Vermont’s grassroots perspective on kinship

By Lynn Granger

Imagine that …

... you recently retired and are planning to travel with your spouse. DCF calls you to ask if you would care for your two middle-school grand-children, ages 12 and 13. They have repeatedly been unsupervised and on the street at midnight. Their parents have opiate addictions.

... you have your teen-age daughter, a grandson, nephew and niece at home. Your oldest daughter gives birth to twins, both drug addicted. It is Christmas Eve, and you are asked to take the children or they will be placed in state custody, not necessarily with you.

... you are close to retirement and you are called to the hospital. Your daughter has been violently attacked by her husband and left to die in their apartment. Your two year old grand-daughter has been with her the entire time. Your daughter never recovers from her injuries, and while you are grieving her, you also are caring for your traumatized grand-daughter and attending court hearings related to your daughter’s murder.

Each of these scenarios has happened in Vermont, and similar ones happen every day throughout the country. In an emotionally laden situation, what decisions do relatives make? What choices do they have when asked to step up to the plate and take the children? What supports and services are they and the children eligible—or not eligible—for? Who helps them sort out the situation so they can make decisions based on facts and not emotion; based on the long term interests of the child, not just a crisis situation?

Vermont Kin As Parents

Vermont Kin As Parents (VKAP) is a grassroots non-profit organization founded in 2005 by a small group of grandparents raising grandchildren who, with the help of kinship support groups, had made it through the court process and recognized that others in similar situa-

A systemic response to secondary traumatic stress

By William Kahn

Massachusetts Department of Children and Families (DCF) is in the midst of a multi-year initiative aimed at reducing the negative effects of secondary traumatic stress on its staff. Historically, child welfare agencies have lagged in such efforts, relative to police, fire and emergency response departments. The state DCF leaders and members who have so far been involved in these efforts have thus struggled, learned, discovered, and created together with few child welfare models on which to rely. They are attempting to create a systemic response to secondary traumatic stress.

The need

Secondary traumatic stress is a fact of life in child welfare work. It occurs as a matter of course. As workers establish relationships with families that become the conduits for information and support, they also become the conduits for emotions. When workers take in clients’ stories they also unconsciously take in the emotions that the families contain. They take in the anger, sadness and pain of parents. They take in the hurt, despair and longing of children. Moreover, they soak up the trauma of families whose lives have been disrupted, whose circumstances and experiences are marked by horror and despair. DCF workers take in such emotional material unwittingly, unconsciously; in meetings, on phone calls, even in emails, they are exposed to clients’ painful emotions. Such exposure allows for much good. It allows for empathic understanding. It builds necessary relationships between those who provide and those who receive. Yet such exposure leads to pain as well, for workers and those who work with them. It leads to secondary traumatic stress.

Secondary traumatic stress occurs when caregivers work closely enough with those who have been traumatized to unconsciously soak up traumatic material that is emotionally charged. This is stressful for workers. It is a different sort of stress than that related to working conditions per se. Work stress is linked to the pressures of time, workload, resources, risk management, and other factors that constrain what child welfare workers are able to accomplish. Secondary traumatic stress is linked to the emotions that workers experience in relation to traumatized clients. Work stress leads to frustration, exhaustion, burnout. Secondary traumatic stress leads to trauma;
Quality kinship care: an evolving practice

By Jennifer Miller

S
ince the beginning of time, grandparents, aunts, uncles, cousins and family friends have stepped in to care for children who cannot live with their own parents. This mutual-honored system of kinship care is a commitment that draws on the natural desire of family members to care for children in need. Unfortunately, kinship care in the context of the child welfare system, which involves complex government rules and regulations, is far from a natural process. States increasingly struggle to honor natural familial relationships while also ensuring the safety, permanency and well-being of children and youth in kinship care placements.

In an attempt to more effectively address this balance, The Fostering Connections to Success and Increasing Adoptions Act, passed by Congress in October 2008, contains several provisions to promote the successful use of kinship care. These include:

• Notice Requirement: A requirement to conduct a diligent search for relatives and provide notice to grandparents and other known family members within 30 days of a child’s removal from the custody of their parents;

• Licensing Waiver Provision: Clarifies the ability of child welfare agencies to grant waivers of non-safety related licensing standards for children placed with relatives on a case-by-case basis;

• Sibling Placement Requirement: Requires states to make reasonable efforts to place siblings together, or to ensure visitation when sibling placement is not in their best interest;

• Guardianship Assistance Program: Provides an option for states to use federal Title IV-E foster care funding to support guardianship for children who exit foster care to live permanently with kin when they cannot return home or be adopted;

• Family Connections Grants: Provides discretionary grants to state, local and private agencies for kinship navigator programs, family finding efforts and/or team meetings designed to utilize a family’s natural support system to make important safety and permanency decisions.

