have been exhausted. I am confident that if the approach used to achieve change is adaptive, comprehensible to families, delivered respectfully, and with attention to being culturally responsive to those being served, the shared goal of safe, nurturing homes for all children will be met.

Tribal Perspectives on Over-Representation of Indian Children in Out-of-Home Care

by Terry Cross, A.C.S.W.
Executive Director,
National Indian Child Welfare Association

Today American Indian children are over-represented in the child welfare system. Indian children in the United States are placed in substitute care at a much higher rate than is the average for all other children in the nation. More than twelve out of every 1,000 Indian children are placed in substitute care, compared to 6.9 out of every 1,000 children from all races (Child Welfare League of America,

1996). Sadly, the reasons are as complex as the history of Indian/non-Indian relations in the United States. From a tribal perspective, it is part of a continuing cycle of oppression in which children and families are mistreated by a system ill prepared to deal with the consequences of historic genocide and a society historically unwilling to meet its trust obligations. To many non-Indians it may seem that Indians are merely caught in a system that does not work for anyone. Others will point to the dramatic and pervasive social problems in Indian communities and blame the circumstances on the victims themselves. This article examines over-representation from the tribal perspective and attempts to put the situation in a historical and policy context. And, it makes recommendations for policy and practices that have the potential of improving the accessibility and quality of services for Indian families and children.

Reasons for the over-representation of Indian children in the child welfare system range from the historical removal of Indian children from their tribes to the present legal and political relationships between Tribes, States and the federal government, to the cultural bias faced by Indian families experiencing the social ills associated with persistent poverty and racism. A discussion of these complex reasons follows.

Historical Trends

Since the earliest colonization of this continent, most attempts to "civilize" Indian people focused on Indian children. For example, in 1609, the Virginia Company, in a written document, authorized the kidnapping of Indian children for the purpose of civilizing local Indian populations through Christianity.

The "Civilization Fund Act" was an early first federal law that directly affected Indian children. Passed by Congress in 1819, it provided grants to private agencies, primarily churches, to establish programs to "civilize the Indian." Later, both the government and private institutions developed large militaristic or mission boarding schools for Indian children who were taken by force. In 1884, the "placing out" system placed numerous Indian children on farms in the East and Midwest in order to learn the "values of work and the benefits of civilization" (Breamner, 1970). Through the beginning of the 20th century, stories have been told of bonuses used to encourage boarding school workers to take leaves of absence to secure as many students as possible from surrounding reservations.

By the 1930's, with the last of the Indian wars more than a half century behind it, white America began to take a romantic view of Indian culture. The social problems of Indian families and children, primarily in the eastern half of the country, began to receive new attention. A new era of liberalism changed the focus of private agencies to humanitarian relief. However, these humanitarian gestures were again aimed at "saving" children and were largely conducted without consultation with Indian communities or respect for Indian culture. These efforts were motivated by the continuing belief that assimilation was the only realistic alternative for Indian children and that tribes were unable to protect their own.

Public Law 280, (18U.S.C. § 1162) passed by Congress in 1953 reflected this new attitude. Under this law, most civil and criminal jurisdictions in many states passed from the federal government and local tribe to the state in which the reservation was located (Canby, 1988). This meant that for the first time tribal children and families were subject to the child welfare laws of effected states. Unfortunately, this law led to confusing and troublesome jurisdictional issues and further eroded tribal authority and capacity to protect children from removal. Ignorance of Indian culture and its child rearing patterns, local prejudices, and the severe and unmet needs of tribal communities led to soaring placement rates.

Throughout the 1950's and 60's, trans-racial adoptions of Indian children, primarily within the private sector, were widespread. In 1959, the Child Welfare League of America (CWLA) in cooperation with the federal Bureau of Indian Affairs (BIA), initiated the Indian Adoption Project. As a result of this project, 395 Indian children were placed for adoption with non-Indian families in eastern metropolitan areas (Georges, 1997; Mannes, 1995). Little attention was paid to providing services on reservations that would strengthen and maintain Indian families.

