Bureau of Milwaukee
Child Welfare Study of Service, Support and Placement Needs

Conducted By
The Child Welfare Policy and Practice Group
In Partnership With
Casey Family Programs

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Executive Summary

The following Study of Service, Support and Placement Needs in the Bureau of Milwaukee Child Welfare (BMCW) was conducted pursuant to the Corrective Action Plan (CAP) between BMCW and Children's Rights, effective December 31, 2008 to address remaining enforceable Settlement Agreement provisions. Among the elements of the CAP was an agreement that the Bureau would conduct an assessment of placements and the services needed by children in the Bureau's care to achieve stability and permanency. The Child Welfare Policy and Practice Group, a nonprofit technical assistance organization, was selected by the parties to conduct this study.

Following the completion of this study and report, findings will be used to contribute to the development of a foster care recruitment and retention plan for the Bureau, also required by the Corrective Action Plan. The Utah Foster Care Foundation has been selected to lead this effort.

This placement and service needs study included a review of previous reports about the Bureau's performance, analysis of data about children served by the Bureau, a case review of 37 children currently unstable and interviews with 26 key informant groups and stakeholders. The findings and recommendations of this study are summarized below.

Underlying Challenges

While the primary focus of the study was identification of the services and supports needed by children in out-of-home care to achieve stability and permanency and determination of the placement needs of the Bureau, the review identified a number of overarching system and organizational challenges that underlie the significant number of children without stability and permanency and lack of needed foster family homes. The first of these challenges is system fragmentation, which contributes to problems with coordination, information sharing and accountability. The multiple case management and support agencies that make up the public-private partnership that is the Bureau, while offering the potential of beneficial competition and flexibility, also create additional fragmentation of functions, roles and accountability. The challenge of coordination and information sharing is heighted within the current structure. The Bureau's use of Coordinated Services Teams (CST) has the potential to mitigate this fragmentation to some extent, but issues of quality and fidelity in the teaming process undermine the CST's value and effectiveness.

Workload is clearly an obstacle to effective practice. While the Settlement Agreement caseload standards are a primary area of focus for the Bureau, functionally case managers struggle to fully address their many responsibilities. The instability of many children adds to this workload, as staff must respond to threats of disruption and transitions to new placements.

Turnover is a significant challenge to achievement of positive outcomes, with actual turnover rates approaching 60 percent at the case management level. The effects of this turnover limit the

Bureau's ability to achieve and maintain a high level of skilled, knowledgeable and responsive practice.

One of the most troubling organizational themes observed in this review is the perception by many staff that instability is inevitable. The organizational and resource barriers that lead to frequent placement changes among children have contributed to a pattern of reluctant acceptance of instability within the Bureau instead of the approach of "Whatever it takes" to prevent placement changes.

Last among these underlying issues is the relative lack of flexible resources and funds that can be used to create individualized plans for children and tailor a support response to their unique needs.

Critical Trends

Fortunately insofar as stability is concerned, the out-of-home population in the Bureau is stable, meaning that the number of children in out-of-home care is not growing. It is currently at 2,526 children. However, the lack of appropriate foster home settings is, according to many informants, too small to accommodate the number of children needing that level of care. As a result, the number of children placed in higher levels of care is growing in group homes and Treatment Foster Care. The number of children placed in group homes has grown from 134 to 160 in the past year and Treatment Foster Care has grown from 522 to 550 children in the past year. The number of children placed out of county has also grown from 433 in 2006 to 484 in 2009. The number of unrelated foster family homes has grown by 51 homes in the past year, to 700.

Case Review

In the case review conducted by the review team, results confirmed many comments by stakeholders, were consistent with a number of past Qualitative Service Review findings and helped create a profile of the support needs of the unstable population. A significant number of the children in the sample had not achieved permanency, which heightened their instability risk. Many of the children did not feel meaningfully involved in agency decisions made about them. Their experiences in foster care which reviewers learned during the review helped inform the review's knowledge about system barriers that impede stability.

Recommendations

Recommendations were grouped in the following categories: Service and Support Needs, Administrative Mechanisms, Placement Needs and Other Systemic Support Needs. They are summarized below.

<u>Service and Support Needs</u>

Educational Advocacy – Due the significant number of children in out-of-home care placed in special education settings or having behavior problems in school and/or experiencing suspension, it is recommended that the Bureau provide 2 full-time educational advocates per region and conduct a more complete estimate of advocacy needs after six months of operations. These

advocates can help caregivers navigate the educational system, with a particular focus on promoting educational rights.

Tutoring – Using statewide Qualitative Service Review data to estimate the number of children in out-of-home care in Milwaukee performing below grade level, it is recommended that the Bureau develop the capacity to provide tutoring assistance to 200 children annually as an initial step in addressing educational achievement and develop the capacity to systematically identify children needing academic assistance. This should be accomplished in collaboration with the Milwaukee Public School System.

Programs for Children Who Are Suspended – The Milwaukee Public School System reports that 28.6 percent of children were suspended at least once in 2008, a statistic which if applied to school age children served by the Bureau would equal 429 children at-risk of placement. School suspensions were a major area of concern among foster parents, most of which work. Estimating conservatively the need for school suspension programs for these children, it is recommended that the Bureau expand the capacity of the current Wraparound Milwaukee school suspension program by 141 more children annually.

Mentoring – Many foster parents and other stakeholders mention the inability to acquire mentors for children as a major barrier to well-being and stability, citing long wait-lists as common. It is recommended that as an initial step the Bureau allocate $100,000 to each region for mentoring assistance.

Recreational Supports – Respondents also spoke of the need to provide normal recreational opportunities for children and youth, such as sports activities and team participation, pursuit of musical and other interests, camp and other activities. Foster parents in particular noted the difficulty in getting financial support for such experiences, stressing the importance of such opportunities to children's emotional and behavioral well-being. It is recommended that the Bureau allocate an additional $120,000 for recreational supports.

In-Home Behavioral Treatment and Coaching – An analysis of service expenditures by the regions reflects only a small amount of identifiable expenditures for In-Home Behavioral Treatment and Coaching, which are among the most effective interventions for children and youth with behavioral issues. The coaching component provides caregivers practical skills in managing behavior that could have otherwise have resulted in a disruption. Based on placement change data, it is recommended that the Bureau develop the capacity to provide In-Home Behavioral Treatment and Coaching to an additional 90 children monthly.

Initial Placement Supports – The Bureau allocates little in funds to offering initially placement supports and supplies, like diapers, formula and minimal clothing to foster parents who accept children arriving without these essentials. It is recommended that the Bureau allocate $20,000 per region for initial placement supports.

Respite – Foster parents are entitled to two days of paid respite per month, but few make use of it or understand its availability. Most foster parents arrange their own respite. The Bureau could not provide written policy regarding respite. It is recommended that the Bureau allocate $300,000 annually for respite support and provide all foster parents written policy about its availability.

Transportation – Transportation services were commonly mentioned by respondents as needing expansion. This is especially an issue with foster parents that work and have difficulty transporting children to their many appointments. While the Bureau does provide a considerable amount of transportation for children to visit with parents and family, more support is needed. It is recommended that the Bureau expand the use of transportation for foster caregivers to include the many other appointments which children must attend.

Administrative Mechanisms

Develop a Child and Caregiver Flexible Funds Pool – To create individualized plans for children, especially those at-risk of disruption, case managers need access to flexible resources that permit a tailored response. Currently, the Bureau provides little in the way of flexible funds and what exists is difficult to access. It is recommended that the Bureau develop a clear policy with simple access to flexible funds for case management and allocate $200,000 for each region for this purpose.

Implement the Child and Adolescent Needs and Strengths (CANS) Process – CANS is a decision tool that helps identify the clinical needs of children at-risk of being placed in higher levels of care. In practical terms it can help identify those children that do not have the behavior and risk levels necessitating a level of care like group homes, TFC or residential treatment. Numerous systems use it to ensure appropriate placement. It is recommended that the Bureau adopt the CANS tool to assist in addressing the issue of inappropriate placement in higher levels of care.

Financing and Expansion of Supports and Services – Unlike many systems, the Bureau does not utilize Title XIX funds (Medicaid) to fund the treatment portion of TFC, using instead another federal matching source with a lower federal match rate to pay for administrative costs. It is recommended that the Bureau explore the feasibility of using Title XIX funding to increase the level of federal participation and using any savings to support greater levels of clinical support in TFC and additional supportive services for children with behavioral issues.

Child-Specific RFP's – As part of a "Whatever it takes" approach to meeting the needs of children in the most normalized family based setting possible, when the Bureau encounters children with high needs for which there are few placement options, it is recommended that the Bureau solicit individualized service or placement design proposals from providers to meet unique needs.

Use of Step-Downs – There is some indication that the practice of stepping children down from a higher level of care to a brief interim placement is occurring in an effort to gradually introduce children to a lower level of restrictiveness. For many children this could be accomplished with flexible services and supports in a permanent placement, avoiding an additional harmful move. The Bureau should ensure Coordinated Service Teams are attentive to this possibility and avoid unneeded step-downs.

Placement Needs

Placement needs were determined based on an analysis of children currently experiencing placement changes, children entering out-of home care, children on runaway status and children

in assessment and placement stabilization centers (which the Bureau expects to close by December 31, 2009). The fact that there few vacancies among current foster home providers, meaning that these resources are operating at functional capacity, was also considered. Based on those data, it is recommended that the Bureau increase foster home capacity by 610 children. The recruitment of these additional homes will be the focus of the work by the Utah Foster Care Foundation in helping the Bureau create a new foster care recruitment and retention plan.

Because it is expected that the use of the CANS process will identify children inappropriately referred to higher levels of care and considerably reduce that population, no additional group home, TFC or residential treatment placement settings are recommended. It is expected that the CANS tool will effectively set the level of need for higher levels of care based on a child-by-child analysis.

Other Systemic Supports

Other systemic changes and supports are needed to fully address the challenges of instability and permanency in Milwaukee. These include the following.

- Create a clear and integrated model of practice that guides the values and approach of staff and providers. The current model provided by the Bureau identifies the expectations for parents and caretakers, but not for the practice of the Bureau itself.

- Consider the caseload standards within the Settlement Agreement as a floor, not a ceiling. To fully implement the case management tasks expected to be performed by staff and achieve safety, stability, permanency and well-being for children, caseloads should be lower. The Bureau should set a target of 15 children per worker for case management and 13.5 cases per worker for IA.

- Strengthen the quality of Coordinated Service Teams. The CST concept is laudable and has the potential to address many of the problems caused by fragmentation. It can also provide greater opportunities for families and youth input into planning, strengthen coordination and deepen assessment. However, the performance of the CST process lacks fidelity to the original wraparound-like values of the model. Attendance by other team members is uneven and planning increasingly attends to Bureau needs at the expense of the input of children and families. The Bureau should create the capacity for full-time coaches to assist in CST implementation at the case management level and employ a fidelity tool to address quality concerns.

- Create additional financial incentives for foster parents that accept teens to increase the availability of family-based settings for youth.

- Utilize Assessment Home parents as foster parent mentors. The assessment homes are being phased out, but these caregivers have years of fostering experience which can be shared with new foster parents. The Bureau should use these seasoned mentors as full or part-time peer supports to other foster parents.

- Develop a system to track foster home utilization. The Bureau does not currently have an information system that accurately tracks placement utilization, which impedes both

planning and placement decision making. Work is underway on addressing this issue through the Department's SACWIS system. It is recommended that the Department give this SACWIS development or an alternative platform a high priority.

The last system recommendation is related to the recruitment and retention of foster parents. The organizational responsibility for foster parent recruitment and retention falls upon the Children's Service Society of Wisconsin (CSSW) and a number of Bureau staff see the total responsibility as CSSW's. However, the experience of foster parents with the Bureau includes interaction with ongoing case management staff, Initial Assessment and many direct service providers as well and these entities impact the impression foster parents have of the system. If foster parents are to remain in fostering and assist in the recruitment of others to the role, all of the Bureau will have to assume responsibility for recruitment and retention by treating foster parents as partners and doing "Whatever it takes" to ensure that children have the best outcomes possible.

Bureau of Milwaukee Child Welfare
Study of Service, Support and Placement Needs

Conducted By
The Child Welfare Policy and Practice Group (CWG)
In Partnership With
Casey Family Programs
May 29, 2009

I. Introduction

On December 31, 2008 the Bureau of Milwaukee Child Welfare (BMCW) and Children's Rights, Inc. reached agreement on a Corrective Action Plan (CAP) to address remaining enforceable Settlement Agreement provisions. Among the elements of the CAP was an agreement that the Bureau would conduct an assessment of placements and the services needed by children in the Bureau's care. Specifically the Bureau agreed to the following:

C. Placement Stability of Children in Out of Home Care (I.D.9)
Provision I.D.9 requires 90% of children in out of home care have no more than three out of home placements.

In an effort to promote placement stability for children in out-of-home care, the Bureau will implement the following strategies:

> 1a) By April 21, 2009, in consultation with a national expert to be jointly agreed upon by the parties, the Bureau shall conduct an assessment of placements and services needed by children in the Bureau's care. The purpose of the assessment is to determine what additional placement resources and supportive services are needed to ensure the appropriate placement of children, to minimize the need for placement moves while in custody, to ensure that children are placed in the least restrictive most family-like setting appropriate for their needs and likely to ensure permanency for children as quickly as possible.
>
> The assessment will utilize the findings of the Bureau's recent study of a sample of children experiencing placement movement and will include an assessment of a sample of children placed in assessment foster homes and children placed in adolescent assessment and placement stabilization centers.
>
> 1b) Foster Parent Recruitment and Retention:
> The Bureau will make diligent and good faith efforts to implement the

> recommendations of the assessment regarding additional placement resources and supportive services. The Bureau, in consultation with a national expert to be jointly agreed upon by the parties, will develop a Foster Care Recruitment and Retention Plan 60 days from the completion of the Placement and Services Needs Assessment required above. The recruitment and retention plan will be driven by data concerning the needs and placements of the foster care population and mapping of the capacity and preferences of the pool of foster parents. The recruitment and retention plan shall include specific strategies to increase responsiveness and support to foster parents at all stages of recruitment, licensing, placement and throughout foster parents' involvement with the Bureau. The plan will include strategies for working with the foster parent organizations to support recruitment, retention and mentoring efforts. The plan shall include specific tasks and timeframes and interim goals. In developing the plan, the expert should consider the Bureau's financial support of a foster parent organization and the establishment of a foster parent mentor program.

To accomplish this task, the Bureau selected Paul Vincent, Director of The Child Welfare Policy and Practice Group (CWG) to conduct the study of services and placement needs and chose Kelly Peterson, Director of The Utah Foster Care Foundation to assist the Bureau in developing a Foster Care Recruitment and Retention Plan. This report addresses service and support needs for children and foster caregivers and the Bureau's placement needs. It is useful to know that there are several related provisions in the CAP, including agreement by the Bureau to phase out Assessment Homes by July 1, 2009, identify options for program models to provide group care for adolescents in a home-like setting and assess the needs of children in assessment or placement stabilization centers to identify alternative approaches to meeting their needs. The Bureau also committed to expand the Mobile Urgent Treatment Team (MUTT) to include unlicensed relatives caring for children under a CHIPS order and by December 31, 2009 increase the number of foster homes by a net gain of 185, to a total of 875 foster homes.

II. Approach

To assess the service and support needs of children in out-of-home care and their caregivers and to identify the placement needs of the Bureau, CWG conducted 26 key informant meetings, interviewed Bureau leadership and reviewed existing Bureau studies about placement issues and trends, including the 2008 report on Children Experiencing Placement Movement, CSSW's Recruitment Plan, the January 2008- December 2009 Settlement Agreement Second Semi-Annual Report, the 2008 Qualitative Services Review Report on the Bureau and the recently released Ombudsman Report, among others. CWG also collected trend data from the Bureau related to characteristics of the unstable population. Stakeholders interviewed were:

BMCW Stakeholders and Key Informants

BMCW Leadership Team
Placement Staff, CSSW
Ongoing Staff and Supervisors
Coordinated Service Team (CST) Facilitators
MUTT Team
Initial Assessment Staff
Partnership Out-Of-Home Committee
Assessment Home Providers
Leadership, United Foster and Adoptive Parents of Greater Milwaukee
Voices United Members
Out-Of -Home Program Managers, CSSW
Planning Council for Health and Human Services
Partnership Council Representative
Group Home Directors
Placement Stabilization and Assessment Center Directors/Staff
CSSW/Children's Family and Community Partnerships (FFCP) Leadership
Assistant District Attorneys
Foster Parent Group
African American Faith Community
University of Wisconsin Milwaukee Training Partnership
Children's Court Judges
Treatment Foster Care Providers
Tribal Representative
Guardians ad Litem and Social Workers
Wraparound Milwaukee
Wisconsin Association of Family and Children's Agencies

With the valuable support of Casey Family Programs, which contributed the services of four experienced staff for a two-week period, a case review of 37 children currently unstable (3 moves or more in the past 12 months) was conducted to provide specific information about service and support needs. The Casey team also assisted in the development of a case review instrument which was used in the review.

The sample for the case review was chosen from a universe of children with 3 or more moves in the past year, stratified to include children placed in assessment homes, assessment centers and placement stabilization centers, children in family foster care and children placed with relatives. In most cases the ongoing case manager, the licensing worker or placement worker, the caregiver and child were interviewed. The case record was also reviewed. A copy of the interview instrument is found in Appendix I.

III. Bureau System Strengths and Initiatives Underway

The Bureau has undertaken a number of initiatives to strengthen child welfare practice in Milwaukee. A few of them are summarized below.

- The Bureau is implementing a Comprehensive Assessment Process to develop a more thorough understanding of child and family needs both at case opening and throughout the life of a case.

- The Bureau is currently evaluating the phone Access function for the Bureau of Milwaukee Child Welfare to determine the following: availability/accessibility to the community; thoroughness of information collection; decision making on reports.

- The Bureau is implementing a technical assistance plan to enhance and increase knowledge and skill of Initial Assessment Region Managers and Service Managers.

- The Performance Review and Evaluation Section (PRES) in the Department of Children and Families (DCF) Office of Performance and Quality Assurance (OPQA) was created to consolidate specific quality assurance functions, including settlement monitoring functions, from the Division of Safety and Permanence (DSP) Bureau of Milwaukee Child Welfare (BMCW) Program Evaluation unit. The purpose of this new section is to provide transparency and objectivity in program reporting and evaluation, while concentrating BMCW program resources toward improved services for children and families.

- The Bureau is completing the medical review process for children under age 5 that is highlighting medical needs. A report is pending.

- The Bureau has an initiative to enhance its work with relative caregivers which should help identify relative resources and strengthen their involvement in the children's lives.

- A new foster parent training approach is being implemented to ensure that core training content is offered once new foster parents actually have a child in their care. Nine training hours are offered prior to licensure with the balance provided over the first two years of licensure. The Bureau believes that much of the training will be more meaningful when timed to coincide with actual fostering experience.

- While not a new process, CSSW points to the work of its licensing workers to reduce instability. CSSW licensing workers create individual support plans for every foster home and follow up every 90 days. CSSW also conducts placement stabilization meetings each time a child is placed in a foster home and follows up 90 days later.

- The Mobile Urban Treatment Teams develop a crisis stabilization plan for children enrolled in their program.

IV. Overarching Challenges Facing the Bureau

While the focus of this report is primarily related to service and support needs and placement needs, the review identified a number of system challenges that underlie the problem of instability and need to be recognized as barriers to stability and permanency. There was considerable acknowledgement of the challenges created by these barriers by Bureau staff and stakeholders and for some of these challenges, the Bureau is working on improvement strategies

to address them. The review team believes that until there is progress in addressing underlying system barriers, improvements in stability will be hard to sustain. A brief summary of major system barriers is provided below.

System Fragmentation: Coordination, Information Sharing and Accountability The case reviews and stakeholder interviews provided considerable description of the organizational fragmentation of the Bureau. The public-private partnership design, which no doubt has merits, has led to a high degree of specialized functions and multiple organizational entities, each of which is involved in child welfare activities. Duties are divided between the central office functions of administration, Access and Initial Assessment (IA) and three private entities, two of which provide ongoing case management and Safety Services with the third providing foster home licensing, recruitment and retention, placement and adoption case management, along with other duties. Foster/adoptive parents themselves, despite being licensed through CSSW, are also separate entities. Training for staff and foster/adoptive parents is provided by another organization, the University of Wisconsin-Milwaukee. Many supportive services are provided by different local and statewide child and family service agencies and Title XIX providers may include other separate entities. The Child Protection Center at Children's Hospital adds another partner to the array of child serving agencies working with the Bureau.

Adding to this complexity are legal partners such as judges, district attorneys, guardians ad litem and parent attorneys, each of which is a separate entity. It is possible that each of these entities would have involvement in a child's case, presenting immense coordination and information sharing challenges.

To illustrate this point, a child and family served by the Bureau could easily interact with IA staff, ongoing case managers, placement staff, the Child Protection Center, foster parents, multiple service providers, multiple legal partners and licensing staff, all in a short span of time. A foster parent would encounter a similar number of different entities and as the 2008 stability study notes, that number would be multiplied if several children were in the same placement. Having so many entities involved presents significant coordination and information sharing challenges due to frequent handoffs among partners, a lack of common knowledge about procedures, policy and case history and in some cases different values and practice approaches about how to address the needs of children and their families. Many stakeholders raised lack of information sharing as a major impediment to good outcomes. This problem was also easily identified in the cases reviewed. Adding to the system's complexity is the fact that the Bureau has a large staff turnover rate, meaning that a disproportionately high level of relatively inexperienced staff will have difficulty in assisting partners and families in navigating the system. Foster parents were highly concerned and frustrated by this limitation within the Bureau.

There is not an effective strategy in place to overcome the compartmentalization of functions and expertise that has evolved from the current organizational structure. The Coordinated Service Team process holds promise as a way to unify knowledge and performance among various team members, but as will be discussed in more detail later, to date it has failed to achieve that goal. The 2008 Quality Service Review reflects that while team formation scores were moderately high at 75 percent acceptability (meaning team meetings were being convened), coordination scores were at 63 percent acceptability and team functioning scores were at 54 percent (meaning that important members were not on the team or that the team was not functioning as a team).

The system fragmentation also impedes accountability. It is difficult to identify a central point of accountability within the Bureau's organizational structure beyond the Director's office. The child welfare team at the case level will always contain multiple members, but when each member works for and is accountable to a different organization, accountability becomes as fragmented as organizational structure.

Role Clarity and Relationships Particularly relevant to relationships between ongoing staff and foster care providers, stakeholder interviews revealed considerable tension over the division of responsibility for support of children in placement. For example, a fair number of case managers expressed frustration over the insistence of some foster parents on help in transporting children to medical visits, therapy and parent visits. There was also concern that some foster parents were resistant to attending school meetings, especially related to discipline issues. Case managers largely felt that providing these supports was an integral part of fostering and resented having to arrange other mechanisms to attend to these issues. Case managers felt that they already have a high and demanding workload, which gets heightened when they have to provide additional foster care supports.

Foster parents reported that they have to work and that it is difficult for them to take off work frequently to transport children to appointments, deal with school conferences over disciplinary issues or arrange for child care when children are suspended. They noted that they are likely to have several children placed with them, often in addition to their own children and are not always consulted when appointments are scheduled.

A similar conflict was found related to treatment foster care providers. Numerous Bureau staff reported frustration over a perceived inability of some treatment foster care providers to meet the needs of disruptive children, saying, "I thought they were being paid to address these behavioral issues rather than asking kids to be moved." In interviewing a group of treatment foster care providers, it was learned that treatment foster care providers have little in the way of additional clinical supports in their programs, relying mainly on their case managers to address behavioral issues beyond the capacity of the Treatment Foster Care (TFC) case manager. In addition, unlike treatment foster care providers found in other systems where at least one foster parent remains at home, many of these treatment foster parents were working and had to juggle work responsibilities with specialized foster care giving responsibilities. It is clear that neither case managers nor foster parents have a clear or consistent understanding of the responsibilities or capacity of their respective team members, resulting in poor working relationships and resentment. Obviously, conflicts like this have significant implications for foster care recruitment and retention.

Turnover Separate from the way turnover is measured under the Settlement Agreement, actual annual staff turnover is reported by the Bureau to be 58 percent. Stakeholders noted that many staff have less than a year of experience, which undoubtedly affects their knowledge of the system and practice skills level. Bureau data reveals that as of December 2008, almost 52 percent of ongoing case managers had 12 or fewer months of experience with their current agency.
Of course some staff may have had child welfare experience in other agency settings, meaning that this rate is somewhat high. However, no one denies that there is a large inexperienced work force in the Bureau. A high turnover rate not only impacts organizational competence, it also

increases the instability in the lives of children who are already experiencing losses due to frequent placement changes.

Workload To a large extent, the workload for the Bureau gets measured against the Settlement provisions related to caseload. As of December 2008, the Bureau reports that the average caseload for ongoing case managers is 20.9 children or approximately 11-12 families. Regardless of Settlement Agreement caseload requirements, functionally, this is a significant caseload size for ongoing case management staff. Ongoing staff now must not only visit each child monthly, but for young children, must visit twice per month. Ongoing staff report that a considerable portion of their time is taken in the placement process, where the shortage of placement options can leave case managers waiting in the office with children that have been detained while placement vacancies are sought or urgently searching for relatives. Because the court is now appropriately insisting on more frequent contacts between children in out-of-home care and their family, ongoing staff experience an increase in workload caused by arranging for visits and scheduling. The increase in Coordinated Service Team meetings, which ongoing staff facilitate, has also added to their workload. To contrast the workload in Milwaukee with a child welfare system performing well enough to have recently exited from court oversight in a Settlement Agreement, caseload standards in Utah are 13.5 cases per worker in child protective services and 15 children per worker for ongoing cases. That system also expects case managers to facilitate team meetings for every family.

To be able to provide the child and family engagement, team coordination, thorough assessment and individualized planning which will be necessary to address child and family needs, especially stability, ongoing staff will need smaller caseloads.

Attitudes Toward Instability Placement staff report that on any given day, there are no more than 8-10 family foster home beds available and that these vacancies may be limited by licensing capacity or the provider's preference for age or gender. Key managers in the Bureau acknowledge that given the shortage of available placement settings, placement decisions are shaped more by bed availability than a careful match between child and caregiver. Where children are not a good fit for the setting they are placed in, the likelihood of instability increases.

Also, the lack of availability of appropriate placement settings results in many foster homes being at capacity, stretching the ability of caregivers to manage challenging behaviors and increasing the likelihood of disruption. And because needed placement supports are not sufficiently available, a fact recognized in the Corrective Action Plan, case managers have difficulty in preventing disruptions.

While more placement settings and supportive services are needed to fully address the issue of placement instability and ultimately permanency, the Bureau will have to address the practice culture as well. There exists a sense of inevitability about placement disruption in the work force, as if it is an unavoidable fact of life in Milwaukee. Workers need a heightened sensitivity to the harmful effects of placement changes that manifests itself in a "Whatever it takes" approach to preventing disruption and achieving permanency. To do that they will certainly need more placement options and flexible supportive services, but also a willingness to take extraordinary steps to ensure placement continuity.

Flexible Funds for Children and Caregivers The Bureau inadvertently sends a signal that it doesn't expect a "Whatever it takes" approach in assuring stability and permanency by failing to make flexible supports and services that could prevent some disruptions easily accessible at the case level. The Bureau has several small funding amounts set aside as flexible funds, one an emergency services fund that is allocated $45,000 per year for the entire Bureau and another totaling $6,000. However these are said to related to the work of Access and IA staff only, not ongoing case management. No specific flexible funds amount was identified as available for ongoing staff, although some funds are available. These finds are described by case managers as difficult to access and requiring multiple layers of approval. Some case managers acknowledged that they've largely stopped trying to use them because it is "too much trouble." Stakeholder contacts and the case review confirm that it can be difficult to tailor a support to the needs of an individual child or caretaker either through flexible funds or flexible contract services.

Without access to flexible resources the creative individualized planning needed by children and caregivers is uncommon, a fact reflected in the level of instability among children served by the Bureau.

V. Stakeholder Interviews

In the course of conducting the 26 stakeholder interview sessions during the review, over one-hundred staff stakeholders, providers and others were interviewed. The input of this diverse group was critical in identifying Bureau strengths and challenges at both the case and system level. Because of the diversity of viewpoints provided it is difficult to briefly summarize the content of the conversations. Also, knowing the source of the input provides context and credibility to perspectives that a summary cannot offer. By way of compromise, this section will provide some common feedback by stakeholders about challenges facing the Bureau in summary form. It should be noted than many of those interviewed asked how they would be able to access a copy of this report and the Recruitment and Retention Report. Appendix II contains a list of the significant comments by each stakeholder group.

There was universal agreement that more foster homes are needed. There was also consistent agreement that too many children are placed out of county and that children in all settings change placements too often. Credible concerns were expressed that some children are unnecessarily placed in treatment foster homes and group homes because more appropriate family based placements are not available. There was also universal agreement that the placement process is almost completely driven by the search for an available bed rather than careful matching of children to caregivers. Both placement and provider staff stated that teens are much more likely to be placed in group homes when placements disrupt. Front-line staff report and foster parents agreed that it can be difficult to access services and supports that would prevent disruptions and that flexible dollars for such purposes are very limited and complex to access.

Bureau leadership is interested in knowing if it is using kinship placement appropriately and believes kinship supports, preparation of kin for placement and kinship training need strengthening. In response to a specific question, most participants in a meeting with leadership agreed that foster care standards can impede foster care licensing, particularly related to relative licensing and income requirements, space requirements and criminal record checks. Ongoing staff echoed this observation. There was less unanimity about this within CSSW. When asked if

the system could be more flexible with kinship providers, participants noted that the Bureau is looking at this as part of a kinship foster home licensing initiative. The leadership team also noted that it is looking for models or approaches that address the tendency among providers to ask that a child be moved with little notice, a practice which is not only harmful to children but also exacerbates the placement shortage. Bureau representatives and front-line staff have concerns about children disrupting in treatment foster care settings, which they expect to be able to manage such behavioral issues.

High turnover was a concern expressed by all. Foster parents see inexperienced staff as not yet knowledgeable enough to help them navigate the Bureau's procedures. Lack of information sharing and poor coordination were frequently mentioned by Bureau staff, providers and foster parents. The lack of information sharing extended to information about children's needs and status as well as information about policy and rules. In response to questions about the quality of Coordinated Service Team meetings, there was shared concern about poor participation by other team members and about the quality of team meetings. Legal partners, Bureau staff and partners recognized the lack of individualization in child and family plans, referring to them as "one size fits all". One of the cases reviewed in the care review reflects the circumstances of children and foster parents where lack of information impairs child well-being and permanency as well as foster parent relationships. It is summarized below.

The Case of E

> *E is a 13 yr old girl living in a general foster home. She has been in out-of-home care since November 2007. She has had 6 placements. She has been in the current foster home since August 2008 and it has been very stable. The official permanency plan is reunification. She entered the system due to a black eye and cut lip by her mother.*
>
> *E has had 3 ongoing case managers (OCM) in the last 18 months. Although the current permanency plan is for reunification, the case worker soon hopes to get an official concurrent plan of 'transfer of guardianship' with her foster family. E reports little chance for reunification and the caregiver gives little chance for reunification.*
>
> *Foster parents complain of rarely being informed of what is going on. Although the case worker wants to pursue transfer of guardianship to the foster family, they (the foster family) have no idea what all that means. From all appearances this young lady seems very happy in this home setting and the foster family reports they love her and are interested in guardianship, but again have no idea what all that means.*
> *E recently was expelled, and has to go to school 45 miles away. She had never been in trouble before. E does not know when reunification is supposed to occur.*
>
> *This foster family, like so many of them, is "in the dark" and cannot understand why such long delays occur and why timelines are not held too.*

As was mentioned earlier in this report, ongoing staff were very frustrated with foster parents that are not able to provide the necessary transportation to children, related to school issues, medical and therapy appointments, visitation and other appointments. Ongoing staff believe that such transportation is an inherent responsibility of foster parenting and resent being required to

address transportation issues when foster parents cannot. Foster parents, many of whom are employed, report that it is difficult for them to get off from work with such frequency, noting that they often have multiple children placed in their homes, sometimes in addition to their own children. Foster parents complain about not being consulted related to scheduling issues in advance, making it even more difficult to rearrange their schedules. Some foster parents state that they feel treated like just another provider by the Bureau, not as a vital partner.

There was some agreement among respondents, ranging from a regional director, to an assistant district attorney and IA staff, that there is a need to strength the Bureau's capacity to protect children in their own homes. Ideas by respondents to improve the in-home response ranged from strengthening the capacity and use of Safety Services to a greater expansion of in-home preventive services. As the data section of the report will note, the placement rate in Milwaukee County is 11.1 children per thousand children age seventeen and under. This is a rate higher than some other metropolitan areas in the US and considerably higher than the national average of 8.9. The Milwaukee team that recently visited the Department of Family and Children's Services prevention response in Los Angeles came away wishing for a similar robust capacity in Milwaukee County.

A number of less experienced foster parents participating in stakeholder discussions mentioned the value that would be offered by some type of organized peer support around issues like discipline and understanding how to navigate Bureau rules and policies. This potential would frequently be validated in the stakeholder meetings when a newer foster parent would raise a concern or problem and be offered solutions by more seasoned foster parents. While the fact that there are two foster parent associations in Milwaukee did not seem to be an issue of the highest importance among respondents, participants did acknowledge that is was unusual. Neither Association appears to generate much attendance at meetings. Some respondents acknowledged the different racial composition of the two organizations, with Voices United being seen as a primarily Caucasian organization and the United Foster and Adoptive Parents of Greater Milwaukee primarily African-American. One foster parent characterized the difference as more central city vs. suburban. The Bureau provides no financial support to either organization. One common issue that both organizations agree on and dislike is the fact that CSSW will not share names and addresses of foster parents due to confidentiality issues. The organizations believe that this fact limits their vitality and growth.

Another concern cited by foster parents was the low reimbursement rate in Wisconsin and what foster parents consider an uneven application of the standards for exceptional payments. Payment issues are outlined in greater detail in the section on characteristics of children served by the Bureau.

There was general support for the contribution made by Wraparound Milwaukee, but a number of respondents complained about problems with Wraparound not always sharing information. The most common issue cited was the return of children by Wraparound to their parents without concurrence by the Bureau. Efforts to determine the extent of such a practice were not successful, but it did not appear to be a frequent occurrence. Judges were particularly complimentary of Wraparound.

