

**State of Wisconsin  
Child Welfare System:  
Input for Change**  
*A private partner perspective*

**January 2010**

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## I. Executive Summary

St. Aemilian-Lakeside, Inc. (SAL) and Anu Family Services, Inc. (Anu) have come together to share input into the current efforts related to State of Wisconsin child welfare system change—including, but not limited to, general input for changes affecting rate regulation, levels of care, graduated licensing, performance-based contracting, regionalization, and other initiatives—from a provider perspective. It is our intention to outline points and perspectives that will assist the State in considering a provider viewpoint when crafting system change that will better serve the needs of Wisconsin children and families. We have intentionally veered away from outlining specific suggestions related to program change, as it is our aim to offer a larger systems perspective on this topic.

The impetus for creating this document is that we agree that there is a different ion of measures of accountability, outcomes and quality within the system. We have worked in collaboration with key colleagues at other agencies; however, as a larger provider community, we have not been able to develop a consensus on recommended measures or standards of quality and accountability within the system. Therefore, we have developed a smaller partnership between our two agencies where we have found common histories and perspectives for recommendations for future standards and measures of quality.

### The key messages:

1. Any systems change should include a **flexible continuum of services** that attempts to **safely serve children in their homes, focuses on prevention and family preservation services and post-permanence supports** and uses **current best-practices and encourages innovation** to put the child and their family at the center of services.
2. The system should include **safeguards to ensure quality delivery of services** including, but not limited to:
  - a. Mandated private agency Council on Accreditation (COA) accreditation
  - b. Incentivized performance-based contracting focused on quality outcomes using accurate bench mark data which may measure: permanence at discharge, re-entry into the system, and length of stay, among other potential variables
  - c. Supported use of research-informed and innovative practices
3. **Public-Private partnership** which sets up systems to ensure an open dialog and collaborative partnership between the State, counties and private agencies. These systems need to be continuously evaluated and improved upon in a non-blaming-based manner which encourages information sharing and shared learning to maximize positive outcomes for Wisconsin's children and families.

SAL and Anu are concerned with preserving the high quality service standards and innovations that produce outstanding outcomes for children and families. We believe in provider accountability to outcomes, and we are committed to working in partnership with our public and private partners to create the best possible outcomes for Wisconsin's children and families. It is in this spirit of mission-driven service to children and families that we have co-created

this paper. We hope that our perspective and combined years of practice will be of benefit to those who are responsible for creating a system of care which is based on quality. For more information regarding the partnership and history between SAL and Anu, please refer to *Appendix A*.

We thank you for your time and express appreciation for your attention to our perspective. We look forward to a time when there is a greater public-private partnership in Wisconsin, as we believe that this can only benefit those we serve together. We are encouraged by recent efforts and dialogues and look forward to increased collaboration in the future. We are available to respond to any questions you may have. In addition, both SAL and Anu extend whatever assistance we are able to give to help support systems change efforts that improve the quality of care and positive outcomes for children and families in Wisconsin.

## II. Key Assumptions and Values

An essential element of understanding the perspective we offer on system change is understanding the key assumptions and values that underlie our responses. Therefore, the following are our values and beliefs which define our perspective:

- In relation to children and families, we believe:
  - that, whenever safely possible, children should be with their families.
  - that it is a child's right, except in extreme cases which would do the child harm, to have contact with their family (not just their parents and their siblings) and with others they care about.
  - that with the proper supports, hardly any child could not be cared for by and/or live with someone in their family.
  - in prevention, rather than deep-end investments.
  - in healing children, not just "treating" children.
  - that children need a sense of permanence, hope, connection, belonging, and purpose in order to heal.
  - there are currently children in foster care and treatment foster care who could be served safely at home with necessary supports and more extensive family searches.
  - that family is the core therapeutic environment where real change happens
  - that caregivers (birth, kin, foster parents, treatment foster parents and other guardians) are vital members of the child's care team.
- In relation to systems, we believe:
  - that major changes—not tweaking—are needed to create a system that provides the best possible services to children and families.
  - that a healthy system is needed to create health in children and families and that open communication is needed between the public and private sector if we expect our workers to communicate openly with our families, our treatment foster parents, with our children, and so on (Ekstein & Wallerstein, 1958).

- that system changes should be inclusive of all voices, well-communicated, and planful; not crisis-focused.
- that there are significant differences between Milwaukee and the other 71 counties in the state, and that both rural and urban systems have achieved successes that can be drawn upon to create the best system of care.
- that the “silos” and fragmentation of services and funding (e.g., medical, public health, child welfare, education, W-2, housing & mental health) create unnecessary hardship for our children and families and create wasteful duplication.
- that providers should be held accountable to provide quality services.
- that the Council on Accreditation is an outstanding tool to help ensure provider quality.
- that providers should be compensated based on the outcomes they deliver (e.g., we support performance-based contracting—in some of its forms).
- that any “cost savings” from a systems redesign must be included in system reinvestment.
- that systems design should be driven primarily by service needs and outcomes and secondarily by funding.
- that to sustain the availability of quality providers in Wisconsin, there must be “risk-sharing” between the State/counties and providers; not just a transfer of risk to providers.
- in using evidence-informed and evidenced-based practices.
- that evidence-informed and evidence-based practices will not and cannot be used if they are not properly funded and supported.
- that issues of race and disproportionality must be addressed more effectively to create less disparity for our children and families.
- that no one provider can be expert in all areas and that families should have access to a diversity of providers who produce quality outcomes.
- in a strength-based, non-blamed-based, system of care (e.g., not blaming providers, families, or children, but finding cooperative and innovative solutions to complex problems).
- that Treatment Foster Care (TFC) is substantively different than “regular” foster care. This model requires intensive staff and treatment foster parent education, supports, and evidence-informed interventions to manage and change intensive and challenging behaviors in community-based settings.
- that it is essential to base any system changes or targets on accurate data and benchmarks.
- that any reimbursement model must include the full cost of providing the service (recruitment, screening and licensing of foster parents, COA, quality measures, evidence-informed practice tools and resources, risk-management, etc.).

- that systems should not be designed to encourage gravitation to the mean or to encourage mediocrity; rather, should allow the support and funding necessary to encourage innovations and application of best-practices.