The Fostering Connections Act raises the bar for public and private agencies to ensure they have strong systems in place to identify and notify relatives, educate them about their options for caring for children, and embrace the unique nature of kinship care as an important source of support for children involved families.

Identification and notification of relatives

Across the country, many child welfare agencies have engaged in Family Finding® for children who have been in care for many years. Family Finding works on the assumption that there is a relative or close family connection for every child, and provides guidance with locating and guidance – quite often a permanent home – as they transition to adulthood. Based on the success of Family Finding for “long stayers” in foster care, agencies are beginning to recognize the value of front-door designs to locate caring relatives from the moment a child becomes involved with the child welfare system.

Agencies use a variety of methods to explore potential relative involvement early in the life of a case.

These include:

• Talking to youth and their parents about who is important to them and with whom they would feel comfortable if they can’t stay with their birth parents;

• Providing written notice to relatives that informs them of their right to be involved in the child’s life and the rights they might lose if they do not respond to the notice;

• Using technological resources, including USS Search, Lexurus-Nexus, Accenture, etc. to locate relatives for the child;

• Working through family group decision meetings, family group conferences, team decision making meetings and similar forums to help parents and youth talk through the potential family resources;

• Developing diligent search checklists to ensure that child welfare staff have explored every possible resource available, including the paternal side of the family that has often been traditionally overlooked, before placing children with an unrelated resource family.

Early identification of relatives can also help to prevent the unfortunate situation in which family members learn about a child’s involvement in the child welfare system long after they have been placed in foster care with another family or needlessly bounced from institution to institution. In fact, it was the heartbreaking stories of grand-parents who learned of their grandchildren’s adoption by strangers that prompted Congress to enact the notice requirement.

Educating caregivers about their options

Too often, caregivers take children into their home without the support and information they need, such as legal representation, financial benefits and other services available for them and their children, and how to navigate the child welfare system. This lack of resources can be unsettling for everyone involved, particularly young people who are also dealing with the emotional trauma of having been separated from their parents.

When children are diverted from agency custody to live with relatives, there are a unique set of challenges for caregivers as they are forced to navigate a complex web of systems to provide basic protections for the children. Caregivers who become foster parents when children are taken into custody also face a daunting set of responsibilities in their efforts to satisfy the continuing licensing requirements of their local child welfare agencies. Unlike traditional foster parents, kinship caregivers do not have the benefit of advanced training to help them understand the expectations of their involvement. They are also dealing with the complicated emotions of guilt, embarrassment and loss over what parents of the children in their care are going through.

When children are placed with relatives, child welfare agencies have a responsibility to fully disclose all the information needed to ensure the safety and stability for the children in their care. Most importantly, caregivers should understand all of the legal options available to them and the implications of each of these options in terms of financial support, involvement of the child welfare agency and courts, and future considerations if a child can not return home to birth parents — including including the availability of adoption if it is available. This educational process should occur as soon as a family becomes involved with the child welfare system and continue throughout their involvement with the system. Full disclosure of all the available options is a critical step in ensuring that families can make decisions based on the best interests of their relative children.

Positive outcomes can also be achieved for children in kinship foster care by offering subsidized guardianship as a permanency option for children who cannot return home or be adopted. In fact, states with federal waiver demonstration projects found that overall permanency rates and timeliness to permanency significantly increased with the availability of subsidized guardianship.

Embracing the unique nature of kinship care

Increasingly, public and private child welfare agencies recognize the unique needs of kinship families and the specialized skills and knowledge required to help them care for their children. Child welfare stakeholders are taking several steps to ensure that staff are able to carefully assess kinship caregivers for their capacity to provide a safe and stable home environment and engage them as full partners in the child’s team. These approaches include:

• Developing specialized Kinship Staff – specialized kinship units and/or kinship coordinators can help to ensure kinship competency in agencies that traditionally have worked primarily with unrelated caregivers.

These specially-trained staff can play many roles, including conducting diligent searches, assessing kinship homes, engaging kinship caregivers as part of the family’s team, navigating public and community resources, and educating them about their options.

• Training Workers – training on the clinical issues that kinship families face can help sensitize staff to the emotional issues they face when they take relative children into their home. These issues include coming to terms with changing family dynamics, as well as guilt, embarrassment, and anger over the actions of the child’s parent.