Some of the most informed discussions about instability came from Assessment and Placement Stabilization Centers, group homes and treatment foster home providers. A number of these providers spoke to the fact that a lack of permanency, control and predictability were ultimately

responsible for a lot of challenging child behaviors that contributed to disruption. Several participants stated that there needed to be better clarity about expectations for ongoing staff, related to role and accountability. In response to the question, "Of the children you serve, what are the behaviors and issues that will most test the next placement?", Assessment and Placement Stabilization Center representatives listed:

- Drug and alcohol abuse, especially with AWOLs
- Refusing to attend school
- Sexual issues, especially with girls
- Also with girls, an inability to process anger
- Property destruction
- A desire by youth to go back to what they consider normal
- Hopelessness - lack of predictability and control over their lives

In the same vein, the MUTT Director stated, only partially in jest, that if he could do one thing that would contribute to improved stability he would inoculate foster parents against reacting to eye-rolling, back talk and arguments about when to go to bed. He added that "the trauma of removal and connection to home is so strong that kids spend ninety percent of their energy wanting to go back home, something some foster parents don't understand. And the placement changes make it worse".

Note: In looking at the relationship between a lack of permanency and behavior, assuming that group home and TFC placements are largely related to behavioral issues, it was revealing to examine permanency goals for these populations. For the 551 children in TFC, 60 had a current goal of APLA with 49 having a concurrent APLA goal. In group homes, among the 170 children placed in those settings, 47 children had an APLA goal and 28 had concurrent APLA goals.

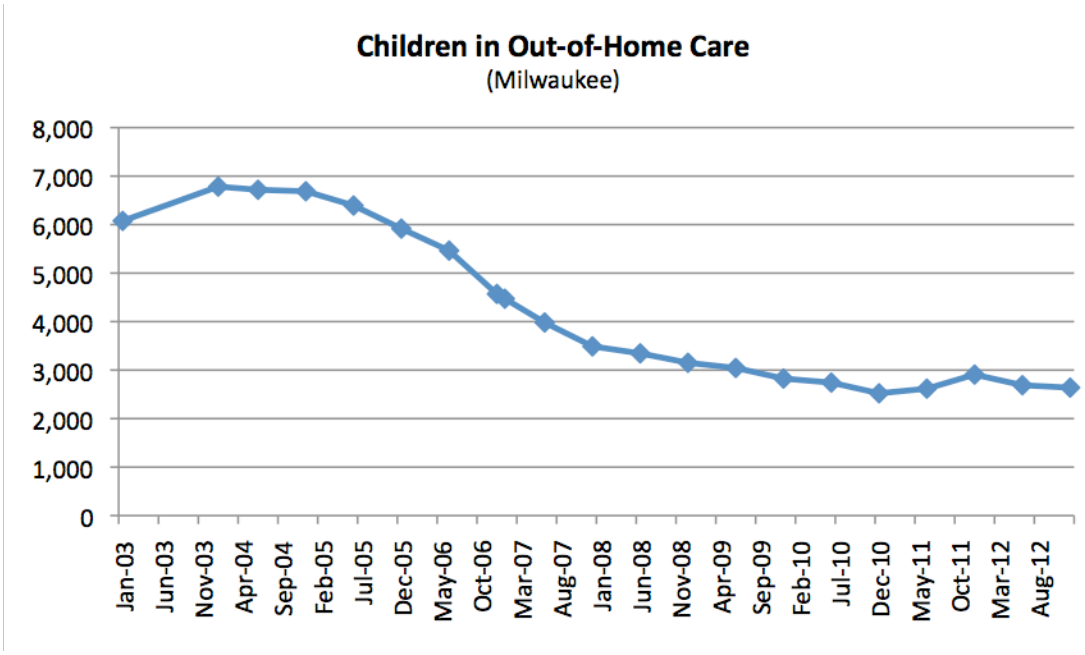
A tribal representative expressed concern that case managers did not fully understand Indian Child Welfare Act (ICWA) requirements about tribal placement and did not consistently practice within the law's provisions. She believes more training and supervisory oversight is needed to improve ICWA responsiveness. Two recommendations made were to include tribal representatives in Bureau planning efforts, including implementation of recommendations in this study and when parent attorneys need to be appointed in tribal cases, the appointment should be from the county where the parent resides.

Children's Court judges voiced concern about the number of children being placed out-of-county. They also noted a tendency in some cases to expand conditions for return as parents satisfy existing plan requirements, which they believe needs to change. (Some stakeholders believe that this occurs because initial assessment of new cases isn't thorough enough, a factor in part due to timelines for creation of initial plans.) Judges also expressed a wish to make plans more individualized, pointing to the current tendency of "one size fits all" plans.

Judges were consistent of their praise for Wraparound. They identified the need for initial mental health screening for all children entering out-of-home care. *(Note: Initial mental health screening is a requirement of the Corrective Action Plan, which states that "BMCW will ensure the initial mental health screen includes a developmentally appropriate mental health screen conducted by a qualified professional.")*

VI. Characteristics of the Milwaukee Child Welfare Population

In considering the placement needs of the Bureau, the review first focused on existing trend data to establish a baseline of the current trends in out-of-home care. The assessment was also undertaken to determine if case trends could be affecting the instability and the need for placement resources. The third purpose for this descriptive presentation of the characteristics of children served by the Bureau is to inform the work of the Utah Foster Care Foundation as they assist the Bureau in developing a recruitment and retention plan. The first issue addressed was, ***"Are more children entering out-of-home care and increasing the demand for placement?"*** As the chart below reveals, in the past 9 years, the number of children in out-of-home care in Milwaukee has fallen from 6,076 in 1999 to 2526 in 2009, a significant drop in the number of children in placement. However, since 2006 the number of children in out-of-home care has remained relatively constant.



The reduction in out-of-home care led to the question, ***"Are fewer reports of abuse and neglect contributing to this trend?"*** An analysis of trends for the past year shows that the number of calls other than for information and referral actually increased from 1035 to 1455 per month between March 2008 and March 2009. (See next chart.) The screen-in rate remained relatively the same.

Access

Calls received **other than information/referral**	1035	1072	1241	1293	1455
Screen-ins	835	706	801	829	883
Screen-outs	470	366	440	464	572
Multiple reports of **same incident**	72	68	84	76	101

Did the increase in calls to Access affect the number of children actually detained? Detention rates tend to be variable month-to-month in systems, but in looking at the chart below, the number of children detained in Milwaukee hasn't been significantly affected.

Initial Assessment

Cases carried **over**	1612	2262	2378	2476	2588
New child **abuse reports**	603	469	570	591	654
Cases open at **month's end**	1664	2378	2476	2588	2459
Children **detained**	100	57	53	106	83

Are Safety Services and Family Intervention Support and Services (FISS) a possible reason that the number of children detained is not increasing? Since the Safety Services caseload has dropped from 318 to 234 between March 2008 and March 2009 and the FISS caseload is static, it seems unlikely that Safety Services or FISS is having a significant additional contributing effect on numbers of children detained.

Safety Services

Open cases	318	229	218	225	234

FISS

Open cases	53	51	48	50	53

To this point existing data has only revealed that that number of children in out-of-home care is relatively static and the reason that it has remained so in spite of increasing calls to ACCESS is

unknown. It may be safe to predict that the out-of-home caseload is likely to remain static, based on trends for the past three years. Knowing this likelihood is useful in projecting the need for additional placement settings.

Ongoing case management data, found in the next chart, reveals that there is slow growth in the use of Treatment Foster Care, from 522 in March 2008 to 550 in March 2009. The number of children in group homes has also increased from 134 in March 2008 to 160 in March 2009. The number of children in residential treatment has changed little in the past year.

There has been a slight decline in the number of children in a licensed relative home and the number of children in unlicensed relative care remains essentially constant.

Ongoing Case Management

Family cases **transferred from IA**	43	51	37	51	49
Family cases closed	43	52	44	66	87
Total children in out-**of-home**	2807	2638	2582	2561	2526
Foster Home-Non-**Relative**	763	671	601	618	599
Treatment foster care	522	522	533	551	550
Group home	134	170	163	170	160
Residential	82	69	72	76	79
Total with relative	995	986	938	906	967
• Licensed **relative home**	205	186	185	191	187
• Unlicensed **relative home**	790	800	743	715	780
Assessment/Stab **Center**	49	46	45	56	52
Children at home **under court order**	636	789	756	749	707
Open family cases at **month's end**	1884	1892	1876	1862	1825

Data from the Out-of-Home Activity report below reveals that 51 foster homes were added in the past year, bringing the March 2009 total to 700.

Out of Home Activity

Homes on **hold**	86	75	75	79	72
New **applications**	44	48	44	55	57
Homes closed	11	12	12	18	11
Homes newly **licensed**	14	20	14	16	20
Active homes	649	695	695	692	700

Data from the adoption report shows growth in finalized adoptions from 12 in March 2008 to 27 in March 2009.

Adoption

Finalized **adoptions**	12	16	22	32	27
TPR granted	25	18	35	19	29
TPR filed	18	36	41	30	14

An important issue in this study is the number of children placed out of the county. Key stakeholders and the Bureau leadership raised concern about this trend where placements are not with kin, as it separates children from their family, school, informal supports and community. It also adds to the already heavy workload of staff that have to travel further to visit the children.

The charts below show that the number of children placed out of county grew from 433 in 2006 to 484 in 2009. In 2006, 82 percent of placements were in county and 3.5 percent out of state. In 2009, 79 percent of placements were in county, with 2.4 percent out of state. This small change reflects fewer placements in county and out of state, with more placements out of county. The issue of greatest concern is that of the children placed out of county, 163 children were placed in unrelated foster homes, 109 children in treatment foster homes and 63 children were placed in residential treatment, a total of 343. All of these children were placed with strangers.

Children Placed Out of County

	Feb 2009	Feb 2008	Feb 2007	Feb 2006
County of placement				
In County	2016	2185	1975	2396
Out of County	484	482	481	433
Out of State	61	85	87	102
	2561	2752	2543	2931
% of placements out of county	**21.3%**	**20.6%**	**22.3%**	**18.3%**

The following charts reflect the number of children placed out-of-county, but in-state, by type of placement setting.

	Feb 2009	Feb 2008	Feb 2007	Feb 2006
Fstr Fam Hm (Relative)	18	18	27	29
Fstr Fam Hm (Non-Rel)	173	167	210	176
Kinship Care - Court-Ordered	71	74	76	58
Relative - Unlicensed	3	0	0	4
Non-Relative-Unlicensed	4	9	1	7
Treatment Foster Home - **Non-Relative**	109	99	70	59
Treatment Foster Home - **Relative**	0	1	1	0
Group Home	3	12	12	11
RCC	62	61	50	41
Pre-Adoptive Home	22	21	12	32
Supervised Independent **Living**	1	0	0	0
Hospital	2	1	2	0
Juvenile Correctional Facility	16	19	20	16
Grand Total	484	482	481	433

Out of State Placement	**Setting Distribution**			
	Feb 2009	**Feb 2008**	**Feb 2007**	**Feb 2006**
Fstr Fam Hm (Relative)	35	41	49	65
Fstr Fam Hm (Non-Rel)	4	4	5	8
Kinship Care - Court-Ordered	19	31	22	21
Relative-Unlicensed	0	5	6	1
Non-Relative-Unlicensed	2	4	4	4
Pre-Adoptive Home	1	0	1	3
Grand Total	61	85	87	102

The next chart shows that children in foster homes have far fewer moves than children in group homes or residential treatment settings.

Foster Home (Relative)	28
Foster Home (Non-Relative)	25
Kinship	33
TFC	39
Group Home	61
Residential	64

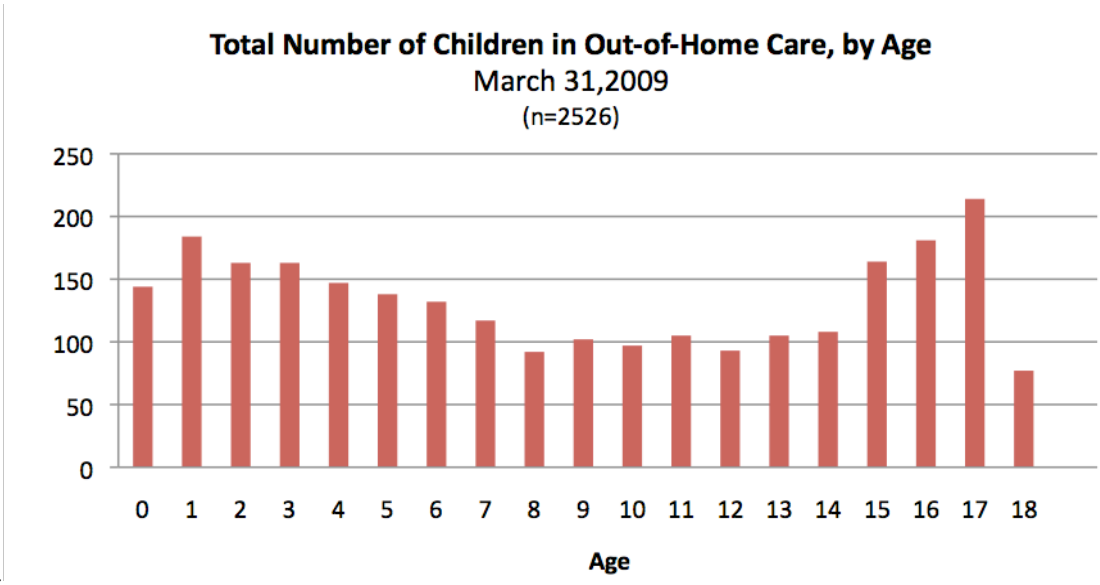
Placement Movement (within past 12 months) by Setting – Children Out-of-Home in February 09

Foster Family Home (Relative)	25
1 move	18
2 moves	6
3 moves	1
Foster Family Home (Non-Relative)	227
1 move	171
2 moves	44
3 moves	9
4 moves	3
Kinship **– Court Ordered**	234
1 move	159
2 moves	46
3 moves	24

4 moves	3
5+ moves	2
Kinship – **Voluntary**	12
1 move	5
2 moves	5
3 moves	2
Relative – **Unlicensed**	5
1 move	3
2 moves	2
Non Relative – **Unlicensed**	16
1 move	10
2 moves	1
3 moves	3
4 moves	2
Treatment Foster Care – **Relative**	1
4 moves	1
Treatment Foster Home – **Non-Relative**	251
1 move	154
2 moves	57
3 moves	18
4 moves	17
5 + moves	5
Pre-Adoptive Home	24
1 move	18
2 moves	5
3 moves	1
Assessment/Stabilization Center	40
1 move	19
2 moves	10
3 moves	7
4 moves	1
5+ moves	3
Group Home	109
1 move	43
2 moves	18
3 moves	13
4 moves	15
5+moves	20
RCC	58
1 move	21
2 moves	10
3 moves	8
4 moves	6
5+moves	13
Hospital	1
1 move	1
2 moves	1

3 moves	1
Supervised Independent Living	9
1 move	3
2 moves	2
3 moves	1
4 moves	1
5+ moves	2
Detention/Juvenile (Adult) Corrections	24
1 move	5
2 moves	4
3 moves	4
4 moves	1
5= moves	5
Missing from OOH Care	28
1 move	5
2 moves	8
3 moves	4
4 moves	6
5+ moves	5

The following chart identifies the number of children in out-of-home care by age and is included both as a reference point for identifying placement needs and for use in the development of the recruitment and retention plan.



For purposes of comparison, the following chart reflects the placement setting distribution in a number of other systems. While it is difficult to compare systems, this comparison clearly shows the disproportionally small percentage of children placed in licensed family foster homes in Milwaukee.

Comparative Distribution of Placement Settings – Other Urban Systems

Indianapolis	28%	47%	06%	*Data pending*	1,218	1,519
Cook County	33%	54%	16%	*Data pending*	10,160	6,616
Los Angeles	49%	45%	06%	*.1%*	10,608	16,087
NYC	34%	49%	14%	06%	8,998	20,400
Milwaukee	38%	24%	12%	22%	707	2,526

Based on an unpublished report by The Annie E. Casey Foundation's Casey Strategic Consulting, with Milwaukee data supplied by the Bureau, Milwaukee has a relatively high rate of children placed in out-of-home care per 1,000 children, as seen below. This suggests that stakeholders that believe the Bureau needs to expand and strengthen its in-home child protective services supports may be correct in seeing an opportunity to further reduce the number of children in out-of-home care.

Rate of Children in Out-of-Home Care per 1,000 Children
(Unpublished report by Casey Strategic Consulting in the Annie E. Casey Foundation. Milwaukee data is from BMCW.)

Philadelphia	18
Allegheny County (Pittsburgh)	9
Los Angeles	9
New York City	8
Cuyahoga County (Cleveland)	7.8
Cook County (Chicago)	6.5
Orange County (CA)	4
Washington DC	4.4
Milwaukee	11.1
Baltimore	30.4
US National Average (**For urban jurisdictions)**	8.9

Numerous stakeholders noted that foster care payment levels were extremely low in Wisconsin, at only $349 per month. The basic rate structure is found in Appendix III. Because there may be a relationship between payment levels and recruitment and retention, thus affecting available placements, the review considered the average payment level, using data supplied by the Bureau. The following tables reflect the current minimum payment, graduated based on child age and the average payments and amount of supplemental payments which are paid. As the chart shows, average payments are more than the minimum and that about 200 foster parents received the minimum. The chart shows that for non-relative foster care, 22% of children received the basic rate, 58% received the supplemental rate and 19% received the exceptional rate. For relative

foster homes, 25% of children received the basic rate, 62% received the supplemental rate and 11% received the exceptional rate.

No conclusions are drawn from this data, except that actual payments are higher than the minimum for many foster parents. Of important significance is the report by CSSW that average supplemental payments are lower in Milwaukee than the rest of the state. The process for setting the supplemental rate is based on a simple tool, but subjective in terms of the calculation of need.

Birth to 4 years old	333.00	**349.00**
5 to 11 years old	363.00	**381.00**
12 to 14 years old	414.00	**433.00**
15 to 18 years old	432.00	**452.00**

Foster Home Payment Levels

February 09 Payments			**# of Children Receiving:**		
Type of Care	**# Children**	**Avg Pmt**	**Basic Only**	**Supplemental**	**Exceptional**
Non-Relative Foster Home	797	$ 561.25	219	558	184
Ages 0-1	152	$ 435.04	68	76	26
Ages 2-4	206	$ 501.26	62	135	49
Ages 5-11	287	$ 612.69	55	231	72
Ages 12-15	90	$ 659.08	15	68	22
Ages 16+	62	$ 689.78	19	48	15
Relative Foster Home	56	$ 550.05	16	39	7
Ages 0-1	7	$ 395.29	5	2	-
Ages 2-4	12	$ 471.67	6	6	1
Ages 5-11	19	$ 620.79	1	18	3
Ages 12-15	10	$ 588.10	1	9	-
Ages 16+	8	$ 587.50	3	4	3

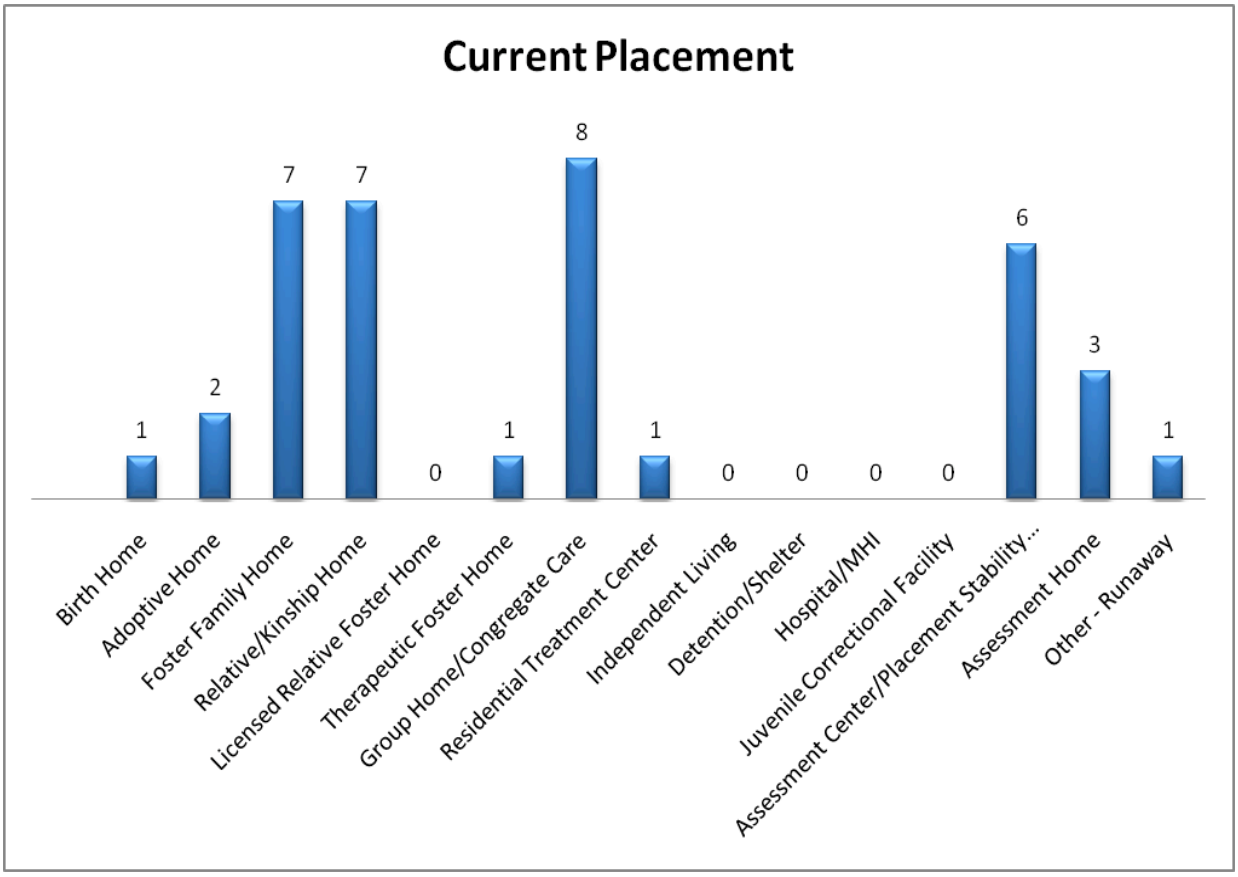
Average Payments 2007-2009

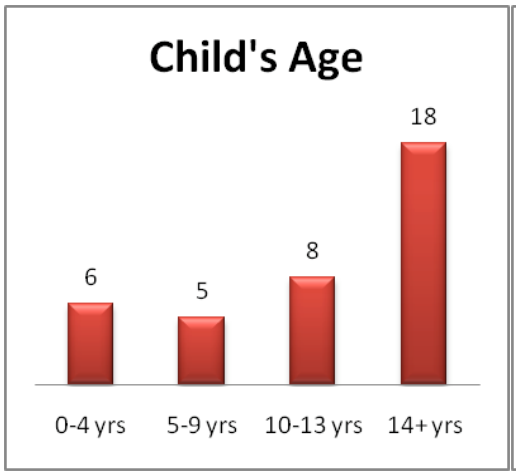
These numbers do not include WRAP children

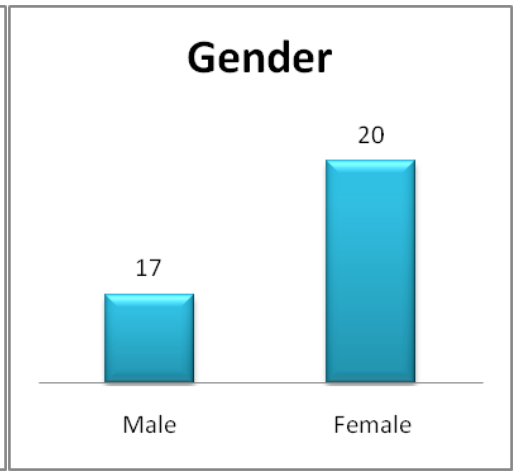
	# of Children in Care			Ave Monthly Payment		
Type of Care	**Oct-07**	**Feb-08**	**Feb-09**	**Oct-07**	**Feb-08**	**Feb-09**
Non-Relative Foster Home	913	853	797	$ 523.44	$ 528.91	$ 561.25
Ages 0-1	167	143	152	$ 383.19	$ 402.26	$ 435.04
Ages 2-4	221	211	206	$ 461.45	$ 457.74	$ 501.26
Ages 5-11	326	304	287	$ 569.56	$ 556.38	$ 612.69
Ages 12-15	114	107	90	$ 626.76	$ 612.30	$ 659.08
Ages 16+	85	88	62	$ 644.69	$ 637.40	$ 689.78
Relative Foster Home	43	44	56	$ 551.23	$ 580.50	$ 550.05
Ages 0-1	5	7	7	$ 345.80	$ 413.00	$ 395.29
Ages 2-4	3	3	12	$ 449.00	$ 515.00	$ 471.67
Ages 5-11	12	10	19	$ 634.08	$ 684.20	$ 620.79
Ages 12-15	11	10	10	$ 555.55	$ 626.20	$ 588.10
Ages 16+	12	14	8	$ 575.58	$ 571.57	$ 587.50

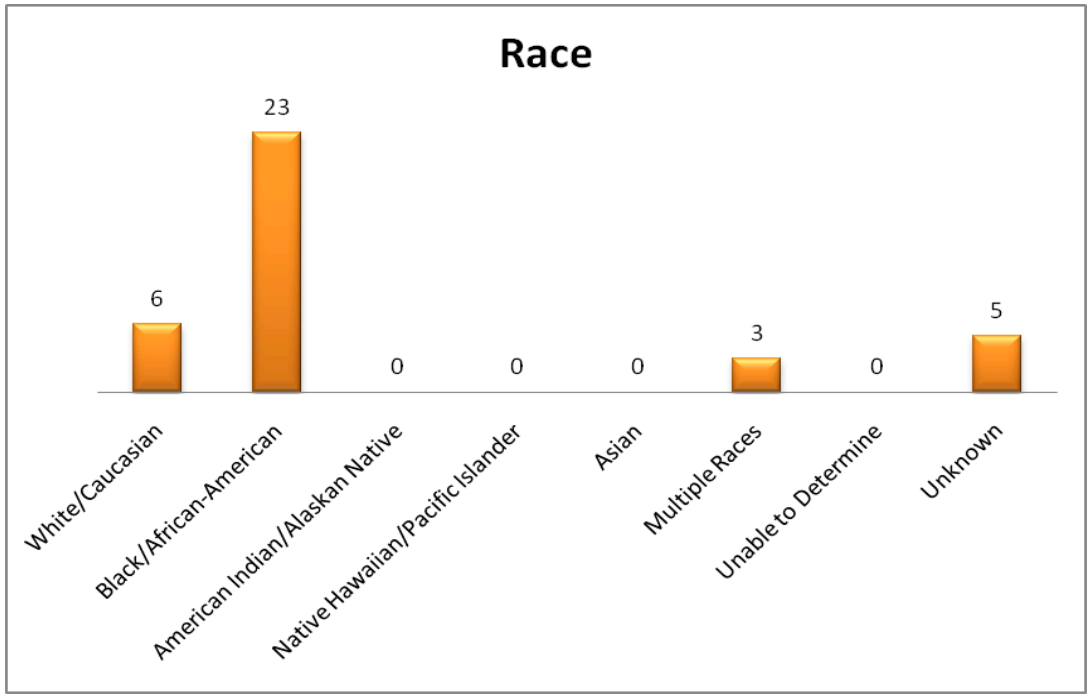
VII. Case Review of Unstable Children

As previously mentioned, the review included a review of 37 children with at least three moves in the past twelve months. Like the 2008 Stability Study conducted by the Bureau, it is largely qualitative in focus and permitted the analysis of actual cases to identify and in some cases verify the service and support needs of children in placement. The characteristics of the children in the sample are as follow:


Current Placement
1
2
7
7
0
1
8
1
0
0
0
0
6
3
1
Birth Home
Adoptive Home
Foster Family Home
Relative/Kinship Home
Licensed Relative Foster Home
Therapeutic Foster Home
Group Home/Congregate Care
Residential Treatment Center
Independent Living
Detention/Shelter
Hospital/MHI
Juvenile Correctional Facility
Assessment Center/Placement Stability...
Assessment Home
Other - Runaway


Child's Age
6
5
8
18
0-4 yrs
5-9 yrs
10-13 yrs
14+ yrs


Gender
17
20
Male
Female


Race
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0
0
0
3
0
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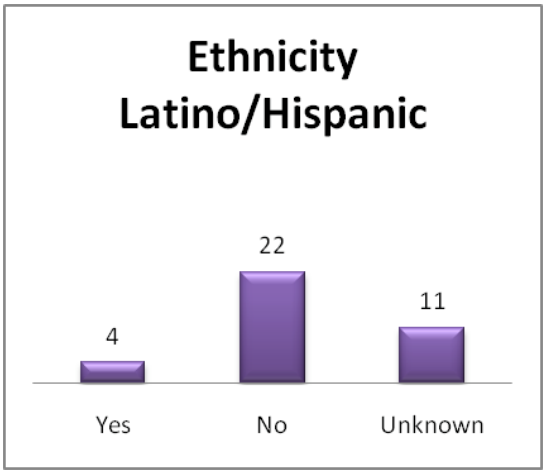
White/Caucasian
Black/African-American
American Indian/Alaskan Native
Native Hawaiian/Pacific Islander
Asian
Multiple Races
Unable to Determine
Unknown


Ethnicity
Latino/Hispanic
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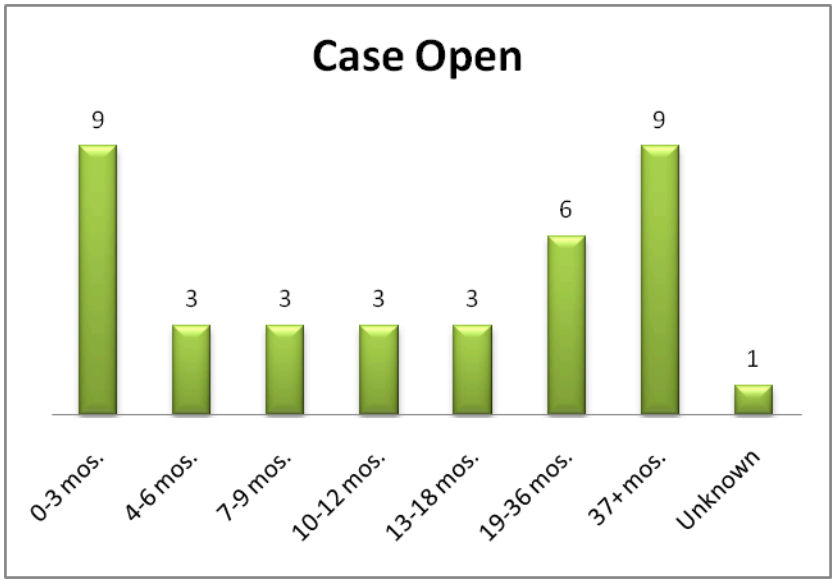
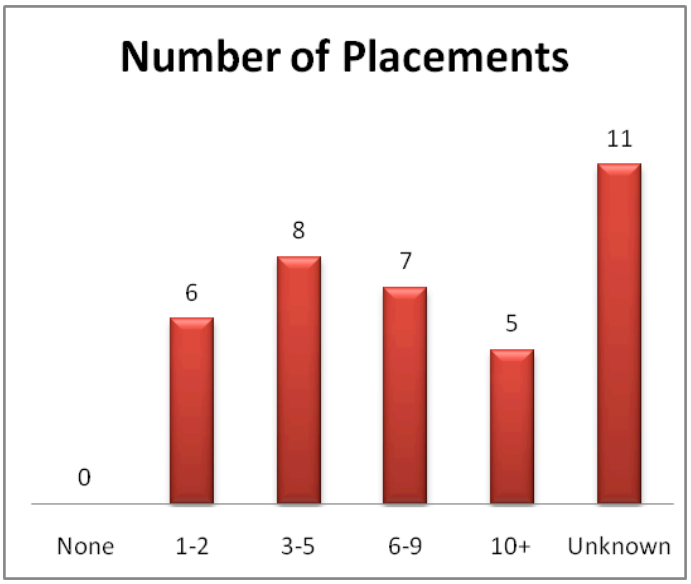
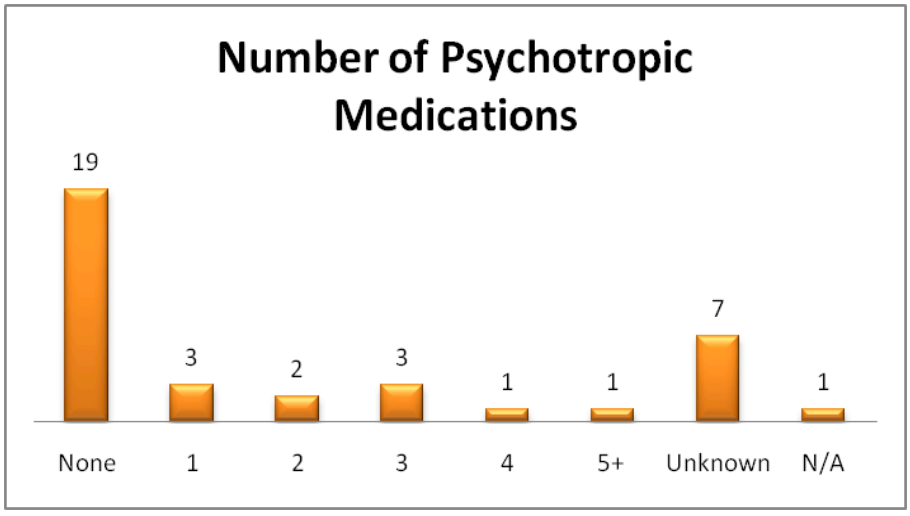
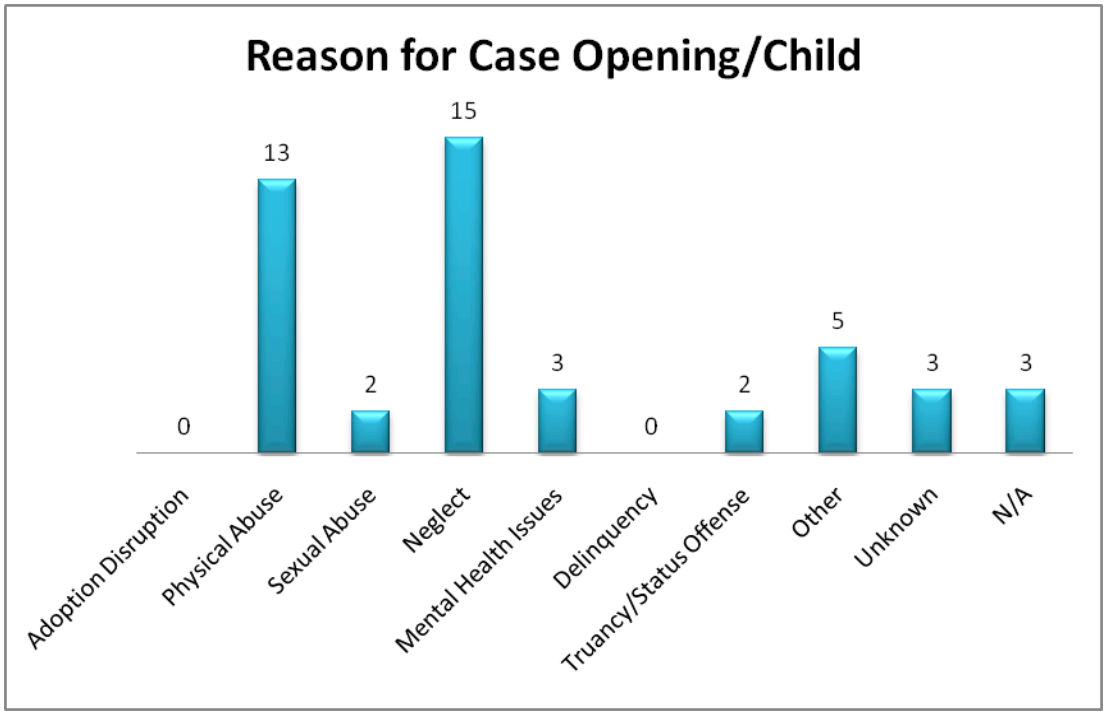
4
11
Yes
No
Unknown

