



MEETING THE
H Health Care Needs
of Children in the
Foster Care System



S I T E V I S I T R E P O R T

The Family Program: Westchester Institute for Human Development

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THE INFORMATION PROVIDED IN THIS PUBLICATION IS THE RESULT of a 3-year project conducted by the Georgetown University Child Development Center to identify and describe promising approaches for meeting the health care needs of children in the foster care system. In response to a national search for promising approaches, information was collected on over 100 different approaches. Multiple publications representing the findings of the study are available.



Georgetown University
Child Development Center



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Overview of the Family Program

The **Westchester Institute for Human Development (WIHD)** is a University Center for Excellence in Developmental Disabilities Education, Research and Service located in Westchester County, NY. WIHD is a part of the Westchester Medical Center, and is affiliated with New York Medical College in Valhalla, NY. As a University Center for Excellence, WIHD's mission is to enhance the quality of life of individuals with or at-risk for disabilities, and their families.

The **Family Program** is a collaborative effort between WIHD and the Westchester County Department of Social Services (DSS) designed to meet child welfare permanency goals by providing developmental and mental health services to all children in family foster care in the county, their birth parents and their foster families.

The goals of this program are to enhance permanency for children in foster care by:

- identifying health, developmental and mental health needs of children entering family foster care;
- providing services to address the unmet health, developmental and mental health needs of children entering family foster care;
- preventing re-placements (moving from one foster home to another);
- preventing more restrictive placements; and
- facilitating the development of permanency plans.

The WIHD Family Program offers many services for children and families in the foster care system. These include:

Assessment of each foster home placement (In-Home Assessment)—A visit to the foster home by a psychologist is conducted when a child comes into care to assess the “fit” between the foster home environment and the child and to identify immediate and ongoing supports that the foster family may need in order to maintain the child's placement.

Comprehensive developmental assessment of each child and a functional assessment of birth parents (Initial Intake Assessment)—All children and their biological parents are referred to the Family Program when a child comes into care. An initial, 3-hour assessment of the child and family consists of a social work intake, parent screening (cognitive functioning and three other questionnaires), evaluation of the child by a psychologist, and an assessment of parent-child interaction. Based on the results of the intake assessment, other evaluations as necessary are completed by members of the child development team including developmental pediatrics, child psychiatry, a psychoeducational specialist, speech/language pathology, occupational and physical therapy, and audiology. Specialized referrals may also be made to child neurology and other pediatric subspecialties available onsite.

Training and support to foster families (Enhanced Foster Care)—These services are designed to support foster families who need assistance in managing a child who has significant behavior and/or developmental problems. A year-long, in-home support/training program is provided, as well as recreational activities for children outside the home which provide respite for the foster families.

Developmental and mental health intervention (Clinical Services)—If intervention services are indicated, the child can receive mental health services under the supervision of a child psychiatrist including play therapy, individual therapy, group therapy, and/or developmental interventions such as speech/language services and educational tutoring at the Family Program and WIHD. Parent training and family therapy are also offered with the biological parent and child(ren). These interventions allow for ongoing assessment of readiness for family reunification.

Background and Context

Child Welfare System

New York's Child Welfare system is administered at the County level by the Department of Social Services (DSS). Child protection and juvenile justice services are administered by the same agency. Westchester County is an affluent New York county and is considered to have an impressive array of services. Approximately 850 children are in foster care at any point in time, with the approximate distribution of placement types as follows: 41% in foster care; 40% in congregate care; and 14% in therapeutic boarding homes. The Westchester County DSS organizes its workers in a Resource Unit, which assigns workers to foster homes and in Casework Units, which assign workers to children and families.

In Westchester County, minority children represent a disproportionate number of children in foster care: 63% African American; 14% Latino; and 12% Caucasian compared to the following distribution in the general population of 18%, 12%, and 70%, respectively. There is an increasing trend of children of Latino origin coming into care. An increasing trend of adolescents entering care was also reported. Forty-eight percent of the children in DSS custody were age 13-21, while 34% were age 5-12 and 18% were under the age of five.