### **III. The Redesign of Wisconsin's Child Welfare: Supportive Suggestions from Private Partners**

To truly achieve the goals of permanence, safety and well-being for Wisconsin's children, we need to enlist in deliberate and collaborative change and improvement in the child welfare system that emphasizes family preservation, child protection, and permanence. The current foster care system, while in existence to create safety, permanence and well-being for a child and his/her family, is inherently fragmented. Our perspective on current system fragmentation and challenges is more thoroughly outlined in *Appendix B*.

The current Wisconsin child welfare system is organized around complicated federal, state and county funding streams and further fragmented by the varied state departments in which they are housed. Although there are a number of critical components offered to families including a continuum of care ranging from preservation services to child protection to reunification, these services often fall short of achieving positive outcomes due to fragmentation, limited scope and duration of services and "siloed" funding.

According to the recent Recruitment and Retention plan, (Utah Foster Care Foundation report 7-29-09) "organization fragmentation and a lack of communication and teaming have created significant challenges and contributed to the disconnected nature of successful child welfare outcomes for Milwaukee County".

There are currently numerous states and organizations across the country focused on the work of reforming child welfare. The National Coalition of Child Protection Reform (NCCPR), an organization that has had success in advocating for family preservation over increasing placement in out-of-home care, cites numerous national examples of the efficacy of family preservation work. After the death of a child in foster care in Missouri, NCCPR's work resulted in a sharp cut of entries into foster care with no compromise of child safety. As a result of a consent decree, Alabama's system of care was required to rebuild its system from the ground up, with an emphasis on keeping families together. They achieved one of the lowest rates of removal in the country. An independent monitor has found that children are safer in Alabama now than before the welfare reform changes. Real systems change does not come from tweaking existing systems.

#### **To advance best practices and prevention strategies to improve outcomes for vulnerable children and families we propose the following:**

**A) Support the Casey Family Programs 2020 Vision** to safely reduce the number of children in foster care by 50% and improve self-sufficiency for those who remain in the system. To effectively serve children and families to achieve the 2020 Vision, the child

welfare system needs to: build political will; develop leadership; provide quality front-line supervision and set reasonable caseloads; engage the community and collaborate across systems such as mental health, employment, education and housing; enforce data-driven accountability and allow time for change. In addition, for children who must remain in foster care, we also support Casey's focus on improving the education, employment and mental health access and support for foster youth.

**B) Serve children in their families** (birth and extended kin) through a continuum of services to prevent child welfare/child protection/juvenile justice system involvement and out-of-home care. Ensure that these services replicate the success of the Wraparound philosophy with an emphasis on prevention and family preservation services and informal family and community supports. Create varied levels of services and intensity to allow for the individual needs of the children and families to be served. Strengthen crisis intervention services and family resource centers as one-stop shops to create locally supported and coordinated resources for families. The return on investment to keeping a child and family together will undoubtedly save the state millions of dollars in higher cost systems such as placement services and prisons.

Connecticut offers another example of effective child welfare reform. As cited in Open Minds newsletter, since 2004, "Connecticut has invested in dramatically expanding and altering the range of services for children and families. The Department of Children and Families (DCF) has developed intensive in-home clinical services and family support services not available prior to 2004. These changes and increased investments in community-based services have resulted in:

- Fewer children being placed in out-of-home care as the result of abuse or neglect—a 16% reduction in four years
- More children being placed in a family setting than previously—72% of children now, compared to 57% four years ago
- A consistent increase in permanency exits from foster care
- A consistent increase in number of child adoptions within 24 months
- Less than 10% of children in care were placed in a residential placement, a reduction of 45% compared to April 2004. This was the 13th consecutive quarter that staff met the outcome measurement standard

(Connecticut Invests in Community-Based Services: Performance Measures Show Leaps & Bounds in Child Placement Outcomes).

As one former foster youth put it, *"If the state had invested the same money they spent putting us in all those placements into weekly visits with our mother and given her skills lessons, it might not have escalated to us needing to go into permanent foster care."* M.D., former foster youth.

**C) Engage in Family Finding** to identify relative options for children early in the life of a case. Case managers are too often given limited information about relatives. The Quality Service Reviews highlight the challenges in engaging birth fathers in their child's life. Multi-

systemic interventions need to be utilized to locate and engage a higher percentage of birth fathers and other significant adults in a child's life. Through research-informed practices, Anu has increased child permanence nearly 20% over the past 3 years. With financial support for the use of family-finding practices such as the Family Search and Engagement model, even more youth would be reunified or adopted. The current system is overtaxed in its ability to complete thorough searches over time. This leaves many children disconnected from family and other significant adults and lingering in the system in multiple placements far longer than necessary which substantially increases both child trauma and public investments.

**D) Support caregivers and ensure family connections are preserved** through placement of children or youth in a home with a relative caregiver (also commonly referred to as a kinship caregiver). Keeping children with family members sustains their connection to their family roots and usually provides closer proximity to other relatives and siblings, which allows them to receive family support that is unavailable or infrequent with non-kin placements. Additionally, relative foster placements may be beneficial, as they avert additional trauma for the child by providing the child with a sense of family support and should be the first standard of out-of-home care for a child.

According to a 2007 national study performed by AARP, "2.4 million grandparents report they are responsible for their grandchildren living with them: 29% of these grandparents are African American; 17% are Hispanic/Latino; 2% are American Indian or Alaskan Native; 3% are Asian; and 47% are White. 34% of these grandparents live in households without the children's parents present. 71% are under the age of 60; 19% live in poverty." (AARP et al., 2007)

If children need to be removed from their homes as a result of neglect or abuse, we need to provide intense services to foster families and kinship homes to move toward permanence. Currently, limited resources are provided to relatives who step forward to care for a child. Similar supports and resources need to be offered to kinship providers to ensure their success. The use of family-finding models would also greatly improve kinship searches and placements.

**E) Engage in performance-based contracts** with private agency providers to achieve positive outcomes (rather than "outputs") for children and their families. A number of states have experienced great success with performance-based contracting in purchasing cost-effective out-of-home care placements and reducing the number and length of out-of-home placements. Currently, out-of-home providers receive no incentive to move a child to permanency. If established correctly, one of the benefits of performance-based contracting to providers is that it offers flexibility and encourages innovation free of categorical and restrictive funding limitations.

**F) Reinvest any savings** of reduced out-of-home care and shorter placements to strengthen services to families and children in their own homes. Currently, the vast majority of federal

funding for Title IV-E is available for children once they are placed into care. Thus, states are inadvertently encouraged to rely on foster care as the main solution to the complex problems facing children and families. Reinvestment dollars that are focused on pre and post treatment and support services have proven to be both cost-effective and to achieve the desired outcomes of safety, well-being and permanence.