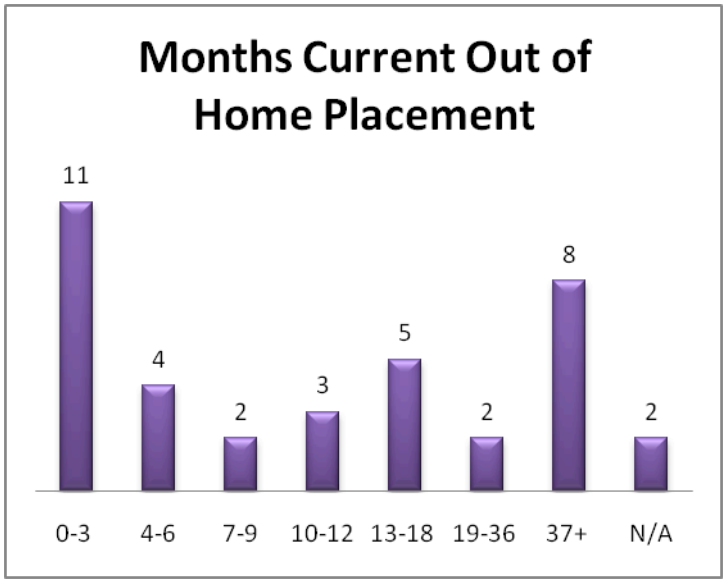

Case Open
9
3
3
3
3
6
9
1
0-3 mos.
4-6 mos.
7-9 mos.
10-12 mos.
13-18 mos.
19-36 mos.
37+ mos.
Unknown

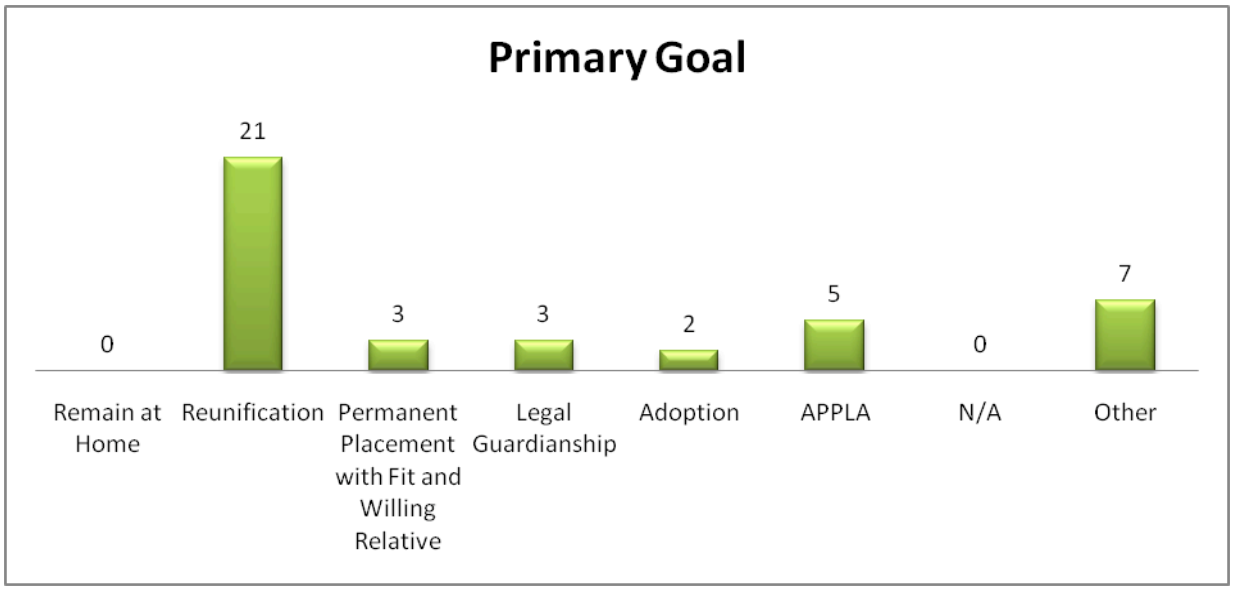

Number of Placements
0
6
8
7
5
11
None
1-2
3-5
6-9
10+
Unknown

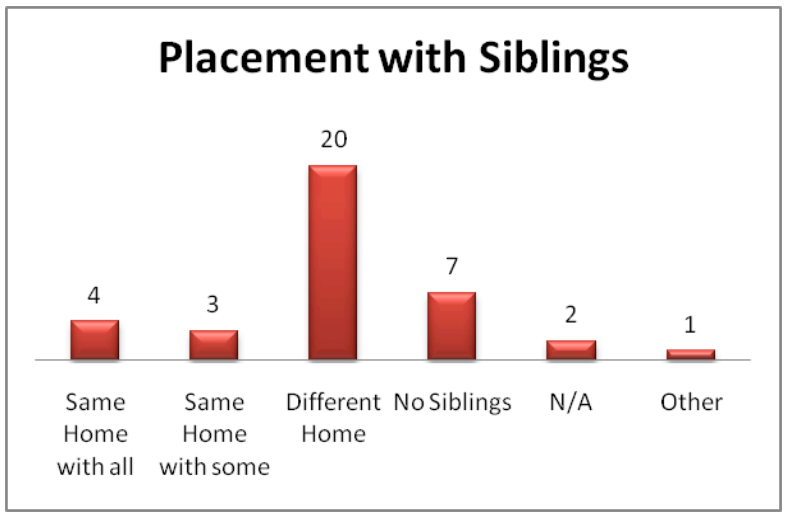

Number of Psychotropic Medications
19
3
2
3
1
1
7
1
None
1
2
3
4
5+
Unknown
N/A

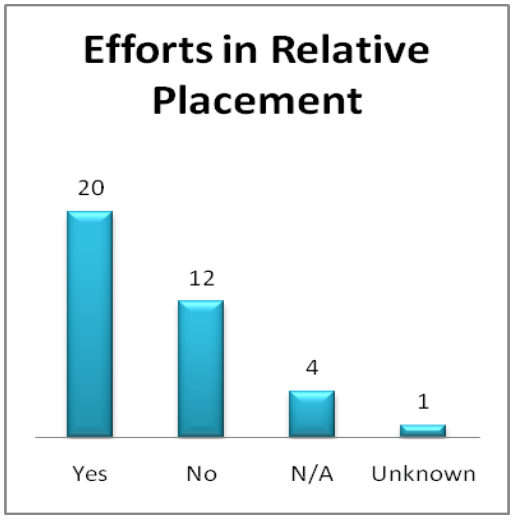


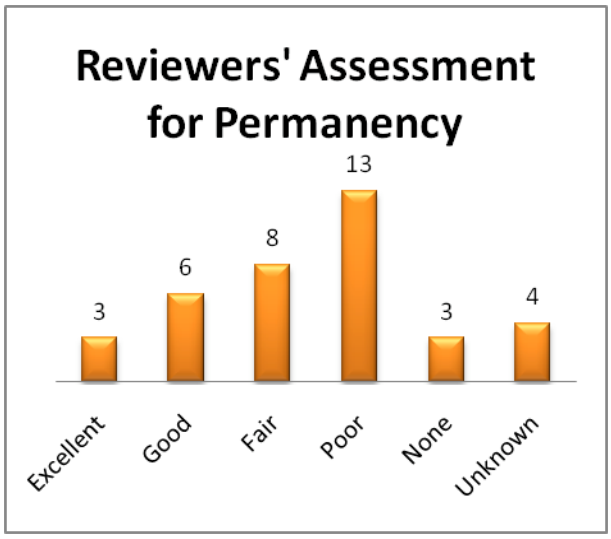
In the chart above, several cases had more than one reason for case opening.

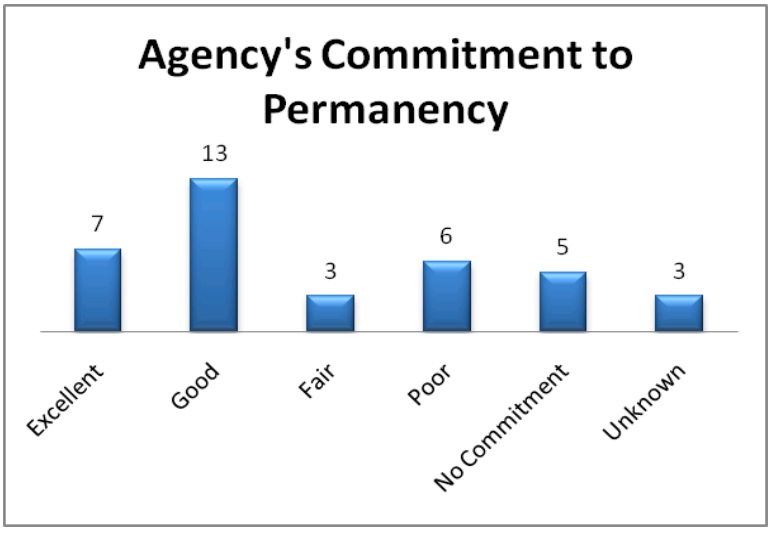


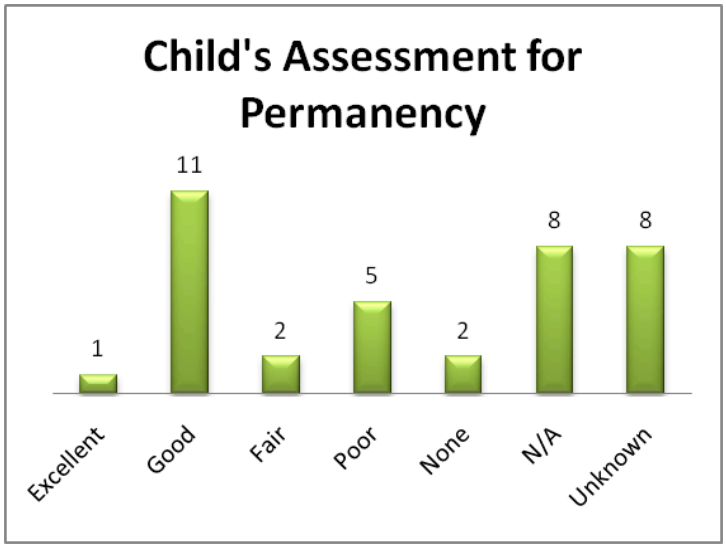

Primary Goal
0
21
3
3
2
5
0
7
Remain at Home
Reunification
Permanent Placement with Fit and Willing Relative
Legal Guardianship
Adoption
APPLA
N/A
Other

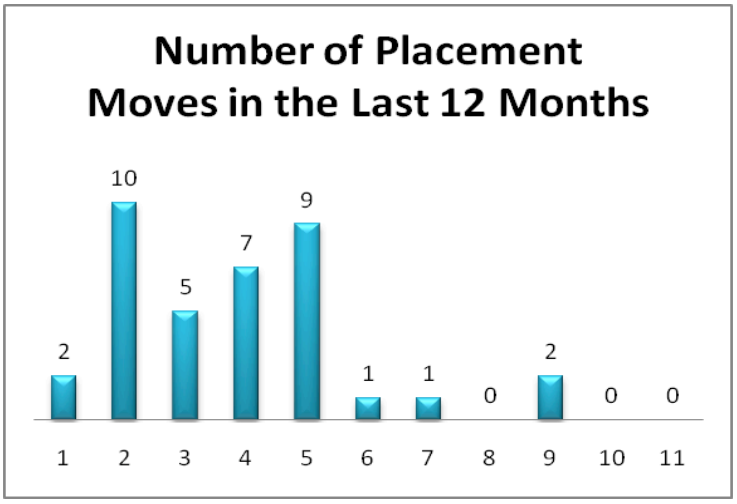

Placement with Siblings
4
3
20
7
2
1
Same Home with all
Same Home with some
Different Home
No Siblings
N/A
Other

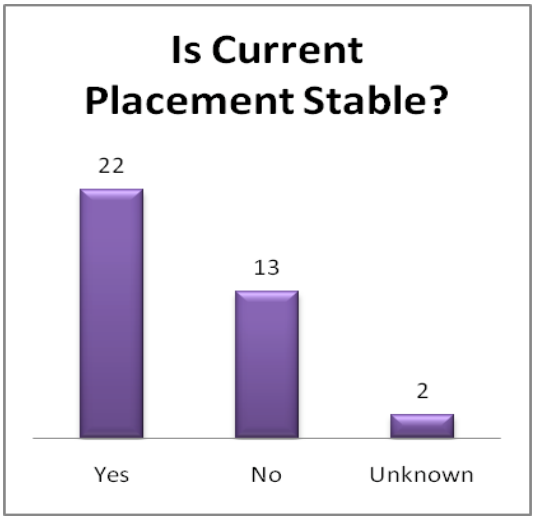

Efforts in Relative Placement
20
12
4
1
Yes
No
N/A
Unknown

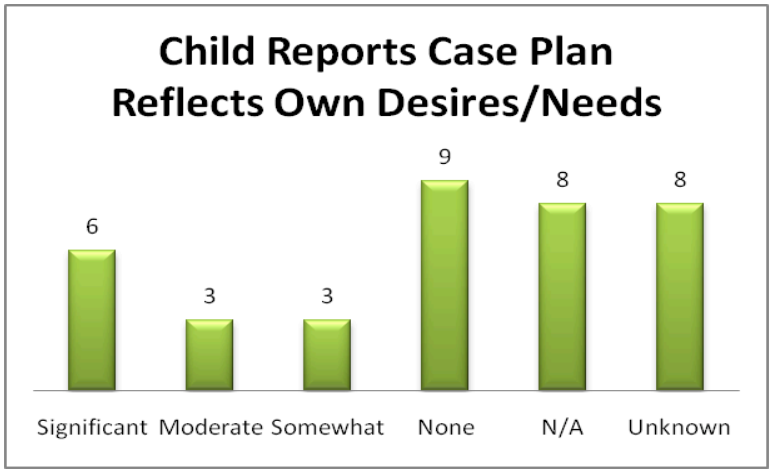

Reviewers' Assessment for Permanency
3
6
8
13
3
4
Excellent
Good
Fair
Poor
None
Unknown

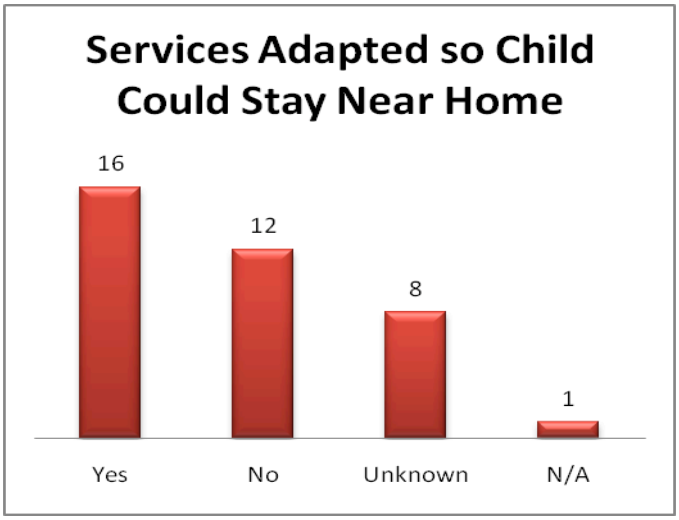

Agency's Commitment to Permanency
7
13
3
6
5
3
Excellent
Good
Fair
Poor
No Commitment
Unknown


Child's Assessment for Permanency
11
8
8
5
2
2
1
Excellent
Good
Fair
Poor
None
N/A
Unknown


Number of Placement Moves in the Last 12 Months
10
9
7
5
2
2
1
1
0
0
0
1
2
3
4
5
6
7
8
9
10
11


Is Current Placement Stable?
22
13
2
Yes
No
Unknown





Analysis

This review was intended to primarily identify the services likely to be needed by the unstable population of children in out-of-home care to maintain stability and achieve permanency. Other questions were added to the instrument to capture demographic information, case history and case practice efforts. The brief time frame in which the review was conducted (two weeks), limited number of team members interviewed (parents and providers other than the placement provider were not interviewed) and limited time to review case files prevented this review from being as comprehensive as a Qualitative Service Review (QSR).

However valuable information was collected about this sample of unstable children which confirms other data about their history and current status and their effects on stability. For example neglect and physical abuse were the primary reasons for case openings. Eighteen of the children had been in placement 10 months or more and 8 over 37 months. Because of the sample stratification, most of the children had a history of multiple moves. While the primary goal was reunification for 21 of the children, reviewers identified only 9 children for whom they believed chances for permanency were fair or better. Twenty children were placed in a different home from some or all of their siblings. The number of children for whom relative placement efforts

were made was more positive, with relative placements sought in 20 cases. However there was no evidence of efforts to place with relatives in 12 cases.

The agency's efforts to achieve permanency was fair or better in 23 cases and poor or lower in 11 cases, according to reviewer assessment. Twenty-two of the children were in placements currently considered stable while 13 were not. In 16 cases services were adapted so children could remain near home and services were not adapted in 12. The following case that was reviewed highlights the need for speedy permanency and the missed opportunity to use CSTs to gather family input and keep all team members informed.

The Case of L

> *L is a 15 year old African American female who has been in kinship care with various relatives throughout her life. She is now placed with her brother in the home of their maternal grandfather and the permanency plan is Transfer to Guardianship (TOG). At the age of 2 she and her 3 year old brother were left by their mother on the doorstep of their paternal grandmother. Their mother, who is borderline mentally retarded and has had a long history of ADOA, has had no role in their lives since. Over the next 12 years the Bureau oversaw L and her brother being passed among several family members (due to an original TOG). They all provided poor and neglectful care, while loose monitoring from the Bureau and no clear permanency planning kept L in a tenuous state, even while living with family. Her OCM and L state that she is in a stable placement for the first time in her life. L ended up in her current relative placement last year by virtue of landing in her first "out of family" placement (a group home where a distant cousin happened to be employed). L's maternal side of the family had been trying for years to ascertain her and her brother's whereabouts so they could enter their lives and possibly provide them a home. L reports that she is now happier than ever and her grandparents and OCM note that she is thriving in the home.*
>
> *But for what some would deem a chance or fluke encounter between L and a cousin, who informed her grandfather of her whereabouts, L might still be drifting through the system undetected by family who love her and have the desire and capacity to provide her with stability and permanency. Unfortunately, the TOG to her maternal grandparents has been repeatedly delayed, much to their chagrin and they have no knowledge of the basis for the delays, further validating the need for improved communication among all key parties. When asked what she would change about the system, OCM emphasized the crucial need for them to investigate ALL family resources and engage them better, from initial stages (IA) and ongoing. L's grandparents said the Bureau must get EVERY family members input to make the best decisions because a youth can be "lost" even while living with family. The communication and coordination gaps in this case STILL need to be closed for the well being of this youth.*

Among the most important feedback the case review provided was confirmation of challenges identified in other interviews. Many cases suffered from a lack of coordination. Among the 21 cases where the child or youth was available and could or would speak to their role in the planning process, 9 reported that they had no meaningful involvement in decisions that affected their lives. It was difficult to quantify the extent to which children were involved in CSTs, in part because they couldn't distinguish CSTs from other meetings and staffings they had attended.

While CSTs were being held in a moderate number of cases reviewed, it was clear that some youth had never experienced them. The number of children having at least some visits with family was fairly high, as long as family members lived in or near Milwaukee. Caregivers and youth remarked on the high turnover among caseworkers. In that context one youth said, "What I wish is for workers who care about me personally, not just me as a case." That kind of relationship is hard to achieve when worker tenure is so brief.

Reviewers were asked to identify services that are either currently needed in each case or was needed to address past instability. The array of service and supports identified as well as practice needed is listed below.

Early and comprehensive exploration of relative resources
Greater focus on fathers and paternal relatives as potential caregivers
Greater involvement of youth in planning and decision making
Extend the use of CSTs to all youth and use the process to improve coordination
Faster permanency
Placement closer to home
Provide support for extra-curricular activities
Mentors
Respite
Individualized behavior supports
Behavior coaching for caregivers and children
In-home counseling
School coaching
Advocacy for IEP
AODA supports
Stronger independent living supports
Job training for youth
Alternative school programs for suspended children
Family preservation services

Respondents (ongoing case managers, youth and caregivers) were also asked to respond to the question, "If you could change one thing about the system, what would it be?" Responses were:

Speedier court process related to permanency
Lower caseloads
Slow down consideration of moving children
More resources committed to Safety Services
Reduce turnover
Stop giving parents so many chances
More comprehensive assessments
More foster home options
Listen to youth
Take a more diligent search for kin
Work harder to keep siblings together
Speed up payment of the clothing allowance
Give caregivers prior notice when appointments are cancelled

The story of one child reviewed in the case reviews effectively illustrates the desire of many children to return home, the resiliency of children in the face of significant losses and the inability of the system to create permanency for many children like B. There is little in current planning to alter the course of this child's experience in the system.

The Case of B

B is a 12 year old girl who has been in OOHC since 2003. She and her 4 siblings were removed because of physical abuse to one of the children. The official "Permanency Plan" is "permanent placement with fit and willing relatives". This has been the plan for quite some time. Although B has been placed with a number of relatives, none of them have been permanent. In addition, it is believed by current OCM that there is not any 'fit and willing' relative available. The last relative she lived with fled the area without notice and failed the ICPC. The BMCW had to retrieve her from Las Vegas.

B has had 6 different placements the past 22 months and 4 in the last 12 months. B is clear that she wants to return home with her mother, who is 28 years old and 6 months pregnant. She is eager to help raise her new infant sibling. 2 younger siblings have been adopted by separate families. B's 14 yr old sister, in a separate foster home, also wants to return home with mom. OCM believes these girls should go home. Her 9 year old brother is in a TFC home. The current OCM and GAL have initiated unsupervised visits with the mother every weekend. Visits reportedly go well.

There have been a number of 1 year long placements. The current foster mother has stated that she would be willing to raise the child as long as she does not have to deal directly with the birth mother who has threatened to kill her.

The birth mother is currently facing charges of threatening to kill the previous case worker. Not one person believes the permanent plan of living with a fit and willing relative is realistic. B is a delightful young lady, and is doing very well in school. She is not involved in any activities but states she would like to be a singer, actor, or model. At her foster home she stays in her room most of the time and presents no problems at school or home.

VIII. Needed Services and Supports

The stakeholder interviews and case reviews provided a consistent description of the kinds of services and supports needed by children and caregivers to improve stability and support permanency. It was also apparent that many of these supports are not available in Milwaukee and others were often difficult to access. Staff reported that some needed services, like an array of education supports or clinically competent in-home therapy simply were not available. Other services existed, but were attached to a different setting in which a child needed to reside. As a result, obtaining a needed service would require a placement change – presenting an unattractive choice of maintaining a placement or obtaining a needed service. A third group of services, such as mentoring, involved long wait lists. And when a unique, individualized service was needed, few flexible funds were available to support it and access required layers of approval.

In identifying needed services related to instability, staff and stakeholders spoke frequently about the need for supports to address child behavior issues such as defiance, aggression, anger and oppositional responses. Therapy and in-home behavioral supports were often seen as an appropriate intervention for these behaviors.

The foster care literature provides ample evidence of the particular challenge to stability and permanence that the high incidence of mental health needs among children in out-of-home care presents. National estimates of the percentage of children in foster care with mental health needs range from forty to sixty percent. Stephen Hornberger, director of behavioral health for the Child Welfare League of America states, "Anywhere from 40% to 85% of kids in foster care have mental health disorders, depending on which report you read."

There is also evidence that frequent placement changes heighten the incidence of emotional behavioral disorders, documented in a Casey Family Programs paper on placement disruption, which referenced:

> Wulczyn and Cogan (2002, p.2) cited an important child development related reason: "Multiple placements are thought to have a pernicious impact on the development of attachment to primary caregivers, an early developmental milestone thought to be essential for the achievement of later developmental tasks (e.g. Lieberman, 1987; Provence, 1989; Fahlberg, 1991)." While the concept of child and adolescent attachment to adults is not an exact science and we have much to learn about helping children build new positive attachments, many youth and foster care alumni have commented on how important it is to minimize placement change and to be placed with siblings as a placement stabilizing strategy (Leathers, 2005, Herrick & Piccus, 2005).
>
> In addition, various researchers have found that multiple placements may lead to child behavior problems (Newton, Litrownik & Landsverk, 2000), and mental health problems (Rutter & Sroufe, 2000), Ryan & Testa (2004) found that these changes were linked with decreased school performance and delinquent behavior of males, and Pecora, Williams, Kessler et al. (2003) found that lower placement change was associated with foster care alumni success in a sample of 20-51 year old alumni.

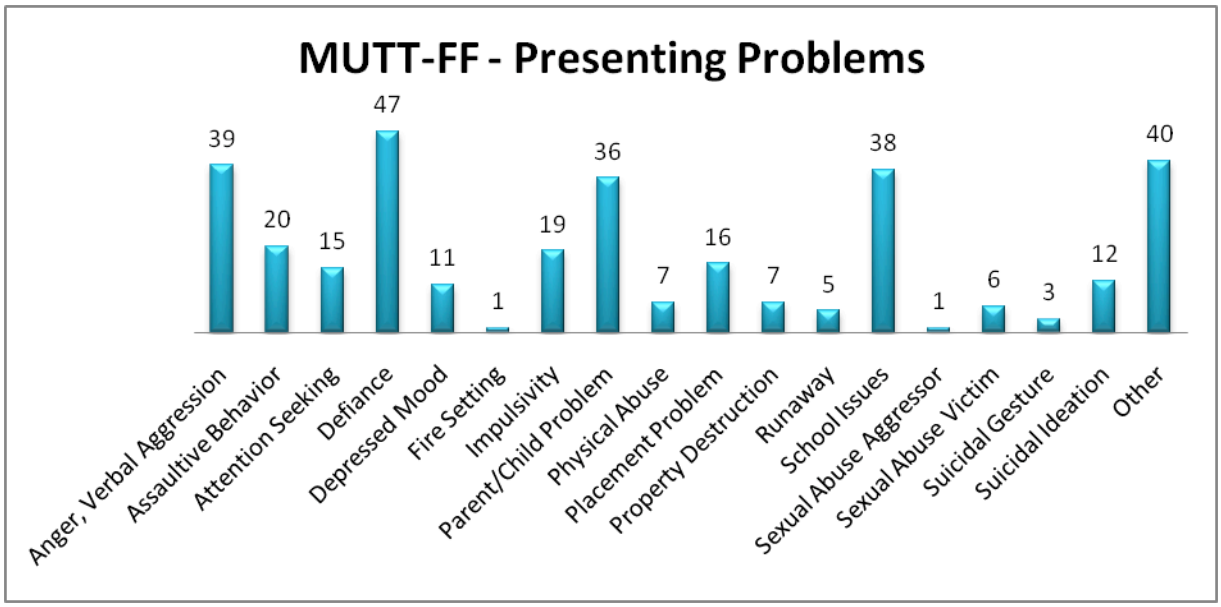
The article also referenced evidence that placement disruptions affect school performance.

> While many child welfare staff and some new state laws try to minimize school change when a placement changes, in too many situations the child is forced to change schools. School mobility has been implicated as a clear risk factor for dropout (Rumberger & Larson, 1998; Rumberger, 2003). David Kerbow's (1996) longitudinal study of school mobility in Chicago found that it acted as both an individual and school level risk factor for low achievement. Highly mobile students fell almost a year behind in achievement by sixth grade. Non-mobile students in schools with high mobility rates were half a year behind by sixth grade.

A 1999 University of Illinois Placement Stability Study of 302 children found that 45 % of foster parents and 39% of caseworkers reported that the inability to meet the child's behavioral needs within the foster placement was the first or second most important reason for the placement ending. Among the study recommendations was, "Individualized service planning: If needed services could not be met within the home, (e.g. therapy, transportation, behavior management), a service plan would be tailored to the placement." The study also recommended the creation of individualized clinical assessments of children before placement.

The case review provided considerable qualitative support for these findings as did a number of stakeholder interviews. As a result, the recommendations for expanded services and supports focus heavily on behavioral and school supports. A recent draft report by the Department summarizing the outcomes from all Wisconsin QSRs to date, covering 436 cases statewide was also reviewed. Thirty-seven percent of cases had special education involvement, 61 percent of children needed modest to significant improvement in emotional/behavioral well-being and 36 percent of children were taking psychometric medications. Conservatively, the report analysis assumes that similar patterns would occur in Milwaukee.

A MUTT Report on Presenting Problems for 1/1/1008 – 1/1/1009 shows the following pattern of behaviors it encountered in addressing emergent problems in placements.



While a specific inventory of needed services can be identified based on findings of this review, there exists an unpredictable set of child and caregiver needs that while difficult to forecast and categorize, are equally essential to maintaining stability. These supports will be addressed under a section related to administrative mechanisms. For an inventory of similar child and family supports created in another system, see Appendix IV for a list of specialized services created by the Alabama Settlement Agreement, taken from *Making Child Welfare Work***,** The Bazelon Center for Mental Health Law.

The Needed Services and Supports section of the report will first describe the discrete service and support needs identified and separately address the administrative mechanisms that will be needed to deliver them. These supports should be equally available to relative settings as well as foster care settings.

Bureau Expenditures

The Bureau provided a list of 2008 expenditures, by service for the three regions. A copy of the list is found in Appendix V. In reviewing the list, the Authorized Amount column represents what the case manager authorized in terms of units and the Expensed Amount column represents actual expenditures.

The following chart reflects a portion of the service expenditures for ongoing case management in the three regions for 2008. The total service expenditures for the regions for 2008 are $12,230,648. The figures below may represent only a portion of the total expenditures in these categories. Some of the services may be embedded in other definitions not included in the table. However, these amounts do provide a representative proportional description of investment in services directly related to the needed services identified in this report. Supervised visiting is included only because it represents the largest single service expenditure for 2008, $5,368,050, and is a surprising 43% of total service expenditures.

The literature certainly supports the importance of visiting to successful reunification, so nothing in this analysis suggests that the priority of contact between children in out-of-home care and their families should be diminished. However, the significant investment in supervised visiting raises questions about the necessity of so much visiting necessitating supervision and whether or not in some cases foster parents or approved relatives or community resources might facilitate such visits. While no specific recommendation is made on this subject it may be useful for the Bureau to give this issue further study.

This distribution of service expenditures also provides a contrast between the investment in what appears to be conventional outpatient mental health therapy and the types of intensive in-home mental health services recommended in this report. The modest expenditures for school supports, behavioral coaching, mentoring and recreational supports are also in considerable contrast with the investments identified as needed by stakeholders.

Service	2008 Expenditures
MH Therapy Outpatient	$ 658,386
MH Therapy In-Home	$ 354,106
Psychological Testing	$499,033
Respite	$97,826
Crisis Stabilization Respite	$21,560
Mentoring	$ 48,813
Crisis Stabilization Mentoring	$ 21,560
Crisis Stabilization	$ 90,574
Supervised Visiting (With and without transportation)	$ 5,368,050
Behavioral Intensive Support Services	$ 5,400
Recreation	$ 6,118
Transportation	$ 466,328
Tutoring	$ 13, 678
Total	$7,651,423

Needed Services and Supports

Current data do not provide a reliable basis for precise projections of the capacity needed and cost involved in expanding services and supports. As a result, the levels of expansion included in these recommendations are conservative and assume the Bureau's initial experience with added services and supports will be successful and lead to further expansion. In some cases, additional research by the Bureau is needed and further exploration and action becomes part of the recommendation. The author also believes that increasing the intensity and scope of in-home supports for families at-risk of having a child enter foster care can prevent additional placements. Because that population was not part of the scope of the review, no specific recommendations are made in that regard.

The following are the expanded services and supports which are recommended for children in out-of-home care.

