B11 Partnering to Transform Foster Care Through the Quality Parenting Initiative (QPI), Part 1

Wednesday, June 13, 2018 1:30 - 3:00 p.m.

C11 Partnering to Transform Foster Care Through the Quality Parenting Initiative (QPI), Part 2

Wednesday. June 13, 2018 3:30 - 5:00 p.m.

Jennifer Rodriguez, Diana Macis, Tracy Schiro, Lucy Salcido Carter

Salon 8

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What is *QPI*?

The Quality Parenting Initiative is an approach to strengthening foster care, by refocusing on excellent parenting for all children in the child welfare system.

When parents can't care for their children, the foster or relative family must be able to provide the loving, committed, skilled care that the child needs, while working effectively with the system to achieve the best possible permanency option for that child. Both the caregiver's parenting skills and the system's policies and practices should be based on child development research, information and tools.

Fulfilling this commitment is challenging, in part, because systems have been primarily focused on finding placements or beds, rather than the most suitable family for these children who are temporarily away from home. This attitude is reflected in the differences between standards for adoptive parents, which focus on the family's strength and weakness, and foster parents, which focus on the safety of the physical home. This influences the public image of adoptive parents, seen as loving and altruistic, as opposed to foster families, who are often seen as financially motivated and uncaring. The foster care "brand" is tainted and deters families from participating rather than encouraging them.

QPI is an effort to rebrand foster care, not simply by changing a logo or an advertisement, but by changing the expectations of and support for foster parents and other caregivers. The key elements of the process are defining the expectations of caregivers, clearly articulating these expectations (the brand statement) and then aligning the system so that those goals can become a reality. When these changes are accomplished, the new brand becomes the basis for developing communication materials and designing integrated recruitment, training and retention systems.

When QPI is successful, caregivers have a voice, not only in issues that affect the children they are caring for, but also in the way the system treats children and families. Caregivers, agency staff and birth parents work as a team to support children and youth. Caregivers receive the support and training they need to work with children and families and know what is expected as well as what to expect. Systems are then able to select and retain enough excellent caregivers to meet the needs of each child for a home and family.

Communities participating in QPI have formed a network that shares information and ideas about how to improve parenting, recruit and retain excellent families. They develop policies and practices that are based on current child research to support skilled loving parenting.

California Partnership Plan for Children in Out-of-Home Care

Teamwork, Respect, Nurturing, Strong Families

All of us are responsible for the well being of children in the custody of child welfare agencies. The children's caregivers along with the California Department of Social Services, county child welfare agencies, private foster family agencies, and contractors and staffs of these agencies undertake this responsibility in partnership, aware that none of us can succeed by ourselves.

Children need normal childhoods as well as loving and skillful parenting that honor their loyalty to their biological family and their need to develop and maintain permanent lifelong connections. The purpose of this document is to articulate a common understanding of the values, principles, and relationships necessary to fulfill this responsibility. The following commitments are embraced by all of us. This document in no way substitutes for or waives statutes or rules; however, we will attempt to apply these laws and regulations in a manner consistent with this agreement.

Caregivers and Agency Staff Work Together as Respected Partners

1. Caregivers and child welfare agency staff will work together in a respectful partnership to ensure that the care we provide to our children supports their healthy development and gives them the best possible opportunity for success.
2. Caregivers, the family and agency staff will conduct themselves in a professional manner, will share all relevant information promptly, and will respect the privacy and confidentiality of all information related to the child and his or her family.
3. Caregivers, the family, and agency staff will participate in developing the plan for the child and family, and all members of the team will work together to implement this plan. Caregivers will participate in all team meetings and court hearings (including review and post-permanency hearings) related to the child's care and future plans. Agency staff will support and facilitate caregiver participation through timely notification, an inclusive process, and the provision of alternative methods of participation for caregivers who cannot be physically present.
4. The Agency will honor and respect the caregiver's right to take a time-limited break from accepting the placement of children into their family without fear of adverse consequence from the agency.
5. Caregivers will work in partnership with agency staff to obtain and maintain records that are important to the child's well being including, medical records, school records, photographs, and records of special events and achievements.