Transracial placement practices continued throughout the 1960's and 70's. A survey by the Association on American Indian Affairs in the 1970's found that 25 to 35 percent of

all Native American children had been separated from their families (Georges, 1997). In 16 states in 1969, 85 percent of the Indian children in care were placed in non-Indian families (Unger, 1977). From 1971-72 approximately 35,000 Indian children lived in institutional settings, more than 68 percent of these in BIA administered schools (Metheson, 1996). The tragic, long-range effects of the placement of thousands of Native People away from their homes were only beginning to be realized. These include not only effects on individuals (Fanshel, 1972; Robin, Rasmussen, & Gonzalez-Santin, 1999), but also consequences for the cohesion and well being of entire communities of Native People.

The Indian Child Welfare Act of 1978

In a response to the overwhelming evidence from Indian communities that the loss of their children meant the destruction of Indian culture, Congress concluded that "there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children," (25 U.S.C.A. §§ 1901-1963). Thus, the Indian Child Welfare Act (P.L. 95-608), was passed in 1978 reaffirming tribal authority to protect their children. The unique legal relationship of "sovereign nation status" between the United States government and Indian tribes and the advocacy of Indian people made it possible for Congress to adopt this new national child welfare policy. Through "sovereign nation status," Indian tribes are nations within a nation. The Constitution of the United States provides that Congress has plenary power over Indian affairs. This means the power to protect the interests of tribes including passing laws to protect tribal children and families. Thus the Indian Child Welfare Act is based on a political relationship and status rather than a race.

The Indian Child Welfare Act (ICWA) established a much needed national policy toward Indian children. The Act reaffirms the tribal right to jurisdiction over its own children. It empowered tribes to:

- set up juvenile courts
- write juvenile codes
- set up services and to provide child protection, and
- establish out-of-home care if needed.

Under the Indian Child Welfare Act, tribal courts have exclusive jurisdiction over adoption and placement of Indian children who live within the reservation of their tribe, unless some federal law such as P.L. 280 provides to the contrary, in which case jurisdiction is shared. Tribes also have jurisdiction over proceedings involving any Indian child who is the ward of the tribal court, regardless of where the child lives (Canby, 1988). The Act sets up requirements and standards for child-placing agencies to follow in the placement of Indian children, including, among other things, providing remedial, culturally appropriate services for Indian families before a placement occurs, notifying tribes regarding the placement of Indian children and, when placement must occur, it requires that Indian homes be the placement of preference for Indian children.

Indian Child Welfare Act: Implications for Over-Representation

The Indian Child Welfare Act of 1978 is one of the best permanency policies ever to be enacted by the federal government, and yet it remains one of the most misunderstood and often maligned child welfare laws of our time. While available data indicates that the Act has brought a reduction in the over-representation of Indian children in the system, there remain serious problems primarily because the Act provided almost no funds for implementation.

The assumption made by Congress during passage of the Act was that ICWA's Title II appropriations would provide start up grants, and that tribes would then be able to find other sources of funds to operate their programs. Unfortunately, Title II of the Indian Child Welfare Act remained the largest ongoing source of funding available to all tribes for child welfare services. Tribes do not have the same mechanism by which to have access to federal or state funding that every other governmental entity uses to support services to children and families. Both the Title XX block grant process or the Title IV-E of the Social Security Act were created without provision for funding Indian programs. This has contributed to Indian children receiving inconsistent services and to tribes being unable to establish comprehensive service systems that prevent family breakup.

Additional Over-Representation Dilemmas

Today, as with all children and families, placements of Indian children often occur because this may be the only programmatic alternative, not because it is the best plan for the child. In most tribes, Indian children who need out-of-home placement often must become wards of the state because there is no mechanism for tribes to directly provide the service because of limited resources. As such, the tribe loses its capacity to directly respond to the needs of one of its members and most often has to give up jurisdiction in the process, further contributing to over-representation of Indian children in the system.

While American Indian children are seriously over represented in the system today, in large part due to a failure to empower tribal responses, these policies and funding issues must be seen in the context of the broader complex social problems. There are over 442,000 Native American families in the U.S. Over a quarter of these are at risk for abuse or neglect. Native American people are the most poverty-stricken group in the nation. Indian families are larger and have proportionately more children, (Bureau of the Census, 1993). Unemployment rates for Indian people on reservations are estimated at 45% (Bureau of Indian Affairs, 1991). Indian children are placed in substitute care more often because of neglect and less often for abuse than the rest of the children in the United States. A University of Iowa study that looked at the factors contributing to child abuse and neglect in Indian and non-Indian families reported that 57% of abuse cases and 85% of neglect cases in the study involving Indian children were alcohol or substance abuse related (University of Iowa, 1993).