In Allegheny County, PA., the county has tripled its spending on prevention and intervention services for families involved with the child welfare system. The county currently spends more than half of its child welfare budget on prevention and in-home services. The county calculates that foster care costs \$25,000 annually per child, compared to an annual per family cost for intensive family support of \$10,000 or less (North American Council on Adoptable Children, November 2007). We also believe that any “savings” in reducing the number of children in care should be re-invested in prevention and post-reunification supports and to be used to fund innovations.

**G) Require accreditation for private agency providers** to ensure quality and incent private agencies to achieve performance. We recommend that all agencies be required to be accredited by the Council on Accreditation (COA). COA is the internationally-recognized best practice standard of quality care in child welfare. The added benefit to requiring COA accreditation is the option for the State to work in partnership on the renewal and application of child placing agencies and to align the standards and regulations, thereby creating a more streamlined and cost-effective process.

**H) Strengthen systems to support public/private partnerships** to leverage the diversity, expertise, and innovation of private partners in the development of public service delivery systems. Without opportunities for open and direct communication, real influence and involvement, and a commitment to true collaboration and partnership, critical change cannot happen for children and families. We must work together to meet our joint goal of promoting the permanence, safety and well-being of Wisconsin’s children.

#### **IV. Summary of Strategic Vision: a provider prospective**

It is our shared vision that resources will be dedicated to do everything reasonably possible to keep families and children safely together. This includes providing services to children in their homes of origin, offering parental supports, and avoiding out-of-home care whenever possible.

When out-of-home care is necessary to protect the child, it is our vision that a significant search of a child’s extended family will occur, and a child will be reunited with someone in their family as soon as possible. Everything possible will be done to preserve a child’s contacts and supports with family and any other significant relationships (e.g., special relationships with ministers, teachers, neighbors, and adults who provide loving, stable support to

a child). In addition, families will receive the post-reunification supports they need to help maintain the child safely in their home.

While in out-of-home care, we believe that the use of contact with family and extended supports, research-informed/evidenced-based practices, and trauma-informed care produces the greatest success in outcomes for children. Our vision is that all TFC agencies will be COA (Council on Accreditation) certified to ensure adherence to quality standards and that agencies will have benchmarks that define and incentivize their performance targets (performance-based contracting).

It is our vision that the skills, education and experience of treatment foster parents will continue to be used to provide treatment in community-based settings for children and youth in need; however, as the use of family-finding and kin resources increases, treatment foster families will also be able to utilize their unique skills in many other ways. Treatment foster parents are highly skilled at managing complex, high-risk, and challenging behaviors in family-based settings. As more and more children are living in kin placements, those kin will need supports to manage those same challenging behaviors in their own families. Treatment foster parents are trained specifically in working with birth families and kin relations. They receive education in this area and are expected to support family relationships and connections for youth permanence. As more kin connections and placements are made, treatment foster parents will continue to use their outstanding education and skill to help teach and support kin families to safely manage their youth in their homes.

In addition, treatment foster parents can serve as a safe place for kin families to call for advice and support, and can function in the role of respite provider and family resource. There may be a time when more treatment foster parents initially work with youth in the foster home, then transition to a para-professional staff role to support post-reunification with kin families.

Our vision is that there will be an open dialogue of collaboration and respect between public and private partners to create a system that uses what we know to be best-practice in child welfare, produces the greatest possible outcomes for children and families, and is fiscally responsible. We believe that all of these goals can be achieved simultaneously if we work together in new and innovative ways to create what the system should be, not just a revised version of what it already is today.

### **Appendix A: SAL and Anu's Collaborative History**

St. Aemilian-Lakeside, Inc. (SAL) and Anu Family Services, Inc. (Anu) (formerly PATH Wisconsin), have a long-standing, collaborative history of working together to further the best interest of Wisconsin's children and families. Over the past 8 years, SAL and Anu have worked together on numerous projects and initiatives rooted in quality services through which we have developed a spirit of trust and collaboration between our agencies and our staff. In addition, since 2005, SAL and Anu have been collaborative partners with Adoption Resources

of Wisconsin to create and manage the newly created Wisconsin Foster Care and Adoption Resource Center.

Given our shared history and our commonalities, it seemed a natural fit for our agencies to come together to craft this paper to put forth our perspective as providers to help inform the current discussions and to shape the change of the State of Wisconsin child welfare system. Although our primary focus is on Treatment Foster Care (TFC), both SAL and Anu have strong histories of providing a continuum of care which is heavily rooted in prevention and reunification supports for children and families. Therefore, in this writing we address many points on the service continuum, not only TFC services.

Although we understand that there is a great deal of expertise and long-time leadership at the State which is being consulted to help craft the changes in Wisconsin's child welfare system, we felt it was important to also document a provider perspective. We recognize and appreciate any current and future efforts to include providers' feedback in the redesign and believe that any and all input is important. We also recognize that there is a wealth of TFC providers in Wisconsin, with new agencies frequently being added and that not all agencies share the same perspective. Both SAL and Anu have encouraged collaboration between Wisconsin TFC agencies as long-time participants of the Milwaukee TFC Provider Collaborative Group and as co-founders of the Wisconsin FFTA (Foster Family-based Treatment Association) Chapter.

Much like the diverse perspectives of our county partners, not all private providers agree on the approach the State should take when facing child welfare changes. However, SAL and Anu share a common vision which prompted the decision to jointly share our vision. As long-time, quality providers and leaders of TFC and other services to Wisconsin's children and families, we offer the following perspective and input in the spirit of collaboration, open communication, and respect. We understand that none of what we have written or offer may be included in any systems changes, but felt it our obligation to provide any insight and practice wisdom we have gained throughout our many years of providing services throughout Wisconsin. In addition, we offer both a rural and urban perspective and will attempt to address these differences whenever appropriate and possible.