• Assessing Kin – even beyond the required background checks, fingerprinting, and

Continued on page 22


Individual Subscriptions: $15.00
Organizational Subscriptions: $25.00
Agency Bulk Subscriptions: $50 to $150
Free to member agency employees
Julie Sweeney-Springwater, Editor
Donna Coppenrath Assistant Editor

Common Ground is managed in the New England States by Bureau Chiefs in each member agency.

Connecticut
Lisa Flower, DCF
Maine
Virginia Marriner, OCFES
Massachusetts
Saf Caruso, DCF
New Hampshire
Christine Tapan, DCFY
Rhode Island
DGYF
Vermont
Lynn Bruce, DCF

Bureau Chiefs’ recruit authors and screen articles for suitability.
Kinship Navigators: the new child welfare system

By Gerard Wallace

With enactment of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (FC), federal child welfare policy finally provides funding for services to the private informal kinship community. The Act targets at least five million dollars for “kinship navigators” to help “children who are in, or at risk of entering foster care reconnect with family members.” FC may signal a new direction in child welfare policy and practice, where private kinship caregivers, where private kinship caregivers provide services to children who are in, or at risk of entering foster care, finally accept the status of kinship caregivers. FC’s Section 102 provides services to all kinship families. Federal child welfare services, where kin may be viewed as a resource but in practice they are viewed as a barrier to access due to laws, regulations, and practices that do not recognize kinship care will finally be fully integrated into the child welfare system.

First and foremost, kinship care refers to children who are living with relatives or fictive kin who assume parental duties. Kinship care is our traditional child welfare system, a natural resource, operating for millennia before the institution of the foster care system and public or formal kinship care. Kinship care is the at the center of our family values, President Barack Obama’s grandparents were his kinship caregivers and he is the son of George Washington cared for two step-grandchildren in this manner.

Kinship caregivers live in every community. Everyone knows a kinship family. Across America, this private system cares for at least twelve times more children than the publicly funded child welfare system. The first two closely align with kinship direct services. A second is public agency staff to face with the family providing a more comprehensive service. A second is public agency staff training in kinship care and family team meetings for kinship families which are often more complex than typical. The third is family finding for teens in foster care.

Rhode Island’s grant is for a startup navigator that will utilize family finding and assist with family reuniting. The program will provide an I&R website, designed with help of the “GrandDvss,” and a grandparent advocacy group and be accessed via 211.

Existing kinship statewide programs

Kinship navigators have used diverse strategies to increase access to services and supports. Defintions of “navigator” vary from state to state and system to system, ranging from strictly I&R, using a website or website plus call center, to I&R plus limited advocacy-assistance, to I&R plus direct services offering case management and/or other direct services.

Navigators already operate in a state neighboring New England; New York offers a website and call center (kinshipnavigator.com). Connect EDI provides web-based 211 information, www.211ct.org/focus/kinshiplist.asp and some other states in the region are moving towards implementation. In New Hampshire, an example for the Division of Children, Youth and Family Bureau for Community and Family Support is dedicated to relative care policy, program and training development, and acts as a resource for both the public and private kinship communities. A recent summary of their experience in New Hampshire’s kinship programs provides information about the standards of the Council on Accreditation and the Alliance of Information and Referral Systems. Programs also employ delivery personnel. In New Jersey, case workers from the child welfare agency take calls and make referrals to local direct services funded by the navigator; grandparents take calls and make referrals in two locales; and make referrals to non-associated programs in a network of direct service kinship programs in New York state; and in a decentralized system, funded mostly by local county agencies, agency staff in Ohio provide services including support groups and some case management.

Information and access

Services accessed are divided into:

1. general services, where kinship families often meet barriers to access due to laws, regulations, and practices that do not recognize them or fail to identify their needs;
2. child welfare services, where kin may be viewed as a resource but in practice they are not treated as partners (for instance, diversion from foster care, failures to place with kin post initial non-relative placements, limited use of kin as a placement option, etc.);
3. specialized services provided by other kinship organizations (support groups, respite, mentoring education, and special programs targeting challenges attributed to trauma, loss, bereavement, and disabilities); and
4. legal assistance (legal information, legal fact sheets, guides, advocacy, attorney consultations, volunteers and/or staff attorneys who can provide representation in contested proceedings).