Health Care System for Children in Foster Care

Primary health care services such as immunizations and other routine health screening tests are conducted at the **DSS Pediatric Unit**, a health care clinic staffed by two part-time pediatricians and three full-time RN's. The clinic has been in existence in Westchester County for nearly 50 years, and is a free service paid for by the county DSS. The clinic serves as a primary care resource for all children in foster care. Every child who comes into foster care is seen by the DSS Director of Pediatrics (one of the pediatricians at the clinic) for an initial health assessment within 10 days, or within 24 hours if physical evidence of abuse is needed.

Foster children in the county are placed on fee-for-service Medicaid, rather than participating in the Medicaid managed care plan. Foster parents may choose to take the child anywhere for routine health care, but it is mandatory that they bring the child to the DSS Pediatric Unit once a year if an outside provider is utilized (about 25% of the families use an outside provider). The providers are required to send yearly reports to the unit as well.

The Pediatric Unit can provide medications onsite (paid for by the County DSS) to cover any gap in time before a child is covered by Medicaid. Immunizations are also paid for by the county. Emergency care such as nebulizer treatment for asthmatic children is available, and children may then be admitted to different facilities as needed. Children under age three who present with a positive toxicology screen are referred to a neonatologist who specializes in this issue and provides extensive follow-up services. Services offered through the clinic also include nutritional assessments and nutritional counseling for foster parents to ensure normal growth and development.

All children are referred by the Pediatric Unit to the WIHD Family Program for comprehensive developmental and mental health assessments. Family Program professionals and the DSS Pediatric Unit work together to ensure coordination of all health care and related services.

Health Care Issues for Children in Foster Care

Administrators from both DSS and WIHD reported that lack of preventive health care, dental care, services for asthma, and behavioral and mental health issues were the most pressing health care issues for children in foster care. Social work supervisors identified additional issues they see as children enter care: lack of basic immunizations, allergies, malnutrition, and lack of training in basic self-care (e.g., bathing and brushing teeth). They also identified significant health care issues for parents of children coming into care, including: lack of information on pre-natal care and birthing; the reliance on tobacco, alcohol and other substances; and mental illness. The Supervising Family Court Judge and her affiliates recognized that parents' illegal immigration status compromises their children's health status and results in missing or incomplete health documentation. The problem of homelessness was also mentioned as having a negative effect on children's health.

The WIHD Family Program

Implementation

The Family Program at WIHD was created in 1987, in partnership with the Westchester County DSS, to provide developmental, behavioral and mental health services to children and families in the foster care system. The program offers an array of support services, including developmentally-focused clinical assessments and intervention.

Discussions about the creation of the Family Program began in 1986 between the Commissioner of the County DSS and the Associate Director of WIHD. There were no legal pressures to create such a program. WIHD's Associate Director had recently come to WIHD from the Kennedy Krieger Institute at Johns Hopkins Hospital where he had developed a comprehensive health care program for children in foster care and then extended that program to create the first hospital/university-based child placement agency to provide family foster care for children with very special health care needs. In invited discussions with DSS, the development of a similar comprehensive health care program for children entering foster care was proposed and accepted. DSS was interested in this approach because of the opportunity it offered to obtain a coordinated array of health care services from a single provider willing to accept Medicaid levels of reimbursement.

The initial program, developed in 1987, provided developmental assessments and services to children in foster care and birth families. Over the years additional services were added including in-home assessments (foster homes), mental health services for children and birth parents, and enhanced foster family services. Several senior staff from both DSS and WIHD have remained involved with the program since its inception.

Components of the Family Program

Intake and Referral

Referrals to the Family Program are made in two ways:

1. The Family Program is notified of all new entries into foster care by a multi-purpose DSS tracking form initiated by the DSS Resource Unit. This triggers the in-home assessment, at the foster home, which will be conducted by the Family Program staff within 2-4 weeks of the child's placement into foster care.
2. At the same time, the Pediatric Unit pediatricians (following the initial primary care pediatric appointment) refer all children to the Family Program for comprehensive developmental, behavioral and mental health assessments and ongoing clinical interventions. Assessments usually take place within 30 days of a referral. The Family Program administrative assistant schedules appointments and notifies the DSS caseworker, who then notifies the birth parents and brings them to the assessment.