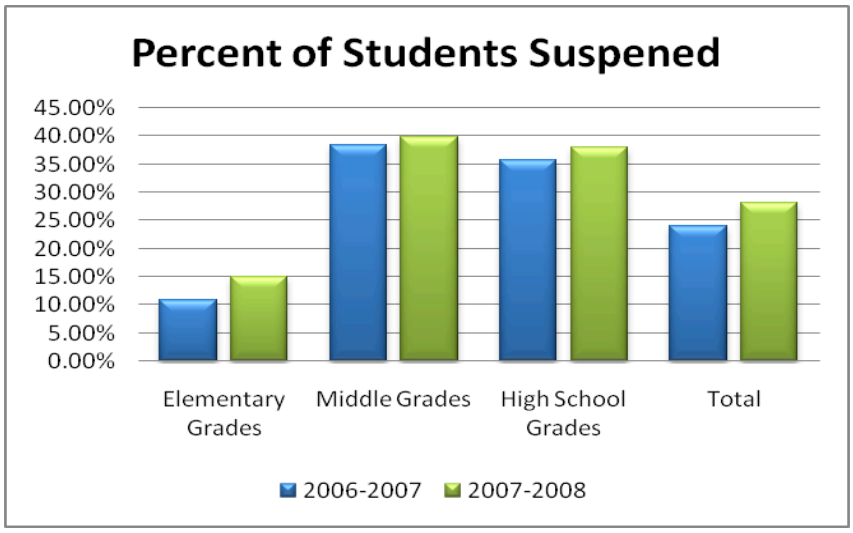
School Related Supports – There are approximately 1,650 school age children (age 5-17) in out-of-home care in Milwaukee. Many stakeholders and caregivers reported a high need for a variety of school supports, including tutoring, one-on-one individual attention supports for children with behavior challenges both in school and in their placement and alternative day educational and activity services for children that have been suspended.

Educational Advocacy – While the percentage of children in out-of-home care placed in special education settings was not determined, stakeholders report that the number of children in special education settings is high. There were frequent concerns expressed about the complexity of the IEP process and the failure of the schools to fully implement them as well as about the high level of school suspensions. Other systems have been successful by developing educational advocates who can help caregivers navigate the IEP process and help advocate for children's rights when needed services are not made available or IEPs not fully implemented.

Based on the statewide incidence of involvement with special education identified in the QSR (37%), over 600 children in out-of-home care in Milwaukee are likely to have special education involvement. While not all children and caregivers will need advocacy support, some portion undoubtedly will during each school year. Educational advocacy is case and incident based, so case activity is likely to be periodic, depending on the school system's response. Some interventions might only require a meeting with the special education coordinator, while others could involve a due process hearing. Since there is not available data on which to judge incidence, it is recommended that the Bureau develop two full-time educational advocates per region and use their experience with demand to assess the system-wide needs as a second stage. Coordinators should provide a more complete estimate of needs after the first six months of operations.

Tutoring – While tutoring may not appear to be a direct placement stability support, the achievement of success in school is integral to children's emotional/behavioral well-being, which is a key factor in stable placements. Again utilizing the statewide QSR data, in the review of 436 children from 2005–2008, 109 children, or 25 percent were reported as being below reading level. Reading grade level performance on another 31 children was unknown. Applying this data to Milwaukee, approximately 412 children in out-of-home care in Milwaukee need some form of remedial educational assistance. While foster parents might be able to address this with some children, arguably half of these 412 children would need tutoring assistance to supplement caregiver capacity. It is recommended that the Bureau develop the capacity to provide tutoring assistance to 200 children annually as an initial step in addressing school performance needs. The Bureau should also develop the capacity to systemically identify children needing tutoring collaboratively with the Milwaukee Public Schools.

Programs for Children Who Are Suspended – Reliable data on the incidence of school suspensions is not available from the Bureau, but it was reported as being a significant challenge to caregivers and a contributor to placement disruption when it occurs.
The Milwaukee Public School system reports that for the school year 2008, of 85,000 students, 28.6 percent were suspended at least once and 387 children were expelled. See the chart for 2006-2008 below:



Assuming that this incidence would also, again conservatively, apply to the Milwaukee school age out-of-home care population, 429 children are at risk of a school suspension annually and a smaller percentage is at-risk of multiple suspensions. Assuming that as little as one-third of these children would need external support activities to manage the suspensions, 141 children would need such support. The Bureau should expand the current Wraparound capacity to provide alternative programs for suspended students to include 141 more students annually.

Mentoring – Numerous foster caregivers and other stakeholders mentioned mentoring as one of the most needed services and noted that it was practically unavailable. Stakeholders believe that effective mentoring would assist youth in addressing behavioral and well-being needs which if unmet, contribute to placement disruptions. While volunteers are a valuable resource as mentors, volunteers alone are unlikely to fill this need. Paid mentors are used successfully in other systems, where college students and other individuals are recruited to support youth in care. As is the case with other specialized services, there are no reliable data on which to base a precise estimate of need relative to the out-of-home care population. However, assuming that youth in out-of-home care age 12-17 are the most likely candidates for mentoring, the universe of likely candidates would be 865 youth. Assuming conservatively that only 25 percent of children age 12-17 need mentoring assistance, 216 children would benefit from mentoring assistance. The Bureau should develop mentoring supports for this subset of children and survey ongoing staff about mentoring needs to assess actual needs.

Data on mentoring needs are not collected by the Bureau, so rather than proposing a specific number of slots, it is recommended that the Bureau specifically allocate an additional initial $100,000 to each region for the creation of mentoring networks. It is also recommended that CSSW have licensing staff survey foster parents about mentoring needs and utilize that estimate to develop a more precise estimate of mentoring needs for the out-of-home population.

Recreational Supports – Many informants complained about the system's inability to support normal recreational activities like sports, music interests, summer events and others by paying for the costs of participation. They believe that these activities give a child an opportunity to succeed, enhancing their self-esteem and well-being, where school and other environments may not have. Foster parents in particular believe that such normalizing supports contribute to stability. Flexible funds need to be available for these normalizing activities. In 2008 the Bureau spent a reported $6,000 on recreational supports. While it is possible that other recreational support expenditures occurred, there is no question that the amount is a small fraction of the total needed. With over 1,200 children in out-of-home care age 8 and older and assuming that one-half need recreational supports, it is recommended that that the Bureau allocate $200 for each child annually, for a total of an additional $120,000.

In-Home Behavioral Treatment and Coaching – The review revealed that many foster and other caregivers need access to behavioral coaching to deal with children and youth experiencing behavioral problems. Caregivers interviewed often thought of training as the solution, basing their suggestions on conventional classroom offerings. But they also said "we need it when we need it", meaning formal training wasn't flexible enough to be timely. Behavioral coaching has the advantage of being an in-home support and one that can be quickly made available. Coaches

can go beyond de-escalating an incident to help equip caregivers to anticipate and manage potentially disruptive behaviors that could threaten the stability of a placement.

MUTT staff offer some level of ongoing behavioral coaching and might be considered as potential providers if current capacity is increased; however other providers may also have this capacity. In most states behavioral coaching such as this is Medicaid reimbursable, so it may be useful to consider existing Title XIX providers already providing mental health services. The intent for this service goes beyond a one-time de-escalation effort. Rather it is intended for more continuous in-home mental health support and coaching

Existing Bureau data shows that in March 2009, 153 children experienced a change in placement, 37 moving to TFC, 23 moving to an Assessment or Placement Stabilization Center, 24 moving to a group home and 8 moving to residential treatment for a total of 92children. At a minimum, most of these children would be candidates for such in-home supports. Also in March 2009, 21 children moved from a kinship setting to an unrelated family foster home, and 6 children moved from one unrelated foster home to another, a total of 27. It is likely that a significant number of these children would be candidates for in-home treatment and behavioral coaching. Assuming that seventy-five percent of the children in these two groups would benefit from this service, the Bureau would need the capacity to provide this service to 90 children. Since the service duration would not be concluded in a month, capacity would need to exist to serve another 90 children the following month. This projection includes only the more acute behavioral needs and assumes that the use of effective CSTs organizing individualized plans through use of flexible dollars and services would address the needs of children at lesser risk of disruption, but still needing in-home supports.

It is recommended that the Bureau create the capacity to serve children needing in-home behavioral treatment and coaching at the rate of 90 referrals per month, assuming that each service duration lasts three months on average.

Initial Placement Supports **–** Foster parents, ongoing case managers and IA workers complain that children placed in emergency placements, which constitute a significant number of initial placements and replacements, may arrive without extra clothes or diapers. Caregivers report having to purchase these items immediately, the cost of which may exceed the eventual clothing allowance reimbursement. Caregiver interviews revealed that this pattern is a source of considerable unhappiness by foster parents and a contributor to foster parents choosing to stop foster parenting. Case managers wished that they had access to a supply of initial clothing, diapers and other staples that could accompany the child in such circumstances. Because foster parent discontent plays such a significant role in retention, the improvement of initial placement supports is included in the array of services needed to improve stability.

It is recommended that the Bureau act on this recommendation by allocating $20,000 per region for initial placement items and supplies.

Respite **–** The Bureau was unable to provide written policy on respite, but suggested that caregivers were entitled to 2 days per month. The Bureau believes that most foster parents arrange their own unpaid respite. Foster parents reported knowing little if anything about the

policy. Financial reports referenced earlier in the report list $97,000 spent on regular mentoring in 2008.

Even if foster parents do arrange their own respite, it would be appropriate to pay for the cost. With 787 children in licensed foster homes, the $97,000 spent on respite in 2008 would equal an average of $123 per year. It is recommended that $300,000 be allocated to respite and that written policy be provided to all foster parents. Once foster parents are aware of how to access respite and actual demand can be assessed, the Bureau should allocate the additional funds required to respond to need.

Transportation – Transportation was one of the services most frequently mentioned as needed by caregivers. While the Bureau has transportation available for visiting, it is not readily available for caregivers in other situations. Some caregivers also stated that at times there were not enough drivers to transport children to visits. Caregivers, many of which work and have may have multiple children in their home, must manage getting children to medical and therapy appointments, attending school conferences, attending CSTs and court, getting children ready for visits and sometimes transporting them and being available for home visits from case managers, licensing workers and legal partners like the GAL/social worker.

Foster and relative caregivers also have the routine responsibilities of home and family management in addition to their foster caregiving role. Either by expanding the current mechanism for transporting children to visits or through a separate contract, expanded transportation services should be made available to enable caregivers to manage so many competing demands.

Mental Health Screening of Children – The Bureau is already required to implement mental health screening as part of the current Corrective Action Plan, a commitment this review also strongly supports. A copy of a tool used in another system is included in Appendix V as an example. Screening children early will permit early intervention and could permit potentially disrupting mental health and behavioral issues from occurring or at least, from spiraling out of control. It is further recommended that children screened as needing further mental health follow-up be linked to mental health, perhaps by expanding the MUTT program to provide for follow-up.

Expand Wraparound Support – Wraparound has been effective in reducing the number of children in residential settings in Milwaukee and many other systems. The Bureau is experiencing an increase in the use of group care and therapeutic foster care, with over 700 children now in these settings. According to stakeholder interviews, these settings are costly, and funded with state dollars only. Key Bureau leadership believes that some children are referred to therapeutic foster care simply because there aren't appropriate foster home beds available. Other stakeholders believe the same practice extends to at least some of the children in group homes.

The Bureau should expand Wraparound by an additional 200 slots, some which of might be funded through savings in matchable dollars now spent on TFC. Those savings could be applied to the non-federal share of Wraparound costs. Some of this Wraparound expansion might include a portion of teams providing what some call Wrap-Lite, a less intensive model using the

same Wraparound values. As a starting point, any children considered for group home placement, residential treatment or TFC should first be referred to Wraparound.

Administrative Mechanisms

The following administrative mechanisms should be put in place to support stable placements and placements matched to individual child needs.

Develop Child and Caregiver Flexible Funds Pool – To quote CWGs own definition of flexible funds:

> *Most narrowly, flexible funds are uncommitted, non-categorical funds, available and easily accessible to caseworkers and the child and family team at the case level. Flexible funds are intended to expand the agency's ability to respond to the unique needs of children and families beyond that possible with inflexible categorical services that may be relevant to only one specific need. Flexible funds are essential to individualized needs based practice, in that no categorical array of services can be broad or diverse enough to meet all of the complex needs experienced by the families and children served through child and family agencies. The complete description is found in Appendix VI.*

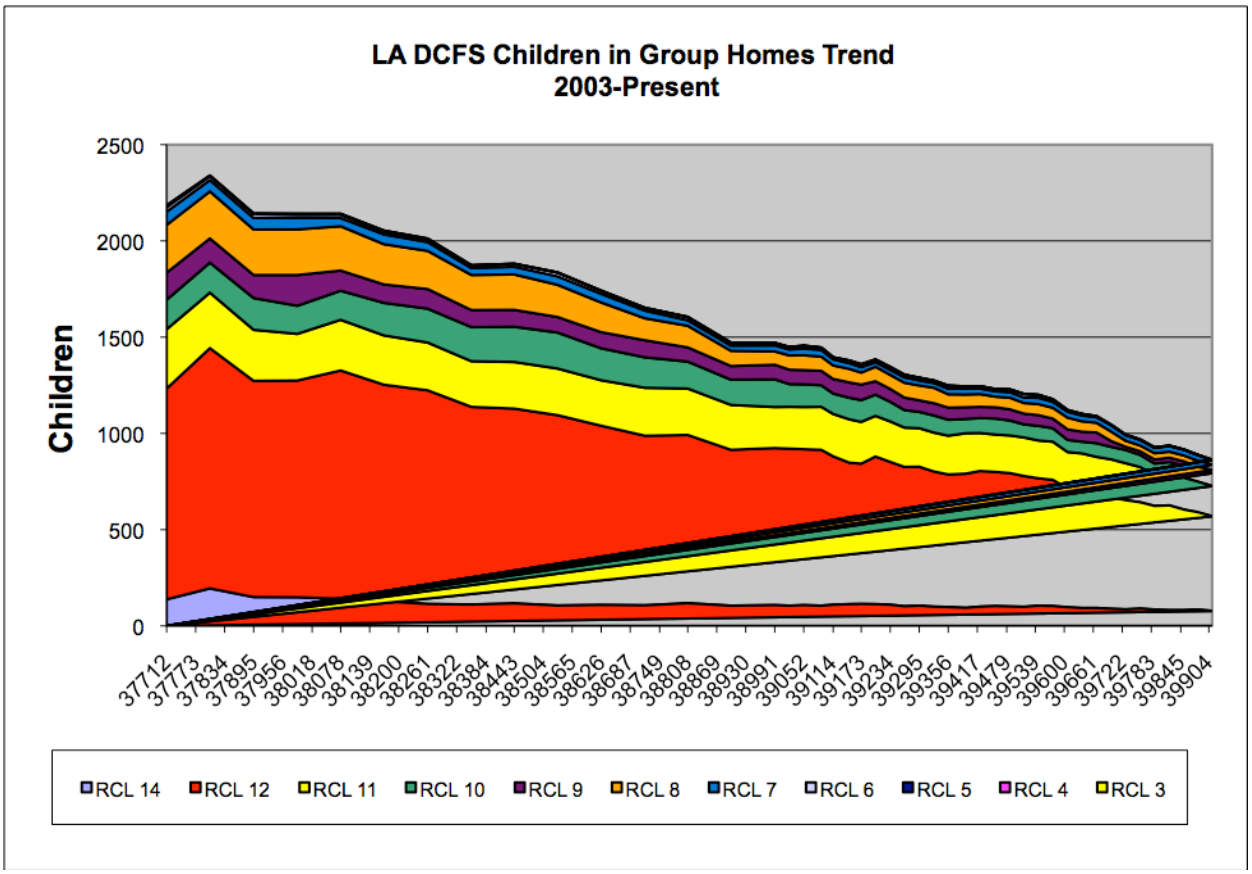
In the case of children in the Milwaukee child welfare system who are unstable, flexible funds are an essential resource with which to address their immediate support needs. The Bureau's reported expenditures in flexible funds are mainly for costs such as rent, utilities, furniture and clothing and the total expenditures are small. The Bureau should expand its approach to flexible funds to permit expenditures for services as well as goods. Where a mentoring service, individualized attention service for a disruptive child, tutor or behavior coach is needed and no provider is immediately available, there is no reason why an individual professional or paraprofessional cannot be secured through a personal services contract, added to the CST and provide individualized supports to a child. The Bureau should develop such administrative mechanisms to permit simple access to such creative service development. There is no data available to use to accurately project the amount of funds needed to serve the at-risk of placement change population in Milwaukee. Experience will guide the ultimate amount needed. Initially, however, it is recommended that the Bureau allocate $200,000 in flexible funds in each region for specialized placement supports. As more tailored, individualized supports are available and demonstrate their value in meeting children's needs, experience in other settings suggests that expenditures for conventional outpatient mental health services will decline and create savings that can enlarge the flexible funds pool.

Implement the Child and Adolescent Needs and Strengths (CANS) Process

Bureau staff asked for help in identifying tools and models that would help do a better job in determining the appropriateness of placements in treatment foster care.

Dr. John Lyons used the CANS tool to help Los Angeles County assess the clinical appropriateness children and youth placed in group homes and in treatment foster care. In that study of 170 youth across 65 group homes, the Lyons study found that 50% of children were appropriate for a group home setting and that 60.2% of children age 12-17 would be appropriate

for treatment foster care. The percentage not appropriate was considered not to have the risk levels, school problems, substance use or delinquency meriting placement in an institutional setting. As a result of this finding, Los Angeles DCFS embarked on an effort, using the CANS tool with all referrals to serve youth in more appropriate family based settings. The number of children served in these settings has since declined considerably since 2003, as the next chart shows.



DCFS Children in Group Homes, data source "Rate Level - Placement Count Report"

Note: See below for children listed in codes "RF", "GF" and "RG"

	RCL 14	RCL 12	RCL 11	RCL 10	RCL 9	RCL 8	RCL 7	RCL 6	RCL 5
Apr-03	138	1095	308	153	141	248	69	23	9
Jul-03	195	1248	288	156	126	244	59	20	3
Oct-03	150	1123	265	165	120	236	60	20	3
Jan-04	149	1126	242	146	160	237	60	16	3
Apr-04	141	1186	263	151	105	230	43	17	3
Jul-04	128	1125	256	169	96	209	51	14	5
Oct-04	114	1110	248	176	102	198	46	14	3
Jan-05	111	1027	237	177	89	182	36	14	0
Apr-05	117	1012	242	183	88	184	40	15	0
Jul-05	106	989	242	187	81	167	44	20	0
Oct-05	109	931	236	166	84	154	45	16	0
Jan-06	107	881	249	158	89	114	40	14	0
Apr-06	118	874	241	140	74	112	29	16	1
Jul-06	105	810	233	131	71	79	27	14	1
Oct-06	108	816	213	144	76	69	31	13	0
Nov-06	105	816	217	118	75	74	31	12	0
Dec-06	108	810	219	118	74	77	35	14	0
Jan-07	105	810	223	112	75	74	35	11	0
Feb-07	110	771	220	106	76	70	32	10	0
Mar-07	113	735	225	112	80	70	30	13	0
Apr-07	114	729	217	113	81	62	28	14	0
May-07	113	767	211	110	70	75	24	13	0
Jun-07	110	742	210	102	67	73	26	14	0
Jul-07	102	724	204	91	65	77	28	13	0
Aug-07	105	722	200	85	60	77	26	14	0
Sep-07	100	702	202	89	64	80	25	12	0
Oct-07	98	689	201	83	63	69	29	16	0
Nov-07	94	697	210	74	61	66	30	12	0
Dec-07	100	705	197	78	58	66	29	12	0
Jan-08	103	697	194	83	59	55	28	11	0
Feb-08	101	693	195	78	58	60	29	14	0
Mar-08	99	680	200	68	56	55	29	18	0
Apr-08	105	662	196	76	56	57	33	15	0
May-08	103	656	198	70	50	56	31	13	0
Jun-08	97	618	188	63	55	61	31	8	0
Jul-08	93	603	200	61	52	54	30	8	0
Aug-08	93	595	190	71	56	50	29	5	0
Sep-08	89	579	197	65	30	49	33	2	0
Oct-08	86	567	192	69	17	31	29	2	0
Nov-08	90	552	183	63	19	30	29	2	0
Dec-08	85	538	159	61	22	32	28	2	0
Jan-09	82	544	158	67	23	31	30	1	0
Feb-09	82	522	165	64	22	30	30	1	0
Mar-09	85	506	159	56	20	33	29	1	0
Apr-09	78	492	157	67	17	27	24	1	0
% Decline	**-43%**	**-55%**	**-49%**	**-56%**	**-88%**	**-89%**	**-65%**	**-96%**	**-100%**

The CANS approach involves use of a tool that rates a child's strengths and needs on a variety of dimensions. Generally, the tool examines Functional Status, Child Safety, Mental Health, Child Risk Behaviors, Substance Abuse, Criminal/Delinquent Behavior, Care Management, Caregiver Needs and Strengths and Child Strengths. The collective rating helps guide decisions about the level and intensity of treatment needed. It is recommended that the Bureau adopt the CANS approach and use it to assess the appropriateness of placement for children considered for placement in treatment foster care, group homes and residential treatment settings. The CANS approach assumes that agency staff can administer the instrument and placement staff may be the best candidates to employ the tool. Adoption of the tool may require an expansion of placement staff to manage the additional workload.

Financing an Expansion of Supports and Services – The Bureau should explore further maximization of Title XIX dollars for behavioral supports of children to help finance an array of placement supports. Interviews with a number of Bureau staff, Department staff and providers revealed the following status of the use of Title XIX to reimburse TFC and other services to children served by the Department. At one point, the Department funded TFC providers for a higher level of clinical capacity than at present. In more recent years, as far back as the creation of the Bureau, the financial resources for clinical supports in TFC declined to the point where today, payment is primarily for specialized case management and foster parent costs. Most ancillary clinical supports needed by children must be authorized separately by the Bureau. While some of these supportive services are technically Medicaid reimbursable, in practice many of the costs are paid with Bureau funds, not federal dollars. In some cases, supportive services are initiated with the intent of transferring them to Medicaid reimbursement, but in practice there is not always pressure applied to maximize Medicaid claiming.

Utilizing Medicaid funds to support TFC could also permit the development of a more clinically capable treatment foster care, using non-federal dollars saved to match higher levels of Medicaid reimbursement, which would support the higher costs of clinical resources. It is recommended that the Bureau explore the feasibly of this capacity building.

The Bureau currently claims Title IV-E dollars for the case management activities of TFC case managers, using random moment sampling to identity eligible administrative costs. IV-E dollars are also used for room and board costs. Both costs are matchable at the 50% federal participation rate. The Bureau claims Title XIX for targeted case management within Safety Services. Targeted case management is not employed for TFC case management.

That portion of TFC case manager's time claimable as allowable clinical activities, of which there may be little in this TFC model, and that of many other clinical support services should be Medicaid eligible in Wisconsin. According to Kaiser Family Foundation State Health Facts, the original Medicaid matching rate in Wisconsin is at 59.4. The rate with ARRA adjustments (stimulus funds) will be at 65.6 for 27 months.

Many cost considerations are involved in choosing to apply Medicaid funds to services, which were not fully explored in this review. Nor was the State Medicaid Plan reviewed. However, based on practice in other states, Wisconsin and the Bureau should be able to utilize Medicaid matching to cover some federally unclaimed costs in TFC, permitting cost savings to help support Medicaid matching for application to a portion of the additional services and supports recommended in this report. Claiming more of the currently provided support services against

Medicaid would have a similar effect. If more services are claimed against Medicaid, the Bureau and State should ensure that the process does not prevent case managers from promptly accessing needed services.

Important information was gathered from some Bureau providers about developing the capacity to provide an array of intensive supports delivered by staff skilled in providing intensive in-home supports. They noted that the Bureau has emphasized inclusiveness in procuring services, opening up opportunities for a wide array of providers to be reimbursed. If this practice is followed as part of a major expansion of supportive services, they point out it could undermine the ability of providers to invest in the kind of capacity building and training needed to provide professionally competent services. They explained that providers are likely to need some assurance of sufficient demand to invest in needed capacity building. If the volume of referrals for each provider is small, capacity building might be a risky investment. Sufficient information was not gathered in this review to address this issue fully, but it appears to be an important policy question that needs attention.

In-County TFC - As of February 2009, 109 children were placed in out-of-county TFC homes. Almost all group home placements were within Milwaukee County. While some staff and stakeholders promote out-of-county placements as a way of separating children from bad environments, this practice has negative consequences for many of the children placed in such completely different environments. Children placed in this manner are separated from family members, familiar schools, siblings in some cases, friends and their case managers. Face-to-face contacts with case managers become more challenging and visits with family members are impeded.

While not recommending that current stable placements be disrupted by moves back to Milwaukee, it is recommended that the Bureau engage the TFC provider community about developing more in-county TFC resources in order to reduce nonessential out of county placements in the future.

Use of Child Specific RFPs – Child specific RFPs are an excellent way to create stable placements for children with exceptionally high need, who are often those most likely to experience frequent placement changes. Consistent with the "Whatever it takes" approach referenced earlier in this report, these RFPs invite providers to design a setting and its supports that will meet specified agency goals for the child. Systems have used them to create supports like a homelike family-based setting (using professional parents) for a transgender youth whose behavior placed him at risk of violence, for example. Services and supervision were wrapped around the youth, permitting him to avoid a locked treatment facility while learning to live safely in the community. The Bureau should employ this approach for those children and youth that conventional programs have not been able to serve. Such placements can be more costly initially, but with attentive case management can lead to both success in stabilizing placements and managing overall costs.

Use of Step-downs – Some staff and providers spoke of the practice of using step-down placements to transition children from higher levels of placement to family based settings. For example, residential providers described using step-downs to TFC as part of the transition effort. Some children in TFC expected to return home may have an interim family foster home placement. The number of children being moved to interim placements could not be determined;

however, this practice should not be necessary for many children moving to a lower level of placement if appropriate transition planning and placement supports are made available. The Bureau should ensure that CSTs carefully examine proposals for interim placements as step-downs and ensure that appropriate placement supports are provided to avoid the use of unneeded stepdowns.

IX. Placement Needs

In considering the placement needs of the Bureau, analysis focused on available trend data, which have limited value in projecting placement needs, qualitative information learned from the case review, stakeholder interviews and the May 2008 study, Children Experiencing Placement Movement and a case review of 37 children. Attention was also given to placement patterns in other systems. The 2008 placement study recommended that the Bureau increase the number of foster homes minimally to 953, an increase of approximately 250 homes and optimally to 1,906, an increase of 1,200. The minimal figure was to accommodate current demand and the optimal figure considered:

- Children being stepped down from a higher level of care
- Children on AWOL status, in detention or hospitals
- Children in assessment settings
- Children entering out-of-home care each month
- Children residing at home under court order who may enter care
- Limiting foster home capacity to 2 children

The study also acknowledged that some foster parents limit consideration for placement to gender or age groups.

Proposed Licensed Foster Home Needs

This current 2009 study of instability, service and placement needs found that the total number of children who changed placements (other than return home) in the past three months are: January 09-155; February 09-142; and March 09-153. The Table below shows the setting where most of the children moved to in March 09. The balance of moves were scattered among lesser used settings.

Foster Family Home (non-Relative)	30
TFC	29
Stabilization Center	25
Group Home	19
Court Ordered Kinship	17
RCC	8
Assessment Center	8
Detention	9

Recognizing some of the indicators considered in the 2008 study, this new 2009 study considers the following in projecting placement needs:

- Only 8-10 foster home vacancies are available at any one time (based on placement staff information)

- 80 children enter out-of-home care each month

- 150 children change placement each month (excludes reunifications)

- 44 children are AWOL the last day of each month, based on the average of the last three months (and presumably would be returning)
- 52 children are currently in assessment and placement stabilization centers that the Bureau has committed to close by the end of the year

- 284 or 40% fewer children will be placed in group homes and TFC as a result of the use of CANS and will need well supported family based placements

Based on this projection, the Bureau needs an additional family foster home capacity for 610 children. If the Bureau raised its foster home capacity to the average percentage of children in family foster home settings in Indianapolis, Los Angeles, Chicago and New York City, which is 48%, the Bureau would need to increase family foster home capacity by 500. Ordinarily, it could be assumed that a meaningful proportion of new foster parents would at some point foster more than a single child, so the Bureau would need fewer than 610 separate homes. However in examining placement data, there are 599 children in non-related foster homes and 187 children in related (licensed) foster homes. CSSW reports that there are 700 related and non-related licensed foster homes in Milwaukee serving these 787 children, which means that the average number of children per home is 1.12. It appears that many of these homes may have only one child and that some have no children. The lack of a placement tracking system makes it impossible for the Bureau to know the current census in each home. There is no available data on which to determine if existing homes have additional capacity. Placement staff state that functionally, current homes are at capacity. Therefore this recommendation assumes that the Bureau needs new homes to serve the additional 610 children needing family-based care. It is recommended that the Bureau develop the licensed foster home capacity from 700 to 1,310 children. It is also recommended that the Bureau survey the current foster home population regarding licensed status and current placements to determine the exact current census of existing homes as a basis for projecting the actual number of additional foster homes that would be needed for these 610 children.

Proposed Higher Level of Placement Needs

Knowledgeable Bureau informants note that at least some children are placed in TFC and group homes because there is not a suitable family foster home placement available. Most of the group homes used are 8 bed settings with a house parent model and few programmatic clinical supports. Most specialized support must be obtained by the Bureau. Most of the treatment foster homes are said to have fewer children than conventional family foster homes, but it is common for caregivers to work. As a result, specialized care is most likely to occur in the evenings and on weekends. One hundred and nine children are placed in treatment foster care settings out of

Milwaukee County. As is the case with group homes, most specialized clinical support in TFC must be obtained by the Bureau.

While these resources serve a placement need for selected children, they are not offering a level of clinical support that for some children could not be provided in a well-supported family foster home or related home. For that reason, findings from this study do not support the need for an increase in the number of higher level placements. Rather, the report recommends that the CANS process be used to provide an individualized process for decision making about higher level placements, including Treatment Foster Care, group homes and residential treatment.

As referenced in the needed services and supports recommendations, this report also recommends an expansion of Wraparound slots by 200, which effectively adds higher level placement capacity by creating intensive supports that can support a wide range of foster home settings. Experience in other systems indicates that practices such as the utilization of the CANS process and adequate support for Wraparound may actually reduce the need for TFC, group home care and residential treatment.

Referrals to Systems Employing Successful Approaches

The following systems and approaches are suggested as possible models for addressing the use of temporary congregate settings, maximization of Title XIX dollars and making better decisions about use of higher levels of care.

A profile of Tile XIX coverage of Therapeutic Foster Care is being provided separate from the report due to its length. It was prepared by Linda Redmond, PhD, a recognized nation expert on Medicaid. Within that publication, particular attention should be given to Arizona, which funds TFC and an array of the type of in-home supports which this report recommends extensively with Title XIX.

Santa Clara County, California has been recommended as a system that has made significant strides in reducing its shelter population.

The Tennessee Department of Children's Services has been successful in eliminating the use of congregate shelters for children.

Los Angeles County has had great success in reducing its use of group homes and residential treatment. Its wraparound programs have been a contributor to this success. Los Angeles is also implementing a tiered approach to Wraparound that provides for a less intensive model, using child and family teams for children with less intensive emotional and behavioral needs. This approach may be instructive in considering how to link new supportive services to CSTs in Milwaukee.

X. Other Systemic Support Needs

In addition to the direct services and supports and placements identified as needed in this report, additional systemic changes are needed to support stability and permanency and improve foster home recruitment and retention beyond these recommendations. These are addressed below.

Develop a Model of Practice to Shape the Approach to Children and Families

The Bureau supplied the following as the Bureau's Case Practice Model:

> **OUR MODEL OF PRACTICE IS BASED ON A FAMILY CENTERED APPROACH** focused and strengthening the caregiver's **behavioral**, **cognitive** and **emotional** characteristics that specifically and directly can be associated with being protective to one's young. Protective capacities are personal qualities or characteristics that contribute to vigilant child protection.
>
> Caregivers with **behavioral** protective capacities:
>
> - have a history of protecting
> - are able to take action
> - are able to demonstrate impulse control
> - are physically able
> - are able to demonstrate adequate skill to fulfill care giving responsibilities
> - possess adequate energy
> - are able to set aside their needs in favor of a child's
> - are adaptive as caregivers
> - are assertive as caregivers
> - are able to use the resources necessary to meet the child's basic needs
> - are able to support the child
>
> Caregivers with **cognitive** protective capacities:
>
> - are able to plan and articulate a plan to protect the child
> - are aligned with the child
> - have adequate knowledge to fulfill care giving responsibilities and tasks
> - are able to perceive reality accurately
> - have accurate perceptions of the child
> - are able to understand their protective role
> - are self-aware as a caregiver
>
> Caregivers with **emotional** protective capacities:
>
> - are able to meet their own emotional needs
> - are emotionally able to intervene to protect the child
> - are resilient as a caregiver
> - are tolerant as a caregiver
> - are able to display concern for the child and the child's experience and is intent on emotionally protecting the child

- have a strong bond with their child and are clear that the number one priority is the well-being of their child
- are able to express love, empathy and sensitivity toward their child by experiencing specific empathy with the child's perspective and feeling

While this provides a useful description of the quality of parenting and caregiving desired, it contains nothing about how the Bureau expects to deliver its casework, services and supports or what it wants children and families to experience. This parent/caregiver-centric definition also contains a strong and unfortunate implication that the only responsibility for change rests with the parent or caregiver. It does not define or address the responsibilities of the system.

A well articulated practice model explicitly states the values and principles that govern the practice of the agency, and clearly states the key functions or capacities that the agency must be able to deliver consistently. An adequate practice model defines how the agency will work with children and families, and with its community partners.

Essentially, a good practice model does at least three things. First, by being clear about how the agency will conduct its work, the key functions or capacities of the agency are defined. This improves clarity about which functions or capacities may be present or absent; and about the infrastructure (training, supervision, workload, resources and policies or procedures) that may be required to introduce or strengthen essential functions or capacities. Second, clarity about the practice model begins to define the logical flow and sequence of work. For example, efficient planning is dependent upon sufficient assessment and understanding. When planning is conducted prior to sufficient assessment, a clear practice model raises an alert. Third, an effective practice model sets expectations for everyone involved -- children and families, the agency, and all of its community partners. Clarity about the practice model establishes both accountability and unity of effort.

Reviewers strongly believe that the lack of an integrated practice model or framework contributes to the lack of emphasis found in enlisting families and youth in decision making, coordination challenges, lack of individualized planning and of special significance to this review, the absence of a "whatever it takes" approach to strengthening stability. The importance of a clear practice model, and of its important contributions to improving outcomes for children and families through strengthening child welfare practice has been developed more thoroughly in a CWG paper, *Adopting a Child Welfare Practice Framework.* This paper is found in Appendix VIII.