Recommendations to Improve Service Accessibility and Quality for Indian Families and Children

When tribes have the capacity to plan and implement their own services, it has been demonstrated that more services are available locally at lower costs and are more culturally responsive to the needs of Indian families. It has been shown that tribes with adequate access to funding can and do provide a continuum of child welfare services including prevention and family preservation services, protective services, foster care supports, and adoption assistance. Experience in several states such as Washington, Montana, Arizona and Minnesota show that when tribes provide child welfare services, children who are placed in foster care return home sooner and have a better chance for long term family reunification. Demonstration projects funded by the National Center on Child Abuse & Neglect have shown that when tribes are empowered to deliver family preservation services, out-of-home placement rates drop significantly. (NCCAN Report, 1993). There is a need for greater tribal autonomy in planning and delivering social and child welfare services so that more culturally responsive assistance is accessible where families live and when services are needed. More creative funding arrangements between the states and tribes are needed. Greater use of tribal state agreements and collaborative service plans can also improve outcomes for Indian children.

The Adoption & Safe Families Act of 1997– Opportunities & Challenges for Addressing Over-Representation of Indian Children

Recently, national child welfare policy has shifted toward greater safeguards on child safety, a tightening of timelines for families to resume responsibility for their children, a greater emphasis on earlier termination of parental rights and adoption when families fail to meet timelines. These policies are embodied in the Adoption and Safe Families Act of 1997 (ASFA). While ASFA and ICWA might seem to conflict, in fact when properly applied together these acts can strengthen permanency outcomes for children. ICWA requires "active efforts" to prevent the breakup of the Indian family. Active efforts are a higher standard than reasonable efforts and apply regardless of ASFA. Further, ICWA requires higher standards of evidence for placement or termination of parental rights and requires that such decisions are supported by expert witnesses. Like ASFA, ICWA's provisions are designed to provide protections for the child. ICWA prevents unnecessary placement and protects a child's sense of belonging to family, culture and community. ASFA protects the child's right to services in a timely fashion and avoids children being lost in the system. ASFA can only be effective for Indian children when applied jointly with ICWA. In fact, ASFA states that cases in which appropriate services have not been provided, agencies cannot proceed to termination. ICWA designates appropriate servic-

es for Indian children. Thus, states must comply with ICWA if they are to be in full compliance with ASFA. These two very different laws, when applied appropriately together seek similar outcomes: safety and permanence as well as developmental well-being for children and families.

(For more information, please contact Terry Cross at (503) 222-4044.)

REFERENCES

Breamner, R.H. (Ed.) (1970). Children and Youth in America, Vol. I. Cambridge: Harvard University Press.

Canby, W.C. (1988) American Indian Law in a Nutshell. St. Paul: West Publishing Company.

Child Welfare League of America, (1996) National Data Analysis System, www.cwla.org

Fanshel, D. (1972) Far From the Reservation: The Transracial Adoption of American Indian Children, Metuchen, New Jersey: The Scarecrow Press.

George, L.J. (1997). Why the need for the Indian Child Welfare Act? Journal of Multi-Cultural Social Work, 5,165-175.

Hubble R. and Dobrec.T. (1989). "The Status of American Indian Families" Indian Child Welfare Digest. August/September of 1989.

Mannes, M. (1993). Seeking the balance between child protection and family preservation in Indian

Metheson, L. (1996). The politics of the Indian Child Welfare Act. Social Work, 41, (2), 232-235.

University of Iowa, National Resource Center on Family Based Services (1993) Family Functioning of Neglectful Families: Final Report.

Robin, R.W., Rasmussen, J.K., & Gonzalez-Santin, E. (1999). Impact of childhood out-of-home placement on a Southwestern American Indian tribe. Journal of Human Behavior in the Social Environment, 2(1/2), 69-90.

Unger, S. (1977) The Destruction of American Indian Families. New York: Association on American Indian Affairs.