Comprehensive Assessment

The Family Program has incorporated two key strategies for completing comprehensive developmental, behavioral, and mental health assessments for children in foster care, their birth parents and foster parents.

In-Home Assessments (at the Foster Home)

A visit to the foster home by a psychologist is conducted when a child comes into care to assess the “fit” between the foster home environment and the child. This in-home assessment is usually completed within two to three weeks of the foster care placement in order to identify immediate and ongoing supports that the foster family may need in order to maintain the child’s placement. DSS caseworkers will accompany the Family Program staff to the home as their schedules allow.

Two areas are assessed during the home visit:

- Appropriateness of the home—The Home Observation for Measurement of the Environment (HOME) is utilized to assess space, safety issues, the availability of appropriate toys and activities to stimulate the child’s development, and the ability of the foster parent to provide a nurturing environment for the child.
- Immediate needs of the child—Several instruments (Vineland Adaptive Behavior Scales, Achenbach Child Behavior Checklist and Trauma Symptom Checklist for Children) are used to assess developmental functioning and emerging behavioral difficulties. Staff also spend time with the foster parent(s) to discuss the adjustment of the child and try to anticipate any difficulties that might emerge based on the child’s history and the findings of the assessment.

The home visits usually last 1½ hours. Family Program staff provide support and technical assistance to the foster parents and specific recommendations are made at that time. Complete findings and recommendations are submitted in a report to the DSS medical director, the resource unit worker and the child’s caseworker.

Initial Intake Assessments (at WIHD)

Comprehensive developmental, behavioral and mental health assessments are conducted at WIHD, typically after the in-home assessment has taken place. The Family Program routinely includes birth parents in the assessment to obtain accurate pregnancy, delivery, and early developmental history and to conduct an assessment of parents’ functioning and interaction with their children to help guide in planning the supports and services they may need. A Family Program social worker initially meets with birth parents alone to obtain family history, birth history, child’s health history and developmental information. The parent’s cognitive functioning is assessed and three brief standardized tools are used to assess parental functioning. Subsequently, the parent(s) meet with their children and the family specialist who assesses the parent-child relationship and the parents’ abilities in managing their children.

An initial assessment of the child’s developmental, behavioral and mental health functioning is conducted by a child psychologist. Based on the results of the initial assessment, other evaluations as necessary are completed by members of the child development team which includes a developmental pediatrician, child psychiatrist, psychoeducational specialist, speech/language pathologist, occupational and physical therapists, and an audiologist. Specialized referrals may also be made to child neurology and other pediatric subspecialties available onsite.

After an assessment is completed, a conference is held with the caseworker, the Family Program director and all staff involved in the assessment process. Recommendations may include the need for follow-up evaluations, referral to Early Intervention, preschool or special education services, or other pediatric subspecialty services. In addition, recommendations may be made regarding the need for services to assist in

the permanency planning for the family such as parent training (typically provided by the Family Program) or mental health and substance abuse counseling services (usually provided elsewhere). It is the DSS caseworker's responsibility to share the results of the assessment with the birth parents, but this is often a shared responsibility with the Family Program staff. Because WIHD is an approved site for assessments for both Early Intervention and preschool services, the initial assessments can easily lead into full assessments approved through these programs.

Follow-Up Care and Services

After all assessments have been completed, there is a conference at the DSS Pediatric Unit with the DSS Resource Unit Supervisor, the Pediatric Unit staff, and the Family Program Director. Reports of all assessments are given to the pediatrician at that time to ensure that the child's medical record is complete. In addition to determining the need for any additional services for the child, the foster family's board rate¹ is set for the child based on the results of the assessments and the needs and level of functioning of the child. If indicated from the results of the In-Home Assessment or the Initial Intake Assessment, a consideration is made for the Enhanced Foster Care program.

