

CASCW Practice Notes

Center for Advanced Studies in Child Welfare

Vol. 3, No. 2 Winter 2000

CASCW Practice Notes is produced by the Center for Advanced Studies in Child Welfare and supported by Title IV-E funds, through the Minnesota Department of Human Services.

Assuring the Well-Being of School-Aged Children in Foster Care

A growing body of research is demonstrating that a large portion of children in foster care suffers significant emotional and behavioral disturbances¹. Further, a high percentage of maltreated children experience difficulties associated with school-based problems².

Given the clear indication that school-aged children may enter foster care with significant risks to their normative functioning in both psycho-social and educational experiences, how competently is the child welfare system responding to these risks?

There is a recurring debate as to the services that are available for children in foster care. The review literature offers differing accounts on whether training, respite care, mental health services, and remedial services are equally available to kin and non-kin foster parents; whether there is enough attention to severely damaged children of egregious maltreatment; whether physically handicapped children get the most help, leaving emotionally disturbed children relying chiefly on the Ritalin/Prozac line-up.

Our search for useful data for intervention strategies and models of exemplary services yielded meager information. Perhaps the field has developed excellent responses to school-aged children in foster care, but these have not yet reached the publication stage. We are eager to hear from the field. We offer in this edition of Practice Notes the valuable observations which our advisory group has provided, as well as insights from published studies.

¹Dore, M. M. (1999). Emotionally disturbed children in the child welfare system: Points of prevention intervention. *Children and Youth Services Review* 21(1), 7-29.

²Egeland, B., & Abery, B. (1991). A longitudinal study of high-risk children: Educational outcomes. *International Journal of Disability, Development and Education*. 38 (3), 271-287.

Facilitating Child Adjustment

Depending on the home situation the child is leaving, placement is often an emotionally difficult transition. Factors related to better adjustment include:

- The child has been provided with information about the reasons for placement and the meaning of foster status. Children who know their biological family makeup, their age when they left home, and where their parents are now are better able to adjust to and do well in foster care.
- The child has been given the opportunity to share feelings of confusion and rejection so that s/he can understand why removal from the home occurred and to minimize the likelihood of experiencing denial, fantasy, and repression of pain and suffering.

Source: Pecora, P. J., and Maluccio, A. N. (In press). What works in family foster care. In M. Kluger, G. Alexander, and P. Curtis (Eds.) *What works in child welfare*. Washington, DC: Child Welfare League of America.

Assessing Child Well-Being

It is assumed that engaging the child in assessment and case planning is routine, but here are a few reminders...

Engaging the Child in Assessment

Former and current children in family foster care stress the importance of incorporating children's perceptions into measures of well-being. Therefore, measures of child well-being should include the child's perceptions of safety, acceptance, permanence, stability, and belonging.

Source: Altshuler, S. J., & Gleeson, J. P. (1999). Completing the evaluation triangle for the next century: Measuring child "well-being" in foster care. *Child Welfare*. 78(1), 125-147.



A child-centered assessment of well-being includes on-going conversations that touch on:

- **The child's understanding of placement decisions**

For example, "Do you know what the court recommends in terms of foster placement and why?" This conversation may need to occur several times over the course of the child's placement. If termination of parental rights occurs, a conversation with the child should include what "termination" means and what is ahead for the child.

- **The child's emotional support system**

The key is to make sure the child is engaged with *someone* throughout the out-of-home placement. If, for whatever reason, the foster parent is unable to assume this role, then be certain that someone is assigned to assure that the child has an emotional support system in place.



Genograms: A Useful Strategy

Genograms are visual maps that graphically display complex multigenerational patterns in families. They resemble written family trees that show how family members get along with each other. They reveal rich data about the child's perception of family relations including the biological parents, foster parents, kinship caregivers, and extended family members.

When genograms are constructed in collaboration with a child, they can serve as an effective rapport-building tool; help caseworkers make more accurate assessments of the needs of the child, especially in cases of ethnic differences; and guide permanency planning efforts. Focusing the interview on a concrete task, such as genogram construction, can reduce the child's discomfort and provide a chance to discuss his/her feelings.

Beginning...

Guidelines for Using Genograms

1. Obtain informed consent from legal guardians.
2. Begin construction by explaining to each child why you are collaborating on a genogram. For example, "I'd like to get to know you. In order to do that, I need to get to know your family, since they are a part of you."
3. Explain genogram symbols to the child including squares (males), circles (females), solid lines (legally connected family members), dotted lines (distant or nonlegal relationships), jagged lines (conflictual relationships), parental lineage, etc.
4. Record the family information on an 18" x 24" sketch pad using colored markers.
5. Color code with different markers to depict various nuclear family systems, relationship types, and descriptive information about family members.
6. The whole process typically lasts 20 to 30 minutes.