United States Bureau of the Census (1991), Census of Population.

United States Bureau of the Census (1993), "We The First Americans."

United States Department of the Interior (1988). Indian Child Welfare: A Status Report.

United States Department of the Interior (1997). Indian Labor Force Estimates.

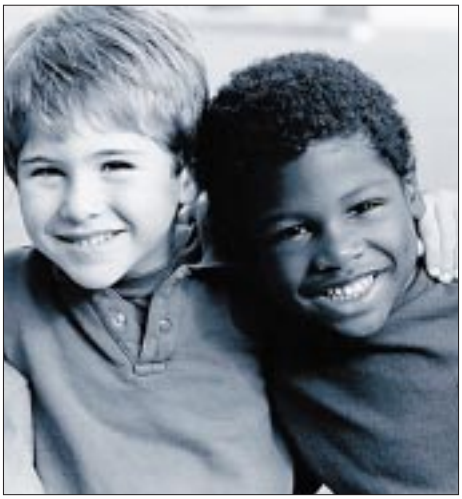
A Different Perspective on "Disadvantaged" Populations in Foster Care

by Max Moran, BSW Student
NRCFCPP Staff

One missing piece of research on foster care seems to be children with immigration status issues. Due to lack of information, no one knows exactly how many legal residents are in foster care. Perhaps the time has come to begin collecting data on this population. One thing is certain: legal and illegal immigrants who are discharged from foster care are at a great disadvantage.

I am a legal resident. I immigrated to this country in 1986 from Latin America at age 10. Unfortunately by age 15, circumstances made my foster care placement necessary. During my six years in the system, none of my social workers assisted me in becoming a citizen, even after I expressed interest in doing so. Becoming an American citizen was something that I needed to do but did not know why. I was never educated about the importance of becoming a citizen.

Today, recent anti-immigration laws have made life more difficult for undocumented as well as legal immigrants. By law I can be deported if convicted of a violent crime. I'm a law-abiding man but this really concerns me. As a member of a minority group, I know I'm more likely than anyone else to be arrested for and convicted of a crime I did not commit. If I were deported, I don't know what would happen to me. I was so young when I



left, that going back would be like immigrating to a foreign country.

Another concern of mine is that some states do not want to provide public benefits to legal residents, often temporarily cutting off legal residents from food stamps, welfare and social security. We may be disqualified from programs that we helped build through our tax dollars. What if I suffered a personal setback? What if I lose my job? How will I eat? Where will I live? Not being an American citizen feels like I'm playing a deadly video game with just one life to spare.

Now that I'm looking at scholarships for graduate school I see the advantages that citizens get. Many of the scholarships, even those specifically offered to Hispanic students are only awarded to American citizens. Another big concern of mine is the right to suffrage. As a legal immigrant, I'm American when it comes to paying taxes but not when it comes to having the right to vote. Without having any political power, once again I find myself at a disadvantage.

According to the "NY Immigration Coalition" these are some of the benefits that American citizens are entitled to: protection from deportation, access to certain jobs that are by law restricted to US citizens, the right to enter and leave the

United States without time limitations, and the right to register to vote and run for local, state and federal office. Today I see how important it is for me and for legal immigrants in foster care to have full participation in American life, through American citizenship.

All children and youth entering foster care should be asked about their immigration status. That could be a way to start collecting data on how many individuals in the system are legal residents. By identifying the problem, state foster care systems can become better equipped to find a solution. Those who are legal residents should be educated about what it means to be a citizen and thus assisted if they decide to go through the process. I've known of cases in which illegal immigrants have been helped by their agencies in becoming legal residents. However, why stop there? Why not help them become citizens?

I want to become a citizen, however I cannot afford the $225 fee for the citizenship process. I don't have a family to help me economically, so I must spend my money on what's most important to me. And that's food, carfare, rent, phone bill and school tuition. Had I been helped with the citizenship process while still in foster care, today I wouldn't have this dilemma. To some people $225 is nothing, to me it helps me put food in my stomach and a roof over my head.