Enhanced Foster Care

Foster families who care for children who are considered difficult to manage are referred to this program by the DSS Resource Unit. WIHD Family Program social workers provide in-home support to 30-40 foster families through a year-long training program. Families receive 12 home visits during the course of the year. In addition to the in-home work, foster parents served through this program are asked to attend two three-hour training sessions that are scheduled at times and in locations that are convenient for the families. Training often focuses on behavioral management techniques, but varies with the needs of the families and the children placed in their care. The social workers help develop a behavioral plan and assist the foster families in understanding developmental issues.

In addition to support around behavioral issues, a recreational therapist provides recreational outlets for the children and respite for foster parents. Children can enroll in ongoing recreational activities in their communities such as ballet lessons, karate classes and gym activities. The recreational specialists are also available to take children on outings. For young children this might include daytime outings such as going to the library for a reading hour or to "kid aerobics". For older children, after school and weekend activities might include going to the movies, attending sporting events or the circus, going for day hikes, ice skating or other age appropriate activities. Attempts are made to use these activities for additional sibling visits for children who have not been placed together. Both the in-home supports/training and the recreational therapy services may continue for a few weeks with the birth parents for support after reunification.

Developmental and Mental Health Intervention

The Family Program provides a range of ongoing treatment services to children in family foster care and their birth families when needed. Services for the children can include play therapy, individual therapy, group therapy, and social skills training. Children can also receive speech/language therapy and educational remediation/tutoring at WIHD. Some children require medication for their symptoms and can be treated by the Family Program's psychiatrist. These services are all provided with the goal of

¹The amount of money paid to the foster family which is determined by the level of care needed for the child.

stabilizing children, and helping them deal with symptoms such as depression, anger, attention difficulties and other reactions to trauma. Ninety percent of the children seen for the initial intake assessments receive services through the Family Program.

Parent-Child Program

Parent training services and family therapy are offered to birth parents together with their children to improve parents' ability to safely care for their children and facilitate the timely return of children to their care. Since the intervention needs of this population are so complex, a Parent Training Curriculum has been developed that addresses basic parent skills training and provides a format for dealing with difficult, sometimes traumatic material. These interventions allow for ongoing assessment of readiness for family reunification and require a substantial commitment to providing technical assistance to the DSS worker, Family Court, and other professionals providing medical, developmental, and mental health services to the family. The curriculum is implemented with the parents during a one-hour per week session. Routine activities for staff include attending six monthly Service Plan Reviews and testifying in Family Court to assist in case planning.

Other Supportive Services

The Family Program can make transportation to WIHD available to all children. Children are transported to and from the Center by ambulette, which is billed to Medicaid. Three to four vans are available through a private transportation company. Drivers and aides are trained by both WIHD and the transportation company. The payment used to be mileage-based, but is now a negotiated flat fee.

Although this transportation service is seen as extremely convenient to DSS, it is not provided for parents, which several caseworkers reported as a barrier. Foster parents appreciate the service, but some reported that they often drive themselves because they want to be present or they prefer to drive younger children.

The Family Program relies on several ancillary programs of the WIHD or Westchester Medical Center to support children and their families. For example, the Learning Evaluation and Achievement Program (LEAP) provides psycho-educational assessment and intervention services, direct specialized instruction, consultation and related services to children referred by the Family Program, schools, or parents. Other services available include audiology, speech-language, otolaryngology, assistive technology, pediatric neurology and the full range of pediatric sub-specialty services.

WIHD is an approved provider of Early Intervention Services and Early Childhood Services. The Intake Unit for this program is located at WIHD. The Initial Service Coordinator sets up an evaluation and schedules an Individualized Family Service Plan (IFSP) meeting within 45 days. Family Connection at WIHD, which is staffed by parents of children with disabilities, assists new families by contacting the family, sending out a welcome packet, talking to the family about the evaluation, and helping the family understand the IFSP process. WIHD also has an Assistive Technology program and loan library, which are available to children and their families.

Staffing

The Family program employs twenty-three individuals to implement the programs described above. The majority of full-time staff are social workers, psychologists, and recreational therapists. Other disciplines

such as developmental pediatrics, child psychiatry, a psychoeducational specialist, speech/language pathology, occupational and physical therapy, and audiology, divide their time between the Family Program and other clinical services at WIHD.