Finding out what works

Prior to FC legislation, kinship navigators, either non-profits or public agencies, were usually administered thru the state child welfare agency as in New York or through an aging agency as in Georgia and other states with specific kinship policies. As children in private kinship care, it is likely that more state child welfare agencies will seek funding for such programs. Also, given that the newly funded programs are demonstration projects, it is likely that many state child welfare agencies will look to follow emerging models. Navigator programs are likely to become a permanent part of child welfare agency planning, both at the state and local levels. Which caregivers get served, what services are provided, and what outcomes are expected are yet to be decided. Part of the discussion will center on placement options for children in foster care—private versus public kinship care, and on the use of the federal education laws that support residential placement options for children in foster care—private versus public kinship care, and on the use of the federal education laws that support residential placement options for children in foster care. Such policies are not only for private kinship care. For instance, federal education laws that support residential placements for children in foster care should be good for the gander (children in private kinship care) and all children should live in families who achieve the CSFR standards. But with the prospect of more federal funding coming in, policymakers will need to succeed in order to convince federal policymakers that help for private kinship families is cost effective and produces better outcomes for children.

Potential for reforms

For the kinship community, Fostering Connections signals a new direction which they hope will lead to more favorable policies focused on private kinship care. Such policies are not only about assistance. The kinship community is very aware that many issues are about their right to care for children. While family law is mainly state law, there are areas for federal reforms which could support private kinship care. For instance, federal education laws that support residential determinations, outreach similar to Food Stamps for kin to access child-only grants, mandates pushing child welfare agencies to target private kinship care, and programs assisting incarcerated parents to assist children in care with relatives are examples.

Kinship advocates hope that Fostering Connections starts a new era of child welfare policy and planning. Perhaps, our tradition of family care will finally be fully integrated into the child welfare system.

Gerard Wallace is the Director of the NYS Kinship Navigator and cochair of the AARP supported NYS KinCare Coalition and the 2009 recipient of Generations United’s National Grandfamilies award for outstanding service to the kinship community. He may be reached at 857-654-4613 or via email gwallace@csfrochester.org.

For a summary of the Kinship Navigators programs go to www.pasi-tech.com.
Grandparents raising grandchildren, from spoiling to toiling

By Kerry J. Bickford and Earl N. Stuck

We all know what grandparents do. They show up, spoil the grandkids, and go home before the hard work begins. They get to be the “good-guys”. It is for many grandparents, a very pleasant, well-earned relationship and in our dreams we all look forward to it.

But what if grandparenthood isn’t always so simple? A recent (12/1/309) article from the New York Times asked this question, “Grandpa Does More Than Baby-sit”. The story describes the long and frustrating road that one grandfather navigated as he sought to gain custody of his two grandchildren and preserve his family. His custody battle was successful, but the reality of parenting a new family presented and continues to provide more challenges than he could have ever anticipated. For many, this might seem an unusual story, but not one that hits home to most families. However, for a large and increasing number of grandparents and other relative “kin” caregivers, the reality of raising children has become an unexpected, challenging experience. It can test the family’s endurance and challenge family members’ health, mental health, financial security, and family relationships.

Grandparents raising grandchildren is not a new phenomenon. Extended families have always pitched-in in times of need. For most of our history, there was no formal recognition of these relationships, and most families chose to keep “dirty linen” a private matter. Yet in recent years, the attention of professionals and advocates from two very different perspectives, child welfare, and elder affairs has converged on major changes in the lives of many grandparents when they become primary caregivers.

These are the facts:

• Nationally, according to census data, more than 6 million children – approximately 1 in 12, are living in households headed by grandparents (4.5 million children) or other relatives (1.5 million). (2007, AARP).

• In Massachusetts, there are a reported 67,651 children in grandparent headed households, plus another 19,721 living in homes headed by older relatives. Of the children living in homes headed by grandparents, 30,615 are living without either parent present and 16% live in poverty. (Grandfacts, Mass AARP 3/08).

• While these numbers are large, they tell only a small portion of the story. These figures do not include the many situations where children living in the home of a grandparent (or older relative) are unreported altogether, maintained by informal understandings and therefore unknown to the child welfare system. According to the US Population survey of 2002, nearly 80% of children in relative care are not placed there by the state and are not formally recognized.

• One grandparent’s comment, “I feel like ‘who cares about my needs?’ expresses the feeling of many. The needs of the children are well documented through the child welfare system, but the needs of the older caregiver have gone largely unnoticed. The added financial stresses to elder caregivers still in the workforce include the needs of the child and such things as day care. For those already on fixed incomes, the added

Continued on page 26
Kinship caregivers as true partners in the MA Integrated Casework Practice Model

By Olga I. Roche

The Massachusetts Department of Children and Families (DCF), is the state agency responsible for protecting children from abuse and neglect. DCF assesses families’ strengths and needs, and works to obtain appropriate services and resources for their needs.