I think a cross-system-collaboration between the federal government, INS and foster care agencies should be instituted to wave the $225 fee for the citizenship process for all legal immigrants in foster care. Also, assistance in the citizenship process should be part of the Independent Living Training Curriculum. Isn't the goal of Independent Living to empower youth to achieve their full potential? Wouldn't helping them become American citizens do just that? Why leave them at a disadvantage like I was. Doesn't being in foster care disadvantage them enough?

Connecting Healthy Development & Permanency: A Pivotal Role for Child Welfare Professionals

by Sheryl Dicker, JD,
Executive Director
& Elysa Gordon, J.D., M.S.W.,
Senior Policy Analyst
New York State Permanent Judicial Commission on Justice for Children

Studies nationwide reveal that foster children have far more fragile health than other children and the quality of their health care can vary greatly. The lack of attention to foster children's health needs increases their vulnerability to a range of physical, developmental and emotional problems that can serve as barriers to permanency. Research also shows that the demands of caring for children with a serious health condition or a disability can create tremendous emotional, financial and physical stress for caregivers. The stress associated with caring for a foster child with unaddressed health needs can jeopardize reunification efforts, impede recruitment and retention of adoptive families and threaten the promise of permanency. Child welfare professionals can play an important role in ensuring that the healthy development of foster children is an integral component of permanency planning.

The Health Profile of Foster Children

Foster children have multi-layered health needs that present challenges for caregivers, health care providers and child welfare professionals. First, foster children have health needs similar to those of all children, requiring well-child health care, immunizations and the treatment of acute childhood illnesses. Second, foster children have health problems associated with poverty such as low birthweight, increased risk of lead exposure and malnutrition. Foster children face further health risks specifically linked to parental neglect, maternal substance abuse, physical or sexual abuse, parental mental illness and the separation and loss associated with out-of-home care. While at high risk for health problems, foster children too often lack the most fundamental resource for ensuring healthy development–a stable, lasting relationship with a caring adult who can observe their daily development over time, advocate on their behalf and consent to evaluation and services.

FACTS ABOUT FOSTER CHILDREN'S HEALTH

- ***Eighty percent of foster children have at least one chronic medical condition and one-quarter have three or more chronic problems.*** *(Silver 1999; Halfon 1995)*
- ***Half of all foster children have developmental delays.*** *(Jaudes & Shapiro 1999; Takayama 1998)*
- ***More than half of all foster children have mental health problems severe enough to warrant clinical intervention.*** *(Jaudes & Shapiro 1999; Halfon 1995)*
- ***In a study of young foster children in Los Angeles County, New York City and Philadelphia County, the U.S. General Accounting Office (GAO) found that 12 percent of the children received no routine health care, 34 percent received no immunizations and 32 percent continued to have at least one unmet health need after placement. The GAO found that 78 percent of the children were at high risk for HIV, but only nine percent had been tested for the virus.*** *(GAO 1995)*

Connections to Permanency

Parenting a child with health problems or a disability can drain the emotional, financial and physical resources of even the most stable families. Research confirms that a caregiver's ability to parent can be undermined by the stress associated with caring for a child with a medical condition or disability. Several studies document the high incidence of abuse and neglect of children with chronic health conditions and developmental disabilities. The National Center on Child Abuse and Neglect found that children with disabilities were maltreated twice as often as children without disabilities. The same study reveals that children with disabilities are emotionally neglected three times as often and physically abused and neglected and sexually abused twice as often as maltreated children without disabilities.

The presence of medical conditions or disability can compound the stress in the lives of parents struggling with substance abuse, mental illness and poverty, making it more difficult to manage the daily challenges of parenting and increasing the risk of family dissolution or failed placement. For example, a parent who is abusing drugs may be unable to appropriately cope with the demands of an infant born premature or low birth weight who may be irritable and difficult to calm. Research reveals that the strain of meeting such demands on these fragile families can lead to neglect, abuse and foster care placement.

While inattention to a foster child's health needs can jeopardize his or her prospects for permanency, early identification and intervention can increase the likelihood of healthy development and family stability. New research on the brain and early childhood experiences reveals that a child's earliest years form the foundation of healthy development. (Hawley 1998) Also emerging from this research is a greater understanding of the influence of the early caregiving and physical environments on the child's development and the impact of the child's behavior on the functioning of the family. To achieve permanency, foster children and their families need services at the earliest possible juncture to enhance the child's healthy development and to support caregivers in their parenting efforts.