SAL and Anu have a great deal in common as agencies which have supported the development of a strong working relationship. Some commonalities between SAL and Anu include the following items, each of them critical to this conversation:

- Agency culture and history of delivering outstanding outcomes
- Certified by the Council on Accreditation (COA)
- Active members with leadership roles in the FFTA (Foster Family-based Treatment Association)
- Founding members and leaders of the Wisconsin FFTA Chapter
- Active members of WAFCA (Wisconsin Association of Family and Children's Agencies)
- Use of evidence-based, evidence-informed, and best practices

- Focus on interventions which heal children by building a sense of connection, purpose and hope
- Organizational cultures which support innovation
- Drive and desire to be national leaders in our field in delivering outcomes to children and families
- Passion for advocacy which furthers the best interest of children and families; including additional supports for children aging out of care, changes in consent requirements to facilitate family connections, and others
- Advanced e-records and outcomes measurement systems
- Actions and decisions guided by the highest level of ethics and integrity
- Strengths-based approaches with our children, our families, our partners, and our staff

In addition, SAL currently serves Milwaukee and Southeastern counties most heavily, while Anu works with 43 counties across the State, primarily in the west, central and Madison areas. Therefore, SAL and Anu do not currently overlap significantly in their service areas. This creates a complementary service culture, rather than a competitive one, which allows for a more open dialogue.

## **Appendix B: System Challenges and Fragmentation: A treatment foster care provider perspective**

The true mission of child welfare becomes blurred as the layers of law, statute, funding streams and lawsuits against states muddy the services based on the best interest of the child, or the best interest of the family. Service delivery is dictated by funding streams rather than needs of the child and family. Prevention services are overlooked in favor of placement options that lack systemic focus. Communication across the service continuum is fragmented. Children are too often placed outside of their communities. Service areas, including treatment foster care, are poorly defined and misunderstood by system partners, and the child welfare system is often blaming and punitive in nature. All of these factors contribute to reduced outcomes for children and families.

Currently in many communities, a primary mechanism for access to services for children and families is contact with child protective services after an incident or allegation has already taken place rather than access to services to support prevention. When a child and family are in crisis, placement in out-of-home care is too often the default intervention. One of the only open doors to families to access services is through maltreating a child or creating an unsafe situation. The family receives services through the complex flow chart that begins with a report of abuse or neglect and the subsequent screening, investigation, intake and assessment. Not all families need the same level of support, yet our systems do not provide for real differences in need and complexities in families. In addition, the system is set up to “close a case” when the child reaches permanence. The services for the families cease unless there is another incident that results in a call to child protection.

Out-of-home care services are mandated by the State, and funding streams provide reimbursement for ongoing case management and placement. Prevention services--designed to assist families in crisis by improving parenting and family functioning, while keeping children safe--are not adequately funded. There is no formal support system or funding for kinship families, and there are inconsistent expectations of foster care and treatment foster care providers. Family preservation services need to be re-examined and comprehensively implemented to create a continuum of care for families identified with high risk needs. As a system, we need to be vigilant in never unnecessarily taking a child from their home and family. The primary question should become, “How do we keep this child safely at home?” The need to strengthen the skills and competencies of caregivers, including kinship and foster care providers, are too often undervalued and underfunded.

In addition, systems of care involved with families in crisis do not effectively integrate or collaborate. School systems, financial assistance providers, homeless services, mental health and other treatment providers are challenged to effectively exchange information and processes. Families, who are already challenged and/or in crisis, are required to interface with multiple, disconnected systems to receive services and make progress. To further complicate things, case workers on whom families rely, are trying to direct the coordination and

communication of multiple providers, while managing court orders, excessive documentation, ASFA timelines and the oversight of 15-30 children.

When placement in out-of-home care is determined to be the necessary path, the child and family often face a disjointed system. Purchasers and providers of the service delivery continuum often fail to communicate effectively with each other and the family about ongoing progress, the needs of the child, and expectations for the return home of the child. Due to the great fear of failing to protect children and the scrutiny of media, the system largely focuses on safety yet fails to effectively communicate about areas of concern and progress related to permanency and well-being. This communication breakdown is sometimes due to insufficient resources within the system, but more often results from a lack of coordination across systems both within and outside of the child welfare arena. Service providers are often reimbursed for actual direct face time with a client and not reimbursed for collaboration and coordination time, which diminishes the ability to truly coordinate a case in the best interest of a child/family.

Although strong efforts have been made, it is challenging to maintain effective communication between public and private foster care agencies; including treatment foster care, regular foster care and adoption. Due to competition (perceived and real), public and private agencies are not inclined to share resources or innovative successes. Public and private agencies struggle to share critical data and placement and service history, and treatment foster care agencies too often place children without the relevant information necessary to determine safe and healthy placement matches.

Due to lack of placement resources, children in out-of-home care are too often placed outside of their communities, sometimes hundreds of miles away from their home, school and family. These children experience significant loss of connections with their family, schools, churches and other community support systems. Reunification and family visitation is difficult due to scheduling and transportation challenges. And, when a child is returned home, the transition back to the family is intensified by the lack of continuity created by a long distance placement and need to manage multiple transitions. Post-reunification, families are often “on their own” to manage and stabilize a child at home.

An additional challenge to the system is that although treatment foster care (TFC) is a distinct model of care, which is significantly different from “regular” foster care, it is often poorly understood. In fact, treatment foster care is a clearly defined, researched model of care which has demonstrated outcomes. The TFC model of care, the standards that govern this model, and the differences between foster care and treatment foster care are clearly delineated in the Council on Accreditation’s (COA) Foster Care Service Standard, the Foster Family-based Treatment Association’s (FFTA) standards, and in the side-by-side licensing rule comparison located in *Appendix D*. The model has also been researched as a more effective and cost-savings model of care. (Bryant 2004). Wisconsin’s licensing regulations also differentiate TFC and regular foster care. However, the administrative codes HFS 56 (Foster Home Care

for Children) and HFS 38 (Treatment Foster Care for Children) do not go as far to delineate the two levels of care as COA and FFTA standards.

Treatment foster care (TFC) combines a unique service approach which allows children and youth with extremely challenging behaviors and needs to be served in families in the community. TFC is able to maintain community-based placements with these youth by using highly educated and experienced social workers and treatment foster parents to support youth in placement. Furthermore, when compared to “regular” foster care, TFC requires significantly smaller caseloads, increased child and treatment foster parent contacts and supports, utilization of evidence-informed assessments and clinical models of intervention, and increased focus on measuring, improving, and delivering outcomes for children in care.

There are a number of significant differences between foster care and treatment foster care (TFC). Treatment foster care implements a child assessment and from this establishes, monitors and reassesses the child and families treatment goals, has frequent visitation requirements between the social worker and child and the foster family, focused on both clinical and development reassessment.. TFC social workers are usually master’s level clinicians. They often have significant experience, education, and clinical expertise and utilize research-informed clinical interventions to assist the caregivers. Treatment foster parents receive more coaching, mentoring, and parenting support. In addition, treatment foster parents are included on the treatment team and are seen as primary change agents who are not only responsible for maintenance of the child, but are also responsible for supporting the advancement of a child’s treatment goals. They are expected to document a child’s progress and challenges and to attend additional training, above the required initial and annual training requirements, when needed to more effectively meet the needs of their foster child.