Driven by new research on best practices in child welfare, DCF established the Integrated Casework Practice Model (ICPM). This model enhances the work of cooperation, support, and socialization. It involves fathers and extended family members to keep children at home. Situations where an out-of-home setting is necessary, 25% of all children placed go into kinship resources, and that children placed in foster homes are with kinship caregivers.

The Integrated Casework Practice Model is designed to:
- Stabilize families so that children can safely remain at home;
- Reduce repeat maltreatment of children; and
- Effectively target DCF resources to meet the needs of families requiring DCF services.

The DCF Integrated Casework Practice Model (ICPM) establishes the framework, structures, processes, expected outcomes, and underlying core values for DCF’s involvement with children and families. Through the ICPM, DCF’s involvement with children and families focuses on strengths-based, family-focused, and building parenting capacities that will support safe, secure, and permanent homes. The new approach also ensures consistency in casework practice and provides opportunities for children, families, and their support systems to be actively engaged and empowered in decision-making.

Key features of the casework practice model include:
- Extended timeframes for screening and investigations to allow greater opportunity to gather information about a family’s circumstances and determine how best to target DCF resources;
- Differential Response to enable DCF to respond to allegations of child abuse and/or neglect based on the unique circumstances of a case and the individual needs of a family. This includes two tracks: Investigation or Assessment, depending on the severity of the allegation;
- Use of new research based assessment and planning tools to support consistent clinical practice in assessing danger, safety and risk; and to focus on what families need to keep children safe; and
- Connections to supports and resources within the child and family’s own community first.

Kinship and ICPM

DCF’s vision in the new casework practice model is for kinship caregivers to become full partners in the protection of children. It establishes a shared vision based on common values and principles with extended family. The effective collaboration between the agency and families can result in the preservation of families and improved well-being of children, since kinship resources are “child-centered”, family-focused, strength-based, and community-based resources in the continuum of care system.

Studies on kinship resources suggest that children are more stable in these settings, and that Vermont’s grassroots perspective

continued from page 1

The Vermont Kin As Parents is committed to support relatives who are raising children and to educate the public and community partners about the joys and difficulties these families experience.

With a grant from the Fanny Allen Corporation, a part-time Coordinator was hired in March 2007, and an office, donated by Casey Family Services, opened in Winooski, Vermont. Since then, VKAP has established strong relationships throughout the state and is recognized as the voice of kinship.

To fulfill the first part of its mission, VKAP offers resource and referral information to relatives who are caring for children, both for families involved in the child welfare system and those who are not. More than a phone referral is needed, the Coordinator works with public and private agencies to get a family the help needed. Attending team meetings, explaining what could be expected in court, or simply listening and talking through situations are all part of the Coordinator’s work. Some relatives seek information electronically onVKAP continually seeks opportunities that result in improved lives for kinship families.

Educating others about the joys and challenges of kinship care

To help meet the needs of these special families and to educate professionals and community members, Vermont Kin As Parents does many things. Presenting at conferences, talking to groups of individuals such as guardians-ad-litem, and collaborating with state and community partners all offer opportunities for VKAP to help others understand the joys and challenges of kinship care. An annual kinship conference entitled “Parenting Revisited” brings together caregivers and service providers to learn about the many aspects of raising children. The conference typically has a national expert, a panel of relatives who share their stories and a “kin speak out”, as well as workshops on topics that are relevant for caregivers and providers. In October 2008, for example, two workshops were presented by VKAP and the New Hampshire Relatives as Parents Program (RAPP) Coalition. It featured Dr. Joseph Cumby, a national expert on kinship care, and a relative caregiver himself. Presenters and attendees were from both states, offering a wonderful opportunity to learn from each other’s experiences.

As the result of strategic planning, VKAP has focused on bringing equity to children and families inside and outside of the child welfare system. Sometimes it is necessary to begin with the system to open doors. The Fostering Connections to Success Act, passed in 2008, offers states the opportunity to implement Subsidized Guardianship for children in foster care who are living with relatives. A committee, set up by the Justice for Children Task Force through the Vermont Supreme Court, has studied the issue; the DCF Commissioners are supportive, and a bill will be introduced in the Vermont Legislature shortly. The hope is that it will pass quickly, giving kinship families another permanency option that also includes financial support. VKAP has participated fully in the discussions and will do so, as it continues its work for kinship families.