A well-articulated case practice model, to quote the CWG's paper, *Adopting a Child Welfare Practice Framework*, should address the following:

> Basically, a practice framework first outlines the values and principles that underlie an approach to working with children and families. For example, commonly chosen principles include concepts as broad as, *Children should be protected from abuse and neglect* and as discrete as, *Children should be placed in the least restrictive, most normalized environment appropriate to their needs.* They may contain expectations based on a set of values but important enough to be described as rights such as, *Children have a right to be protected from inappropriate physical or chemical*

restraints, seclusion and timeout. The core principles can establish a moral authority guiding expected practice.

A practice framework may also describe specific approaches and techniques considered fundamental to achieving desired outcomes. They may include "evidence based" approaches, promising practices and/or approaches believed to be effective through practice based experience. A principle embodying a specific approach might address expectations for the use of family conferencing as a routine practice such as, *Plans and decisions affecting children and families should be made in a meeting of the family team, including the family and its informal supports as well as relevant professionals.*

Some systems have incorporated explicit organizational principles in their practice framework, extending expectations beyond front-line practice to address issues such as agency leadership and management and/or relationships with the community.

It is recommended that the Bureau develop and employ a revised practice model, informed by ambitious practice principles, including those inherent in Wisconsin's Qualitative Service Review protocol.

Caseload Standards

Consider the caseload standards within the Settlement Agreement as a floor, not a ceiling. To fully implement the case management tasks expected to be performed by staff and achieve safety, permanency and well-being for children, caseloads should be lower. The Bureau should set a target of 15 children per worker for case management and 13.5 cases per worker for IA.

Strengthen the Quality of Coordinated Service Teams

Information from stakeholders, staff, children, youth and providers consistently described the current Coordinated Service Team process as insufficiently responsive to the child, family and caregiver voice, lacking key formal and informal team members, missing opportunities to share information and coordinate services and too focused on conforming to agency process to the exclusion of creating creative, individualized child and family plans. This challenge was also recognized in the 2006 and 2008 BMCW QSR.

The 2008 BMCW QSR found:

- The Coordinated Service Team process is a natural vehicle for strengthening practice in many areas, as team meetings offer a face-to-face convergence of family informal supports and the professionals that can facilitate lasting change. While significant progress has been made in implementing CSTs, the next stage of implementation is to improve the quality and focus of the teams. Good team functioning can strengthen permanency.

- Develop and regularly employ a CST fidelity tool and process that assesses the degree of family engagement in team meetings, family voice and choice, depth of assessment, composition and degree of strength-based individualized planning. Use this process to

provide feedback to the team, strengthen facilitation skills and address resource barriers to successful plan implementation.

- Train staff involved in facilitation to guide the team to assess all appropriate family life domains, not just safety and to lead the team to a unified long-term view.

- Convene a work group of providers to assess reasons that provider CST attendance is uneven and to develop strategies to increase provider participation.

The current stability and placement review team believes that effective CST's can mitigate some of the fragmentation in the system, improve vital information sharing and coordination, empower youth and families, strengthen assessment and build family capacity for lasting change.

For that to occur, it is recommended that the Bureau secure and provide new training in the CST process for all ongoing staff, develop and support a group of full time expert facilitators in each region that can provide coaching to case management staff facilitating meetings and develop and employ a fidelity tool that will help assure that the quality of team meetings meets the CST model. Because the workload of the Bureau will make it difficult for Bureau staff to assume the coaching role, it is recommended that the Bureau use a partner organization like the UWM Training Partnership to recruit, maintain and manage teams of CST coaches for each region.

Create an Initiative Directed at Licensing Barriers

CSSW stated that it is initiating a study of kinship barriers; however it is recommended that this issue have the full attention of the entire Bureau. A variety of staff and stakeholders mentioned barriers to licensing relatives and foster parents, for reasons such as certain past criminal offenses, structural/housing barriers and financial barriers. For example, an uncle might have a felony on his record, a potential foster parent might be in a home that needed some modifications to meet licensing standards or a grandmother might have to satisfy an outstanding debt before a lessor would let her rent a large house for a sibling group of grandchildren. Respondents advised that certain past criminal offenses are subject to rehabilitation depending on the offense and length of time that has transpired since its occurrence. Respondents also state that by statute, some prior offenses can't be "rehabilitated".

It is recommended that the Bureau make this initiative a high priority, convening a workgroup, including foster parents, relative caregivers, CSSW and senior staff of case management agencies to quickly and fully review opportunities to mitigate standards that bar licensure in the absence of meaningful risk. It is also recommended that the Bureau identify funds that can be used to address modest financial or structural barriers and provide clear policy guidance on their use. This issue may need further exploration in the upcoming work by the Utah Foster Care Foundation on recruitment and retention.

Provide Incentives for Foster Parents That Accept Teens

Many stakeholders stated that teens were the hardest age group to find foster home placements for. Teens are also one of the largest age groups in the out-of-home population, with more than 550 aged 15-17. Because of the resistance of many foster home providers to accept teens, it seems unlikely that the number of resources for this age group will increase unless foster parents have confidence that needed supports of sufficient intensity and duration are available and there are incentives for caring for them. Limits should be placed on the number of children placed each home accepting teens as well.

The Department should consider increasing the supplemental and exceptional rates for teen placements concurrent with expanding its placement supports and services. It is vital that incentives to foster teens supplement strengthening confidence among foster parents that needed supports will be there when they are needed, rather that function as a substitute for confidence. This is an issue that should also be addressed in the foster care recruitment and retention plan.

Utilize Assessment Home Parents as Foster Parent Mentors/Supports

Many of the current assessment home parents participated in a key informant discussion as part of this review and were impressive in their experience in fostering, commitment to children, assertiveness about getting the needs of children met and caregiving skills.

These foster parents were specifically selected by the Bureau for their assessment home role. Since their assessment home role is being phased out, they seem to be a natural resource to provide peer mentoring, coaching and problem solving assistance to foster parents. It is recommended that the Bureau consider utilizing some of these foster parents in a full or part-time paid foster parent mentoring role. As basic administrative information becomes available to support planning and decision-making, it will also be useful to begin the organized collection of information that will help to identify the strengths and needs of individual foster homes. Often anecdotes passed between licensing or placement staff provides the only guidance available in attempting to improve the matching of children and specific homes. The ability to identify homes that work successfully with defiant teens, toddler sibling groups, or wary parents is essential to moving past locating beds and crafting successful placements. The same knowledge can contribute to peer training of new foster parents.

Develop a System to Track Foster Home Utilization

Currently the Bureau cannot accurately track the utilization of foster homes, although efforts to modify WiSACWIS for this purpose continue. CSSW reports that much of the information collected about placement availability is collected by contacting foster parents directly.
For example, Bureau staff report that because the SACWIS system doesn't collect information with enough detail, the functional foster home capacity may not be identified. Because a foster home's capacity might be limited by gender or room size, simplifying knowing how many beds are not occupied does not provide reliable data about placement potential. There is apparently old data in the system that includes thousands of previously closed kinship providers, requiring laborious sorting. The system cannot distinguish that a bed is temporarily unavailable unless a hold is placed on all placements in the home. And the system cannot distinguish available beds

when a licensed relative or non-relative foster family also accepts a voluntary placement of a child. There are other examples of system limitations as well.
To support both the placement needs study and the later recruitment and retention assistance, the Bureau was asked for the following data:

- Number of currently licensed homes by neighborhood
- Number of "adopt only" homes by neighborhood
- Placement capacity
- Number of homes with no placements
- Total number of openings in all homes
- Number of families willing and able to care for sibling groups
- Number of families willing and able to care for children between the ages of 7-13
- Number of closures for the past year by neighborhood location
- Total number of children in care, ages, level of care (basic-specialized-structured), sibling status, ethnicity, permanency goals & special needs
- Number of CPS removals for the past year by neighborhood

The Bureau continues to work on producing this data.

Because knowing about available capacity is so crucial to placement decision making, recruitment and retention, the development of an accurate placement resource availability system needs to have a high priority.

Responsibility for Recruitment and Retention

Based on interviews with Bureau staff, it is clear that many Bureau staff outside of CSSW believe that CSSW is responsible for recruitment and retention. While CSSW may currently be held accountable for recruitment and retention, this review confirms that all the individuals that make up the Bureau are responsible for recruitment and retention. The Bureau's poor performance in recruiting and maintaining foster family homes is in large part a result of high staff turnover that limits the knowledge and ability case managers need to be responsive to foster parent needs, high workloads that impede foster parent access to and time with case managers, the system's tendency to treat foster parents more as providers than essential partners, lack of information sharing and coordination and the absence of a "Whatever it takes" attitude to achieving stability and permanence. These factors are so frustrating to foster parents that many report they are wary of encouraging other individuals to consider fostering and more likely to cease fostering because of system unresponsiveness. Since foster parents are such a key recruiting resource, urgent attention is needed to improving their experience with the system.

While CSSW is the focus of the work on recruitment and retention, the entire Bureau must support this effort. It is clear that the Utah Foster Care Foundation is well aware of this fact and is considering the Bureau's responsibility in the next phase of this work.

XI. Timetable

The Bureau will need to translate the recommended tasks into an implementation plan that prioritizes the tasks, identifies the plan for securing necessary resources (when the task requires additional resources), and sets timeframes for when each task is to be completed. However, there are some tasks that are suitable to early implementation and achievement with a modest financial investment and those are highlighted below. The Bureau should consider beginning work on these initiatives immediately.

Foster Care Recruitment While increasing foster home resources by over 600 is a multi-year undertaking, it is possible for the Bureau to begin by setting interim time objectives. The Bureau has already committed to increasing the number of family foster homes by 185 by December 31, 2009. Two of the groups identified by stakeholders as hard to place are teens, because of their behavior and infants, because of the challenges their needs present to working foster parents. There are over 300 children birth to age 1 in out-of-home care and 550 children age 15-17. It is recommended that the Bureau seek to recruit 50 homes for each age range within the 185 additional homes goal.

Assessment Home Parents It seems likely that at least some assessment home parents will continue in a fostering role even if they aren't performing their former formal assessment role. As assessment parents at least one caregiver does not work. Through an existing agency or individually, contract with those interested on at least a part-time basis to serve as a mentor to new foster parents. Establish a goal of completing this arrangement by August 31, 2009

Initial Placement Supports To signal to foster parents that the Bureau is committed to creating a new positive relationship with foster parents, implement initial placement support funding, even if at a reduced level, for initial placement needs. This should be accomplished by July 31, 2009.

Transportation A relatively simple change related to transportation of children that would provide relief to foster parents is to ensure that case managers consult with foster parents before committing to appointment schedules. The Bureau should develop policy guiding case management practice in this regard and provide in-service training to appropriate staff by August 21, 2009.

Educational Advocacy Of the educational supports recommended, the simplest to implement is the development of educational advocates. Until more intensive school related supports can be financed, educational advocates can use the existing legal obligations of public schools to enlist the school related services needed by children in out-of-home care. The addition of educational advocates should be accomplished be September 1, 2009. It may be possible to secure the assistance of the State's disabilities advocacy program to train them.

Mental Health Screening The Bureau has already agreed to implement mental health screening as part of the CAP. If a date for implementation has not already been established, it is

recommended that the Bureau select a screening instrument, train staff in its use and establish a linkage for referral for mental health follow-up for positive screens by August 31, 2009.

Flexible Funds The practice of crafting individualized service plans tailored to need represents a major shift in approach for child welfare staff. Both training and practice are required to master these skills. Until significant amounts of flexible funds can be made available, it is recommended that the Bureau identify $50,000 that can be accessed by ongoing case management staff. Ongoing staff, supervisors and fiscal managers should be trained in using flexible funds creatively and policy should be developed to permit the use of funds, while assuring accountability. The Utah Division of Child and Family Services developed such a brief (half-day) training session that it delivered to all staff, which was effective in improving individualized service provision. Their training content could be a resource for the Bureau. This incremental approach will permit staff to develop greater mastery of service crafting until more significant resources can be made available. It is recommended that this be accomplished by September 30, 2009.

Appendix I

MILWAUKEE PLACEMENT STABILITY AND PERMANENCY REVIEW INSTRUMENT

1. GENERAL REVIEW INFORMATION

1. Client ID Number:_____
2. Child's Name:_____
3. Counselor/Caseworker:_____
4. Review Date:_____/_____/_____
5. Reviewer:_____
6. Number of persons interviewed:_____

2. CURRENT PLACEMENT

7. Childs Placement (check only one item)

- ☐ Birth home
- ☐ Adoptive home
- ☐ Foster family home
- ☐ Relative/kinship home
- ☐ Licensed relative foster home
- ☐ Therapeutic foster home
- ☐ Group home/Congregate care
- ☐ Residential treatment center
- ☐ Independent living
- ☐ Detention/shelter
- ☐ Hospital/MHI
- ☐ Juvenile correctional facility
- ☐ Assessment Center/Placement Stability Center
- ☐ Assessment Home
- ☐ Other:_____

3. DEMOGRAPHIC

8. Child's Age

- ☐ 0-4 yrs
- ☐ 5-9 yrs
- ☐ 10-13 yrs
- ☐ 14+ yrs

9. Child's Gender

- ☐ Male
- ☐ Female

10A. Child's Race

- ☐ White/Caucasian
- ☐ Black/African-American
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Asian
- ☐ Multiple races
- ☐ Unable to determine
- ☐ Unknown

10B. Ethnicity

Latino/Hispanic

- ☐ Yes
- ☐ No
- ☐ Unknown

4. DEMOGRAPHIC & SERVICE INFORMATION

11. Case Open

- ☐ 0-3 mos.
- ☐ 4-6 mos.
- ☐ 7-9 mos.
- ☐ 10-12 mos.
- ☐ 19-36 mos.
- ☐ 37+ mos.

12. Number of Placements

- ☐ No placements
- ☐ 1-2 placements
- ☐ 3-5 placements
- ☐ 6-9 placements
- ☐ 10+ placements

13. Placed Out of Home with Siblings

- ☐ NA-in birth home
- ☐ All
- ☐ Some
- ☐ None
- ☐ Contra indicated
- ☐ No siblings

14. Grade & Reading Level (insert number in box)

Grade Level Assigned:

_____

Current Reading Level:

_____

15. Full Scale IQ

Score:_____

Date:____/____/____

16. Educational Placement or Situation(check all that apply)

- ☐ Regular K12 Ed.
- ☐ Full inclusion
- ☐ Part-time sp. Ed.
- ☐ Self-cont. sp. Ed.
- ☐ Adult basic/GED
- ☐ Alternative Ed.
- ☐ Vocational Ed.
- ☐ Expelled/suspended
- ☐ Day treatment program
- ☐ Supported work
- ☐ Completed/graduated
- ☐ Dropped out
- ☐ Other:_____

5. CO-OCCURRING CONDITIONS

17. Identify the special needs or co-occurring conditions (check all that apply)

Child	Parent	
☐	☐	None
☐	☐	Autism Spectrum Disorder
☐	☐	Behavioral Disorder (serious nature)
☐	☐	Sensory Impairment ☐ Vision ☐ Hearing
☐	☐	Mental Illness
☐	☐	Mental Retardation
☐	☐	Neurological Impairment/Seizure Disorder/TBI
☐	☐	Specific Learning Disability
☐	☐	Degenerative Disease
☐	☐	Chronic Health Impairment
☐	☐	Medically Fragile/Complex
☐	☐	Orthopedic Impairment
☐	☐	Physical Disability
☐	☐	Developmental Disability
☐	☐	Trauma Victim
☐	☐	Suicide Risk
☐	☐	Pregnant
☐	☐	Substance Exposed
☐	☐	Substance Abuse/Addiction
☐	☐	HIV/AIDS
☐	☐	Other_____

6. DEMOGRAPHIC & SERVICE INFORMATION

18. Identify an substantial functional limitations (check all that apply)

Child	Parent	
☐	☐	None
☐	☐	Self-care
☐	☐	Mobility
☐	☐	Communication
☐	☐	Self-direction
☐	☐	Economic Self-sufficiency
☐	☐	Diminished Capacity
☐	☐	Independent Living
☐	☐	Other _____

19. Other Agencies Involved (check all that apply)

☐ Child Welfare ☐ Dev. Disabilities ☐ Sub. Abuse ☐ None
☐ Mental Health ☐ Juv. Justice ☐ Collaborative Mobile Crisis
☐ Special Ed. ☐ Voc. Rehab. ☐ Other _____

20. Number of Psychotropic Medications Prescribed (focus child only)

☐ No psych meds ☐ 2 psych meds ☐ 4 psych meds
☐ 1 psych meds ☐ 3 psych meds ☐ 5+ psych meds

Page 2: Child's Name:_____ Reviewer:_____ Date:____/____/____

7. DEMOGRAPHIC & SERVICE INFORMATION

21. LEGAL STATUS (check only one item)

- ☐ Voluntary
- ☐ Court Ordered
- ☐ Delinquent
- ☐ Other:_____

22. REASON FOR CASE OPENING (check all that apply)

CHILD	FAMILEY ISSUES (if applicable)
☐ Adoption disruption	☐ Failure to protect
☐ Physical abuse	☐ Absent parent
☐ Sexual abuse	☐ Substance abuse
☐ Neglect	☐ Domestic violence
☐ Mental health issues	☐ Neglect
☐ Delinquency	☐ Mental health issues
☐ Truancy/Status offense	☐ Housing
☐ Other:_____	☐ Other:_____

23. MONTHS CURRENT OUT OF HOME PLACEMENT (check only one item)

☐ 0-3 mos.	☐ 13-18 mos.
☐ 4-6 mos.	☐ 19-36 mos.
☐ 7-9 mos.	☐ 37+ mos.
☐ 10-12 mos.	☐ Not applicable

PERMANENCY GOALS

24A. PRIMARY GOAL (check only one)

- ☐ Remain at home
- ☐ Reunification
- ☐ Permanent placement with fit and willing relative
- ☐ Legal guardianship
- ☐ Adoption
- ☐ APPLA
- ☐ Not applicable
- ☐ Other:_____

ALTERNATIVE PERM PLAN

- ☐ Independent living
- ☐ APPLA

24B. CONCURRENT GOAL (check only one)

- ☐ Reunification
- ☐ Permanent placement with fit and willing relative
- ☐ Legal guardian ship
- ☐ Adoption
- ☐ APPLA
- ☐ No concurrent goal
- ☐ Other:_____

ALTERNATIVE PERM PLAN

- ☐ Independent living
- ☐ APPLA

8. ADDED REVIEW FINDINGS

1. PLACEMENT WITH SIBLINGS (check only one)

- ☐ Same home with all
- ☐ Same home with some
- ☐ Different home
- ☐ No siblings
- ☐ Not applicable

2. PLACEMENT WITH RELATIVE (check only one)

- ☐ Yes
- ☐ No
- ☐ NA

3. EFFORTS IN RELATIVE PLACEMENT (check only one)

- ☐ Yes
- ☐ No
- ☐ NA

CASE HISTORY (provide a brief synopsis of the case i.e. the circumstances of how the child came into the child welfare system. Visual aid charts are attached to assist in collecting case history):

Reviewer List of Needed Services/Support to Prevent Instability (For Prior or Current Placement)

PERMANENCY & STABILITY				
Current permanency goal: Date current permanency goal established: Expected time to achievement?	Reviewers' assessment for achieving permanency? Excellent Good Fair Poor None What is the commitment level of the agency to achieve permanency? Excellent Good Fair Poor No commitment	What is the child's assessment for achieving permanency? Excellent Good Fair Poor None What is the birth parent's assessment for achieving permanency? Excellent Good Fair Poor None	What is the caregiver's assessment for achieving permanency? Excellent Good Fair Poor None	Length of time in current placement (# of months): # of placement moves the child has experienced in the last 22 months: # of placement moves the child has experienced in the last 12 months:

Number of total placement moves the child has experienced while involved with the child welfare system (please list placements in the chart below)		
Placement Type	Placement Dates	Reason for change in placement setting

Is the current placement stable? Why or why not?	If the placement is unstable, describe efforts made to prevent disruption:

CHILD CHARACTERISTICS/NEEDS		
Dose the child have a current case plan? Yes No	Who signed the case plan (circle all that apply): Youth Birth mother Birth father Caregiver Caseworker Other (describe)	Who reports participating in the development of the case plan (circle all that apply): Youth Birth mother Birth father Caregiver Caseworker Other (describe)
Degree to which the child reports the case plan reflects his/her own desires and /or needs? Significant Moderate Somewhat None		
Needs identified in case plan:	**Services identified in case plan:**	
Child:	Child:	
Birth Parent(s):	Birth Parent(s):	
Caregiver(s):	Caregiver(s):	
Does the caregiver/birth parent/youth report they understand the case plan and know when it will be achieved?		

MENTAL HEALTH	
Was an assessment completed?	**Is there a mental health diagnoses?**
Child:	Child:
Birth Parent(s):	Birth Parent(s):
Caregiver(s):	Caregiver(s):
Needs identified:	**Services identified:**
Child:	Child:
Birth Parent(s):	Birth Parent(s):
Caregiver(s):	Caregiver(s):
Needs not identified:	**Services identified but not provided:**
Child:	Child:
Birth Parent(s):	Birth Parent(s):
Caregiver(s):	Caregiver(s):

EDUCATION				
Currently attending school? Public Private Facility School Home School	Current grade: Is this child functioning at grade level?	Is this child receiving special education services? If yes, what is the qualification?	Does the child have an updated individual Education Plan on file?	Does the child receive any additional academic support services? If yes, please describe:

CHARACTERISTICS			
Birth Family		**Caregiver**	
How often is the child scheduled to meet with his/her birth family?	How often does the child and caregiver report he/she meets with birth family?	Does the child and/or caregiver report the birth family contact is meaningful?	How often does the worker meet the youth in person in the home?
ACCESS & AVAILABILITY OF SERVICES/SUPPORTS			
Were services coordinated or adapted so the child could remain near home and in the same community? If yes, how? If no, why not?			
When appropriate were family members and/or other supporters involved or invited to be involved? Please describe:			

COORDINATION OF SERVICES				
Date of CST meetings in the last 6 months:	Date:	Date:	Date:	Date:
Attended by (circle all that apply):	Case Manager Youth Caregiver Birth Parent Providers Informal Supports Other:	Case Manager Youth Caregiver Birth Parent Providers Informal Supports Other:	Case Manager Youth Caregiver Birth Parent Providers Informal Supports Other:	Case Manager Youth Caregiver Birth Parent Providers Informal Supports Other:

What was the level of involvement in the CST meeting by:

	Excellent	Good	Fair	Poor	None
Child					
Birth Parent					
Caregiver					
Other					

If you could change one thing about the Milwaukee child welfare system that would improve stability and increase permanency, what would it be? Please list response for the following individual below:

Case Worker:

Child:

Birth Parent:

Caregiver:

Other:

SYSTEMIC BARRIERS
Did the family report experiencing any inter agency barriers to services? If yes, what were they?
As a result of receiving services, did the family experience any form of discrimination or stigma in the community? If yes, please describe:

Appendix II

Milwaukee Key Informant and Stakeholder Interviews

BMCW Leadership

The group noted that the Governor's budget is looking at creating a levels system for payment for specialized care, creating a more rational way to relate the intensity of child needs to rates. Current rates are inconsistent among providers and providers are concerned about the budget impact of this initiative.

Participants suggested that the system needs to understand if it is using kinship providers appropriately – look at support and training needs and extent of kinship preparation for placement.

The Bureau has an image problem, which hurts recruitment of foster parents.

The leadership team asked for information from systems that have had success in requiring more notice before children are ejected from placements. Too frequently providers/caregivers demand immediate placement of children they find challenging.

Several participants complained about TFC providers ejecting children for the behaviors that necessitated TFC placement to begin with. They expressed concern that TFC foster parents may not be any more experienced/trained than regular foster parents – they just are paid more and have fewer children in the setting. (It was difficult to get a sense of the frequency of this practice, but a number of key informants commented on it during the weeks of interviews.)

Parental interference with placement is an important reason for disruptions.

In response to a specific question, participants agreed that foster care standards can impede kinship licensing, especially income requirements, space requirements and criminal record checks. When asked if the system could be more flexible with kinship providers, participants noted that the Bureau is looking at this as part of a kinship foster home licensing initiative.

CSSW now has a relative search specialist assigned to the court and is adding 3 relative coordinators to strengthen the use of kin.

When asked if courts get involved in the selection of placement settings when children disrupt, participants stated that the court becomes involved when any party objects to the placement, usually a GAL or parent. In later discussions with ongoing staff, court involvement appeared to be infrequent.

Placement Staff (CSSW)

The participants explained the role of the Placement Unit, which has specialized staff who are responsible for finding placements in certain settings (assessment homes, assessment centers and placement stabilization centers, higher levels of care, foster homes, etc.). IA or ongoing case management staff contact placement staff whenever a child needs a placement.

If openings in regular placements are not available, which is a chronic problem, many cases are referred to TFC, which has expanded considerably. Staff believe that many of these children don't really need a level of care that high. Some stated that the pattern of placing children without high needs makes some TFC providers less tolerant of children that do present problems. Staff also say that regular foster parents are quitting to become TCF providers – they couldn't cite a number.

Older kids referred usually end up in an assessment/placement stability facility or group home. Young kids go to assessment homes.

Hardest to place children?

- Sexualized children
- Medically needy
- Girls age 7-11
- Children with behavior problems
- Some foster parents don't want children unless they've been toilet trained
- Infants (because so many foster parent have to work and can't meet the demands of infant care)

Disruptions often occur because of communication problems between ongoing workers and the caregiver – workers don't know if a disruption is brewing until the caregiver can't tolerate the situation any more.

Licensing Barriers?

- Sketchy background info on household members
- Space
- Income

Judges are pushing hard on regular parent-child visits, sometimes more than weekly with young children –this can be a stress on caregivers who have to transport and/or ongoing case managers.

In TFC, when the rate goes down due to improved child functioning, some caregivers ask for the child to be moved.

Current standards permit foster parents to be licensed for 4 with exception for 6.

Placement statistics:

- 8-9 placement requests per day
- 60%-65% same day placement requests
- Daily rate can be as few as 0 on Christmas Eve to a high of 35
- Largest sib group in past year – 13
- Approximately 30% of placement requests for a higher level of care

Resource snapshot:

- 17 assessment homes (down from high of 24) after 30 days the rate goes down from $1,000 per month to the basic rate plus any supplemental or exceptional payments based on the rate setting for the child
- 6 Assessment/Placement stabilization centers containing 49 beds
- 19 TFC agencies
- Group homes – 2 co-ed facilities, 17 general girls, 16 boys, 8 teen moms
- RTC – 12 registered with BMCW (others around the state could accept BMCW kids)

It can be difficult for ongoing staff to get exceptional rates above basic foster care rates – some staff find it easier to move a child than advocate for a higher rate.

How hard is it to get supportive services that will prevent disruption? There are waiting lists for mental health and other supports, "hard to think outside the box regarding creative interventions". "Staff have to know which words to use". Participants noted that it can be hard to arrange transportation if a school change occurs.

What are the most critical placement support/service needs?

- School transportation
- Day care for foster parents – Approval requires spending a day at W-2 the agency for approval and must be repeated with each new placement
- Foster parents worry about having to take time off from work for day care application, court, school disciplinary/suspensions
- We are having more and more young kids approved for TFC, including a 3 year old
- Mentoring
- Therapy
- Psychiatric eval/med check
- After school activities

Now have only 8-12 placement openings at any one time and some of these have restrictions type of child accepted.

Are you involved in CSTs? "Almost never".

What is the quality/value of assessments from assessment homes and centers? "We find them useful but ongoing is not consistently utilizing them."

If you could change one thing about the system, what would it be?

- Higher priority for relative placements
- Expand disruption prevention supports
- More contact/monitoring with caregivers/children in placement
- Too easy for foster parent to demand removal, need enforceable policy
- More information about children at placement
- More foster/kinship homes
- More emergency placement resources
- More listening to what foster parents are saying
- More strategic use of safety services to prevent placements

Ongoing Staff and Supervisors

Turnover is increasing and ongoing due to workload. Participants report getting 16/17 new referrals per month (supervisor). Now we have to see some kids twice a month. The medical community is a big reporter and can have a "knee-jerk" reaction to risk.

"We are getting cases that don't rise to the level of CAN. The county's substantiation rate is the lowest in Wisconsin at 11%."

Children are being placed in TFC who don't need that level of care just because they have an available bed. A lot of foster homes are converting to TFC. Some TFC providers have gotten used to serving kids without high needs and don't want to deal with behavior challenges. TFC caregivers seem to be too quick to eject. (No data have been found that verifies this, but the concern was expressed by several stakeholder groups.)

Standards for TFC providers seem less rigorous than regular foster care regarding training and experience.

There is lack of oversight/accountability about TFC performance.

We are missing opportunities to use relative placements. We could use them more frequently if standards were more flexible.

Workers, especially ongoing staff, spend too much time assuming the responsibility foster parents should have regarding getting children to appointments.

In response to a specific question, participants stated that they don't see much partnership between bio-parents and foster parents. Peer parenting isn't a familiar concept.

In response to a specific question about parent child visits in foster parent homes, participants stated that the use of a visiting center is a regular practice for parent/child visits and that there is little visiting in foster family homes.

What's the availability of flexible dollars to support placements/prevent disruptions? Flexible funds exist, but are hard to access and can require layers of approval and require documentation that community resources are tried first. Often takes a court order (hinting that some workers invite court involvement) to access them.

CSTs are facilitated by workers and held every 90 days (or more frequent if needed). Foster parents don't want to come and their attendance is infrequent. "It's hard to get everybody to the table" (management later stated that there is no reliable central tracking of participation, but work on this is underway). "The system doesn't philosophically support family teaming model."

What formal reporting do you get from assessment placement settings about child progress and how useful is it? Reporting is uneven, often just weekly notes and we don't find it very useful. Usually we have to request it.

What placement supports are needed?

- Mentoring
- Placements that don't require school changes
- Ways to maintain sibling relationships
- Respite
- Day care (1/3 of kids are pre-school age)
- Coaching for relatives and caregivers with child behavior problems
- Emergency resources (accessible diapers, formula, clothing) for children placed without necessities at placement. (Participants seem particularly exasperated by this.)
- Support group for relative placements

If you could change one thing about the system, what would it be?

- Accountability for all
- More intensive use of Safety Services Respect
- Fewer cases

CST Facilitators

It appears that there are only 4-6 full time facilitators and two of those at La Cause have reassigned duties. They handle difficult cases, but seem to provide little in the way if coaching for staff learning the process.

CST's were described as becoming one more compliance task. "Current meetings aren't about quality, just volume." They are agency meetings, not child and family team meetings.

In response to a specific question, participants stated that there is facilitator training, but these few facilitators don't have the capacity to do much coaching. They say that conformity to the guide for facilitation is uneven. There is no fidelity tool or process in use.

The new PCFA approach doesn't talk about teaming – the two need to be integrated. Parents don't always understand the protective capacity language used in the approach.

The PCFA form drives the CST more than child and family needs.

Participants stated that it is not common to have parent informal supports in CST's, but some of the group added that parents don't often have useful and desirable informal supports.

If you could change one thing about the system, what would it be?

- Evaluate when CST's are appropriate and when they are not (mentioned in regard to not needing CSTs when few providers involved)
- Improve CST quality
- Buy- in by upper management in the family based model
- The CAP process is more a matter of following the form, not real understanding of child/family
- More bi-lingual staff and improve cultural responsiveness

MUTT Team

MUTT responds to placement crisis. Its goal is to de-escalate and stabilize the child. MUTT can offer some limited ongoing one-on-one. One of biggest problems is getting foster parents to call early enough. When Mutt is involved, 90% of children get stable or get to a higher level of care like TFC. MUTT is offered 24/7, provides crisis intervention and planning. They respond to 130-140 families per year and have some un-used capacity, which they would like to provide. They try to raise awareness about their availability.

Foster parents are lacking in training about how to deal with behavior problems. "I joke that if I could do one thing for foster parents I would immunize them against getting angry at eye-rolling, back talk and arguments about when to go to bed." Regarding what children need, it was stated that "the trauma of removal and connection to home is so strong that kids spend 90% of their energy wanting to go back home, something foster parents don't all understand. And the placement changes make it worse. "

What would prevent the need for MUTT?

- Peer support network for caregivers
- Respite
- Greater MUTT involvement in schools

Invited to CSTs? "Occasionally."

MUTT is not involved in TFC, but could be if contract revised. MUTT is involved in group homes.

IA (Investigative) Staff

Turnover is a big problem.

IA caseloads in the group were in the following range – 53, 34, 44, 59 and 55. The group explained that policy expects cases to be cleared in 60 days and a fair number of the open cases are pending more minor details. Those present said the children had been seen, but could take a while to complete supervisory signoff, transcription, etc.

Participants stated that they don't have a good relationship with juvenile justice or mental health, complaining that children who belong in those systems too often end up in Bureau custody.

The group felt that the "front-end" was not managed well or used enough and that too many cases screened were in. They stated that they don't discover that the case was not appropriate until the family was seen. These participants referred to Milwaukee as having an 11% substantiation rate.

The group referenced continued tension with the Children's Hospital child protection unit, (which was found to be a big issue in last year's QSR).

Participants thought Safety Services offered useful supports and mentioned that Safety Services did a good job with risk cases, but not with safety cases. One participant said that Safety Services had become a check box to document reasonable efforts.

Involved in CSTs? "No."

Group felt they worked fairly well with District Attorney staff.

There were numerous complaints about the lack of placement resources, which meant that ongoing staff can sit in the office for hours with the children waiting for a bed. Participants sometimes see placement staff referring them to relatives when no foster home is available, suggesting that kin placement were not a first priority. The group reports that they search for relative placements themselves. The group also mentioned the default to placement in TFC when not regular foster homes available.

Participants said that the placement "computer" doesn't do a good job of matching. Placement data about vacancies, preferences, non-negotiables are not always up to date.

Placement needs?

- Infants
- Adequately trained foster parents for all type of kids
- Foster parents that co-parent (mentor parents and also carry out parenting duties, like school appointments and doctor visits)

Value of MUTT team? It would be more helpful if they could respond more quickly.

Needed supports and services?

- MUTT respond more quickly
- Training for foster parents and kin in dealing with behavior

If you could change one thing about the system, what would it be?

- More accurate screening
- More services for bio-families
- Assessment homes for all new intakes
- More capable foster parents (child behavior issue)

Partnership Out-of-home Committee

Regarding low foster care rates, participants noted that many foster parents get special needs rates also.