The culturally diverse staff expressed satisfaction with having a mix of roles and being assigned to programs based on their interests and skills. Staff reported a lot of cooperation with each other due to working so closely together. Weekly staff meetings are conducted. There is a weekly schedule outlining which children and families are being seen. Each child's chart indicates which staff members are involved with the family. Supervision is taken very seriously and there are weekly meetings with supervisors and staff.

WIHD's location at the same site as the Westchester Medical Center and New York Medical College provides staff with easy access to expertise and technical assistance. In addition, all staff reported that the Program Director was extremely accessible to them and does a lot of central coordination.

Funding

Family Program services are funded through contracts with DSS and through Medicaid billing. DSS contracts with WIHD to conduct the In-Home Assessments, Initial Intake Assessments, and the Enhanced Foster Care program. Currently, the contract covering all three services is \$410,000 per year. DSS, in turn, bills Medicaid for these costs. WIHD bills Medicaid directly for its clinical services (developmental and mental health intervention services). The amount billed for these services is approximately \$900,000 per year.

Collaboration Across Systems

Collaboration with DSS

The relationship between DSS and the Family Program of WIHD can be characterized as collegial and collaborative with complementary missions and philosophies. While there are written contracts articulating general roles and boundaries, the actual staff of each agency reported making efforts to be flexible and accommodating in order to meet the needs of the families. Administrative staff reported that many efforts take place to coordinate the work at the front line. Staff are able to put issues aside when necessary in order to work for the children. There was agreement that the administrators have ready access to one another.

Collaboration between DSS and the Family Program takes place in several ways. The child's caseworker and Family Program staff try to go out together to conduct the in home assessments of foster homes. This practice has gradually declined recently, but consideration has been made to renew this practice as DSS staff time allows. In addition, meetings between the DSS Pediatric Unit, DSS Resource Unit, and Family Program Director occur at least monthly to review results of developmental assessments, discuss care coordination and to determine foster care board rates.

DSS staff generally report satisfaction with the Family Program and feel that the opinion and judgment of Family Program staff is credible to them and to the courts. DSS medical staff reported that the Family Program is their primary resource. Also, the Foster Parent Satisfaction surveys sent out by DSS indicated high regard for the Family Program.

Communication between DSS and WIHD is seen as frequent and informal. There has been a perceived reduction in frequency of written, formal “service reports”. DSS staff reported Family Program staff to be very accessible by phone, but that updates are provided only when asked for. Some DSS staff also reported that assessment reports take too long and that there was a waiting list of up to 3-4 months to get an assessment. It seems that this problem was remedied when DSS began to give consent to release records, rather than waiting for birth parents to do so. Staff of the Pediatric Unit stated that reports take three months now (sooner if requested) and they are satisfied with that time frame. Other workers said that reports were timely and comprehensive. One DSS staff member reported that “We have more problems with our own agency than with the Family Program.” It was also reported that “the Family Program Director makes this work” (referring to the relationship between DSS and the Family Program).

Family Program staff report a complete flow of information between the two agencies and also characterized the relationship with DSS as very good. They feel that child welfare is the discipline they relate to the most. Family Program staff believe that they can maintain consistency with families through Family Program, even when DSS workers change. They believe their work is valued and appreciated by DSS. All in all the relationship is seen as positive by both agencies and throughout the hierarchy.

Collaboration with the Court System and CASA

The County’s Supervising Family Court Judge, the Director of the Court Appointed Special Advocates program, a Senior Policy Analyst from the Permanent Judicial Commission on Justice for Children and affiliated program staff were interviewed during the site visit. They reported that the Family Program helps attorneys because the staff is knowledgeable and the records are detailed. The staff knows the children and when offering testimony they provide measurable goals in basic and concrete terms and offer timelines for when these goals should be met. The staff is seen as fair, non-judgmental, reasonable, and hard-working. In addition, they believe in the agenda to reunite families and individualize their efforts to each child and family. More children are returning home sooner because their needs are identified sooner.