Resources to Enhance Healthy Development

Existing federal and state laws and programs provide a pathway to enhance the healthy development of foster children and assist their families. Foster children have a right to receive health care under federal law and may be eligible to participate in early intervention and early childhood programs that offer child-focused and family-supportive services.

Medicaid and EPSDT

In all states, foster children are eligible for Medicaid. All children under the age of twenty-one enrolled in Medicaid are entitled under federal law to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services (42 U.S.C.A. §1396). EPSDT is a comprehensive benefits package that requires medical, vision, hearing and dental screens to be performed at distinct intervals that meet current standards of pediatric and adolescent medical and dental care. The medical screen must include at least five components: a comprehensive health and developmental history assessing both physical and mental health; a comprehensive unclothed physical exam; immunizations; laboratory tests including testing for high-risk exposure to lead; and health education. EPSDT requires state Medicaid agencies to assure the provision of necessary treatment for both physical and mental health conditions to the extent required by the needs of an individual child (42 U.S.C.A. §1396d (5)).

Individuals with Disabilities Act

Children from birth to age three who have a developmental delay or a condition with a high probability of resulting in developmental delay are entitled to early intervention services under Federal

and State law. Early intervention provides an array of services, including hearing and vision screening, occupational, speech and physical therapy and special instruction for the child. The early intervention program is premised on a large body of research that demonstrates the importance of providing services to the family to enhance the child's development. (Brookes-Gunn et al. 1994) These services include parent training and counseling, respite care, home visits and service coordination. Both biological and foster parents can benefit from Early Intervention services which are enumerated in an Individualized Family Services Plan developed collaboratively by the family, the evaluator and early intervention professionals.

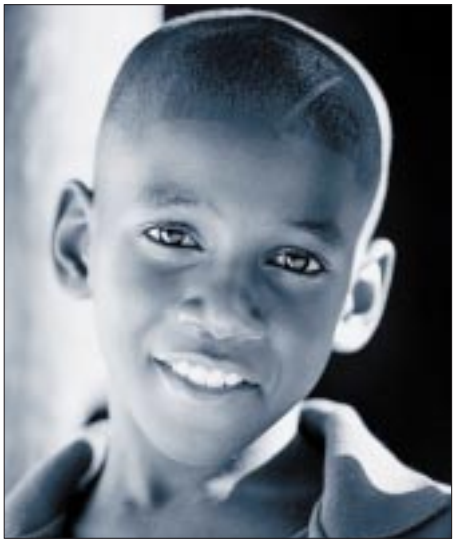
Children age three through five who have a disability in one or more domains – physical development, hearing and vision, learning, speech and language, social and emotional development, and self-help skills that affect their ability to learn – can receive special education and related services under the Federal Preschool Grants Program. Children older than five may be evaluated for school-age special education services.

Early Childhood Programs

High quality early care and education programs can enhance healthy development for foster children, offer families information and direct services to assist with the problems of parenting and create an additional opportunity for the child to establish a stable relationship with an adult caregiver. Head Start is a federal program that provides comprehensive and developmentally appropriate preschool services for children from low-income families. Like Early Intervention, Head Start is child-focused and family-supportive, making the program a rich resource for foster children and their caregivers. Quality early childhood programs also have a two-generational approach-providing early childhood education for the child and support for the parents. As Medicaid eligible, foster children meet Head Start's eligibility requirements. Other federal programs provide funding streams for day care to low-income children including Temporary Assistance to Needy Families, the Social Services Block Grant (Title XX) and the Child Care Development Block Grant.

Connecting Healthy Development and Permanency in Practice

During the past eight years, the New York State Permanent Judicial Commission on Justice for Children has undertaken several reform initiatives to promote better outcomes for foster children and their families. The Commission is chaired by Chief Judge Judith S. Kaye and its members include judges, legislators, state and local officials and child advocates. As part of its efforts to reform the Family Court's handling of foster care cases, the Commission formed a Health Care for Foster Children Working Group to consider the health needs of foster children. The Commission found that foster children had serious, unmet health needs that were seldom the focus of any entity in the child welfare or court systems. Following the Working Group's recommendations, the Commission has published a booklet, "Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals," to ensure that at least one person involved in the court process ask questions about a foster child's health and spotlights the critical link between a child's healthy development and permanency. The booklet provides ten questions to identify a foster child's health needs and gaps in services as well as reasons for asking each question and references to expert sources. Child welfare professionals can use the following ten questions as a tool in developing service plans that respond to both the child's needs and the caregiver's ability to meet those needs.