Nurturing Children and Youth

1. Excellent parenting is an expectation of caregivers. Caregivers will provide and agency staff will support excellent parenting. Excellent parenting includes:
    - a loving commitment to the child and the child's safety and well being;
    - equal participation of the child in family life;
    - awareness of the impact of trauma on behavior;
    - respect for the child's individuality, including likes and dislikes;
    - appropriate supervision;
    - positive, constructive methods of discipline;
    - involvement of the child in the community;
    - a commitment to enable the child to lead a *normal life;*
    - encouragement of the child's strengths; and
    - providing opportunities to develop the child's interests and skills.
2. Agency staff will provide caregivers with all available information in a timely manner to assist them in determining whether they are able to appropriately care for the child. Children will be placed only with caregivers who have the ability and willingness to accept responsibility for caring for the child in light of the child's culture, religion and ethnicity, physical and psychological needs, sexual orientation, gender identification and expression, family relationships, and any special circumstances affecting the child's care. Agency staff will assist them in obtaining the support, training, and skills necessary for the care of the child.
3. Caregivers must be willing and able to learn about, be respectful of and support the child's connections to his/her religion, culture, and ethnicity.
4. Agency staff will provide caregivers with information on expectations for excellent parenting. Caregivers will have access to and be expected to take advantage of all training they need to improve their skills in parenting children who have experienced trauma due to neglect, abuse, or separation from home; to meet these children's special needs; and to work effectively with child welfare agencies, the courts, biological families, the schools, and other community and governmental agencies.
5. Agency staff will provide caregivers with the services and support they need to enable them to provide quality care for the child. Caregivers will be expected to identify, communicate, and seek out their needs without fear of judgment or retaliation.

6. Caregivers will fully incorporate the child/youth into their family, including equal participation in family activities such as vacations, holiday celebrations, and community activities. Agency staff will support families in overcoming barriers to full participation in family life and activities.

7. Once the caregiver accepts the responsibility of caring for the child, the child will remain with the caregiver unless:

   - the caregiver is clearly unable to care for him/her safely or legally;
   - the child and his/her family of origin are reunified;
   - the child is to be placed with a relative or non-relative extended family member;
   - the child is being placed in a legally permanent home in accordance with the case plan or court order; or
   - the removal is demonstrated to be in the child's best interest as determined through consultation with agency staff and other resource partners.

8. If the child/youth must leave the caregiver's home for one of the above reasons and in the absence of an unforeseeable emergency, the transition will be accomplished according to a plan developed jointly between the caregiver and agency staff. The development of the plan should involve cooperation and sharing of information among all persons involved. This transition will respect the child's developmental stage, psychological needs and relationship to the caregiver family, ensure they have all their belongings, and allow for a gradual transition from the caregiver's home, and, if possible, for continued contact with the caregiver after the child leaves.

Supporting Families

1. When the plan for the child includes reunification, caregivers and agency staff will work together to support that plan and to provide continuity for the child by assisting the biological parents in improving their ability to care for and protect their child, including as appropriate, participation in medical/related care, school, and other important activities. Agency staff will support caregivers in the reunification process, respect their input, and will not *retaliate* against them as a result of this advocacy.

2. When the plan for the child includes adoption, relative placement, or a move to a new foster family, with the support of the agency, the existing and the prospective caregiver will work together, with the support of the agency, to facilitate a smooth transition by sharing information about the needs, experiences and preferences of the child. To provide continuity for the child, prospective families are encouraged to participate in medical/related care, school, and other important activities. Continued contact between the child and the initial foster family is encouraged as long as it is in the child's best interest. The transition plan from foster care to adoption or relative home shall focus on meeting the developmental and other needs of the child.

3. Caregivers will respect and support the child's ties to family (parents, siblings, extended family members), and other significant relationships, and will assist the child in maintaining these relationships through facilitating appropriate visitation and other forms of communication in accordance with the case plan. Agency staff will provide caregivers with the information, guidance, training, and support necessary for fulfilling this responsibility.

Strengthening Communities

1. Caregivers will advocate for children with the child welfare system, the court, and community agencies, including schools, child care, health and mental health providers, and employers. Agency staff will support them in doing so, respect their input and will not retaliate against them as a result of this advocacy.
2. Caregivers will participate fully in the child's medical, psychological, and dental care, including:

    - identifying doctors and needed specialists;
    - scheduling regular and necessary appointments;
    - accompanying children to appointments;
    - sharing information with medical, psychological and dental professionals as needed to provide care to the child and as permitted by law;
    - supporting and comforting children during and after visits; and
    - implementing any needed follow-up care in the home.

Agency staff will support and facilitate this participation. Caregivers and agency staff will share information with each other about the child's health and well being.