The relationship between the TFC agency and their licensed foster parents also sets TFC apart from regular foster care. The TFC agency’s work in this relationship begins with recruitment of the foster family. Throughout a family’s licensure, the TFC agency is focused on understanding the relationships and dynamics in the foster family, nurturing the foster parent’s strengths and enhancing their skills. The quality of this relationship provides the necessary support for the TFC parent to meet the numerous and complicated demands of the varied team players, in addition to the disruptive challenges of the children placed in their home. Case managers in regular foster care do not have the resources or expectation to work with the foster family in the same way as TFC workers.

Treatment foster care agencies across Wisconsin have struggled to define and communicate the essence of this distinct and unique model of care. In Wisconsin there are no consistent expectations of TFC agencies on outcomes achieved and required agency accreditation. There is a range of practice, quality and rates across TFC agencies. There is a misunderstanding of the types of children placed in regular foster care in comparison to treatment foster care. This confusion is not surprising due to the reality that sometimes the lack of family resources or the increase of children detained from their homes and needing out-of-home care puts a burden on

the system to place children in higher levels of care than may be necessary. It's also fair to acknowledge that children with intense emotional and behavioral needs are sometimes placed in regular homes that may or may not be capable or equipped to manage the needs of that child, sometimes leading to disruption. Ideally, TFC homes and services would be reserved for children who have serious levels of emotional, behavioral and medical needs, and who require services above and beyond the care and protection provided in regular foster care.

When considering challenges to the system, funding must always be considered. Anu has history with operations in a 4-state agency. With that experience, a number of state systems have been experienced. It bears mentioning that when there are inadequate administrative rates, the consequences are devastating to children. In order for agencies to sustain in inadequate rate environments; caseload sizes are increased to dangerous levels; applications of clinical or evidence-informed models become impossible to provide; support for birth families is not possible; training is greatly diminished for both staff and treatment foster parents; visits are performed at minimal standards, even when more are needed to provide stability; and adherence to quality standards is significantly challenged.

FFTA promotes a small and manageable caseload average for workers (eight per worker) to honor the necessary coordination and treatment and important family work that is expected to occur. There are some neighboring states where it is not possible for a provider to become COA accredited for treatment foster care due to the administrative reimbursement structures. This means that more children are placed in higher levels of care than is necessary because community-based/family-based treatment is not supported. It has long been established that, "even for those youth with longer lengths of stay in treatment foster care, efficacy promotes economy."(Bryant 2004)

In addition, complexity in systems has been shown to decrease an agency's ability to effectively serve children. For example, in Minnesota each child is assigned a "Difficulty of Care" or "DOC" rate. This creates extraordinary administrative complexity and time demands to properly record and bill each child's individual rate. In addition, the complexity is tied to increases in billing errors which lead to increased agency financial write-offs and loss of revenue. The complexity of a system where each child may have a different rate increases cost for both public and private systems. Decision makers are encouraged to consider simplicity—such as fewer levels—when creating rates, structures and other systems.

The foster care system is highly monitored and scrutinized by the government, media and the general public. Therefore, it is often a blame-based system where families, foster care workers and foster care agencies too often point fingers at one another instead of working together to find solutions. This blame dynamic prevents families from stepping up to be care providers, encourages compliance at the expense of innovation and creates public alarm and political overreaction resulting in workers focusing on paperwork rather than children.

## **Appendix C: Agency Profiles, Innovative Services and Outcomes**

### **St. Aemilian-Lakeside's Agency Profile**

St. Aemilian-Lakeside (SAL) is a dynamic non-profit, non-sectarian child welfare organization with over 150 years of services to children and families. Founded as an orphanage in 1850, the agency has evolved into a multi-service provider of treatment, educational and mental health services. St. Aemilian Orphanage became a residential treatment center in the early 1960's and over the past 40 years has continued to develop a continuum of services geared at prevention and treatment. In 2009, 1,271 children and adults were served through a wide array of family-centered, community-based services including; Treatment Foster Care, Care Coordination, Day Treatment, Residential Services, Community-based Mental Health, School-based Mental Health and Independent Living for young adults aging out of foster care.

Meeting the needs of children and families with complex needs is the primary focus of SAL's mission and history. SAL embraces a philosophy of family-centered care grounded in respect for diversity in all our programs. The family is central to the well-being of children and, as such, must be an integral part of any service or treatment. In addition, we fully recognize that each individual and family unit holds unique cultural and ethnic values that shape their every day behavior. Our staff has a proven track record of providing culturally proficient, family-centered services to a wide range of children, youth and families in southeastern Wisconsin. This belief is carried out in all activities of the agency and has its source in the agency mission:

*St. Aemilian-Lakeside, Inc. provides innovative family-centered care and educational services that embrace diversity and empower children, families and adults to improve the quality of their lives.*

### **St. Aemilian-Lakeside's Foster Care Services**

SAL's Foster Care Services are committed to facilitating permanence for children in out-of-home care, as well as to providing mental health and advocacy services for children with exceptional needs. Our treatment foster care (TFC) Program is guided by the belief that the well being of children is best nurtured through the program's positive involvement with birth family members, school personnel, agents of the court and social services, and other community members. Program staff and treatment foster parents are committed to participating in all spheres of the lives of children in care and understand that the primary goal for every child must be the timely achievement of a permanent home.

The TFC treatment philosophy is based on a solution focused/strength-based, trauma-informed approach focused on empowerment and a family systems approach. Staff sees their role as helping families generate solutions using their innate strengths to create change. This work is done within the context of family systems work, which assumes that each family member is an integral part of the larger system and affects the system's overall health. This work also

assumes the foster parent or caregiver to be the primary change agent within a systems context. From this perspective, extensive effort is made to effectively support and develop foster parents and caregivers.

SAL has provided extensive organizational training in a parenting approach known as Emotional Regulatory Parenting. This approach, applied in foster parent and staff training in multiple states, provides caregivers and the staff who work with them common language training in the crucial areas of trauma and brain development and provides a framework from which adults can respond to traumatized children's behavior with knowledge, empathy, and maximum support. Emotional Regulatory Parenting is focused on expanding caregiver's emotional capacity in order to provide an adequately nurturing home environment for traumatized children.