The Permanent Judicial Commission on Justice for Children CHECKLIST for the Healthy Development of Foster Children

- ✓ Has the child received a comprehensive health assessment since entering foster care?
- ✓ Are the child's immunizations up-to-date and complete for his or her age?
- ✓ Has the child received hearing & vision screening?
- ✓ Has the child received screening for lead exposure?
- ✓ Has the child received regular dental services?
- ✓ Has the child received screening for communicable diseases?
- ✓ Has the child received a developmental screening by a provider with experience in child development?
- ✓ Has the child received mental health screening?
- ✓ Is the child enrolled in an early childhood program?
- ✓ Has the adolescent child received information about healthy development?

Establishing a service plan is the first step toward ensuring healthy development and permanency for foster children. If the goal is reunification, children need services to address their health conditions or disability and biological parents need education and support services to enhance their understanding of the child's needs and their own parenting skills. Where the goal is adoption, the service plan should reflect the needs of the child, educate the foster or adoptive parents about health issues and assist parents in accessing referrals.

The grim health status of many foster children, the presence of substance abuse and other stresses in their families and the complexities of the child welfare system necessitates a care coordinator to insure that services are identified and actually provided. Care coordination is imperative because foster children and their caregivers face many barriers in obtaining and managing health care. Foster children have more intensive health needs than other children and their caregivers often must interact across multiple systems including child welfare, health, mental health, education and welfare. The transient nature of foster care and the high turnover among child welfare caseworkers can further impede the provision of even basic health services to foster children. The numerous medical specialists and multi-disciplinary services often required to achieve foster children's healthy development can strain a caregiver's ability to coordinate their care.

Child welfare professionals can also educate caregivers and all parties about linking healthy development and permanency and the importance of using the child's needs to guide permanency planning. They can collaborate with professionals working in fields not traditionally accessed by foster children and their families including early intervention and early childhood.

By asking questions about a foster child's health, child welfare professionals can spotlight the critical connection between healthy development and the child's prospects for a permanent home. More importantly, the inquiry can ensure that needed services are provided to promote better outcomes for foster children and their families.

SOURCES

Brookes-Gunn, Jeanne et al. (1994) Early Intervention in Low-Birth-Weight Premature Infants: Results through Age 5 Years from the Infant Health and Development Program. JAMA 272, 1257.

Jaudes, P. & Shapiro, L. (1999) Child abuse and developmental disabilities in Silver, J. et al. (1999) Young Children in Foster Care: A Guide for Professionals. Baltimore, MD: Paul H. Brookes Publishing.

Halfon, N. et al. (1995) Health status of children in foster care. Archives of Pediatric and Adolescent Medicine, 149, 386-392.

Hawley, Theresa. (1998) Ready to Starting Smart: How Early Experiences Affect Brain Development, A Paper of the Ounce of Prevention Fund and Zero to Three, National Center for Infants, Toddlers and Families.

Hawley, Theresa. (1998) Ready to Starting Smart: The Lasting Effects of Early Relationships, A Paper of the Ounce of Prevention Fund and Zero to Three, National Center for Infants, Toddlers and Families.

National Center on Child Abuse and Neglect (1994) Child maltreatment 1992: Reports from the states to the National Center on Child Abuse and Neglect. Washington, DC: U.S. Government Printing Office.

Silver, J. et al. (1999) Starting Young: Improving the health and developmental outcomes of infants and toddlers in the child welfare system. Child Welfare, 78, 148-165.

Takayama, J. I. et al. (1998) Relationship between reason for placement and medical findings among children in foster care. Pediatrics, 101, 210-207.

U.S. General Accounting Office (1995). Foster care: Health needs of many young children are unknown and unmet (GAO/HEHS-95-114). Washington D.C.