Foster parents want simple things – being called back, immediate placement supplies like clothing/formula, cribs, car seats and to be honored and respected.

Educational advocacy is needed for foster families to navigate the school system.

Simplify the day care and food stamp process.

Foster parents can be intimidated at encounters with the legal system (re attending court hearings).

Need consistent application of special needs rates among regions, suggesting inconsistency among offices.

Assessment Homes

11 assessment home couples/parents present. All serve younger children, some infants. Currently serve as follows:

Capacity	Current Number Served
2	1
4	3
3	2
3	0
3	1
4	2
2	2
3	2

3 2
1 1
3 1
2 1

Children almost always stay longer than 30 days.

Is written feedback about child needs provided? Foster care staff take notes in visits about progress. "We often talk to next caregiver about likes/ needs, routines." Sometimes we communicate with bio-parent."

Most foster families like getting children from assessment homes – children have routines and more information is available.

In assessment homes, one parent must stay at home. Foster parents selected by Bureau based on experience, skill and aptitude. All those present loved the role and wouldn't want to return to regular fostering. They took great pride in their work. They struck the interviewer as potentially great mentors for parents and foster parents. Participants stated that "80% of our children stay stable," a fact the interviewer has been unable to verify. In response to a question, they reported their experience with Bureau superior to that of regular foster parents – frequent contact, calls returned and more attention. They spoke of spending a lot of time getting children set up in a medical home, getting to appointments, establishing WIC, etc.

Attend CSTs? "Invited, but rarely attend due to time constraint!"

When asked about participation in foster parent associations, they complained that there was too much complaining in meetings, so they didn't participate.

When asked if they experienced health care barriers, they focused on the temporary Medicaid card, which "often" has not been activated at the time of early medical visits. This got a lot of comment as a problem.

How can the Bureau do a better job in retaining foster parents?

Keep assessment homes
Prepare foster parents for the experience of fostering
Work on improving the media image of the Bureau
More support
Speed up resolution of maltreatment reports by children in their homes – suspensions during the investigations take too long to resolve

If you could change one thing about the system, what would it be?

- Treat foster parents as part of the team (spirited discussion about the frustration with workers agreeing to visit schedules that are disruptive and which they weren't aware of)
- Permit longer than 1 month for the assessment home stay (the rate issue was part of this discussion)

- Increase regular foster care payments
- Resolve the medical card problem
- Training of social workers in working with foster parents

CSSW Recruitment Team

Number of children legally free and waiting for adoption? 75-100

Percent adopted by foster parents? 85%

Support for marketing in recruitment efforts? There is part-time support from public relations division in Children's Hospital.

Budget for recruitment and retention marketing and campaigns? Whatever is left in the budget, about $70,000 this year.

Frequency of foster/adoption preparation training? 7-8 sessions per month.

Training hours required before licensure? 30, however, this will be changing to permit placement before the entire 30 hours are completed.

Level of inquiries about fostering/adoption? 150-200 initial inquiries per month.

Most frequent reason for inquiry? Word of mouth.

Rate that inquiries convert to application and licensure? 25% of those that attend the initial meeting fill out an application and about 10% of those become licensed.

Reasons for inquiries not resulting in licensure? No follow up, background checks reveal criminal history in household where rehabilitation not possible, lack of agreement about fostering/adopting by other members of household.

Length of time to complete licensing process? 60-90 days.

Typical foster parent demographics? Single female, age 40-50, working.

Access to peer support by foster/adoptive parents? Peer support is managed by the two foster parent associations, Voices United and the Foster Parent Association of Greater Milwaukee.

Service and support needs?

- Transportation to get children to appointments

- Easy access to child care (Note: Foster parents are eligible for subsidized child care, but complain about the time spent at W-2 office to complete the process)
- Initial clothing and supplies at placement

Senior Region Manager

Access to placement is a significant challenge. There are not enough placement settings available and the ability to match placement choices to children's needs is limited. Ongoing case management is frustrated by the lack of choice about placements and sometimes wait for months for the best placement.

Foster parent retention is also a major challenge.

To what degree is the Bureau able to keep children safe in their own homes, avoiding placement? Safety services are significantly underutilized. IA workers need help in knowing how to fully utilize it and the service needs more focused attention. The Director's focus on assessment is a good step toward slowing down hasty decision making, which leads to problems that could have been avoided. A strong family preservation resource would be an asset.

Effectiveness of CST process? The capacity to engage families needs strengthening.

Use of Wraparound? There is room for improvement in information sharing between Wraparound and Bureau case management.

The agency needs to validate case management's frustrations about having to take responsibility for getting children to appointments, to school, etc. Case managers clearly get the message that they are accountable for everything.

The addition of nurses to regions as consultants is a positive step.

Needed services and supports? Foster parent supports that build skills rather than just substitute for the foster parent role in discipline, setting limits, etc. There are also some children that don't want to be part of a family and we need to help foster parents understand and not be offended by that.

Other issues needing attention?

- While the increased priority on parent-child visits by judges is appropriate, the system needs to realize that it has a financial cost in terms of transportation and supervised visit agencies as well adding new demands on case managers and foster parents to arrange and support visiting.

- The Bureau need to support and structure the role of foster parents in shared parenting – using their skills to help birth parents develop greater parenting capacity.

United Foster and Adoptive Parents of Greater Milwaukee Leadership

A major system issue is the lack of uniformity in the capability and practice of case managers, which is related to the turnover and their lack of experience.

The pre-service training for case managers seems too long; perhaps they need a briefer period so they can get into the field more quickly.

How is your Association functioning? It's the oldest and there are 76 people in the organization, with 8-11 attending the monthly meetings. Financial support is through activities like raffles. The organization is made up more of central city residents while Voices United is more suburban in makeup.

Recruitment tips for the Bureau and needed services and supports?

- Foster parents need to feel more supported, for example, the Association would like a list of foster parent addresses so it can send newsletters to members. CSSW says it cannot release the names and addresses due to confidentiality.
- Bureau should pay foster parents mileage costs for transporting children.
- More frequent foster/adoptive parent appreciation events.
- Reimbursement for damages to property caused by foster children.
- Training on specific child behaviors and conditions for case managers so they can advise and support parents with challenging children.
- Clothes closets for children that are placed without clothing.
- Respite.

Would financial support for the organization from the Bureau be helpful? We would prefer not to be state funded so we can retain our independence.

Voices United Leadership

How does the Bureau support foster/adoptive parents? CSSW has monthly support group meetings for foster/adoptive parents and a regular newsletter. The licensing worker is also a support to individual foster/adoptive parents.

Issues of concern?

- Participants were concerned about the portrayal of foster parents in the media and frustrated that they care confused with kinship providers, referring to the recent publicized child death. This is described as negatively impacting recruitment.

- Participants don't understand why CSSW will not provide the names and addresses of foster/adoptive parents to the Association so it can reach them about Association activities. CSSW does provide the Association space in its own newsletter.
- Uneven capability of case managers related to knowledge of the system and follow-up issues.
- Then differential for serving more challenging children is not enough to compensate for the difficulties experienced – it essentially adds about $72 per month. There is also concern about the subjective way it is applied, creating inconsistency in amounts from region to region.
- Foster parents essentially have to find their own respite.
- There is some reluctance to placing kids from the central city in the suburbs.

Experience with CSTs? Foster parents are not always invited in time to participate. The meetings are helpful in getting everyone together. Often team members do not attend. It would be helpful if the attorneys attended routinely, but they rarely come.

Needed services and supports?

- Training in behavior management. Basic training doesn't deal intensively with specific behavior issues and when problems occur, training can't be provided individually or quickly.
- Basic information what foster parent expenses can be paid for.
- Respect from the Bureau and partnership role.
- Speed up the permanency process, hold parents accountable to meeting plan/court expectations and if not, move on to permanency elsewhere.

CSSW Out-of- Home Program Managers

A significant pending issue is the Governor's initiative to create a levels system with consistent and rational rates for care related to intensity and need. This has many treatment foster care providers concerned. 15-16 new licenses are issued monthly and the contract benchmark projects 25 per month. The contract anticipates a 90% retention rate and CSSW is at 91%.

Is there a goal for the addition of foster homes? The Secretary has projected a net gain of 185.

Apart from an insufficient number of placements, are there other placement challenges? If we got notice of the need for placement early enough, CSSW can do a better job of matching.

At times it seems easier for overwhelmed case managers to place a child in a foster home than the effort involved in finding a fit and willing relative. CSSW now has a relative placement consultant who goes to court to improve the consideration of relatives.

Are there missed opportunities to keep children safely with their families by using intensive supports? Yes, there are. More attention could be paid to this option.

Are foster parents utilized as mentors for birth parents? Not specifically based on policy and training, although the issue is being explored with the Training Partnership.

Milwaukee foster parents receive $300 less per month than in other counties. Milwaukee seems to be more conservative in qualifying children for a higher level of payment.

Planning Counsel for Health and Human Services

This interview was about the respective focus of the Placement Service, Support Review and the Planning Council's separate review of the Bureau in an effort to make the reports complimentary.

Partnership Council

The early part of the interview provided a description of the history of the Bureau's creation.

Emerging trends? There needs to be a greater focus on a trauma informed response to children.

Expressed concern about 500 children being placed out of Milwaukee County.

It may be helpful to explore the current organizational structure of the Bureau.

The stability and placement report needs to address the organizational culture of the Bureau as well as leadership issues.

Group Home Providers

Participants stated that group homes serve children 12-17 and have an 8 bed capacity. If children need additional services like therapy, the case manager arranges it. Some facilities take only girls, others only boys and some take only teen mothers and their children. The stakeholder interviews were at the end of a regular provider meeting and available time was brief.

Biggest challenges?

- Keeping children involved with their families (who have so many issues of their own).
- Boys – Bureau children may also have delinquency issues and a probation office. In such cases better role clarity is needed about responsibility.
- More staff training is needed to address behavioral issues.
- Lack of access to services, less red tape in acquiring them, simple rules needed on how to navigate the system.

Services and supports needed?

- Options for children who are suspended. There is no day programming for these children.

- Support/advocacy for the many children now have IEP's in getting them fully implemented.
- Mentors, which are almost impossible to get.
- Access to MUTT.

There followed a long discussion about the pros and cons of calling the police which children become aggressive or destructive and it appeared from the discussion that this is not uncommon. There were mixed opinions about how useful it is.

System barriers?

- Can't get psychological evaluations.
- Help in knowing the system's rules.
- Supports for dealing with runaways.
- Resources for AODA, violent behavior, sexual acting early and behavioral intervention.

One provider stated that the reason that children were so angry and disruptive is that they don't have permanency – they want to go home.

If you could change one thing about the way the system functions, what would it be?

- To know the expectations for ongoing staff – related to who's responsible for what issues.
- Authority to secure services without parent/guardian consent.
- Place more African-Americans in leadership positions in the Bureau.
- Greater empathy by workers about the life of urban kids placed in these settings.
- Diversity training for Bureau staff.
- Better communication between workers and group homes.
- Lower the turnover rate.

Placement Stabilization and Assessment Centers

Participants stated that there were 49 beds available in this setting with 43 children in placement. They are aware that the Bureau plans to phase these settings out by the end of the calendar year and some consideration has been given by the Bureau to creating a specialized group home for this population.

Participants described their programs as for children 12-17. There are two group homes for children frequently AWOL.

In response to a question about how children responded to the structure in their programs, participants stated that because this population was not often accustomed to structure it had to be utilized creatively. Others mentioned that "Kids are in an awkward spot, they are waiting for placement – the unknown - and this creates anxiety and frustration. They may not like structure, but they do want predictability."

Where do children generally go when they leave? They usually go to a higher level of care or with relatives. "It makes you wonder why they couldn't have been placed with relatives earlier," said one participant.

What are the behaviors/issues that will most test the next placement?

- Drug and alcohol use, an especially big problem with AWOLs
- Not going to school
- Sexual issues, especially with girls
- Also especially with girls, an inability to process anger
- Property destruction
- Desire to go back to what they consider normal

"For some of these kids, the big issue is hopelessness – lack of predictability and control over their lives."

"It's especially hard for kids to see other kids come and go and know that they are stuck because a placement can't be found – they are some of the ones that get difficult."

Experience with CSTs? They are effective when they occur and when we are invited. It is helpful to have the placement specialist come to meetings with kids. We are not routinely invited and we just found out we could we could request that a CST meeting be convened.

Today there are 20 children in Assessment Homes/Placement Stabilization Centers who came from higher levels of care – TFC, group homes and RTCs.

Needed Services and Supports?

- We need trauma informed interventions
- School supports related to behavior
- Educational advocacy
- In-school behavior coaches
- A way of helping foster parents deal with school issues (coach, mentor and to deal with having to get off work to deal with school problems)
- Ways of helping relatives address housing issues so children can be placed with them
- Respite

CSSW/FCPC Leadership

Status of CAP development? Training has been provided and an overview provided for judges. There is a June 1 start date with the court. Participants believe the initiative will be valuable but acknowledge it will be hard to implement.

Relative care placements are increasing. Additional support/approaches are needed to deal with things like space issues, modifications and debt that prevents rental of more suitable housing to qualify more relative caregivers for licensed care.

One challenge is that even if flexible resources permitted use of very individualized supports, staff are not accustomed to using the creative case planning needed to utilize them.

Recent system changes/initiatives?

- The use of training teams to prepare new workers is a positive effort.
- We are seeing more supervisors in court, especially in complex cases.
- There is more effort to assess relatives.
- CSSW added a family investigator to look for relatives.

How present/active are foster parents in court? It is not unusual for foster parents to be in court, but they rarely speak as they are not a party. Participation varies depending on the judge.

Delays in TPR court continue to be frustrating due to continuances.

The inexperienced work force does contribute to unevenness in case management performance, often found in lack of clarity about permanency process.

Assistant District Attorneys

Judges are generally supportive of family based/kinship placements. There is a need for early, in-depth evaluation of relative placements.

There was considerable concern about the frequency of moves.

Relationship with Wraparound? There is some unevenness among providers. Case managers express concerns about a lack of information sharing in some cases.

Experience with CSTs? We support the concept but the quality can be poor.

Placement Needs?

- Homes for siblings
- More foster homes for adolescents
- More specialized group homes
- Foster parents willing to let parents visit in their home.

Needed services and supports?

- Simple access to day care for foster parents.
- Treat foster parents as partners.
- Provide more supports like MUTT that prevent disruption.
- Pay more attention to the mental health needs of children.

Foster Parent Group (some overlap with same Assessment Home Parents interviewed previously)

One parent complained about having to wait the full thirty days after asking that a child be moved for being abusive to her, which made it difficult for the caregiver and child. The child was ejected by the day care provider, making child care plans difficult and it appears the child will be returned home. Caregiver also complained that she wasn't fully reimbursed for clothes the child destroyed. Therapy for the child was delayed while seeking consent from the parent. "I kept asking for help, but the worker kept saying just give it another month. I work and I'm single and I can't deal with all these needs by myself."

Another foster parent was frustrated because the Bureau refused to reimburse her for damage the child caused, instead advising her to file a homeowner's claim, "which will make my insurance go up."

Another participant complained about difficulty in reaching ongoing workers. There were also frustrations expressed about Bureau staff making appointments for children that foster parents weren't consulted about.

Other participants reported few problems with their workers and most expressed praise for their licensing workers. The group acknowledged that the turnover among ongoing case managers affected quality.

Participants universally wanted to be treated as partners by Bureau staff.

Some participants mentioned that they wished that the PACE training could address behavioral issues more fully, instead of providing advanced training only after children were in the home. Others felt that PACE provided a good foundation.

Several group members stated that they wished they had more peer support.

One adoptive foster parent offered a list of suggestions:

- Recruit more workers before you recruit more foster parents – ongoing workers don't have enough time.
- The licensing worker asks, "What can we do?" It would be great if others had that approach.
- Pay foster parent liaisons to mentor other foster parents, especially new ones.
- Don't overreact to tragedies.
- Be honest about the challenges in recruiting new foster parents.
- There is actually a simpler way to apply for day care rather than the W-2 ordeal, but no one seems to know about it.
- Be fair and consistent with clothing reimbursement.

African-American Faith Community (Agency helping the Bureau with Recruitment)

There is a significant cultural gap in Milwaukee. Most of the agencies involved are not African American and don't live in the communities the children and families served come from. Recruiting culturally competent workers is a challenge.

To what extent are their families in the African American community who are licensing prospects (asked in regard to some perception among respondents that there are few families interested and who can meet standards)? African American families are resources that can be tapped if the approach is right and supports/relationship adequate.

What would you want your relationship/role with CSSW and the Bureau to be?

- Relationship
- Building a coalition of the faith communities
- Based on the number of families that apply rather than based on completion of licensure (over which we have no control)
- Support of two full time positions

It is difficult to get accurate data on where families we recruit are in the process. If we knew this we could trouble-shoot.

Milwaukee UWM Training Partnership

The Training Partnership has 16 teams of trainers who provide mainly core training. They are in the midst of substantially revising the training to help screen out early those who won't qualify for licensure. They are also looking at designing training to address issues like discipline, to be delivered when a foster parent actually has a child placed in the home. The Partnerships believes the current curriculum isn't strong enough on foster parents partnering more with bio-parents. The same will be needed for case manages, some of whom tend to treat foster parents as service providers.

In response to a question about strengthening the quality of CST's. The Partnership stated that a clear model and purpose would be needed so the team meetings were more than just an agency meeting – greater team building would be needed.

Children's Court Judges

Are you seeing emerging trends in the cases that come before you? "We seem to be seeing more adolescents and children placed out of county."

Several judges expressed concerns about the comparative lack of supports for relatives compared to foster parents. Concern also expressed about the tendency in some cases to expand the conditions for reunification once a child was placed and the "one-size-fits-all" approach to case plans.

When asked about the value of Wraparound involvement, one judge stated, "I don't know what we would do without them. They do a better job of getting support services in place, especially informal supports." There were also comments about the high sustainability of improvements after Wraparound involvement. Another judge stated that CSTs should be able to create Wraparound-like supports.

What types of mental health screening occurs at placement? None at present. (The Bureau states that it is examining this issue as part of corrective action efforts).

Needed services and supports?

- Educational supports
- Educational advocacy
- Tutoring
- Mentors (Big Brother type supports)
- Parent coaching
- In-home therapy
- Capable foster parents that can actively support reunification

One judge expressed concern about the loss of placement access to foster parents that adopt.

Consider using permanency consultants at the front-end.

Treatment Foster Care Providers

Homes serve children birth to 18 and behaviorally, children's issues range from sexualized behavior, physical aggressions, AWOL, school issues and more. Providers say they are seeing more teens age 12-17 referred. The average length of stay is around 2 years. Younger children tend to return home with older children leaving for other out-of-home placements or aging out.

Is one TRC foster parent required to stay at home with children? No, most work.

While some homes offer some limited clinical support, others are primarily dependent on the TFC case manager to address clinical issues. Supportive services like therapy must be authorized by the Bureau.

Participation in CSTs? We are not consistently notified and sometimes our foster parents are discouraged from attending.

Value of CSTs? They are almost like the plan was prepared in advance, with little preparation of the team. The participants don't function like a team. The quality is variable depending on the worker. They are sometimes convened to satisfy compliance requirements, such as meeting every 90 days. They are system dominated, with parents/youth/foster parents having little influence.

They have less fidelity to the original Wraparound-like model than when newly introduced. Key professional partners, like an AODA provider, are present. TFY youth are rarely present.

What are the major contributors to disruption? Once TPR occurs, kids finally realize their lack of permanence and react behaviorally. Long lengths of stay in foster care have a similar effect. The system creates many of the mental health problems children have through instability and lack of permanence.

Several prodders complained that case managers make visiting plans without consulting the TFC foster parents.

Service and support needs?

- Therapeutic services like play therapy and attachment treatment
- After school activities
- Mentoring
- Recreational opportunities
- School support
- Tutoring
- Coaching for foster parents in dealing with behavior issues
- Programming for children who are suspended
- Pre-placement visits
- Comprehensive information prior to placement
- Respite

If you could change one thing about the system, what would it be?

- Better information sharing and communication
- Begin providing mental health screening for children when they enter care
- Follow through on commitments
- Earlier decisions about placement
- Advocacy by the Bureau and partners for children's needs
- Bureau should trust the programs it contracts with
- More flexibility about past kin transgressions (criminal records) that bar placement
- More culturally responsive practice
- More efforts to strengthen families
- More ability for creative planning
- In-home therapy

GALs and Social Workers

Challenges? There are too many layers for approval related to case issues. The necessity to get parent guardian approval for things like therapy can be very frustrating and interfere with meeting children's needs. The court can approve such supports, but it's yet another step to take in an overworked system.

There are not enough good therapists and mental health supports for young children. There is a significant need for more foster homes, which results in children not being in optimal placements and too much haste in using kin prior to a thorough assessment overlooking a criminal history until after placement was cited.

Frequent court continuances delay permanency.

Foster providers lack supportive services, like in-home behavioral supports.

Needed supports and services?

- Transportation for children in care
- Clothing allowance for kin
- Recreational supports
- After school supports
- (Early) supports for children aging out that permit a successful transition to adulthood
- In-home mental health supports

Wraparound

Wraparound currently services 210 Bureau children. The number of children in residential settings has declined from 600 in 1996 to less than 100. Wraparound also serves the juvenile justice population and recently added 200 slots, which will include support of schools. The FISS and MUTT programs are related services. Wraparound does not currently serve kin or TFC settings.

Appendix III

Department Maintenance Rate Structure

The maintenance payment is determined by the ongoing case manager and approved by their supervisor or management. Calculations for the cost of additional care are to accompany the recommendation for the Region Rate Setter and case file.

The maintenance payment is broken down into three components, basic, supplemental and exceptional. Total payment including the basic, supplemental and exceptional payments cannot exceed $2,000. The basic portion of the payment is set by the State of Wisconsin statute. The following table outlines the basic monthly rates for 2008 and 2009.

Child's Age	Rate Effective 1/1/2008	Rate Effective 1/1/2009
Birth to 4 years old	333.00	349.00
5 to 11 years old	363.00	381.00
12 to 14 years old	414.00	433.00
15 to 18 years old	432.00	452.00

The supplemental payment is based on the Department of Health and Family Services, Division of Children and Families form CFS-834. The form is divided into three sections, Emotional Care Needs, Behavioral Care Needs and Physical and Personal Care Needs. Within each section, point values are assigned based on child characteristics. The child can receive point values of 0, 4, 8 or 12 in each section, for a maximum total point value of 36 points. Each point value is then multiplied by $9 to determine the monthly payment for the supplemental payment. Maximum payment for this component is $324 per month.

Exceptional payments are based on the individual need of child. The amount of an exceptional payment is determined by assessing the placement and determining the needs of the foster child relative to the cost of maintaining the child in placement. There are two categories of exceptional payments outlined below.

1. A foster parent may be paid an exceptional rate, in addition to the basic and supplemental amounts, for care of a child if the additional payment will:

    - Allow a child to be placed in a foster home rather than in an institution, nursing home or hospital;

    - Allow a child to be moved from an institution, nursing home or hospital to a foster home;
    - Allow the replacement of a child's basic wardrobe which has been lost or destroyed through other than normal wear and tear;

    - Allow a foster parent of a minor parent residing in their foster home to support the minor parent's child (not under court jurisdiction) in the same foster home. In these circumstances, the allowable payment amount is determined by the age of the minor parent's child and what the corresponding base rate would be if the child was under court jurisdiction.

2. May be used for additional expenses incurred by foster parent for:

    - Replacing sheets and mattresses for a chronic bed wetter;

    - Additional travel time incurred for medical/dental/psychological appointments in excess of normal expected appointments; or

    - Other necessary supplies beyond normal including clothing.

    These additional category 2 expenses will require receipts to support the need for the additional supplemental payment. As an example, replacement of sheets and mattress: The mattress and sheets need to be replaced every three months due to destruction because of chronic bed wetting. Receipts for replacement total $275 for the mattress and $25 for the sheets for a total expense of $300 every three months. The monthly foster care maintenance payment will be increased by $100 per month ($300 / 3 months) to provide reimbursement to the foster parent for the added expense. Any mileage reimbursement would be at the current state mileage reimbursement rate which is $.465/mile in 2008.

Appendix IV

SOME OF THE SERVICES CREATED IN ALABAMA

- Home-based instruction and support for parents on responsiveness, discipline, routines, and healthcare with specialized guidance for parents with developmental disabilities or mental illness
- Behavior aides providing instruction on self-regulation to the behavior-disordered child at home and in school and suggestions to parents and school staff on consistent support for the child's self-regulation
- Coaches for children with emotional problems to help them improve their self-confidence and develop success in activities and normal social activities
- Home-based substance abuse treatment for parents to help them recognize how the abuse causes them to neglect or maltreat their child, teaching them how to make sure their own needs do not obscure the child's needs and helping them get involved in outpatient or inpatient treatment
- Accompanying a parent to AA/NA
- Home-based treatment to help parents recognize how domestic violence harms their children, teaching them how to make sure their own needs do not obscure the child's needs and helping them learn how to develop positive relationships and safely manage their anger
- Assistance in daily school attendance
- Teaching parents how to help with homework
- Helping parents advocate in school on behalf of their child
- Specialized reunification services, including therapeutic and instructional visitation, hands-on family support before and after return, school placement assistance and crisis intervention
- Specialized support for foster parents managing children with behavior disorders or emotional disturbances
- Respite for biological families and foster parents
- Home-based individual attention for children to address depression, anger, inadequate relationship-building skills, feelings of worthlessness or other problems associated with sexual abuse, physical abuse and school failure
- Home-based individual supports for parents who are immature, depressed, easily victimized, or overwhelmed
- Home-based parent-child or family counseling, directed specifically at capitalizing on the strengths of the family to meet the child's needs

- Group counseling for children who have been sexually or physically abused or who have substance-abusing or mentally ill parents
- Parent/foster parent support groups
- Social behavior instruction for children and adolescents with developmental disabilities
- Home-based support for physically handicapped children and their families
- Home-based health care for pregnant women, infants and children (including monitoring birth weight, intervening in developmental delay and giving immunizations) and referral for needed specialized services
- Home-based medication monitoring
- Specialized support for runaways and instruction and support for their parents, foster parents, school staff and other caregivers
- Specialized counseling for members of incestuous families
- Assistance in finding housing or repairing housing
- Vocational training, job readiness, job search and support on the job for adolescents
- Transportation for children and families

From *Making Child Welfare Work:*
How the R.C. Lawsuit Forged New Partnerships to Protect Children and Sustain Families
Bazelon Center for Mental Health Law

Appendix V

Total Authorizations/Expenditures for Services in 2008 - Ongoing Only: BMCW Regions 1 and 2

ServiceCode	ServiceDescription	Authorized Amount	Expensed Amount
5000	Mental Health Assessment	$2,307.00	$465.00
5001	AODA Assessment Outpatient	$164,739.25	$38,995.25
5002	AODA Assessment In-Home	$11,993.00	$3,448.25
5003	Assessment/Evaluation - Other	$9,059.00	$5,400.00
5005	Bonding/Attachment Assessment	$16,930.00	$10,080.00
5050	Psychiatric Medication Review	$122,655.00	$44,541.25
5051	AODA Chemical Therapy Management	$900.00	$315.00
5080	Interpretation/Telephone Contacts	$487.50	$337.50
5101	AODA Counseling Outpatient	$457,070.00	$62,641.75
5102	Mental Health Individual Therapy Outpatient	$1,337,765.70	$284,848.22
5114	Mental Health Family Therapy Outpatient	$392,000.42	$99,284.83
5120	MH - Group Therapy	$13,520.00	$2,376.00
5121	AODA Group Counseling	$162,770.00	$24,277.76
5130	Special Therapy	$140,750.50	$61,225.20
5131	Special Therapy Group	$512.00	$64.00
5142	Special Therapy - RAD	$120,716.00	$48,916.00
5159	AODA Counseling In-Home	$46,652.00	$19,415.00
5162	Mental Health Individual Therapy In-Home	$481,035.00	$223,956.25
5166	Mental Health Family Therapy In-Home	$347,915.00	$130,150.00
5172	Mental Health Day Treatment	$385.00	$385.00
5180	Psychological Testing Services	$619,897.00	$309,861.00
5181	Psychiatric Evaluation	$93,250.00	$29,450.00
5201	Kinship Care Support Program	$44,200.00	$6,597.50
5202	After-School Program	$10,608.00	$0.00
5301	Respite - Residential	$2,474.10	$2,474.10
5351	AODA Women's Residential Treatment w/ Children)	$150,341.00	$116,943.00
5352	AODA Women's Residential Treatment	$393,793.81	$268,297.62
5353	AODA Day Services	$615,984.00	$101,935.50
5357	AODA Men's Residential Treatment	$11,345.00	$7,980.00
5410	Respite - Hourly	$0.00	$0.00
5411	Respite Foster Care	$69,343.54	$50,219.64
5412	Respite - After School	$3,993.00	$3,448.50

5420	IL - Supervised Independent Living Program	$186,024.00	$135,365.00
5430	IL - Supervised Independent Living Program with Child(ren)	$49,296.00	$42,660.00
5431	IL - Transitional Living	$75,561.00	$48,327.00
5440	Daycare/Childcare	$37,999.20	$23,756.40
5516	Community Living	$47,424.00	$14,801.00
5517	Community Living - Assessment	$1,960.00	$1,000.00
5518	Specialized Parenting Support Svcs	$322,840.00	$93,758.00
5519	Specialized Parenting Support Svcs w/o Transport	$59,478.00	$16,238.00
5521	Tutoring	$20,243.50	$9,610.00
5521A	Literacy Training	$0.00	$0.00
5522	Parent Assistance	$872,937.00	$250,735.00
5523	Parenting Classes	$222,126.60	$37,382.00
5524	Mentoring	$52,538.00	$25,448.00
5525	Crisis Stabilization	$203,490.00	$90,547.50
5526	Child Supervision	$35,355.00	$16,922.50
5528	Crisis - Tracking	$0.00	$0.00
5529	Group Mentoring	$0.00	$0.00
5530	Suspension Intervention Program	$3,410.00	$2,400.00
5535	Advocacy Services	$4,298.00	$1,458.00
5540	Supervision/Observation	$6,690.00	$2,760.00
5560	Job Coaching/Employment Services	$27,390.00	$6,270.00
5561	IL - Adolescent Daily Living Skill Development	$68,061.00	$15,173.50
5563	IL - Life Skills Practicum	$118,460.00	$29,848.00
5564	Nurturing Program	$173,016.00	$47,846.50
5565	Anger Management Group	$53,753.00	$8,992.50
5590	Home Management Services	$380,616.00	$75,995.00
5595	Housing Assistance	$182,137.50	$25,012.50
5600	Interpretation/Translation Services	$182,180.00	$112,870.25
5650	ICP - Wellness Recovery Program	$360.00	$30.00
5652	ICP - Freedom Self Advocacy Group	$0.00	$0.00
5655	ICP - Tier 1	$44,000.00	$27,450.00
5657	ICP - Tier 2	$0.00	$0.00
5700	AODA Lab & Medical Services	$381,159.00	$67,630.75
5703	AODA Breath Alcohol Test	$0.00	$0.00
5708	Child Support	$0.00	$0.00
5710	WIC	$0.00	$0.00
5712	SSI	$0.00	$0.00
5714	Food Stamps	$0.00	$0.00
5716	W2 Financial Assistance	$0.00	$0.00
5717	W2 Liaison	$0.00	$0.00
5718	Mental Health Inpatient Hospitalization	$0.00	$0.00
5720	Special Education Services	$0.00	$0.00
5723	Birth to 3 Program	$0.00	$0.00
5724	CHS Child Care	$5,349.00	$1,744.00
5726	Clothing Bank	$0.00	$0.00
5727	Food Pantries	$0.00	$0.00
5728	Energy Assistance	$0.00	$0.00
5729	Household Goods	$0.00	$0.00

5730	Special Medical Services	$0.00	$0.00
5731	Nursing Care	$8,140.00	$1,900.00
5740	Organized Sports	$0.00	$0.00
5741	Organized Arts	$0.00	$0.00
5742	Informal Sports/Other Recreation	$0.00	$0.00
5750	Other - Discretionary	$0.00	$0.00
5806	Supervised Visitation with Transportation	$7,817,620.13	$3,471,231.06
5807	Supervised Visitation without Transportation	$144,265.88	$22,290.36
5808	Supervised Visitation Assessment	$0.00	$0.00
5809	Unsupervised Visitation Support	$300.00	$0.00
5810	Family Reunification/Prison Visit Orientation	$11,550.00	$4,970.00
5811	Family Reunification/Prison Visits	$204,050.00	$95,150.00
5812	Family Reunification/Prison Visit No Show	$1,440.00	$1,035.00
5850	Transportation-Milwaukee County	$940,835.40	$409,632.20
5851	Transportation-Outside Milwaukee County	$3,124.00	$1,776.00
6003	DV - Education	$0.00	$0.00
6004	DV - Shelter	$0.00	$0.00
6007	DV - Batter's Anonymous	$180.00	$0.00
6051	Psycho-educational Group	$1,464.00	$264.00
6100	Family Works Program	$43,038.00	$21,357.00
6110	MHMAH 1	$0.00	$0.00
6580	Behavioral Intervention Support Services	$16,410.00	$5,400.00
6601	Family Interactions Program - Visitation	$1,465,343.79	$613,406.01
6602	Family Interactions Program - Assessment	$83,706.50	$18,497.50
6603	Parent Empowerment Group	$0.00	$0.00
6930	IL - Graduated Adult Living Services	$0.00	$0.00
7000	Badgercare Enrollment Assistance	$270.00	$135.00
	Region 1 and 2 2008 Totals:	**$20,405,281.32**	**$7,857,404.65**

Total Authorizations/Expenditures for Services in 2008 - BMCW/Region3

ServiceCode	ServiceDescription	Authorized Amount	Expensed Amount
L0000	SSI Spend Down	$15,162.42	$13,405.78
L5000	La Causa Billable - Initial Mental Health Assessment	$19,196.00	$7,237.25
L5001	La Causa Billable - AODA Assessment	$57,740.75	$32,414.00
L5003	Screening/Assessment - Other	$15,077.00	$11,033.00
L5050	La Causa Billable - Psychiatric Reviews/Medication Checks	$13,065.32	$6,336.32
L5051	Chemical Therapy Management	$9,368.00	$6,066.00
L5101	La Causa Billable - Individual AODA Therapy	$222,868.00	$69,471.80
L5102	La Causa Billable - Outpatient Individual Therapy	$449,060.50	$172,485.90
L5103	La Causa Billable - Outpatient Individual Counseling (PhD Level)	$103,031.00	$52,015.00