3. Caregivers will support the child's school success through activities, including:

    - participating in school activities and meetings, including IEP (Individualized Education Plan) meetings, back to school nights and other school events;
    - assisting with school assignments;
    - accessing and supporting tutoring;
    - meeting with teachers, including teacher conferences;
    - coordinating school transportation;
    - working with the biological parent as educational rights holder or educational representative or surrogate if one has been appointed;

- encouraging and supporting the child's participation in extra-curricular activities; and
- Agency staff will support and facilitate this participation. Caregivers and agency staff will share information with each other about child's progress and needs, academic performance, behavioral functioning and issues regarding school placement.

4. Caregivers will provide developmentally appropriate opportunities to allow children and youth to learn and practice life skills and have hands-on experiences in preparation for transition to adulthood, including:
   - participation in family decisions;
   - routine age appropriate household activities and chores;
   - conflict resolution;
   - money management and financial planning;
   - assistance with job and career exploration/development;
   - assistance with higher education and financial aid exploration/processes;
   - obtaining housing;
   - obtaining legal documents; and
   - support the youth in accessing and taking advantage of agency and community resources.

Caregiver Signature:

Name:

Agency Staff Signature:

Name:

Date:

Group Care in the United States: A Brief Review of Prevalence, Problematic Outcomes, and Alternatives

Lindsay Zajac
Doris Duke Fellow

What is the prevalence of congregate care in the United States?

- In the United States, approximately 60,000 children are living in congregate care settings, with approximately 34,000 in institutions and 26,000 in group home settings (U.S. Department of Health and Human Services, 2015). This represents 14% of the foster care population in the United States (U.S. Department of Health and Human Services, 2015). For those children and youth who are placed into group care settings, the average length of stay is eight months; however, 34% typically spend more than nine months in group care settings (National Center for State Courts, 2017).

Why is group care problematic?

- *Group care makes it more challenging for children of all ages to develop a secure, healthy **attachment** to at least one adult.*
    - Attachment during infancy is critical while children's regulatory capabilities are not fully developed. Primary attachment figures help children regulate their physiology, attention, and behavior (e.g., Bowlby, 1969/1982). **Children who develop insecure attachments with their caregivers are at increased risk for problematic outcomes**, including externalizing behaviors (Fearon et al., 2010) and psychopathology (Lyons-Ruth et al., 1997). Secure attachments have been linked with optimal outcomes, such as social competence, self-reliance, and strong emotion regulation (Sroufe et al., 2005).
    - Shift care (even when shifts lasts hours or days) interferes with accessibility to a consistent parent figure (Hawkins-Rodgers, 2007). In group care settings, there are often rules and regulations that prohibit activities that would encourage relationships between staff and youth (Dozier et al., 2014). These experiences make it difficult for children to develop a secure attachment relationship to a consistent adult figure.
    - Children in group care settings report seeing family members less often than children in kinship care. They are also less likely to be reunified with their biological caregivers, and this is particularly true for children between the ages of 6 and 12 (Barth, 2002; Wulczyn, Hislop, & Goerge, 2000).
    - When children are not able to access adults for consistent, emotionally close relationships, they must rely on peers (Kobak, Herres, Gaskins, & Laurenceau, 2012). These peer relationships can be maladaptive when peers have emotional and behavioral problems (Dishion, McCord, & Poulin, 1999).
    - It is also important for adolescents to develop healthy attachments to adults. When adolescents lack a relationship with a parent figure, they are more likely to become susceptible to **deviant peer influence** and **engage in risky behaviors** (Allen et al., 1998; Dishion et al., 2004). Moreover, living with peers who have behavioral and emotional problems can further compound this risk (Dishion et al., 2004). A committed and invested adult provides resources and support (e.g., providing structure and supervision, encouraging engagement in the future, planning for school) for adolescents that are unique from peers (Allen et al., 1998). These types of support are essential as adolescents transition into adult roles.
- *Group care is not conducive to helping older children develop **autonomy**.*
    - For older children, a critical developmental task is balancing the desire for autonomy and the need for parental control and regulation. This is a complex process, which begins when children are as young as eight years of age, and involves learning the rules and values of cultures, maintaining close relationships, and becoming self-reliant (Collins et al., 2005; Kobak et al.,

2012; Smetana et al., 2015; Sroufe, 2005). Given the nuances of this developmental task, it is essential that rules and consequences be **tailored to individual children** and that rules are modified as children mature (Smetana, 2011).
    - A group care setting that requires standardization (e.g., fixed rules and procedures that are applied to everyone) interferes with the development of autonomy and prevents older children from developing critical planning and decision-making skills. Settings that overregulate older children's lives, particularly in the areas of privacy and personal choices (e.g., leisure and recreational activities), might lead to defiance and decrease children's willingness to disclose information (Dozier et al., 2014).