Source: Altshuler, S. J. (1999). Constructing genograms with children in care: Implications for casework practice. *Child Welfare* 78(6), 777-790.

A Child Services Model

In September 1996, Hennepin County Children and Family Services changed its approach to planning and providing services for children in out-of-home placements.

The Framework: While traditional models would have complete families assigned to a single child protection social worker, this model assigns each child his/her own Child Services social worker. The parents continue to work with a child protection social worker. The goal is to provide children with a consistent social worker with whom they have a significant relationship as a means to increase stability while in out-of-home care and to accelerate the process of obtaining permanency for children who do not return to their parents.

The model is based on the premise that each child in out-of-home placement should: a) receive child-centered services focusing on educational, social, psychological, medical, cultural, and spiritual needs; b) be cared for in the community by a single household of relatives/kin as often as possible; c) have one personal social worker until permanency has been achieved; and d) be placed in a permanent home within two years of out-of-home placement.

Child Services units consist of seven to nine social workers who carry caseloads of up to 25 children. Sibling groups are assigned to the same Child Services social worker when possible.

Preliminary analysis shows that there has been increased and better services for children in out of home placement. The challenge in this model is to integrate the perspectives of the child's social worker with the comprehensive case plan for permanency.

Source: Beman, N., et al. (October 1999). The child services model: *An Assessment of a Child Focused Approach to Social Work Practice with Children in Out of Home Placement*. Program evaluation report. Minneapolis: Hennepin County Children and Family Services.

Setting Standards for Caregivers of Children in Foster Care

1. Caregivers are in it for the long haul.
2. Sufficient professional back-up and relief for caregivers are built into the system of care.
3. Caregivers are part of an extended family model.
4. Caregivers have sufficient satisfaction in their own lives that their self-esteem does not depend on how the child responds.
5. Both caregivers and supervisors have cognitive and emotional understanding of attachment resistance... they don't personalize the child's behavior and they do recognize that the child's behavior is an adaptation to the trauma of separation.
6. Caregivers understand proper control of distance: As in the image of a ten-foot pole... they are emotionally available, but not intrusive.
7. Caregivers are aware of and take responsibility for their personal responses to the child.
8. Caregivers are open to discussing their own confusion and frustration.
9. Caregivers possess other personal qualities such as a sense of humor, patience, and the abilities to admit being wrong and to tolerate uncertainty.
10. Potential exists for allowing placement to become permanent if the child forms a successful attachment.

Note. These standards might also apply to all those who are engaged with the child who is "attachment resistant."

Excerpted from materials provided by Dr. Paul D. Steinhauer, Professor Emeritus of Psychiatry and Public Health Science, University of Toronto; Former Chair of the Institute for the Prevention of Child Abuse, Toronto.

Improving the Educational Experience

The Critical Impact of School

- "School is the single greatest predictor of a failed placement."
(*Observation of Dr. John Landsverck, Forum on the Mental Health Needs of Children in Foster Care, University of Minnesota, April 1996.*)
- A sense of success is crucial... This should be established in the early grades
- Children with serious problems are likely to get help while there is often insufficient attention for those children struggling at a marginal level that registers "under the radar."
- Changing schools often accounts for serious deterioration of a child's academic experience
- Socialization difficulties are often overlooked, but children will often say that lunch and recess are profoundly isolating experiences. A "peer buddy" should be identified to help the child make friends in a new school

Helping Foster Parents Get Help From Schools

- If a problem occurs in the school setting, personnel should be advised to contact the foster parent.
- Empower foster parents to advocate for their foster child by providing them with the name and phone number of the school social worker, nurse, psychologist, etc.
- Assist the foster parent in finding community resources for after-school programs such as:
 - Mentoring
 - Special recreational/arts programs
 - Funding for field trips

The Itinerant Mentor

Children in foster care are reported to have difficulties in keeping up with homework. Special problems in reading, math, and conceptual development are often reported as well.

One suggestion has been to recruit college students and others to serve a group of foster homes with school-aged children. The mentor/remediation expert would rotate among a group of foster homes, specifically to help school children with academic problems.

This model acknowledges that foster parents are often overburdened and overstressed with limited time to focus on education problems. This idea has not been thoroughly tested, but warrants an experimental project.