L5111	La Causa Billable - Outpatient Family Therapy (PhD Level)	$9,900.00	$4,170.00
L5113	La Causa Billable - Outpatient Family AODA Therapy	$256.00	$0.00
L5114	La Causa Billable - Outpatient Family Therapy	$121,912.00	$42,392.50
L5120	La Causa Billable - Outpatient Group Therapy	$1,728.00	$896.00
L5121	La Causa Billable - Outpatient Group AODA Therapy	$72,646.00	$16,978.98
L5130	La Causa Billable - Special Therapy - Individual	$82,797.50	$45,055.25
L5131	La Causa Billable - Special Therapy - Group	$5,675.24	$3,316.60
L5132	La Causa Billable - Special Therapy - In-Home	$5,400.00	$412.50
L5159	La Causa Billable - In-Home AODA Therapy	$54,435.00	$33,615.00
L5162	La Causa Billable - In-Home Lead Therapist	$441,450.00	$252,804.00
L5165	La Causa Billable - In-Home Case Aide	$4,400.00	$1,850.00
L5166	La Causa Billable - In-Home Family Therapy	$114,630.00	$53,140.00
L5180	La Causa Billable - Evaluation Services - Psychologist	$219,395.02	$182,115.02
L5181	La Causa Billable - Evaluation Services - Psychiatrist	$15,052.51	$4,802.51
L5183	La Causa Billable - Evaluation Services - Other	$4,950.00	$4,950.00
L5200	Caretaker Support Program	$70,736.25	$24,115.00
L5201	Camp	$2,985.50	$2,960.50
L5202	After School Programs	$18,974.00	$15,108.00
L5221	Professional Consultation	$320.00	$0.00
L5351	La Causa Billable - Residential AODA Treatment - Woman with Child(ren)	$9,100.00	$9,100.00
L5352	La Causa Billable - Residential AODA Treatment - Woman	$285,930.10	$230,718.54
L5353	La Causa Billable - AODA Day Treatment	$105,147.00	$28,990.50
L5392	Foster Care	$3,301.00	$2,597.00
L5410	Respite Care - Hourly	$1,477.00	$945.00
L5411	Respite Care - Daily	$45,450.00	$40,740.00
L5420	IL - Supervised Independent Living - Individual	$63,135.00	$47,748.00
L5430	IL - Supervised Independent Living with Children	$24,411.00	$24,095.00
L5431	IL - Transitional Supervised Living	$1,424.00	$0.00
L5440	Child Care	$1,492.00	$1,056.00
L5500	Case Management	$1,600.00	$300.00
L5518	Specialized Parenting Support Services with Transportation	$200,144.00	$117,857.60
L5519	Specialized Parenting Support Services without Transportation	$141,576.50	$83,151.90
L5521	Teacher's Aide/Tutor	$8,992.50	$4,068.75
L5522	Basic Parenting Assistance (Individual)	$166,603.00	$75,363.50
L5523	Parenting Class	$31,694.50	$7,929.50
L5524	Mentoring	$41,411.00	$23,365.70

L5525	Recreational Activities	$3,158.22	$3,158.22
L5527	Crisis Stabilization Mentoring	$57,630.00	$21,560.00
L5560	Supportive Work Environment	$640.00	$0.00
L5561	IL - Adolescent Daily Living Skills Development	$28,404.00	$10,610.50
L5563	IL - Life Skills Training	$6,400.00	$945.00
L5564	Nurturing Classes	$31,559.00	$20,092.00
L5565	Anger Management Group	$16,752.00	$3,021.80
L5570	Transportation - Local	$7,481.77	$2,149.09
L5571	Transportation - Out of County	$31,584.46	$23,559.31
L5577	Discretionary - Security Deposits	$4,450.00	$2,720.00
L5578	Discretionary - Rent	$5,874.58	$5,824.58
L5579	Discretionary - Utilities	$4,428.52	$4,428.52
L5580	Discretionary - Medical	$4,171.57	$4,151.57
L5582	MCTS Bus Tickets	$23,777.00	$23,010.60
L5583	MCTS Bus Passes	$19,088.00	$17,680.00
L5585	Discretionary - Furniture	$14,401.73	$14,183.45
L5586	Discretionary - Clothing	$5,400.83	$4,970.83
L5587	Discretionary - Non-MCTS Transportation	$10,559.00	$10,414.75
L5589	Discretionary - Other	$15,464.70	$14,922.53
L5590	Basic Home Management Services	$44,112.50	$13,197.50
L5595	Housing Assistance	$9,340.00	$3,156.25
L5600	Interpreters	$95,012.75	$58,596.40
L5650	ICP Wellness Recovery	$510.00	$0.00
L5651	ICP Parenting Skills for Persons w/Mental Illness	$360.00	$0.00
L5652	ICP Freedom, Self-Advocacy Program	$120.00	$0.00
L5655	ICP Integrated Service - Tier 1	$67,550.00	$59,737.50
L5656	Job Coach	$2,652.00	$1,072.50
L5657	ICP Integrated Service - Tier 2	$23,575.00	$20,700.00
L5700	Random Urine Surveillance	$167,868.00	$52,979.00
L5701	Random Urine Surveillance - 5 Panel Screen (Dynacare Only)	$242.26	$228.25
L5702	Random Urine Surveillance - 6 Panel Screen (Dynacare Only)	$5,098.50	$4,987.45
L5703	Breath Alcohol Test	$1,291.00	$80.00
L5704	Random Urine Surveillance - 10 Panel Screen	$5,160.00	$900.00
L5806	Supervised Visitation with Transportation	$2,676,620.37	$1,836,504.13
L5807	Supervised Visitation without Transportation	$72,832.25	$38,025.50
L5810	Orientation Interviews	$4,480.00	$2,205.00
L5811	Prison Visitation	$107,800.00	$74,525.00
L5812	Prison Visitation - No Show	$495.00	$225.00
L5850	Transportation - Within Milwaukee County	$199,966.00	$121,010.00
L5851	Transportation - Outside Milwaukee County (Standard Rate)	$147,325.20	$109,095.00
L5854	Foster Parent Mileage	$21,354.54	$21,119.99
L6002	Domestic Violence - Crisis Intervention	$5,160.00	$1,968.00

L6003	Domestic Violence - Education	$6,030.00	$2,370.00
L6004	Domestic Violence - Shelter	$1,267.98	$0.00
L6007	Domestic Violence - Batterer's Anonymous	$2,230.00	$1,147.50
L6602	Family Interactions Assessment	$5,600.00	$4,837.50
	Region 3 2008 Totals:	**$7,250,379.33**	**$4,373,244.11**

Bureau Totals: Authorized – 27,655,660.65

Expensed – 12,230,648.76

Appendix VI

Flexible Funds in Child and Family Services

Most narrowly, flexible funds are uncommitted, non-categorical funds, available and easily accessible to caseworkers and the child and family team at the case level. Flexible funds are intended to expand the agency's ability to respond to the unique needs of children and families beyond that possible with inflexible categorical services that may be relevant only one specific need. Flexible funds are essential to individualized needs based practice, in that no categorical array of services can be broad or diverse enough to meet all of the complex needs experienced by the families and children served through child and family agencies.

More broadly, flexible funds are a core process of the strengths based, individualized, needs based approach to practice that increasing numbers of systems are adopting. The flexible funds approach is closely tied to the wraparound movement that came into use in the 1980's. The wraparound approach was coined by Lenore Behar, who defined wraparound as a way to surround multi-problem youngsters and families with customized services rather than institutionalized walls. This approach broadened the practice of bringing services to the child and family's environment, rather than limiting parents and especially children to services that are

attached to a place or location. The only effective way to achieve customization for many families is to have the ability through flexible funds to create or craft new services for one child or family at a time.

One particular asset of flexible funds is the ability through their use to match a particular individual who can provide the service to the child and family. This flexibility strengthens capacity to utilize more informal supports, capitalize on existing or promising personal relationships and strengthen the provision of culturally relevant services.

Flexible funds are characterized by the following qualities:

- Uncommitted to existing services
- Free of unnecessary and arbitrary policy restrictions
- Easily accessible to caseworkers and the child and family team
- Minimally limited by multiple levels of approval*
- Routinely perceived as available at the front line
- If financed by categorical funding streams, the categorical origin is invisible to the front line worker (i.e. matching of cost to funding source should be made at levels other than the worker)
- Retain their flexible funds identity even after they have been committed to a provider for a specific service (i.e. not re-categorized for the long term related to the service provided)
- Applicability to recurring costs (such as an ongoing services) as well as to non-recurring costs (rent or automobile repairs)
- Reflect some parity across service/provider types (i.e. formal vs. informal, agency provider vs. individual provider, recurring vs. non-recurring costs)
- Ability to be quickly committed and paid
- Integrally linked to a needs based, individualized practice culture

Flexible Funds Application Examples

Short-term individual attention services

Mentoring supports

Educational advocacy

In-home medication management

Behavior coaching

Individualized, home-based parenting skills development

Self-esteem building experiences (music lessons, athletic participation)

Concrete living supports (rent, transportation, repairs)

* Limiting the layers of approval for flexible funds use does not suggest that competent oversight of the use of flexible funds should be limited. Supervisory oversight and staff training are essential for the effective and appropriate use of flexible dollars.

Appendix VII

Mental Health Screening Tool (MHST)

5 Years to Adult

California Institute for Mental Health
1119 K Street
Sacramento, CA 95814
(916) 556-3480
Made possible through a grant from the Zellerbach Family Fund

ABOUT THE FOSTER CARE MENTAL HEALTH SCREENING TOOL (MHST)

What is the MHST?

The MHST is a brief tool intended to be used primarily by non-mental health professionals to rapidly screen children and youth ages 5 through adult who are being considered for outof-home placement. The purpose of the instrument is to identify which children/youth should be referred for a mental health assessment. Additionally, the instrument is designed to prioritize the urgency of the referral.

Does the MHST apply only to children being considered for out-of-home placement?

Not necessarily. The tool was designed for children being considered for out-of-home placement in response to requirements set down in SB 933; however, the tool should identify any child in need of follow-up mental health assessment. Several California Counties are utilizing the MHST in a variety of ways within their child and family service system.

How was the MHST developed?

The MHST was developed by a multi-agency workgroup consisting of representatives from

county child welfare, juvenile probation, public health and mental health departments; state representatives from the Department of Social Services, Mental Health and the Board of Corrections, and a parent representative. The project was undertaken by the California Institute for Mental Health (CIMH) and funded by a grant from the Zellerbach Family Fund. Six counties pre-tested the MHST and found that it can be completed quickly, is easy to use and is helpful. They reported that it accurately identified children and youth meeting medical necessity criteria who were in need of mental health services.

Who can use the MHST?
The tool was originally designed to be used by social workers and probation officers, but other non-mental health professionals working with children may find it useful, and the MHST may also be valuable when used by mental health professionals as a step in the overall referral and assessment process.

When should the MHST be used?
The tool has been designed to meet the requirements of SB933 that requires that fully-funded System of Care counties must screen and assess all children and youth going into group home placements. Originally, the screening instrument was designed to be used by social workers within the
first few days after a child is removed from the home, and by probation officers when outof-home placement is first being considered. Each county system will determine how the MHST fits within its child serving system; however, the tool may be used at any time a social worker or probation officer feels it is appropriate.'

What do Mental Health and Social Services/Probation departments need to do to implement the MHST in their county?

All departments who are to be involved need to work together to develop an implementation plan. Among other things, there must be agreement regarding the following:

- The populations to be screened
- When the MHST will be administered
- How, and to whom in mental health, the information will be transmitted
- The process by which consent to release information, allowing mental health to follow up on the screening, is secured
- How and what feedback will be given by mental health back to the referent

After a county has decided to use the MHST, what is the suggested process for completing the screening instrument?

The caseworker/probation officer should complete the MHST as soon as possible after the youth is determined to be in need of out-of-home placement, or in need of a mental health screening. A "yes" answer to any of the questions on the front page indicates an "Identified Risk" with a high priority need for a mental health assessment. When a "yes" box is checked on the front of the form, this form should be faxed immediately to the designated mental health staff person. It is recommended that an assessment be scheduled to take place

no later than five days following the receipt of the MHST.

A "yes" answer to any question under the "Risk Assessment" section on the back of the form also indicates a need for referral, although the need is not as urgent and the assessment may not need to be completed as quickly.

Circling the behaviors outlined in Italics after each question allows the person completing the screen to quickly and easily offer more specific information that will assist with the mental health assessment.

Because they are so broad, won't the questions in the MHST screen every child in out-of-home care as needing mental health assessment?

The MHST is designed to utilize the questions in conjunction with the more specific examples of events or behavior. Using the examples to determine the answer to the question allows the MHST to discriminate, and identify those most in need.

Because the examples are so severe, won't the MHST screen too many children as not needing mental health assessment?

The examples were developed with considerable input from experienced representatives of county department of social service systems. They reflect the scale, or standards, most welfare workers use in determining children most in need of mental health services.

Don't all children in foster care or out-of-home placement need a full mental health assessment?

It is widely held as a "Best Practice" that all children in out-of-home care should receive a full mental health assessment. The MHST may be less relevant to systems that are committed to doing so. However, the MHST can be useful in a number of situations that include:

- Child Service systems that do not have the resources, or have otherwise determined that it is not necessary to assess all children in out-of-home care.
- Child Service systems that seek to triage, or identify those children most in need of mental health assessment, to more effectively utilize resources and serve children.
- Child Service systems that serve a broader child population than those children who are in out-of-home care. For example, some systems may want to screen all children who come into contact with law enforcement.

How will the Mental Health Department respond to answers of "Unknown?"

Each county child serving system will have to develop its own response to these answers. If possible, a child whose screen only indicated answers of "No" and "Unknown" should be screened again after one or two weeks when more information regarding the child is

available.

How is the MHST currently being utilized?

Several counties that participated in the MHST Pre-Test, and others who learned of its development, have already integrated it into their child and family service systems. Because each system is unique, the MHST will be utilized differently across the state. Some examples follow:

How can we get assistance/training on the use of the MHST in our county?
Contact the California Institute for Mental Health at (916) 556-3480, and ask for information regarding the Foster Care Mental Health Screening Tool.

MENTAL HEALTH SCREENING TOOL (CHILD 5 YEARS TO ADULT)
Referent: Date:
Telephone: Agency: ⭘ Social Services ⭘ Probation ⭘ Other:
Child's Name: Date of Birth:
Child's Ethnicity: Primary Language:
Child's Current Telephone: SSN#:
Child's Current Residence: ⭘ Shelter ⭘ Group Home ⭘ Relative ⭘ Juvenile Hall ⭘ Foster Care ⭘ Other:
Caregiver/Contact Person (if known):
Child's Current Address:

Please check applicable boxes on both sides of this form. Following each question are examples of behaviors or problems that would require a "YES" check. ***Please circle any that apply****. This list is not exhaustive. If you have a question about whether or not to check "YES," please indicate the issues under the COMMENTS section on the reverse side of the form.*

YES NO Unknown IDENTIFIED RISK

⭘ ⭘ ⭘ 1. Has this child been a danger to him/herself or to others in the last 90 days?
Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.

⭘ ⭘ ⭘ 2. Has this child experienced severe physical or sexual abuse or has s/he been exposed to extreme violent behavior in his/her home in the last 90 days?
Subjected to or witnessed extreme physical abuse, domestic violence or sexual abuse, e.g., severe bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc.

⭘ ⭘ ⭘ 3. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy?
Persistent chaotic, impulsive or disruptive behaviors; daily verbal outbursts; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other discipline, etc.

⭘ ⭘ ⭘ 4. Has the child exhibited bizarre or unusual behaviors in the last 90 days?
History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (e.g., head banging) or vocalizations (e.g., echolalia); smears feces; etc.

⭘ ⭘ ⭘ 5. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill?
Either needs immediate evaluation of medication or needs a new prescription.

If you checked any of the above boxes YES, the child requires urgent referral to Mental Health. Please forward this form to the agency listed on reverse side of this form immediately. Please continue on reverse.

COMMENTS/ADDITIONAL INFORMATION:

YES NO Unknown RISK ASSESSMENT

O O O 1. This child has a history of the behaviors or experiences listed on the front page, "Identified Risk" section, that occurred more than 90 days ago. List:

O O O 2. Does the child have problems with social adjustment?
Regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; truant; steals; regularly lies; mute; confined due to serious law violations; does not seem to feel guilt after misbehavior, etc.

O O O 3. Does this child have problems making and maintaining healthy relationships?
Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.

O O O 4. Does this child have problems with personal care?
Eats or drinks substances that are not food; regularly enuretic during waking hours (subject to age of child); extremely poor personal hygiene.

O O O 5. Does this child have significant functional impairment?
No known history of developmental disorder, and behavior interferes with ability to learn at school; significantly delayed in language; "not socialized" and incapable of managing basic age appropriate skills; is selectively mute, etc.

O O O 6. Does this child have significant problems managing his/her feelings?
Severe temper tantrums; screams uncontrollably; cries inconsolably; significant and regular nightmares; withdrawn and uninvolved with others; whines or pouts excessively; regularly expresses the feeling that others are out to get him/her; worries excessively and preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; constantly restless or overactive; etc.

O O O 7. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication?
Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.

O O O 8. Is this child known to abuse alcohol and/or drugs?
Child regularly uses alcohol or drugs.

If any of the above boxes are checked "YES", the child needs to be referred to Mental Health to determine if an assessment or services are required. Please forward the form to:
(Could be preprinted to have the address of local Mental Health agency.)

COMMENTS/ADDITIONAL INFORMATION:

Mental Health Follow Up Response

Name: Date:

O MH Assessment complete; no follow up MH service required.

O MH Assessment complete; MH follow up required.

O Other:

Appendix VIII

A Nonprofit Organization Committed to Improving Outcomes by Improving Practice

Adopting a Child Welfare Practice Framework

Introduction

This paper on creating a practice framework is intended for child welfare professionals in leadership positions interested in grounding and reshaping frontline practice in a thoughtful, integrated model of practice. Its content was heavily influenced by the experience of The Child Welfare Policy and Practice Group (CWPPG), a nonprofit technical assistance organization with a lengthy history in directing and assisting in broad child welfare reform efforts. The CWPPG's experience in managing public child welfare systems, in conducting Qualitative Service Reviews (QSR) in fifteen states and in training caseworkers and coaching practice at the front line has affirmed the value that a coherent practice model can offer. Most significantly, our organizational interest in the issue stems from the experience of a number of senior staff and consultants as managers of the

Alabama child welfare system during implementation of the RC class action settlement and the CWPPG's role as consultant, curriculum developer and court monitor in Utah's David C. settlement. In both states, a practice framework or model (in Alabama it was a set of twenty-nine principles and fifteen statements of class member rights) became the foundation of the reform and contributed heavily to improved outcomes and ultimately exit from court oversight. Both practice frameworks are found in the Appendix.

What is a Practice Framework?

A logical place to begin a discussion about the adoption of a framework for practice is, "What is it?" Borrowing from dictionary and professional literature definitions, a practice framework (sometimes called a practice model) may be defined as:

Practice *– the values, principles, relationships, approaches and techniques used at the system and casework practitioner level to enable children and families to achieve the goals of safety, stability, permanency and well-being.*

Framework *– a structure to hold together or support something; an underlying set of ideas: a set of ideas, principles, agreements or rules that provides the basis or outline for something intended to be more fully developed at a later stage.*

Basically, a practice framework first outlines the values and principles that underlie an approach to working with children and families. For example, commonly chosen principles include concepts as broad as, *Children should be protected from abuse and neglect* and as discrete as, *children should be placed in the least restrictive, most normalized environment appropriate to their needs.* They may contain expectations based on a set of values but important enough to be described as rights such as, *Children have a right to be protected from inappropriate physical or chemical restraints, seclusion and timeout.* The core principles can establish a moral authority guiding expected practice.

A practice framework may also describe specific approaches and techniques considered fundamental to achieving desired outcomes. They may include "evidence based" approaches, promising practices and/or approaches believed to be effective through practice based experience. A principle embodying a specific approach might address expectations for the use of family conferencing as a routine practice such as, *Plans and decisions affecting children and families should be made in a meeting of the family team, including the family and its informal supports as well as relevant professionals.*

Some systems have incorporated explicit organizational principles in their practice framework, extending expectations beyond front-line practice to address issues such as agency leadership and management and/or relationships with the community.

The Primacy of Practice

The "product" available to at-risk children and families served by child welfare systems is essentially practice. Practice is delivered by public and private case managers, their supervisors and by a variety of social service providers. Caseworkers make up the majority of staff and whether in public agencies or contract agencies have the most contact and influence with children and their families. To some extent foster parents could be included in this category, as they also contribute significantly to shaping the lives of children in their care. Yet much of the attention of the field, especially at the policy and management level, is devoted to management processes, policy and regulation, information systems, documentation and procedural accountability. Beyond the investment in pre-service training and occasional in-service training session, in many systems little further attention is given to strengthening the ability of front-line staff to help families change.

The CWPPG examined its experience in training and coaching caseworkers and analyzing system performance through use of the QSR to identify the factors and conditions in child welfare interventions that facilitate improved outcomes. Aggregating QSR findings, across states in particular, reveals a correlation between certain aspects of practice and improving child and family status. These factors, some of which are also supported by results from promising practices, suggest core elements that should be a foundation for any practice model. Described simply, they are:

- Children and families are more likely to enter into a helping relationship when the worker or supporter has developed a trusting relationship with them. The quality of this relationship is essential to engaging the child and family in a process of change.

- Children and families are more likely to pursue a plan or course of action that they have a key role in designing.

- When children and families see that their strengths are recognized, respected and affirmed, they are more likely to rely on them as a foundation for taking the risks of change.

- Children experience trauma when they are separated from their families. When children must be removed to be protected, their trauma is lessened when they can remain in their own neighborhoods and maintain existing connections with families, schools, friends and other informal supports.

- Assessments that focus on underlying needs, as opposed to symptoms, provide the best guide to effective intervention and lasting change.

- Plans that are needs-based, rather than service driven, are more likely to produce safety, stability and permanency.

- The family's informal helping system and natural allies are central to supporting the family's capacity to change. Their involvement in the planning process provides sustaining supports over time.

- Decisions about child and family interventions are more relevant, comprehensive and effective when the family's team makes them. Families should always be core members of the team.

- Coordination of the activities of case contributors is essential and works most effectively and efficiently when it occurs in regular face-to-face meetings of the family team.

- Reunification occurs more rapidly and permanently when visiting between parents and children in custody is frequent and in the most normalized environment possible. Office based visits and supervised visits are the least normalized environment.

- Success in school is a reliable predictor of child well-being. When the direction of planning for safety, stability and permanency is fully integrated with school needs and plans, children are more likely to make progress in all of these areas.

- Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time.

- The service array should be sufficiently flexible to be adapted to the unique needs of each child and family. Services and supports best meet child and family needs when they are provided in the family's natural setting or for children in custody, the child's current placement. If services are limited to delivery in a particular place, children often have to move to receive them. Services should be flexible enough to be delivered where the child and family reside.

- Many of the services and resources that children and families find most accessible and responsive are those established in their own community, provided within their own neighborhoods and culture.

Fidelity to these principles in practice at the front-line can produce important gains for children and their families. The QSR provides an excellent opportunity to see the positive effects of principle-driven best practice. Examples from reviews may best illustrate how the application of such principles can shape improvements in practice, why these improvements matter and how outcomes are changed. The following excerpts from QSR written case stories provide that insight into the importance of engaging families, working

in a team environment and strength/needs based assessment and planning, three areas vital to any practice framework.

Child and Family Engagement

The reviewers see [the youth's] case as a successful Family Preservation case. The worker established a very positive relationship with [the youth] and his family through excellent engagement skills and genuine caring. It was evident that the DCFS worker "went to bat" for this family and an out-of-home placement and State custody were prevented. Mom's commitment to getting help for her son and keeping him at home have also been essential factors in the success of this case.

An excellent strength in this case is the good relationship between the caseworker and the family. It is apparent that the worker genuinely cares for this family, and the family respects and feels very comfortable with the worker.

The family stays in contact with the worker even though the case is closed, and this will likely continue for some time. [the youth] states that he just "drops in" at the office to say hello to his worker, which is very remarkable. Certainly the worker is to be commended for the high marks and positive feedback received from the family. There is no question that this relationship has had an impact upon the positive outcome of this case. In addition, the worker kept up with the progress of this family and adapted services according to their needs, which is also to be commended. Of special note is the fact that the caseworker applied for and received special grant money in order for [the youth] to continue in treatment with his therapist even though his case is now closed.

Child and Family Teaming

The team has worked closely together over the last four years to help stabilize [this youth] emotionally, to help him graduate from high school, to enroll in college, to prepare him to live on his own and to develop… long-term relationships for [the youth] to fall back on when needed. Team participation has been positive as the caseworker has timed his home visits with the visits from [the therapist] so that the majority of the team was meeting at least once each month. The youth, his foster parents, and his therapist all felt as if they had input to the service plan, and that they are a meaningful part of the child and family team. This frequent and coordinated contact contributed to positive scores in the areas of child and family participation, child and family team and coordination, child and family planning process, plan implementation, and effective results.

[the youth] does not realize it, but she is now the child and family team leader. She calls the time and place for the meetings and makes most of the participants aware of the time and place. A majority of the meetings are held at the mental health office, since she is heavily involved and invested in their services. [the youth] has a team of individuals

and array of services that have made a great difference in her life and that of [her child]. The Department's attorney stated that because of investment of DCFS in family preservation services this family has remained intact. She stated that several years ago this same case would have been an out-of-home episode. [the youth] has a blatant distrust for the legal system in her life, but sees her DCFS caseworker as more of a trusted friend than as an agency representative.

Assessment and Planning

This family had nothing but praise for the caseworker, the division and all other parties affiliated with this case. The parents both state that the service plan is something that they feel they wrote. Both stated that the caseworker heard them and their needs and incorporated them into the service plan. They are happy with the team meetings and the accomplishments that take place in those meetings. They know that the meetings are their meetings and not the Division's.

The child and family assessment completed by the team has information from a number of sources and incorporates the family's strengths and needs. The Child and Family Service Plan has been developed from the information from the assessment. The reviewers were impressed with the individualization of the plan. For example, for each objective the caseworker not only included the typical information such as "[the youth] needs to be in a safe, stable, and structured environment that will provide him with his basic needs." but it goes on to include "He needs to have a level of structure and supervision to aid in controlling his behavior." This information came directly from the RTC therapist who indicated to us during our interview with him that [the youth] feels the most comfortable when there is a high degree of structure in his daily life. When the team met with the school prior to [the youth] returning they spent time selecting the teacher with the best combination of nurturing and structure for him so that he could succeed. This was a great example of using the information from the Child and Family Assessment, incorporating it into the CF plan and then making it happen in [the youth's] life. The plan also includes a great analysis of the family and [the youth's] strengths, desired results and steps to meet the needs for each objective. The work is detailed and draws from the assessments, both internal and external. Long term view scored very high on this case because there is a well written statement of the long term view for this case. The team members all understand and agree with it. The major transitions for this child and family have been identified and carefully planned for.

Assuming that these principles are valid as predictors of improved performance and outcomes, the challenge becomes how systems might produce practice that effectively reflects these principles.

Changing Practice

Teaching caseworkers to practice consistent with principles such as those above requires a major organizational commitment. First, the system has to decide if it wants to use its usually limited training capacity to teach practice instead of policy. Policy content often crowds out real skill development in pre-service training, meaning workers have learned more about the environment in which they work but little about how to succeed in it. Much conventional child welfare training is topical, with modules addressing issues like investigations, substance abuse, permanency plans and transitions to adult living, lacking an integrated approach to practice.

The two systems that have most intensely focused on practice as the core of reform efforts, Utah and Alabama, organized their training functionally, not topically. Pre-service training follows the process of working with families: engagement/building trusting relationships, team formation and facilitation, assessment, planning and intervention. Each module builds on the others and develops fundamental skills in the five functional areas referenced. A major portion of training is devoted to exploring personal values as a foundation for understanding families. A portion of this values exploration facilitates the reframing of harmful or unproductive family behaviors in the context of history, strengths, stresses and positive intentions. This process helps diminish the differences workers may feel between themselves and families and anchor skills in a set of beliefs about why strength-based approaches work.[1]

The training curriculum should be based on the principles of the practice framework and reflect a learning design that delivers the following:

- Information – Trainers provide content that informs participants about the policy, practice and legal environment in which they work, the basis for interventions, the circumstances and conditions of the families and children served and their role in meeting child and family needs.
- Modeling – Trainers demonstrate the skills workers are expected to acquire.
- Practice – Participants practice the skills supported by trainer coaching and mentoring.
- Feedback – Participants receive feedback on their performance and guidance regarding areas of strength and those needing additional attention.

Both systems used the training to develop all staff, not just staff newly hired. The system also required that supervisors were trained before experienced staff in their units. Retraining existing staff is essential to insuring that new skills and approaches are accepted

[1] *In service to full disclosure, The Child Welfare Group staff were heavily involved is helping shape the Alabama curriculum and for developing the Utah curriculum.*

and adopted by seasoned workers. Developing supervisory mentoring capacity is vital to assuring sustainability.

Training was also followed by coaching by trained practice experts, who could model the new skills and approaches and mentor workers as they developed competency. The coaches also helped develop the skills of supervisors to permit them to lead the coaching effort with the larger workforce. Coaching is a vital and essential element of successful practice change.

Why is a Practice Framework Necessary?

Many systems operate without a formal explicit practice framework. However, most have created at least a statement of mission, which may include core values and at least a general set of guiding principles, such as being family-focused or strength-based. General statements of values like these are useful in expressing general practice themes and suggesting a desired approach to work with children and their families. However, they aren't specific enough to guide the creation of policy, training or other practice supports and offer little guidance to the practitioner at the front-line about how they are to be operationalized. As a result, there can be substantial discontinuity between stated values and actual practice.

An argument for creating a practice framework may be most convincingly found in examining the advantages gained by working within explicit principle driven underpinnings.

A Practice Framework Can Provide a Moral Authority for Practice An effective practice framework provides staff with a moral imperative for practice that goes beyond compliance with policy and rules. When internalized, such practices are more likely to be sustained over time and more likely to be applied consistently. As mentioned previously, some practice frameworks elevate certain principles to rights. A common example is c*hildren should be protected from inappropriate use of medication, seclusion, chemical and physical restraints and time out.* Making this principle an explicit practice boundary, operationalized in standards, training and provider oversight enables practitioners to approach practice based on what is best for children and their families, not just because rules require it.

A Practice Framework Can Force Attention to How Children and Families Should Experience the System When practice frameworks are detailed enough to permit comparison of the principles to actual policy and practice, a constructive tension is produced that can lead to important changes in the approach to practice. For example, in the Alabama RC litigation one of the principles of the settlement (which formed an extensive framework guiding the implementation plan) had a major impact on the approach to service delivery. The settlement included the following principle: *Class members and their families shall receive individualized services based on their unique strengths and needs…The type and mix of services provided shall not be dictated by what is available…Services must be adapted to class members and their families.*

This principle, in conjunction with the principle that children and families should be treated as partners in planning, made it evident that the conventional service array of parenting classes and counseling did not respond to the unique strengths and needs of the families served. To respond to this principle, providers had to diversify their service array and flexible dollars had to be made available to workers at the front-line. Both objectives became a major part of the resource development effort and contributed significantly to the successes of the reform.

A Practice Framework Can Promote Consistency in Approaches Across the Organization In all systems, practice approaches are influenced by emerging trends and evidence, reactions to crises, legislative mandates and the experience and priorities of those in leadership positions. These changes often overlie, rather than replace existing practices, resulting in a patchwork of policies and approaches that do not share an underlying vision. For example, a system engaging in a change process to implement more strength-based, family-centered practice might find itself continuing to use a Child Protective Services (CPS) risk assessment instrument that is largely deficit focused, creating two conflicting cultures of practice. When applied in comparison to current practice, use of a practice framework would help expose such incongruities and foster greater consistency in approach.

Perhaps most importantly, a practice framework can enhance consistency of performance among staff at the front-line. Without the support of an integrated, cohesive and principle driven framework of practice, implemented through clear policy, effective training and accountability, systems are vulnerable to practice overly dependent on individual values and approach. When staff internalize the principles of practice and are enabled to become competent in applying them in their casework, greater uniformity of action occurs.

A Practice Framework Guides the Content of Policy While the impact of a practice model on policy seems obvious, its reach can be surprising. In a system responding to a practice model principle about the rights of children in out-of-home care to have regular contact with their families, implementation of policy to support the principle had a broad impact on foster parents and residential providers. As part of new policy, children in foster care were given the right to communicate by phone or mail with their parents, a change that initially alarmed foster caregivers about disclosing their location to parents (most of whom already knew where their children were).

Once implemented with training supports and even compensation for the cost of long-distance calls offered, experience revealed that policy safeguards protected those caregivers where there were legitimate safety concerns and that the change was not disruptive to daily life. To the surprise of caregivers, children were generally less disruptive when they could have regular, normalized contact with their family.

Other systems have found that their SACWIS case plan templates prevent the translation of strength and needs based individualized plans into the information system format, undermining the potential of well-crafted child and family plans to achieve needed outcomes. As a result, a number of states have revised their planning format to make them more flexible.

A Practice Framework Informs the Design of Training A well-developed practice framework provides a useful tool by which current training can be assessed for conformity with the system's approach and goals and also will identify new knowledge, skills and abilities that should to be included in new or revised training. Examples include principles such as p*lans and decisions about families shall be created within a child and family team,* which would necessitate training in preparing families to shape and participate in a team and in facilitating family meetings. Another example is a principle mentioned earlier related to resource design and development, c*lass members and their families shall receive individualized services based on their unique strengths and needs*. For a system operating on a service driven approach to practice, meaning reliance on a common categorical array of supports provided to most families, shifting to a strengths and needs based approach to practice has significant implications for training redesign. Learning to build on functional family strengths, distinguishing services from needs and individualizing the response to family need requires a very different set of skills that must be supported by policy, training and coaching.

A Practice Model Can Shape the Design of the Quality Assurance Process Quality assurance systems often mirror the same inconsistencies and incongruities with a functional practice framework as may be found in training and policy. One of the best examples of the effect of a practice framework on Quality Assurance (QA) is found in Utah.