Being a kinship caregiver gives one the unique opportunity to understand from personal experience the many different aspects that impact life in a kinship situation—from the relationship with the child’s parent, who is also the son, daughter, or sibling of the caregiver to the deep emotional impact that the children experience when they cannot live with their parents to the daily family living that must continue. The personal experiences can be valuable to help community partners more fully understand the joys that kinship families experience, as well as the unique challenges. VKAP works to bring a genuine face and a clear voice to kinship care in all the states.

Lynn Granger, one of the founding members of Vermont Kin As Parents, served as its first Board President, and now is the sole employee and Coordinator for VKAP. She has been raising her 13-year-old grandson for 11 years. She may be reached at Vermont Kin As Parents, P.O. Box 382, Winooski, VT 05404, or by phone at 802-338-4725 or email at kinmg@comcast.net.
Celebrate being a grandparent raising a grandchild

By Cate D.

My granddaughter has been living with me for the past ten years. She came to live with me just before her 4th birthday and turned my life upside down! She and her brother were the important part of my life. Ten minutes after my daughter gave birth to her, she turned her little head towards me and it was instant love. Just thinking about that time can bring tears of joy to my eyes. Ten years ago I lived a much different life. Without my grandchildren I would have been relatively calm and uneventful. The after school tooth fairy came to the hospital while she was there. All the other children treated her like one of the 18 other students. Towards the end of the kindergarten year she had a tonsillectomy. I spent the night with her in the hospital, which really happened. Before I knew it, it was time for kindergarten. It was a little sad leaving Head Start but it meant I didn’t need to drive an extra 30 minutes in the morning. We lucked out having a wonderful kindergarten teacher. I was able to explain my situation without feeling shameful or apologetic. She scooped her up and loved her along with the 18 other students. Towards the end of the kindergarten year she had a tonsillectomy. I spent the night with her in the hospital, which was another bonding episode. When I took her back to school one of the little boys noticed she had a tooth fairy pillow. She wanted to know if the tooth fairy came to the hospital while she was there. All the other children treated her like one of them and I felt cloaked in love and protection.

The next five years in Elementary School was relaxing relative to kindergarten. The school program was kind and supportive. The Director helped keep me stable and informed about cur-
All children deserve a permanent home: Generations United's work for grandparents and kinship care

By Donna Butts and Carol Scott

Donna Butts knew he had to run away, and he had to take his two younger brothers and sister with him. His mother had mental, health problems, including diagnoses of schizophrenia and bipolar disorder, left her unable to care for her four children. His father turned to alcohol to numb his pain and often became abusive. As the oldest, JJ felt it was his duty to protect his younger siblings. He took on the brunt of the physical abuse, but he couldn’t shield them from the verbal abuse.

To JJ, his grandparents offered the only stability he had ever known. So, one by one, JJ and his brothers and sister moved in with their maternal grandparents. When their father protested, Child Protective Services became involved. JJ’s grandparents agreed to become licensed foster parents and eventually adopt JJ and his siblings.

Taking care of JJ and his siblings became an extended-family affair. JJ’s aunt put her school on hold and took a job to help with finances. But the family still became mired in a trap of overwhelming requirements and housing regulations. To keep JJ and his siblings together, they had to build a new house that met state requirements. The grocery bills, gas bills and housing costs were more money than JJ’s grandparents had. Eventually, they were forced to file for bankruptcy.

J J and his siblings are just four of the six million children being raised by grandparents or other family members in this country today. His grandparents and aunt provided safe and stable homes for him and his siblings at great personal sacrifice, one they were willing to make because of their love and commitment to caring for family. Yet they could have had a less extensive financial burden. The Fostering Connections to Success and Increasing Adoptions Act, which became federal law in October 2008, was written to help ease that burden for families like JJ’s.

At Generations United (GU), we know that grandparents and other family members make incredible sacrifices and invaluable contributions. Inspired by the 1995 White House Conference on Aging, our newly recruited board endorsed Grandparents and Other Relatives Raising Children as our first major initiative. Since then, GU has worked closely with national and local partners to advance a public policy and awareness building agenda in support of grandparents.

In 1997, we convened the first national expert symposium on grandparents. This successful symposium marked the first time the issue of grandparents raising grandchildren was explored from a multigenerational perspective. Symposium participants examined the issues, keeping in mind both older caregivers and children. The resulting recommendations were published in our first action agenda. This was followed by a 2004 symposium to review progress, celebrate our successes and develop the next action agenda to lead our future work.