The Family Program is used by the Court to expedite educational evaluations and staff are considered to be excellent parental supports. Although the Family Program may recommend services or an approach, there was concern that sometimes DSS does not follow through. Team meetings are held monthly with service providers, e.g., attorneys, DSS, CASA, law guardians, and the Family Program Director to talk about issues. All stakeholders reported difficulty coordinating with schools and ensuring that comprehensive programs continue when a child changes placement.

Family Involvement

Families are involved in WIHD’s programs in a variety of ways. Both birth families and foster families receive assessments. Input is sought from birth and foster families on the child’s history, health, and current functioning. Families may also be involved in planning for children and in getting information from the Family Program about their children. There are complex relationships that exist between and among birth families, foster families, the Family Program, and DSS. There is a general attitude among Family Program staff that families are involved or that they may be involved. There is a perception among foster families that they may be involved, but their involvement is not always actively sought. When foster families described their involvement, at times it was difficult to distinguish whether they were referring to the Family Program or to DSS.

Some staff reported that DSS workers do not always notify foster families in advance that Family Program services have been authorized, so when the Family Program worker calls there is some concern that the foster parent feels she is being singled out for a special visit. It was reported that foster parents might be left out when assessment reports are being reviewed at DSS request. If the foster parent requests, they are always included.

Birth parents find the Family Program services to be better than they thought initially (“I thought it was just going to be another parenting class.”). The parent training program also provided them an extra opportunity to see their child, and siblings can attend as well. Parents felt that they were respected (“They accept you where you are and respect your needs as a family.”). Parents felt free to call the Family Program staff with concerns or questions. When children have special health care needs, training is provided to families at the specialized clinics serving the children.

Foster and adoptive parents reported that the Family Program cuts through the red tape and paperwork and is easy to access. The program also helps in getting services from the school system. There were mixed reports about the information provided to foster parents. Some found that interns did not summarize accurately, sometimes had incorrect information, and did not understand the child’s needs. They found that information was shared when requested but was not always offered. Foster parents also reported that, in their experience, the Family Program gives the best response of all the community agencies with which they work.

None of the foster parents interviewed seemed to be aware of the in-home assessment, which the interviewers understood to occur for every new placement of a foster child. It was unclear whether this was due to lack of awareness of the name of the service or of the service itself. The foster parents did recognize that their foster child may have had a developmental assessment at their home. One veteran foster parent was unaware of the DSS Pediatric Unit. This foster parent accesses medical care through local physicians.

Enhanced foster care was seen as “too much” for some foster parents who found themselves to be too busy, but the support group component was reported by another foster parent as “what kept our family together.” One foster parent reported that “the enhanced foster care was very helpful and a life saver for us and our foster child who is autistic.” This service is optional, so was not considered a problem. Many other foster parents were not aware of this program.

Re-assessments are conducted to determine appropriate adoption subsidies. Family Program staff meet with the adoptive parents and often introduce the new family to the child during play therapy sessions.

Attention to Cultural Issues

Throughout the two days many comments were made about the importance of being non-judgmental and respectful of all families served by the Family Program. This was considered paramount regardless of past actions, race, ethnicity, language, or socio-economic status. It is apparent that careful attention is paid to promoting competence of all staff in respecting diverse cultures and in building on the strengths of each family. Many staff are bilingual. However, written reports are not translated into the family’s native language.

Staff attend cultural awareness training conducted at the hospital. The training primarily focuses on cultural attitudes and beliefs as they influence health care utilization. In addition, staff have participated in cultural awareness training opportunities off campus. A recreational therapist works with children on cultural issues during outings with the children and wherever possible helps them participate in activities that reflect their cultural heritage. Family Program staff work with the birth parents and are sensitive to their needs, especially in regards to alternatives for discipline. During the parent-child assessments, staff ask families of different cultures about their beliefs and acknowledge their culture.