As a result of a class action settlement in the 1990's, the system adopted an extensive case process review approach that included annual case record reviews of a statistically valid sample size that addressed 180 different items in the settlement agreement. Needless to say, the Alabama Department was unable to even document, not to mention comply with, so many requirements and actions, all of which were treated as if they had the same priority.

After being ordered to essentially start over with a new enforceable implementation plan, The Child Welfare Group helped the system develop a practice model, redesign it's training and implement a new QA system that reduced the case process review items to 46, initiated annual regional QSR's (which assessed practice consistent with the core practice principles) and produced regular outcome reports. These changes not only measurably strengthened practice and outcomes but also aided in the exit of the system from court supervision in 2007.

A Practice Framework Can Reshape Employee Performance Expectations **As expectations for the treatment of children and their families change, so should the formal expectations for practitioner performance. Utah is a state that translated its practice framework into written staff performance expectations. The following expectations, influenced by the Utah practice framework principles related to child and family engagement, are cited below:**

- Effectively uses engagement skills that include active listening. Provides options, guidance, suggestions and effective feedback across the three stages of exploring, focusing and directing.

- Understands the dynamics of the family within the context of their own family rules, traditions, history and culture. Is sensitive to these differences and incorporates them into the "big picture" as decisions are made.

- Understands the role of the caseworker to the family system.

- Effectively works with each family's resistance as they move through the change process.

- Effectively utilizes the assessment process to develop a working functional assessment, which is modified over time and as the family changes.

- The employee will treat staff, children and their families and others with respect, dignity and fairness at all times regardless of position, assignment, training or circumstance. Consideration will be given to the cultural context as decisions are made.

A Practice Model Can Help Shape the Organizational Design Organizational designs, like practice, are heavily influenced by past structures, convenience and trends in organizational development. For example the business model of "flatter", less hierarchical organizational structures may be seen in some government organizations. Yet rarely do child welfare systems model their organizational structures on the needs of children and their families or in many cases, practitioners at the front-line. With organizational implications in mind, a thoughtful review of a practice framework can identify opportunities to strengthen the organization through its design.

One system that followed its practice model faithfully turned its attention to the different philosophies of its three primary (separate) policy offices: CPS, foster care and adoption. These three units were known for their distinct perspective about families. The CPS office had a strong deficit focus in its work and strong alliances to law enforcement and prosecution partners. The foster care office was extremely compliance driven, influenced by federal regulatory requirements, lawsuits and liability concerns in ways that at times seemed to have priority over the experience of the children in care. And the adoption office was considered elitist and solely child-focused. In practice, they tended to promote conflicting goals, with CPS issuing policy that fostered an over reliance on removal as a safety mechanism, foster care disproportionately addressing maintenance rather than permanency and adoption, undermining reunification and kinship settings as options.

In support of a more strength-based and family-centered model of practice, the organization combined the policy offices into a single unit, which would be driven by all the practice principles and less programmatic in its support of children and families. Another system created a resource development office to provide support and technical assistance to county offices working to strengthen and diversify their service array. A third moved the training office, which had been buried under the human resources office, to a status of prominence within the program division to maximize its influence on front line practice.

Early Versions of Practice Frameworks

While the concept of a principle driven practice framework is new to many in the field, versions of practice frameworks date back to the System of Care movement in mental health and the development of Wraparound approaches. Examples from these two approaches are included below.

Children's Mental Health System of Care Practice Model

Core Values

1. The system of care should be child-centered and family-focused with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the focus of services as well as management and decision-making responsibility resting at the community level.

3. The system of care should be culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

Guiding Principles

- Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social and educational needs.

- Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

- Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

- The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.

- Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordination of services.

- Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

- Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

- Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.

- The rights of children with emotional disturbances should be protected and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.

- Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics and

services should be sensitive and responsive to cultural differences and special needs.[2]

Wraparound Principles

Wraparound literature provides a description of the wraparound approach, which includes the following principles.

Ten Principles of the Wraparound Process

1. **Family Voice and Choice** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives and the team strives to provide options and choices such that the plan reflects family values and preferences.

2. **Team Based** The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal and community support and service relationships.

3. **Natural Supports** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

4. **Collaboration** Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates and resources. The plan guides and coordinates each team member's work toward meeting the team's goals.

5. **Community-based** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible

[2] *From Stroul, B. & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbance (rev. ed., p. 17). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.*

and least restrictive settings possible; and that safely promote child and family integration into home and community life.

6. **Culturally Competent** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture and identity of the child/youth and family and their community.

7. **Individualized** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

8. **Strengths Based** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

9. **Persistence** Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.

10. **Outcome Based** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.[3]

Both the System of Care and Wraparound models provide a simple and clear description of an approach to practice that is easily understood by the field and offer guidance about practice that is specific enough to operationalize. The System of Care model has a greater system focus and the Wraparound principles are more focused in front-line practice. The principles inherent in these approaches have produced enough success in their application that they are often found at the core of more recent, comprehensive frameworks for practice. They are now generally considered best practice.

The Essential Elements of a Practice Framework

Practice frameworks currently vary in their scope, from those focused mostly on practice principles to those that also include an organizational focus. Based on organizational experience in working from a practice framework and assisting states in designing and implementing their own, the following principles are recommended as core elements for system practice frameworks. They are also the framework adopted by CWPPG.

What Are Our Goals for Children and Families?

[3] *Walker, J.S., Bruns, E.J., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.*

Goals

1. To protect children from abuse and neglect.

2. To provide children with stability and timely permanency in their lives.

3. To permit children to live with their own families, when possible, through the provision of services that strengthen families.

4. To enable children to achieve success in school and become stable, gainfully employed adults.

Practice Principles

The following principles of practice are the standards to which systems should hold themselves and its service providers accountable. They represent the ambitions of best practice and the belief that children served by the system have a right to the same protection and supports that any parents would expect for their children. The principles of practice set a standard that the system is intent on achieving. The practice principles should be the foundation for improvements in practice, system supports, design of the resource array and accountability.

These principles should be the governing influence for shaping policy design, staff training, resource development and service contract design, supervisory role and accountability, quality assurance and outcome evaluation. The process of designing strategies that effectively implement these principles requires the experience and contributions of all the system's partners: families, staff, the court, providers and communities.

I. General Principles

Children should live with their families. Exceptions should be made only when it is not possible through the provision of services (including intensive home-based services), to protect a child living with his/her family from harm or to protect a child from harm upon reunification with his/her family.

The most natural and effective way of helping children to achieve safety, permanency and well-being is usually by strengthening the capacity and skills of their own families.

The system's efforts to assist children to achieve permanency should be conducted with the

urgency appropriate to a child's sense of time.

The response to children and families shall not discriminate based on race, sex, religion ethnicity, national origin or sexual preference.
Children should have freedom from excessive medication, unnecessary seclusion and restraint.

II. Principles Relating to Resource Allocation and Service Design

Neighborhood and community resources and institutions should be treated as key partners in serving children and families, both in planning for individual families and as a partner in system design and operations.

Children and their families should have access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families or to achieve timely permanency.

Services should be flexible and adapted to child and family needs. Children and families should not be expected to adapt to ineffective services.

To enable children to live safely with their families, vigorous early intervention services should be offered to families-at-risk before the risk rises to a level necessitating involuntary intervention.

The system should be sensitive to cultural differences and the special needs of minority ethnic and racial groups. Services should be provided in a manner that respects these differences and attends to these special needs. These differences and special needs should not be used as an excuse for failing to provide services.

III. Principles Related to Assessment, Planning and Intervention

Services to children and their families should be planned and delivered through an individualized service plan crafted by the child and family team. Children, their parents, the family's informal support network, caregivers and foster parents should be full participants on this team. Involvement should include regular participation in family team meetings as a point for engagement, assessment, planning intervention and assessment of progress.

Children, parents and foster parents should be accurately and timely informed, in language understandable to them, of their rights, the goal for the child/family and their individualized service plans.

Children and their families should receive individualized services based on their unique strengths and needs. Children and parents should be encouraged and assisted to articulate their own strengths and needs, the goals they are seeking for themselves and what services they think are required to meet these goals.

The assessment process should address the underlying conditions creating the challenges experienced by the child and family, not just the symptoms of functioning. The system's assessment should be developed with the suggestions and contributions of the full family team.

The mix of services provided should be responsive to the strengths and needs of the child and his/her family. Conceptualizing the needs-based plan should not be constrained by the availability of services. Where needed services are unavailable, appropriate services should be created.

The system should ensure that the services identified in individualized service plans are timely, accessible and responsive to children and families and delivered in a coordinated and therapeutic manner that integrates the efforts of the contributors.

The system should carefully monitor implementation of the individualized service plan and the progress being made toward the goal and objectives of the plan.

The goal and the objectives of the individualized service plan should be updated as needed. Services identified in the plan should be modified as needed to meet the goal and objectives of the plan (for example, by adding new services or providing services in a different way).

IV. Principles Relating to the System's Response to Alleged Child Abuse or Neglect

The system should respond promptly to reports of abuse and neglect.

The response to reports of abuse and neglect and requests for assistance should be met with an offer of help.

Where children are found to be unsafe, immediate safety (protection) plans should be implemented.

V. Principles Relating to Children Who Must be Placed in Foster Care

When children cannot live safely with their families, the first considerations for placement should be with kinship connections capable of offering and demonstrating the resource of a safe, stable and appropriate home.

Siblings should be placed together. The system should develop a policy identifying circumstances in which exceptions to this principle may be permitted.

Children should be placed in their own communities, where they can maintain relationships with family and friends and continue to attend the same school they were in prior to placement.

Placements should be made in the least restrictive, most normalized setting responsive to the child's needs.

The system should avoid temporary, interim placements. Children should be placed in settings that could reasonably be expected to deliver long-term care if necessary. To this end, the use of congregate shelter placements should be avoided in favor of family based settings. The system should not place children younger than six in congregate settings unless it is necessary to maintain connections with siblings placed in the same setting. When shelter is used, the placement should be short-term.

Children should receive prompt and appropriate attention to their health care needs.

The system should vigorously seek to assure that children, when in foster care or custody, are integrated to the maximum extent feasible into normalized school settings and activities and achieve success in school.

The matter of visiting, both between children in care and their parents and among siblings, should be addressed in the child's individualized service plan. The frequency and circumstances of visiting should depend on age and need. Visiting should be viewed as an essential ingredient of family reunification services. Hence, when the goal is for the child to return home or live with a family member, visiting should be actively encouraged. Visiting plans that require agency oversight or participation should take into account the work, education and obligations on the part of the parents. After hours and weekend visits should be options to permit parents to meet necessary obligations. Visiting may be arranged by the child, the child's parents or family, or the foster parents, as well as by staff and the staff of residential facilities, in accordance with the individualized service plan.

Supervision of visiting should be required only when there is a danger that the parent or family member with whom the child is visiting will harm the child unless the visit is supervised.

The system should forbid summary discharges of children from placement. The system should develop a policy that describes steps that should be taken prior to a child's discharge from a placement. The system should be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the child.

VI. Principles Related to Transitions from Care to Reunification or Independence

Families whose children are reunified should receive ongoing supports that will enable them to safely sustain their children in their homes.

Youth in custody who are expected to remain in care until adulthood should receive a full array of preparatory supports for independent living, addressing educational, emotional, relationship and vocational development.

The system should promote smooth transitions for children to adult service. Planning for youth in custody who will reach adulthood without permanence should connect them with caring adults, both relatives and other resources, whom they can turn to for help after system supports are no longer available.

VII. Principles Related to Effective Collaboration with Other Service Systems

Communication and interaction with the court should reflect timeliness, preparation, knowledge, respect and accuracy.

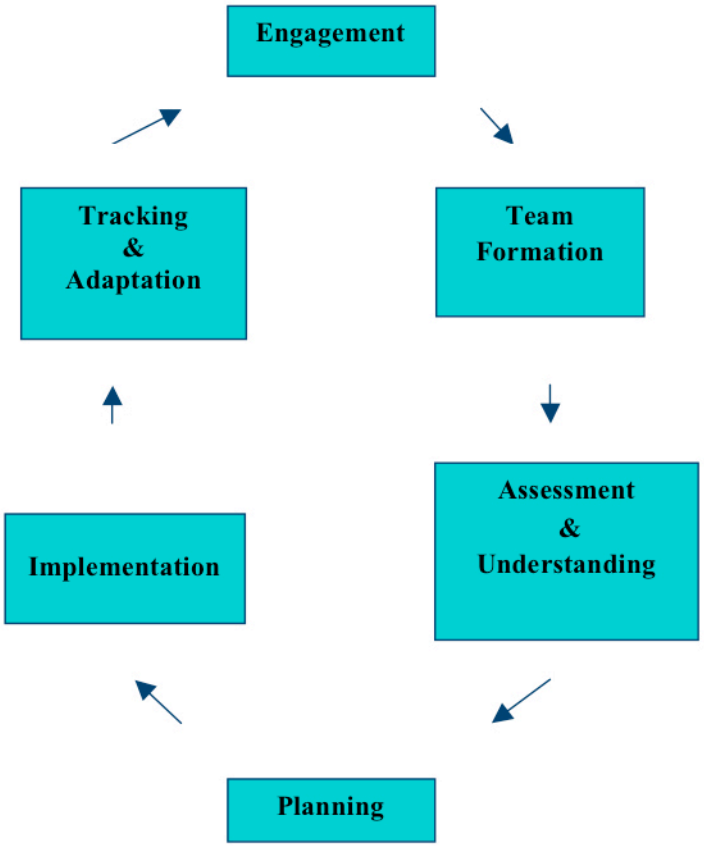
The system should take an active role in seeking to ensure that local education agencies (i) recognize children's educational rights and (ii) provide children with educational services in

accord with those rights. [4]

Communicating the Practice Framework to the Field

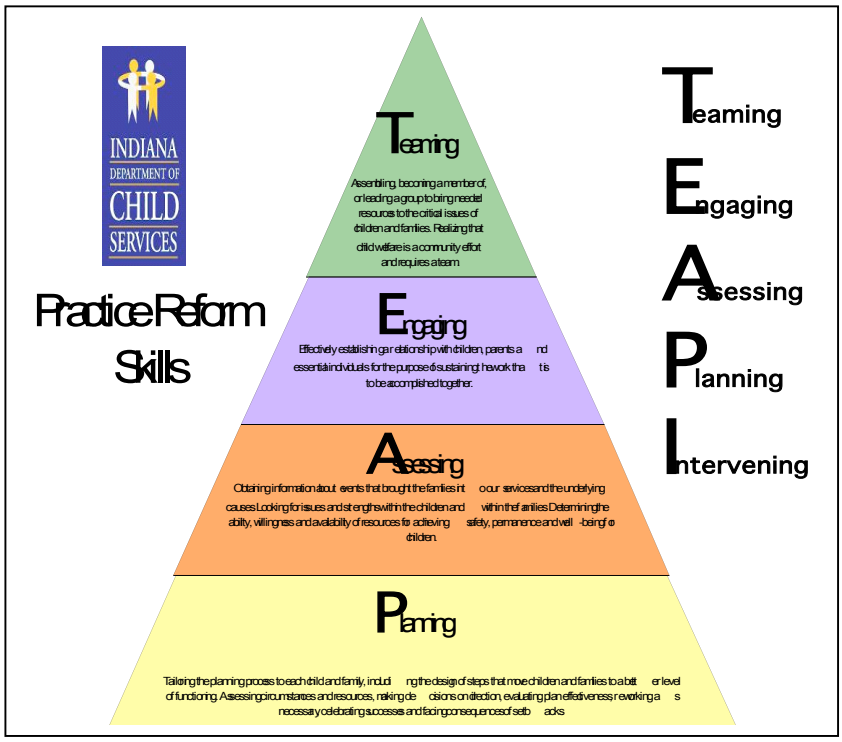
One colleague remarked that for use in the field, a practice framework should be brief enough that you could print it on a napkin. While meant in jest, the advice does capture the need to have a concise practice framework message that has concrete meaning to practitioners. Such shorthand has been used effectively by several systems to express the central approaches within the chosen framework. One used by CWPPG and Tennessee's DCS is the "Practice Wheel". Within this framework, practice is conceptualized as a process continuously involving engagement, teaming, assessment, planning, intervention and tracking. Core training is organized within these themes and the QSR is used to measure conformity and fidelity to them.

Visually, the Practice Wheel appears as:



[4] *Practice Framework Principles document developed by Paul Vincent, CWPPG and Steven D. Cohen, The Annie E. Casey Foundation.*

In Indiana, another state where CWPPG has provided technical assistance, the simple visual of a pyramid called the Teaming, Engaging, Assessing, Planning and Intervening (TEAPI) serves the same purpose. It includes the same elements, listing teaming, engaging, assessment, planning and intervening. Like Tennessee, their training is organized along the same themes and their QSR process attends to these core elements. The TEAPI symbol is conceptualized as follows:



In both systems, staff increasingly knows what these symbols mean, recognize and understand their priority and are trained to employ them accordingly.

The Role of Leadership in Using a Practice Framework

Like any change strategy, the effectiveness of a practice framework is dependent on the priority given it by system leadership. For a practice framework to realize its potential to change practice, it should be seen as an overarching mandate at the state and local management level as well by front-line staff. Leaders that have successfully employed their practice framework to drive reform demonstrate its influence in their own management decisions, monitor its use and hold staff accountable for its application. In addition, they regularly assess its impact on outcomes for children and their families.

The payoff, where systems have fully committed to converting to practice consistent with their framework, has been greater unity of effort, more thoughtful and effective decisions about change strategies and most important, improving outcomes for children and families.

This paper benefitted from the thoughtful input of Child Welfare Group staff and consultants as well as Steve Cohen and Jessie Waldrous of the Annie E. Casey Foundation.

APPENDIX

ALABAMA R. C. CONSENT DECREE GOALS AND PRINCIPLES

The consent decree spells out as the goals of the new system of care, to:

1. Protect class members from abuse and neglect; and

2. Enable class members to:

    - Live with their families; and when that cannot be achieved through the provision of services, to live near their home;

    - Achieve stability and permanency in their living situation;

    - Achieve success in school; and become stable, gainfully employed adults.

To achieve these goals, the new system of care is expected to operate according to the following principles:

1. **Class members shall live with their families.** Exceptions are to be made only when:

    - It is not possible, through the provision of services (including intensive home-based services), to protect a class member living with his/her family from imminent, serious harm; or

    - It is not possible, though the provision of services, including intensive home-based services, to protect a class member from serious harm upon reunification with his/her family.

2. **Class members and their families shall have access to a comprehensive array of services, including intensive home-based services, designed to enable class members to live with their families.**

    These services should be designed to enhance the natural support networks of class members and their families. Other services to which class members and their families shall have access, if required to enable class members to live with their families, are: parenting skills and household management training; peer support; homemaker services; day care; respite care; help with housing; crisis services; mental health services; services for substance abuse; and "facilitative" services. Class members and their families shall have access to such services when the class member is living with his/her family or when the goal is for the class member to return home or live with a relative. When the goal is for the class member to return home, services should also be

provided to the parents to prepare and enable them to care for the class member when he/she returns home.

When the goal is for the class member to live with a family member, services should also be provided to the family member to prepare and enable the family member to care for the class member.

3. **Class members, while in foster care or DHR custody, shall have access to a comprehensive array of services that address their physical, emotional, social and educational needs.**

4. **Both class members and family members may refuse placement-prevention services.**

   Class members and family members may refuse other services, to the extent permitted under law.

5. **Class members and their families shall be encouraged and supported to access services.**

   To this end, the "system of care" shall develop and implement strategies to promote the utilization of services by class members and their families. These strategies shall include the use of community aides, the provision of transportation services, the development of ethnically and culturally sensitive services and referral to peer support groups. When class members or their families refuse or fail to access services the reasons for their doing so shall be assessed and the services that have been offered shall be modified or alternative services shall be offered to encourage acceptance of services.

6. **Class members and their families shall receive individualized services based on their unique strengths and needs.**

   The strengths and needs of the class member and his/her family shall dictate the type and mix of services provided; the type and mix of services provided shall not be dictated by what services are available. Services must be adapted to class members and their families; class members and their families must not be required to adapt to inflexible, pre-existing services that are unlikely to be effective.

7. **Services to class members and their families shall be delivered pursuant to an individualized service plan.**

   There must be a reasonable prospect that the services provided will achieve their purpose. The services must be of a type and mix likely to achieve the goal for the child. The services must also be of a type and mix likely to be effective in meeting the needs to which the plan is designed to respond.

   a. Individualized service plans shall be based on a comprehensive, individualized assessment of the strengths and needs of the class member and his/her family. In the case of class members

in foster care or DHR custody, this assessment shall include an examination of the class member's (i) developmental, behavioral, emotional, family, and educational history and (ii) strengths and weaknesses in behavioral, emotional, educational and medical/physical areas.

b. Individualized service plans shall include specific services to reinforce the strengths and meet the needs of the class member and his/her family. Each plan shall identify the specific steps to be taken by DHR staff, other service providers, class members and the class members' parents and family toward meeting the short-term and long-term objectives of the plan.

c. The "system of care" shall carefully monitor implementation of the individualized service plan and the progress being made toward the goal and objectives of the plan.

d. The goal and the objectives of the individualized service plan will be updated as needed. Services identified in the plan will be modified as needed to meet the goal and objectives of the plan (for example, by adding new services or providing services in a different way). Steps shall be taken to prevent and address deterioration in the functioning of class members.

8. The "system of care" shall address the needs of class members believed to be victims of sexual abuse.

a. Timely, professional assessments shall be conducted of class members believed to be victims of sexual abuse. DHR shall ensure that such assessments provide clear, prescriptive guidelines for treatment of the sexual abuse.

b. The individualized service plans of class members believed to be victims of sexual abuse shall specifically identify both the class member's needs as a sex abuse victim and services to be provided in response to those needs.

9. Class members, parents and foster parents shall be accurately and timely informed, in language understandable to them, concerning: rights under the decree (including the right to be treated in accordance with the "principles" or "standards"); the goal for the class member; individualized service plans, including objectives; services, including placements; and options.

10. Class members, parents, and foster parents shall be encouraged and assisted to articulate their own strengths and needs, the goals they are seeking for themselves and what services they think are required to meet these goals.

11. Class members, their parents and foster parents shall be involved in the planning and delivery of services.

This includes the ISP. The right of class members, parents and foster parents to participate in treatment planning and delivery may be restricted only according to a specified administrative process.

DHR shall promulgate a policy, acceptable to both parties, describing under what circumstances and according to what procedures restrictions may be imposed.

a. The class member shall be treated as a partner in the planning and delivery of services if the class member is age 10 or older and, if the class member is under the age of 10, when possible.

b. The class member's parents shall be treated as partners in the planning and delivery of services if the class member is living at home or if the goal is for the class member to return home.

c. Foster parents shall be treated as partners in the planning and delivery of services whether or not the goal for the class member is to return home.

d. When necessary, services shall be provided class members and parents to enable them to participate as partners. Such services shall include transportation assistance, advance discussions and assistance with understanding written materials.

12. The "system of care" shall promote class members' visitation with their parents and family.

a. The matter of visitation shall be addressed in the class member's individualized service plan. The frequency and circumstances of visitation shall depend on age and need. Visitation shall be viewed as an essential ingredient of family reunification services. Hence, when the goal is for the child to return home or live with a family member, visitation will be actively encouraged; assistance with transportation will also be provided.

b. Visitation may be arranged by the class member, the class member's parents or family or the foster parents, as well as by DHR staff and the staff of residential facilities, in accordance with the individualized service plan.

c. Supervision of visitation shall be required only when there is a danger that the parent or family member with whom the class member is visiting will harm the class member unless the visit is supervised. 'When supervision of visitation is required, such supervision may be provided, as appropriate, by the class member's foster parents, as well as by DHR staff, the staff of residential facilities or other designated persons.

13. The "system of care" shall be sensitive to cultural differences and the special needs of minority ethnic and racial groups.

Services shall be provided in a manner that respects these differences and attends to these special needs. These differences and special needs shall not be used as an excuse for failing to provide services.

14. The "system of care" shall conduct timely investigations of allegations that class members are being abused or neglected while living at home or with a relative or while in foster care or DHR custody.

15. The "system of care" shall embrace the philosophy of service delivery in home-based and community-based settings.

Class members shall receive services in the least restrictive, most normalized environment that is appropriate to their strengths and needs.

a. Class members shall be placed in the least restrictive; most normalized living conditions appropriate to their strengths and needs. The class member's own home shall be considered the least restrictive, most normal placement. Following are other placements listed in ascending order in terms of restrictiveness: independent living; a foster home; a therapeutic foster home; a group foster home; a group home; a child care institution; an institution. Institutional care shall be used only in an emergency and as a last resort. Class members shall be placed in family settings, whenever they can be cared for in such a setting with supportive services.

b. Siblings shall be placed together. DHR may promulgate a policy, acceptable to both parties, identifying circumstances in which exceptions to this principle may be permitted.

c. The "system of care" shall not initiate or consent to the placement of a class member in an institution or other facility operated by DMH/MR or by DYS unless the placement is the least restrictive, most normalized placement appropriate to the strengths and needs of the class member.

d. Class members, when in foster care or DHR custody, shall be integrated to the maximum extent feasible into normalized leisure and work activities.

e. DHR shall vigorously seek to assure that class members, when in foster care or DHR custody, are integrated to the maximum extent feasible into normalized school settings and activities.

16. Class members from Jefferson, Mobile, Montgomery, Madison, Houston, Tuscaloosa, Etowah, Calhoun, Walker, Lee and Dallas counties shall be placed within their home county when removed from their homes.

Class members from other counties shall be placed within the region in which their home county is located. Exceptions to this principle are to be permitted only in exceptional circumstances with the written permission of the Director of the Division of Family and Children's Services or his/her designee.

DHR shall promulgate a policy, acceptable to both parties, that describes when such exceptional circumstances are present.

17. The "system of care" shall promote permanency in class members' living situations.

a. When the goal is that the class member shall return home or be discharged to a family member, the "system of care" shall vigorously seek to achieve this goal.

b. When the goal of return home or discharge to family has been achieved, the

"system of care" shall vigorously seek to avoid reentry of the class member into foster care.

c. The "system of care" shall make timely, competent decisions concerning whether and when class members should return home.

d. When a decision is made that a class member should not return home, DHR shall seek a timely dispositional hearing.

e. When the goal is that the class member not return home, the "system of care" shall vigorously seek a permanent living situation for the class member.

18. The "system of care" shall promote stability in class members' living situations.

a. The "system of care" shall be designed to minimize multiple placements. The "system of care" shall be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the class member.

b. Individualized service plans shall identify whether a class member is at risk of experiencing a placement disruption and, if so, will identify the steps to be taken to minimize or eliminate the risk.

c. Appropriate training will be required for, and appropriate supportive services will be provided to, foster parents and staff of residential facilities in order to minimize placement disruptions. In the case of foster parents, the services shall include intensive home-based services and respite care.

d. The "system of care" shall forbid summary discharges from placements. DHR shall promulgate a policy, acceptable to both parties, that describes steps that must be taken prior to a class member's discharge from a placement. The policy may permit in exceptional circumstances the placement of a class member in a temporary, emergency setting without prior notice to DHR.

e. The "system of care" will avoid temporary, interim placements. Class members shall be placed in settings that could reasonably be expected to deliver long-term care if necessary. To this end, DHR will not place class members in shelters unless (i) the full array of services the class member needs can be provided the class member while residing in the shelter and (ii) it is likely that the class member's stay in foster care will not extend beyond his/her stay in the shelter.

f. The "system of care" will vigorously seek to ensure that law enforcement officers, juvenile court personnel and others do not remove class members from their home and place them in foster care or DHR custody without first notifying the "system of care" and providing the system an opportunity to intervene to prevent the removal or placement.

19. The "system of care" shall ensure that the services identified in individualized service plans are accessed and delivered in a coordinated and therapeutic manner.

20. Services shall be provided by competent staff who are adequately trained and supervised and who have appropriate caseloads.

The competence of staff training and supervision, and staff's caseloads shall be deemed adequate when the "system of care" is able to comply with the standards set forth in this decree.

21. Services provided to class members and their families, shall meet relevant professional standards in the fields of child welfare, social work and mental health.

22. The "system of care" shall require that any behavior modification program employed in the treatment or management of a class member be individualized and meet generally accepted professional standards, including that:

a. The program relies primarily on rewards instead of punishments;

b. The program be based on a careful assessment of the antecedents of the behavior that the program is designed to change; and

c. The program is consistently implemented throughout the day, including in school, residential and leisure activity settings.

d. The "system of care" shall take an active role in seeking to ensure that local education agencies and the Alabama Department of Education (i) recognize class members' educational rights and (ii) provide class members with educational services in accord with those rights. Among other things, the "system of care" shall advocate for class members who are subjected to inappropriate and/or illegal disciplinary measures.

23. The "system of care" shall promote smooth transitions for class members to adult service systems and/or independent living when class members "age out" of the system.

The individualized service plans of class members who are expected to "age out" of the system shall provide for such transitions.

24. The "system of care" shall accord class members the following rights: the right of access to counsel and the courts, the right of access to family members, the right to be free of excessive medication and the right to be free from unnecessary seclusion and restraint.

DHR shall promulgate policies, acceptable to parties, describing and protecting these rights. The policies shall provide that:

a. Class members shall be permitted to freely communicate by telephone or mail with (i) legal counsel of the class member's choosing, including the class member's guardian ad litem and (ii) organizations that provide legal services.

b. Class members shall be permitted to freely communicate by telephone or mail with (i) the class member's parents and family members and (ii) adult friends of the class member including former foster parents. This right may be restricted only pursuant

to procedures and in circumstances specifically identified in written policy.

c. Class members retain the right to communicate and visit with their parents and family even when the class member is in the permanent custody of DHR (i.e., parental rights have been terminated). When the class member is in permanent custody, the matter of his/her communication with parents and family members shall be addressed in the class member's individualized service plan. Such communication may be restricted when it would undermine or defeat attainment of the goal or objectives identified in the plan.

25. Class members, parents and foster parents shall be made aware, in an effective manner, of the availability of advocacy services to assist them in protecting and advancing their rights and entitlements.

26. Class members shall be provided effective assistance and support in applying for SSI benefits. (Where it is necessary that the class member's parents apply for benefits, such assistance and support shall be provided to the parents.)

27. Class members shall be enrolled, if eligible, in the EPSDT program and shall receive comprehensive screens that meet the requirements of federal law and are provided according to a professionally acceptable schedule.

28. The "system of care" shall promote early identification and timely intervention in order to enhance the likelihood of positive outcomes.

29. The "system of care" will identify, assess and disseminate state-of-the-art methods, strategies and materials for serving class members and their families.

Utah Division Child and Family Services Practice Model

Core Values

Protection Children have the right to be safe from abuse, neglect and unnecessary or needless dependency. Swift intervention is necessary when this right is violated.

Development Children and families need consistent nurturing in a healthy environment to achieve their developmental potential.

Permanency All children need and are entitled to enduring relationships that provide a sense of family, stability and belonging.

Cultural Responsiveness Children and families have the right to be understood within the context of their own family rules, traditions, history and culture.

Family Foundation Children can be assured a better chance for healthy personal growth and development in a safe, permanent home with enduring relationships that provide them with a sense of family, stability and belonging.

Partnerships The entire community shares the responsibility to create an environment that helps families raise children to their fullest potential.

Organizational Competence Committed, qualified, trained and skilled staff, supported by an effectively structured organization, helps insure positive outcomes for children and families.

Treatment Professionals Children and families need a relationship with an accepting, concerned, empathic worker who can confront difficult issues and effectively assist individuals in their process toward positive change.

These foundation principles will lead to the kind of child welfare practice that the citizens of the state of Utah want. These principles have already promoted strong performance expectations and have assisted DCFS in identifying the types of skill training needed to increase the effectiveness of child welfare staff.

Though they are necessary to give appropriate direction and to instill significance in the daily tasks of child welfare staff, practice principles cannot stand alone. In addition to practice principles, the organization has to provide for discrete actions that flow from the principles. The following list of discrete actions or practice standards, have been derived from national practice standards as compiled by the CWPPG, and have been adapted to the performance expectations that have been developed by DCFS. These practice standards must be consistently performed for DCFS to meet the objectives of its mission and to put into action the above practice principles. These standards bring real-life situations to the practice principles and will be addressed in the Practice Model development and training.

Standards of Practice

1. Children who are neglected or abused have immediate and thorough assessments leading to decisive, quick remedies for the immediate circumstances, followed by long-range planning for permanency and well-being.

2. Children and families are actively involved in identifying their strengths and needs and in matching services to identified needs.

3. Service plans and services are based on an individualized service plan, using a family team (including the family, where possible and key support systems and providers), employing a comprehensive assessment of the child's and family's needs and attending to and utilizing the strengths of the child and his/her family strengths.

4. Individualized plans include specific steps and services to reinforce identified strengths and meet the needs of the family. Plans should specify steps to be taken by each member of the team, time frames for accomplishment of goals and concrete actions for monitoring the progress of the child and family.

5. Service planning and implementation are built on a comprehensive array of services designed to permit children and families to achieve the goals of safety, permanency and well being.

6. Children and families receive individualized services matched to their strengths and needs and, where required, services should be created to respond to those needs.

7. Critical decisions about children and families, such as service plan development and modification, removal, placement and permanency are, whenever possible, to be made by a team including the child and his/her family, the family's informal helping systems, foster parents and formal agency stakeholders.

8. Services provided to children and families respect their cultural, ethnic and religious heritage.

9. Services are provided in the home and neighborhood-based settings that are most appropriate for the child and the family's needs.

10. Services are provided in the least restrictive, most normalized settings appropriate for the child and family's needs.

11. Siblings are to be placed together. When this is not possible or appropriate, siblings should have frequent opportunities for visits.

12. Children are to be placed in close proximity to their family and have frequent opportunities for visits.

13. Children in placement are provided with the support needed to permit them to achieve their educational and vocational potential with the goal of becoming self-sufficient adults.

14. Children receive adequate, timely medical and mental health care that is responsive to their needs.

15. Services are provided by competent staff and providers who are adequately trained and who have workloads at a level that permit practice consistent with these principles.

The Practice Model informs front-line staff members of what is expected in their daily work and also provides direction to administration on needed administrative resources. The performance expectations need additional administrative supports, such as adequate funding and staffing, effective training, clear policies and effective administrative structures to assist staff in reaching the above expectations.