Improving Mental Health

Using Mental Health Consultants

in Staff Development and Support for Foster Parents

One of the most effective and efficient ways of providing mental health care to children in foster care is to tap into the knowledge of a mental health professional for staff development, consultation, and direction on how to respond to a child's behavioral difficulties. In this model, seasoned mental health clinicians share their expertise with those who work with the child in out-of-home placement. The experienced clinician offers an excellent value in that s/he can provide:

- Broad knowledge and familiarity with the most recent research literature
- Knowledge from a related, but different field (i.e., clinical psychology, special education, sexual abuse) that offers a new perspective on difficult cases
- Help in formulating and implementing case plans
- Consultation to the worker and to the foster parent for understanding the child and his/her behaviors

Improving Physical Health

A significant portion of children enter foster care in a poor state of health and with developmental, behavioral, and emotional disturbances.

A GAO study found that “As a group they [children in foster care] are sicker than homeless children and children living in the poorest sections of the inner city.” Chronic medical problems effect 30-40% of children and youth in the child welfare system. Often these chronic conditions have been untreated or only partially treated (Schor, 1988).

Source: CWLA Testimony submitted to the Senate Finance Subcommittee on Health Care for the Hearing on the Health Care Needs of Children in the Foster Care System. (October 13, 1999).



Health Passports

Health care delivery for foster children frequently suffers from a lack of adequate recordkeeping. The Federal Omnibus Budget Reconciliation Act of 1989 mandated that a foster child’s case plan “shall include the health and education records of the minor.” As a result, San Diego County, California initiated its “medical passport,” a computerized database that serves as a repository of health and education information (in summary format) for each child in out-of-home placement. The information can then be printed and distributed for professionals on a need-to-know basis. Many San Diego County workers have embraced the health passport as an effective case-management tool that provides consistent and timely health and education interventions.

Source: Lindsay, S., Catwalk, D., Landsverk, J. Pierce, E. (1993, Nov-Dec.). A computerized health and education passport for children in out-of-home care: The San Diego model. *Child Welfare LXXII* (6).

Initiatives in Other States

Rhode Island's “Healthy Tomorrows” program provides a visiting nurse who ensures that children in placement are linked to primary care providers, Coordination of care and medical records follow the child.

Utah developed the “Fostering Healthy Children” program, a statewide nursing case management model using a computerized tracking/case management system (including a mental health component). The State also developed a system to identify, monitor, and evaluate indicators of quality, effectiveness, and efficiency of care across agencies.

Alaska has implemented a computerized Health Passport/case management program for foster children in Anchorage. A public health nurse serves as case manager for all children in custody over 30 days. Public health nurse case managers, along with Medicaid eligibility workers, mental health workers, and substance abuse treatment providers, are co-located at the Child Welfare agency.

Illinois developed the “Health Works” program in which a preferred provider network of primary care providers reimbursed fee-for-service to care for children in foster care. This program has ensured that foster children receive screening and treatment according to CWLA’s standards.

Massachusetts is working on a plan to enroll children in foster care into managed care. The State developed and distributed screening and treatment protocols based on the American Academy of Pediatrics standards to providers, caseworkers, and foster parents to ensure that foster children are getting the care they need.

Source: Rawlings-Sekunda. (1999). *The state of the state in delivering health care for children in foster care: Findings of a state survey*. National Academy for State Health Policy: Portland, ME. September.

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Special Thanks

to the following people for their assistance in compiling this issue of Practice Notes:
Nancy Anderson, PATH; Nan Beman, Hennepin County Child Services; Dan Capouch, Hennepin County Child and Family Services;
Richard Powell, Human Services Associates; Dorothy Renstrom, Minnesota Department of Human Services; Joan Riebel, Family Alternatives;
and Sandy Robin, CASCW .

For Further Reading

- Altshuler, S. J., & Gleeson, J. P. (1999). Completing the evaluation triangle for the next century: Measuring "child well-being" in family foster care. *Child Welfare* 78(1), 125-147.
- Horvath, J. (1997, March). *Health care protocols and standards for treatment of children in foster care: Overview of issues*. Portland ME: National Academy for State Health Policy.
- Kurtz, P. D., Gaudin, J. M., Wodarski, J. S., & Howing, P. T. (1993). Maltreatment and the school-aged child: school performance consequences. *Child Abuse and Neglect* 17, 581-89.
- Lutz, L. L., & Horvath, J. (1997, October). *Health care of children in foster care: Who's keeping track?* Portland ME: National Academy for State Health Policy.
- Simms, M. D., Freundlich, M., Battistelli, E. S., & Kaufman, N. D. (1999). Delivering health and mental health care services to children in family foster care after welfare and health care reform. *Child Welfare* 78(1), 166-183.

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