St Aemilian-Lakeside is accredited by the Council on Accreditation (COA), and a member of the Foster Family-Based Treatment Association (FFTA). Our TFC program adheres to the high quality standards and best practice guidelines put forth by both.

### Caregiver Support Program

SAL believes that the primary caregiver is the most effective agent of change for the child. This program provides supportive services to the caregiver including, parent education and coaching, emotional support, and problem-solving of complex family-systems issues. Services designed specifically for the caregiver are not widely available within the current structure of child welfare. Some support and guidance is available to generally licensed foster parents and kinship caregivers through case managers, relative support specialists and licensing specialists. However, none of these regulatory or oversight roles include a dedicated support person for caregivers themselves.

SAL's Caregiver Support is designed to provide licensed and unlicensed caregivers with a variety of supportive services with the goals of increasing placement stability, facilitating children's identified permanence goals, ensuring that the mental health service needs of children and caregivers are met, advocating for children in the educational arena, and ensuring that children in kinship care are safe from abuse, neglect, and marginal care.

The services provided through Caregiver Support are foster/kinship parent driven and clinical in nature. The primary method of service delivery is face-to-face contact within the foster/kinship home. Staff providing this service are bachelors or masters level social workers with specific training and experience working with out-of-home caregivers.

### **Recent Agency Innovations**

#### Trauma Informed Care

SAL is a leader in providing trauma informed care services and has sponsored trainings with nationally renowned speakers including Dr. Bruce Perry and Julie Alvarado. We currently participate in ongoing consultation with both Dr. Perry and Ms. Alvarado. We participate at

the state level in policy making related to trauma informed care services and played an integral part in drafting Governor Doyle's Prohibited Practices memo in partnership with the Department of Health Services and The Department of Children and Families. This memo outlines unsafe practices in restraint that contribute to re-traumatizing clients.

Our agency provides training to all staff on the Principles of Trauma Informed Care, Positive Behavioral Support, Trauma Informed Sensory Assessment & Intervention, and Caregiver Capacity. We are using innovative therapeutic techniques with clients in various programs utilizing sensory interventions and pattern repetitive interventions aimed at enhancing lower brain functioning.

### Independent Living Services

The misfortunes that result due to the gap in services for youth aging out of foster care and foster care alumni are well known within the child welfare community. Beginning in 2005, SAL determined to be part of the solution in Wisconsin – in fact to Keep Our Promise to this population. Our journey to contribute to building a multi-faceted, community-based continuum of care for this population has resulted in implementation of the following programs:

**Independence Place** serves foster care youth ages 16-19 who are preparing for living independently upon leaving the foster care system.

**Youth Transitioning to Adulthood (YTA) Scholars** provides long term support and guidance to foster care alumni, ages 18-24, primarily through the work of a YTA counselor.

**Supportive Permanent Housing** provides stable, safe housing and supportive services to homeless young adults, ages 18-24, who have a mental illness diagnosis.

**Youth Moving On (YMO)** provides stable, safe housing and supportive services to foster care alumni, ages 18-24. YMO is an 18 month transitional program funded through the American Recovery and Reinvestment Act.

Creation of new programs reflects only part of our efforts in this area. Our journey has also included reaching out to young adults to include their voice in this work, partnering with the volunteer and business communities to support the building of a continuum of care, advocating at the State level to increase the age of foster care reimbursement to 21 and sponsoring local advocacy events to educate the community and create political will for this work.

### **SAL Outcomes**

SAL has a well-established quality assurance program and compliance system in place. Tools used in the outcome/evaluation process include the Child And Family Functional Assessment Scale (CAFAS), agency generated satisfaction surveys and other agency defined methods of data collection. An essential element of our quality assurance system is customer feedback gathered through a variety of means, including written questionnaires, face-to-face interviews, and telephone surveys tracked through our agency's management information system.

Agency outcomes for 2009 include the following:

- 74% of clients were discharged to a less restrictive setting;
- 64% of clients showed an improvement in behaviors on their CAFAS scores;
- Overall satisfaction with agency services was 91%;
- Satisfaction with cultural competence of agency staff was 100%.

In Treatment Foster Care in 2009, 79% of youth served experienced no disruption in their foster care placement.

### **Anu Agency Profile**

The mission of Anu Family Services is to:

*“Create permanent connections to loving and stable families.”*

At Anu Family Services, our treatment model is guided by our belief that children develop best when connected to loving and stable adults and are best served in family environments. We accomplish excellence in treatment through low caseloads, family search and engagement, high treatment foster family involvement, extraordinary treatment foster parent and staff education and frequent contacts with each child, adult and treatment family.

Anu Family Services is a child and family service agency (formerly known as PATH Wisconsin) with an 18 year history serving children and families across Wisconsin. Anu Family Services incorporated as a non-profit agency in 1992, establishing a long tradition of quality outcomes for children and families. Anu Family Services has been nationally accredited by the “gold standard” in child welfare—Council on Accreditation (COA)—since our inception in 1992. With our early roots in Western Wisconsin, Anu Family Services has since expanded to now serve 45 counties, 5 Native American tribes, the State of Wisconsin, and a number of private agencies across the entire State of Wisconsin from Bayfield to Milwaukee.

Our service specialization started with our roots in treatment foster care and has expanded to service offerings in mental health, in-home family services, parent support services, parent visitation services, medically fragile treatment foster care, respite care, family-to-family mentoring, family search and engagement, DeafBlind wraparound services, family preservation and reunification services, and other individualized programming for special populations.

We serve special needs children who face medical, emotional, behavioral, cognitive, mental health or juvenile justice challenges. Many of our children have experienced multiple prior placements before referral to Anu. The trauma and challenges our foster children have faced requires the diligence of Anu Family Services’ staff to ensure for their safety, permanency and well-being. At present 53% of Anu children are between the ages of 13-19, 20% are ages 6-12, and 27% are 0-5 years. 60% are victims of abuse or neglect, 29% are referred due to

delinquent or disruptive behaviors and 8% have severe medical needs or mental health and substance abuse issues.

### Anu Research and Outcomes

At Anu, we have focused on becoming a national leader in connecting children in out-of-home care with their families or with adoptive families. We believe that every child deserves a place to call “home”. There is no more basic need for a child than having a family. Because we are passionate about this mission, in 2006, we set an enormous goal “*to be the last placement prior to permanence for 90% of the children we serve.*” With the help of a grant from the Otto Bremer Foundation in 2006, Anu has engaged in a research partnership with the University of Minnesota, CASCW.