Training and Education

Family Program staff are trained to work in all aspects of the program. In addition, staff development activities include attending state and national training conferences that focus on child welfare issues, adoption, and, in particular, treating child sexual abuse victims. There is a solid curriculum for parent training which has a developmental approach and relies on coaching and empowerment strategies. The Family Program Director conducts training with the judges, CASA volunteers, foster parents and community agencies on WIHD, the Family Program and evaluations.

Family Program staff reported spending a lot of time on training DSS social workers in clinical issues related to specific children. In the past, Family Program staff provided a 2-day in-service training to DSS staff on developmental and clinical issues. Some Family Program staff wished it would resume and some DSS staff thought it was a good idea as well.

Monitoring and Evaluation

Although there is no systematic evaluation of outcomes of the services across the two agencies, the Family Program reports much descriptive information. DSS recently conducted a Foster Parent Satisfaction Survey, which indicates that families are pleased with the Family Program. DSS staff reported that they know these services are good because there is a decrease in placement changes and foster parents are happy. It is perceived that children are living in less restrictive placements due to these programs.

Summary of Learnings from the Site Visit

Essential Elements and Strengths of the Approach

Strong Relationships

The strength of the collaboration between WIHD and DSS is the rich relationship between the individuals representing each agency. This is indicated by a sense of trust and familiarity with each person's skills and styles. The flexibility and informal structure of the Family Program complements the rigid mission and bureaucratic structure of a county DSS. The Family Program staff are well-versed in child welfare issues and stay current with these issues. They also provide real technical assistance to the caseworkers.

Leadership

The Director of the Family Program is credited with the success of the Family Program. It is her word and her work that is trusted and she makes this approach work. She is reported to be very accessible to staff.

Communication between DSS, WIHD, and Family Program Staff

The general pattern of communication is very strong in this approach. It is informal yet frequent. Easy accessibility of individuals to one another is noted. There is a commitment from the top administration through the ranks to make this collaboration work.

Centralized Urban Location

Services are provided in a centralized location where a critical mass of children and families need the offered range of services. Although most liked the "one-stop shopping" model, there are limits to its utility for residents far from the site. A second "outpost" site is located in the southern part of the county in Yonkers, however it has just one office. In the summer of 2001, a move to a larger site in Yonkers will provide space for five offices.

Stakeholder Satisfaction

The reported satisfaction with the partnership is the ultimate strength of this program. WIHD's contract is regularly renewed by DSS. Family Court interviewees believe the testimony from the program staff in court cases is invaluable. Parents report the Family Program is the most responsive agency with which they deal.

Service Array

An extensive range of developmental and mental health services is provided.

Family Involvement

Birth families are included in assessments and are provided services. There is strong, in-home support for foster families.

Enhanced Foster Care

An Enhanced Foster Care program is provided and includes recreation therapists. These individuals routinely take foster children out into the community for age appropriate activities. This unique program gives children a chance to experience cultural events, affords them an opportunity to get together with siblings, and also provides foster families a respite.

Established Organization

WIHD, which operates the Family Program, is a strong, established organization in the community. It is a University Center of Excellence in Developmental Disabilities Education, Research and Service.

Barriers and Challenges

As with any program, different entities are looking for different outcomes and therefore, it is difficult to meet everyone's needs. Following are areas that were reported or observed to be challenges to the optimal performance of the program.

Need for Consistent Information about the Program

There is inconsistent awareness about the services of the Family Program, which results in unmet expectations by some. For example, DSS staff and foster families were not always aware of the breadth of programs offered and could not identify the services received by the program names. There is little understanding by all interviewees about the limitations of the Program, for example, where the contract is capped by DSS or when the delays in reports may be due to a DSS policy or the need to coordinate multiple services for the same family. Foster parents did not really understand why some families have access to enhanced foster care and others do not. Clarity about how services are authorized and referred as well as expected time frames for these services would help to remedy this situation. This information could be presented in training sessions to foster parents.

Early Intervention

Early Intervention (birth to three years) services are provided by the Department of Health as the lead agency. The system developed is different than that for ages three and older, so it is sometimes confusing. School systems are also overburdened and sometimes cannot provide needed services.