Gu’s Grandparent Advisory Group—consisting of national organizations and experts from across the country—has met regularly since 1998 and continues to act as the coordinating body for effort on behalf of grandparents. The members also identify emerging issues the families face. In 2008, Casey Family Programs provided funding to formally establish this group as the Grandfamilies National Partnership Working Group.

At GU, we know that grandparents and other family members make incredible sacrifices and invaluable contributions.

Legislative victories

Changing federal policy to support grandfamilies is a top GU priority. The first legislative victory was the inclusion of grandparents in the National Family Caregiver Support Act (NFCSA) when it was signed into law in 2000. GU provided information and testimony to the U.S. Congress and negotiated the compromise with other advocates to ensure the recognition of these special caregivers. GU went on to assist with the implementation of the NFCSA by developing materials and training programs for the aging network. Another victory took place in 2006 when Congress voted to lower the age for older relatives raising children from 60 to 55. Now, nearly 50% of grandparent caregivers qualify for services provided through the NFCSA, rather than the original 27%.

In 2001, we launched GU’s National Center on Grandparents and Other Relatives Raising Children. The Center, known now as the National Center on Grandfamilies, is the umbrella for all of our work on behalf of the families. This was the same year GU began working on LEGACY (Living Equitably - Grandparents Aiding Children and Youth), the first legislation seeking to create affordable housing and services for grandfamilies. Three important elements of LEGACY were signed into law in 2003. GU continued to advocate so that the provisions would be implemented and funds would be appropriated. In 2005, 4 million dollars was earmarked for LEGACY and the first national training for housing professionals took place. We also held the first symposium on affordable housing for grandfamilies releasing subsequent recommendations.

Generations United continues to champion grandfamilies and encourage positive media and congressional policies. Towards this end, in 2005 we worked with communications experts to determine messages and terminology that would resonate with the general public with the goal of increasing understanding and support. This resulted in coining the term “grandfamilies” which is now widely used.

Resources for families and policymakers

Our work with the American Bar Association established www.grandfamilies.org. This is a rich resource that includes every state’s laws, case examples and lessons from the field. It is the one-stop shop for advocates interested in supportive state policies for grandfamilies, including Fostering Connections.

Generations United is proud to work with many partners on projects such as developing and maintaining state fact sheets (www.grandfact-sheets.org) and the three national GrandRallies in Washington, DC (www.grandrally.org), beginning in 2003, which each brought close to 1000 grandparent and other relatives raising children from around the country to Washington, DC. While in the nation’s capital, they shared their stories with federal policy makers and made a lasting impression which has helped move Congress to action.

Today, JJ is doing well. He majored in Public Administration and Policy at Oakland University and works as an advocate and a resource for human services and foster care groups. JJ’s story is a success, but he is always sure to say that it is only because of the help of his grandparents. At GU, we know that grandparents and other family members make incredible sacrifices and invaluable contributions. Children in these households report feeling loved, culturally rooted and connected with their family’s heritage and history.

GU continues to work to shape policies and programs that will help support the success of grandfamilies—because their success means the success of our neighborhoods, our communities and our country.

Donna Butts has served as the executive director of Generations United since 1997. She has 30 years of experience working with non-profit organizations at local, national and international levels. She can be reached at (202)289-3979 and at dbutts@gu.org. Visit Generations United on the web at www.gu.org.

Carol Scott is Generations United’s communications coordinator. She has been a newspaper reporter and a teacher, and can be reached at (202)289-0113 or cscott@gu.org.
Families are their own experts and have the best available understanding of both the strengths and deficits of those surrounding them.

Successful kinship placement requires commitment from the social work level on up. The number of tasks involved in the removal of children is overwhelming even to the most experienced worker. These tasks include but are not limited to making sure the children’s immediate needs are met, managing the legal process, collaborating with the family, gathering information regarding the individual child’s needs, obtaining school records, and completing the necessary documentation. In addition there are other families you are working with, the paperwork on your desk, and the due dates of other things creeping up. However if the long-term advantages for the worker, the child, the family, and the agency are well known kinship should move up on the list and become a priority. Identifying kin is an expectation of the majority of child welfare agencies already; however, a system within the agency which ensures an extensive search is completed must also be present.

While the number of children entering foster care is increasing, the number of unrelated foster care providers is decreasing, creating an even greater need for child welfare workers, supervisors, and managers to embrace and prioritize the identification and maintenance of kinship resources. The benefits of utilizing a kinship resource do not end with a formal placement. Permanency within kinship placement allows for more openness with biological parents. If reunification occurs, often times there is an increased level of support available for the parents. Literature on the policy, and legislation, demonstrate the importance of kinship, but the true test lies with the children we serve.