When we increased efforts to find permanent families for children in out-of-home care in 2006, 40% of the children leaving our care were going to permanent homes. Today, just three years later, that number is 60%. To put that success rate in perspective, Minnesota just finished a multi-year project with Federal funding, Minnesota Department of Human Services funding, and Dave Thomas Foundation funding. After a \$1.4 million, 5-year project, they achieved 38% permanence for youth in out-of-home care. In addition, in a long-term study of the nation’s top performing treatment foster care agencies, the average number of children achieving permanence upon discharge (e.g., kids who were adopted or reunited with members of their family), was 45%.

Anu aspires to significantly influence the field of treatment foster care through research partnerships with the academic community and piloting innovative practices in creating permanent outcomes for children in treatment foster care. Anu is committed to disseminating the research findings to the broader community of treatment foster care providers both public and private. In May of 2009, the collaborative research by the University of Minnesota and Anu Family Services sponsored in part by the Otto Bremer Foundation was highlighted by the Children’s Bureau of the Administration of Children and Families.

Today, children placed with Anu are experiencing more stability in care than ever before. In 2009, 95% of all children in Anu Treatment Foster Care remained with the same family during their stay. Anu also monitors another critical component of placement stability for children and the consistency of the social worker they work with while placed at Anu.

The tracking of transfers is a common example of one of the types of minor practice changes which Anu has implemented in order to better align agency practice with practice that the literature identifies as contributing to the protective factors for successful discharge from treatment foster care.

The final report detailing the comprehensive review of literature on preventing placement disruptions and promoting placement stability in treatment foster care is available on the Anu

Family Services website, as well as the Center for Advanced Studies in Child Welfare at the University of Minnesota. A full brief on the research was highlighted and can be accessed on the Children's Bureau website at

<http://cbexpress.acf.hhs.gov/index.cfm?event=website.viewPrinterFriendlyArticle&articleID=2605> (The Children's Bureau Express).

In addition, from 2005 to 2009 Anu Family Services was involved in a national bench-marking project of outcomes in treatment foster care as part of membership in the Foster Family-based Treatment Association (FFTA). The Benchmark TFC Project collected intake and discharge data from 45 TFC agencies across 20 states including 5,677 youth who were admitted into their treatment foster care programs and 2,151 youth who were discharged during the period. Among other metrics the project examined permanency outcomes at the time of discharge, finding that 45% of the aggregate cohort during the period found permanency at discharge 45% of the time. During that period Anu Family Services improved their ability to discharge children to permanent families, discharging 57% of children to permanency by 2008 **and 60% year-to-date in FY10** (Foster Family-based Treatment Association).

Anu begins focusing on achieving permanency for a child from the first day of the placement. Anu Family Services' treatment foster parents and staff work in collaboration with a child's family to return them to the care of their family. Permanency is achieved through reunification with the child's family, transfer of legal custody, legal guardianship or adoption. If a return to family is not an option, achieving permanency through adoption is pursued.

At Anu Family Services treatment foster parents and staff work with a child's family to return them to the care of their parents as soon as we safely can. Treatment foster parents and social workers work closely with biological families coordinating home visits and mentoring biological families. Treatment foster parents have the role of temporary parents supporting children and families as they work toward reunification or as permanent resources for children in situations of concurrent planning. Our treatment foster parents also play a critical therapeutic role in helping facilitate a child's transition to their permanent family, supporting this transition over many months.

#### Innovations:

Anu Family Services has roots as an early founder of the Treatment Foster Care model and continues today as a national leader and innovator in treatment foster care and other services. (For more details on agency innovations year by year see Attachment A.)

Anu has focused on preventing placement disruptions while at the same time promoting placement stability and safety for children and their caregivers. In 2006 Anu became a restraint-free agency, implementing the research-informed model of Therapeutic Crisis Intervention for Family caregivers (TCIF).

In FY09 no restraints occurred in the organization's treatment foster homes. We believe that when restraints are utilized as a response in times of crisis, that it creates a situation which re-enacts the trauma that many abused and neglected children had formerly experienced. As the developers of TCIF at Cornell University projected, Anu did experience; "fewer physical restraint episodes after implementation and training, fewer injuries to children and staff as a result of physical restraints, an increased knowledge and skill on the part of facility personnel to handle crisis episodes effectively, and an attitude change among treatment foster parents, staff and supervisors on the use of physical action in crisis situations" (*Family Life Development Center*).

Staff and treatment foster parents continue to receive ongoing training on the TCIF model every 2 years in order to retain a high level of model efficiency and to retain proficiency at de-escalating situations that would commonly result in therapeutic set-backs and potential placement disruption.

Anu found the implementation of the practice of TCIF critical at the time the agency established the treatment foster parent policy of no-restraint interventions with foster children. With the adoption of TCIF, treatment foster caregivers were empowered with the tools to feel more confident in their ability to manage crisis situations, prevent, de-escalate, and manage acute crises.

In 2008 Anu Family Services initiated a pilot project aimed at actively pursuing permanence for children in long-term foster care. Using a 6-step child-specific recruitment model called Family Search and Engagement (FSE) and The 3-5-7 Model: Preparing Children for Permanency, Anu combines the best practices in intensive family search, family engagement and child preparation for permanence in an effort to move children out of the foster care system and onto their permanent family (Louisell, 2007 & Henry, 2005).

In the pilot project Anu Family Services explored other permanency options for children unable to return to their biological parents. This included a thorough search of extended family members, both paternal and maternal; other kin; fictive kin (non-blood related persons the child knows); and lastly explored permanency with other caring adults whom the child had not yet met.

Excellence in training is a core value of Anu's model of care. All Anu treatment foster parents are trained in 30 hours of TCIF and will also be trained in FY 10 in FSE & 3-5-7 models of permanence. In addition, Anu Family Services developed a Treatment Foster Parent Certificate Program established to focus further on development of the core competencies of treatment level fostering. The Anu Family Services Treatment Foster Parent Certificate program is comprised of coursework addressing critical topics that form the foundation of the work as a treatment foster parent. The courses include:

- Orientation (4 hours)
- New Foster Parent Training (9 hours)

- Cornell University (TCIF) Therapeutic Crisis Intervention for Family Care Providers (30 hours)
- Child Welfare (3 hours)
- Child Neglect and Abuse and its Impact on Development (4 hours)
- Healthy Families (3 hours)
- Separation, Attachment, Grief and Loss (4 hours)
- School Systems and Your Foster Child (2 hours)
- Cultural Diversity (2 hours)
- Child and Adolescent Mental Health (4 hours)
- Child and Adolescent Alcohol and Other Drug Abuse (3 hours)

Anu also believes that involving treatment foster parents improved quality of care for children; therefore, an advisory board of treatment foster parents licensed by the agency help advocate on behalf of the children they serve and themselves in agency matters. Best practice in licensing and supervision of treatment foster parents strongly directs agencies toward processes that are inclusive of foster parents. Foster parents who have an opportunity to make decisions are more likely to feel valued and have a good relationship with the licensing agency (Semanchin Jones, A., & Wells, S.).