Location

The convenience of having so many services at WIHD was mentioned several times as a strength. However, this was also seen as a barrier to DSS workers whose families live in the outskirts of the county. Foster parents reported dissatisfaction with access to parking at the center.

Staff Turnover

An area of concern reported by DSS staff and parents is the turnover among the Family Program social worker interns and psychology fellows (especially when they are the primary providers). They explained that summer services are greatly lacking due to a reduction in available counselors because the interns are not around in the summer (the interns and fellows are with the Family Program for just an academic year). The foster parents expressed how traumatic it is for the child when the interns/fellows leave and there is a gap in therapy until the next intern begins. Foster parents also noted that the quality of the services offered by student interns are not of the same caliber as the services provided by Family Program staff.

Waiting Time

The parents conveyed that it can take a long time to get an appointment at WIHD, that parking access is an obstacle, and that sometimes staff are so busy, they have to return for an evaluation.

Unique Features in Westchester County

There are several features of the Westchester County service system that contribute to the success of this approach.

DSS Pediatric Unit

This unit coordinates all aspects of health care for children in foster care, functioning as a primary care physician and health care case manager. As such, staff interact routinely with caseworkers, foster parents, schools, and health centers. They are the referral source for the developmental and mental health assessments conducted by the Family Program and authorize any subsequent medical service for all children in foster care. The strong coordination of this unit with the Family Program promotes the success of the Family Program.

Transportation Services

The transportation services that are provided to children in foster care sets the county apart from other programs that will not or cannot provide such services. Transportation was seen as a very positive service.

Court System

The Court System in Westchester County has been actively involved in addressing health care issues for children in foster care. The New York State Permanent Judicial Commission on Justice for Children, located in Westchester County, formed a working group to address health care needs, and produced a guide for judges, advocates, and child welfare professionals on “Ensuring the Healthy Development of Foster Children.” The Family Program maintains a strong relationship with the County Family Court System, especially with the supervising Family Court Judge. The Court System values the expertise of the Family Program staff. Team monthly meetings are held to discuss issues.

Recommendations and Advice for Other Communities

- Consider location carefully. Some strongly advocated for co-location of the developmental assessments within the Pediatric Unit and others wanted more satellite offices for the clinical services. This suggests that one must carefully consider prevailing goals when determining whether to have one stop shopping or easier access to certain services.
- Involve local and state foster parent associations in order to design the program in a family friendly way and to promote understanding of the program.
- Obtain support and commitment from top administration and ensure that this is passed on through supervisors to the front-line workers.
- Administrative interviewees attributed the success of this program to the clear but distinct focus of the two agencies. All staff and families need to have a clear understanding of what the provider can and is supposed to do.
- Training for caseworkers on community services and school services.

- Training for Family Program staff on legal and court issues.
- Aftercare services for at least three months after reunification.
- Get the whole community involved—be sure they are committed to the children, to meeting mandates, and to establishing a good working relationship.
- When developing a parenting curriculum for birth parents, it needs to be based on a non-judgmental approach with a focus on basic skills and problem solving skills as well as a “coaching model” or “empowerment model”.
- It is important to assess the child **and** the birth parent during the initial assessment.
- Provide services for birth families.
- Be creative with your funding stream.
- Make sure that all parties, especially foster parents, are aware of available services.

For more information on the approach described in this document, contact:

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Appendix A: WIHD Family Program

Site Visit Interviews Conducted

Westchester County DSS

- Administrators
- Supervisors
- Social workers

DSS Pediatric Unit

- Director (pediatrician)
- Health Services Coordinator

WIHD

- Director
- Associate Director
- Family Program Director
- Developmental pediatrician
- Speech-language pathologist
- Social workers
- Psychologists
- Child psychiatrist
- Office manager
- Administrative assistant
- Registration clerk
- Educational specialist (LEAP program)

Parents

- Birth parents
- Foster parents
- Adoptive parents

Court System

- Supervising Judge, Westchester County Family Court System
- Educational specialist to the judge
- Law guardians
- CASA program director
- Senior Policy Analyst, Permanent Judicial Commission on Justice for Children

Westchester Medical Center

- Behavioral Health Center staff



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