For more information: For copies of the Perm-anent Judicial Commission on Justice for Children's booklet, please contact PJCJC, 140 Grand Street, Suite 404, White Plains, NY 10601.

In The Wings

We are currently in the planning phase of our renewed five-year cooperative agreement with the Children's Bureau. Our work will continue to assist State, Tribal and other publicly administered or supported child welfare agencies to effectively implement child welfare legislative and policy mandates and to improve the quality of foster care and permanency planning initiatives. Toward these goals, we strive to target our efforts to meet the training, technical assistance and information needs of child welfare agencies; we are therefore very interested in learning what you would like to know more about. Please let us hear from you by sending us a letter or e-mail to the attention of Sharon Karow, editor of our newsletter, at (212) 452-7432 or skarow@shiva.hunter.cuny.edu.

We look forward to hearing from you and working with you in the coming months.

Upcoming NRCFCPP Newsletters

Summer/Fall 2000
FINDING, PREPARING & SUPPORTING FOSTER & ADOPTIVE PARENT RESOURCES

Winter/Spring 2001
PART 1: BEST PRACTICES IN PERMANENCY PLANNING

PART 2: OUT-OF-HOME CARE

PERMANENCY PLANNING TODAY
The Semi-Annual Newsletter of the
National Resource Center for Foster Care and Permanency Planning
Hunter College School of Social Work of the City University of New York
129 East 79th Street
New York, NY 10021

WHERE CAN I FIND MORE INFORMATION?

The following is a listing of reports, summaries and materials available through the NRCFCPP, unless otherwise noted. Copies can be obtained by contacting: Karolyn Fernandes, *Information Services Program Coordinator,* at (212) 452-7431 or e-mail: kafernan@hejira.hunter.cuny.edu

Listening to Youth Report

The Listening to Youth Project was designed to capture the experiences of youth formerly in foster care and their recommendations about how to improve the system and strengthen services. This report describes the projects' goals and methodology, lists the interview questions and the moving, thought-provoking youth responses, and provides recommendations for change offered by the former youth in care. Copies of the report can be purchased from NRCFCPP for $5 each.

Bridging the Gap Workday Proceedings

On November 19, 1999, NRCFCPP hosted a workday to foster collaboration between child welfare and substance abuse communities, and to develop protocols for achieving timely permanency for children with parents who are drug-affected. Copies of the proceedings will be available for purchase from the NRCFCPP after May 15th for $8. each.

"Tools for Permanency"

NRCFCPP "Tools" for Permanency fact sheets are available on Concurrent Permanency Planning, Family Group Decision Making and Child Welfare Mediation. Copies of each "Tool" can be purchased from NRCFCPP for $3. each.

Concurrent Planning: Tool for Permanency, Survey of Selected Sites

Lorrie Lutz, an independent consultant working with NRCFCPP, compiled a survey of 12 state's progress in planning and implementing concurrent permanency planning initiatives. A copy of the report can be purchased from NRCFCPP for $8.

The Implementation of Managed Care in Child Welfare: The Legal Perspective

Denise Winterberger McHugh, an attorney and NRCFCPP consultant, has completed an overview of the legal issues raised by the implementation of managed care principles in child welfare during the early and mid-1990's. A copy of the report can be purchased from NRCFCPP for $8.

Bibliographies

The following bibliographies can be obtained from NRCFCPP free of charge: *Permanency Planning, Concurrent Permanency Planning, Child Welfare Mediation, Family Group Decision Making, Permanency Planning and Kinship Care*

Guidelines for a Model of Protective Services for Abused and Neglected Children

The National Association of Public Child Welfare Administrators (NAPCWA), an affiliate of the American Public Human Services Association (APHSA), has recently published a revised version of the Guidelines for a Model of Protective Services for Abused and Neglected Children. Guidelines addresses issues related to the definition, reporting, decision-making, service delivery, and management aspects of Child Protective Services. This document also demonstrates that there is a developing national consensus among public child welfare administrators around the major policy issues in the field. In addition, Guidelines includes supplemental papers submitted by leaders in the field of public child welfare. Guidelines can be purchased from NAPCWA/APHSA (202/682-0100 Publications Dept.) at a cost of $14. for members of NAPCWA and APHSA and $16. for non-members.