- *Group care itself may be associated with* ***an increased risk for problem behavior, academic difficulties, and physical danger.***
    - A large-scale study compared youth in group settings to a sample of youth living in foster care (Ryan et al., 2008). After controlling for race, sex, abuse and placement history, presence of behavior problems, and history of running away, **youth placed in group care settings were 2.4 times more likely to be arrested than youth in foster care** (Ryan et al., 2008). Similarly, a recent systematic review comparing group care and foster care estimated that foster care prevented almost half of the delinquent or criminal acts over the course of 1-3 years (Osei et al., 2015).
    - Compared to children placed into family foster care arrangements, children in group homes are more likely to receive mostly Cs and lower in school, have truancy problems, take remedial classes, and attain lower levels of education (Berrick et al., 1993; Festinger, 1983; Knapp et al., 1987; Mech et al., 1994). Moreover, **children and youth who have *extended* placements in group homes are also more likely to test below or far below in basic English and math** and drop out of high school (Ryan et al., 2009; Wiegmann et al., 2014).
    - Children in group care settings are at increased risk for maltreatment compared with children placed with families (Euser et al., 2013, 2014). A study comparing the prevalence of maltreatment in foster and residential care to the prevalence in the general population suggests that **sexual and physical abuse occur more frequently in residential care settings** than the general population (Euser et al., 2013). Sexual abuse occurred more frequently in residential care than in either foster care or the general population, whereas the rate of sexual abuse in foster care did not differ significantly from the general population. The rate of *self-reported physical abuse in residential care was almost double that of foster care* and *triple that of the general population* for same age adolescents (Euser et al., 2013). This violence and abuse might be due to the instability of providers in residential care leading to fewer secure attachment relationships between staff and children, high staff turn-over, and instability of the groups (Alink et al., 2012; Winters et al., 2011).

There are other options…

- Children are frequently placed into residential care settings due to substance abuse, sexual acting out behavior, and delinquency (Dishion et al., 1999). However, **these problems can most times be treated effectively and safely in the community outside of a residential care setting.** Cognitive-behavioral, family systems, and motivational enhancement therapies are effective treatments for addressing adolescent substance abuse and can be delivered in outpatient settings (Winters et al., 2011). Multisystemic therapy (MST) has been adapted for juvenile sexual offenders and is associated with significant reductions in sexual behavior problems, delinquency, substance use, externalizing problems, and out-of-home placements (Letourneau et al., 2009; Swenson et al., 2010). Multidimensional Treatment Foster Care (MTFC), which is another community-based treatment for serious juvenile offenders, has been compared with group care. Youth who received MTFC had higher completion rates, lower rates of recidivism, and fewer subsequent days in detention centers than youth who received group care interventions (Joseph et al., 2014; Schaeffer et al., 2013).

- **Even children who have histories of abuse and neglect and who have a late placement in foster care are still able to develop secure attachments with a caregiver** (Joseph et al., 2014). Of note, the quality of adolescent-parent interactions is related to the likelihood that a child develops a secure attachment to a foster caregiver. The adolescents who develop secure attachments to their foster caregivers show better behavioral and social adjustment than adolescents who develop insecure attachments (Joseph et al., 2014). Additionally, foster parents demonstrate higher levels of commitment to children living in their homes than staff in group care, and this finding holds when children's externalizing behaviors and the number of children the caregivers had cared for were controlled (Lo et al., 2015).
- The cost of placing children in non-family based placements is ***7-10 times higher*** **than the cost associated with family based settings** (National Center for State Courts, 2017). *What about temporary group care while children and youth participate in assessments and treatment planning?* Research suggests that this group care is also significantly **more costly than foster care and is not associated with a significant reduction in likelihood of re-abuse or the number of future placements** (DeSena et al., 2005). Moreover, conducting assessments in the context of group care is problematic because the setting is unnatural and attachment relationships are disrupted.
- Over 40% of children and youth placed into group care do not have a documented clinical or behavioral need that might require such a placement (National Center for State Courts, 2017). Group care should be used as therapeutic treatment in children only when clinically necessary and is the least detrimental alternative. ***Group care should never be preferred over family care*** (Dozier et al., 2014).

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Questions?

Contact Lindsay at lzajac@psych.udel.edu.

Lindsay Zajac, M.A.
Doris Duke Fellow
PhD Candidate at University of Delaware
Advisor: Mary Dozier, Ph.D.