To further involve and support parents, share and support meetings offer treatment foster parents the opportunity to share challenges, gain information and support, camaraderie and receive mentorship from their peers. This approach to support is strongly recommended in the literature as well (Semanchin Jones, A., & Wells, S.).

Attachment A

## How does Anu Family Services create permanent connections to loving and stable families?



### HISTORY



Anu Family Services is the treatment foster care agency connecting children to permanent, loving and stable families. For the past 18 years we have been dedicated to serving at risk children and families.

### MISSION DRIVEN



Anu Family Service, formerly known as PATH Wisconsin, separated from its parent company PATH Inc. of Minneapolis Minnesota in 2008 in order to strategically re-focus its resources and mission with children and families. Anu Family Services' practice is innovative and research-informed.

### INNOVATIVE



Anu is forward thinking and has a vision for transforming the practice of child welfare with efforts to increase the number of children in out-of-home care achieving lifelong permanence with loving and stable families for children in treatment foster care.

### STRATEGIC



As an agency, Anu stands at the precipice of the next generation of child welfare practice with a new name, newly-enhanced mission, and a strong commitment to serving children and families by creating permanent connections to loving and stable families.

### GOAL FOCUSED



In 2006, Anu Family Services established a long term goal to become the agency of choice in treatment foster care, providing the last placement prior to permanence for 90% of the children we serve.

## We've taken some bold steps to achieve our goals.

#### In 2006

We became a restraint-free agency (we no longer engaged in the common practice of holding children to control aggressive behavior). Besides being a humane way to practice, this practice supports children with difficult issues, helping them maintain stability in the least restrictive setting.

#### In 2007

We partnered with the U of M to conduct research on the most effective ways to practice in order to promote placement stability and prevent placement disruptions.

#### In 2008

We began putting research findings into practice, including the development of a pilot project recruiting adoptive resources for specific children with specific needs, then supporting those families so that adoptions can be permanent and lifelong.

#### In 2009

95 percent of children remained in the care of the same foster parents during their stay. No children were restrained for any reason, and the number of children who transferred social workers was cut in half over the previous year.

Attachment B



## Levels of Care for Treatment Foster Care

Enhanced	Treatment	Intensive	Exceptional
<ul style="list-style-type: none"> <li>• 24 days of respite for foster parents</li> <li>• social worker in-person visits a minimum of once per month</li> <li>• age-appropriate supervision</li> <li>• treatment usually for youth with mild or moderate emotional and psychological needs; primarily used for transition</li> <li>• treatment plan reviewed at minimum every 6 months; usually more often</li> <li>• monthly progress notes from foster parents</li> </ul>	<ul style="list-style-type: none"> <li>• 24 days of respite for foster parents</li> <li>• social worker in-person visits a minimum of twice per month</li> <li>• increased supervision usually for youth with moderate emotional and psychological challenges, usually with needs such as grief and loss issues, anxiety disorders, moderate behavioral issues and other heightened treatment and supervision needs</li> <li>• treatment plans reviewed every 90 days</li> <li>• bi-monthly progress notes from foster parents</li> </ul>	<ul style="list-style-type: none"> <li>• 24 days of respite for foster parents</li> <li>• social worker in-person visits 2 - 3 times per month</li> <li>• intensive levels of supervision usually for youth with issues such as aggression, run away, theft, drug use, mild enuresis or encopresis, and other inappropriate behaviors</li> <li>• treatment for severe emotional and psychological needs</li> <li>• treatment plans reviewed every 60 days</li> <li>• bi-monthly progress notes from foster parents</li> </ul>	<ul style="list-style-type: none"> <li>• 24 days of respite for foster parents</li> <li>• social worker in-person visits 3 – 4 times per month</li> <li>• exceptional levels of supervision, usually for youth with issues such as fire starting, sexual perpetration, violence to people or animals and other severe and dangerous behaviors and youth with a shortened school day, day treatment or severe medical needs</li> <li>• treatment for profound emotional and psychological needs</li> <li>• treatment plans reviewed every 60 days</li> <li>• weekly progress notes from foster parents</li> </ul>

## Appendix D: A Comparison of Regular Foster Care and Treatment Foster Care

	Regular Foster Care	Treatment Foster Care
<b>Licensing codes</b>	Chapter HFS 56 Foster home Care for Children	Chapter HFS 56 Foster Home Care for Children  Chapter HFS 38 Treatment Foster Care for Children
<b>Philosophy of care</b>	Provides nurturing, safe and custodial care for children who require placement outside of their family.	Provides alternative to residential treatment  Combines treatment interventions typically associated with more restrictive setting with the nurturing and individualized family environment.
<b>Reason for placement</b>	Care and protection	Care and protection  Addresses treatment goals that led to placement
<b>Foster parent education</b>	Not mandated  Provided at varying intensity across 72 counties	Minimum of 18 hours of pre-placement training  Minimum of 24 hours of training in the second 12 months following licensure  Minimum of 18 hours of training in every subsequent 12 month period
<b>Respite</b>	Not required	Minimum of one unit per month of placement. Unit consists of 8-24 hours
<b>Social worker college education requirement</b>	No educational requirements	Master's Degree in social work related field <i>or</i> 2 years post-degree experience + Bachelor's in social-work related field
<b>Social worker visits child</b>	No standard requirement, generally provided by ongoing case manager once per month	Minimum of every other week and in a variety of settings
<b>Social worker visits foster parent</b>	No standard requirement	Minimum of every other week, at least one contact face-to-face per month
<b>Role of foster parent</b>	Caregiver and nurturer	Caregiver and nurturer  Primary change agent  Active member of treatment team
<b>Crisis/emergency response</b>	Not mandated Provided at varying intensity across 72 counties	Provided 24 hours a day, seven days a week

## Appendix E: Resources and Bibliography

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