“So it isn’t the same but it is like the same” (10 year old foster child)

Rissa Carl is a social worker in the North Central Area Office of the Massachusetts Department of Children and Families (DCF) where she has been employed since 1999. She is working on her MSW at Salem State College.

Robin Cormier has worked for the DCF for the past 16 years. She currently holds the position of Supervisor for the Family Support Unit at the North Central Area Office. Both authors may be reached at 978-353-3600.
Fostering connections, implementing change

By Sania Metzger and Lee Mullane

Advancing the agenda for children and their relative caregivers

“I’m so grateful to be here today,” said Carolyn Jackson at the October “Fostering Connections: Implementing Change” Boston Roundtable on Relative Caregivers on October 29, 2009. “Every time I come to a conference like this, I get information. I get knowledge. I get power. I get motivation — and I really need motivation right now.”

For this grandmother, who is raising three grandchildren, last year was especially difficult: in September her son died and in November she had a stroke. “Grandparents go through trauma, too,” she said. “Whether it be for their children or grandchildren, they have to deal with all those situations and so they need help too.”

The caregivers, advocates and policy makers, including child welfare commissioners and directors from New England and Maryland, attending the conference listened intently as Ms. Jackson described how she got help caring for her grandchildren and how she, in turn, is helping other grandparents.

The direct testimony of relative caregivers was a highlight of a day of the discussions on service needs and supports for relative caregivers co-sponsored by the Annie E. Casey Foundation/Casey Family Services, Generations United and the New England Association of Child Welfare Commissioners and Directors.

“We think we have the right people in the room to help us better understand the opportunities and mandates provided by Fostering Connections,” said Donna Butts, Executive Director of Generations United. “And it is the most comprehensive act supporting grandfamilies.”

At the meeting, individuals and organizations shared innovations that have worked so far and their plans and ideas for the future. “With Fostering Connections, we all feel we have turned a corner, that we can now see a very different child welfare system in the next three to five years than we have experienced in the past 10,” said Joyce Duva, Executive Director for Planning and Program Development, the Annie E. Casey Foundation/Casey Family Services.

Over time there has been progress toward implementation of the mandatory and optional provisions of the Fostering Connections Act. “I’m just thrilled at how many different provisions of the act — with regard to notice, with regard to subsidies — are really being put into place in New England and New York,” said Ms. Metzger. “It bodes well for the work that states were doing before Fostering Connections was enacted, as well as the great impetus and support that has come from the legislation.”

Broader definition of family

A first step was clarifying the meaning of relative caregivers and what role they play. Some relative caregiver families provide services within the child welfare system as foster parents. The largest group of relative caregivers does it informally.

It has been hard for some families to understand all these distinctions. “I had one foster youth who said at a Congressional briefing, ‘You would pay a stranger to take me, but you won’t help my grandmother care for me.’ And that really sort of stuck out as a policy disconnect,” said Sonja Nesbitt, Deputy Staff Director of the House of Representatives Ways and Means Committee.

Barbara Kates, Director of Maine Kids-Kin, described how they have been “looking into our formal and informal systems and how we can help families on each side make it less of a fall-off point from one system to the other. And, what can we learn from each of those systems about what makes best practice for families? Because

Continued on page 27
The State of New Hampshire's (NH) commitment to promote and evolve kinship trends was initiated by the hiring of a Kinship Specialist in April 2008. The Division for Children, Youth and Families (DCYF) has long recognized that the kinship care option is key to success in furthering the permanency initiative that was well underway by the time this kinship position was created.

My supervisor/mentor at the time had a vision for Kinship Care and she and I, lightheartedly referred to 2008 as the “Year of the Kin” or YOK. However, this project did not progress with the hiring of a kinship specialist alone, but rather is a result of a home diligent effort on behalf of the agency and a very committed Kinship Focus Group.

The Kinship Focus Group was comprised of volunteer Child Protective Service Worker’s (CPSW’s) that recognized the importance and relevancy of this initiative to their every day work. Its purpose was to look at DCYF’s current values and beliefs, to assess how these were reflected in policy and practice and propel the field toward expansion of an operative and recognizable kinship program.

The Fostering Connections to Success and Increased Adoptions Act of 2008 also played a pivotal role in the development of NH’s Kinship Policy. It was long recognized that that kinship Care was designed to improve child welfare practice in the United States by building the normative practice of working with relatives. New Hampshire believes that connecting children with their relatives will provide stable and permanent families for children. It was an exciting time to be spearheading new initiatives for the field.

Key questions asked and answered

The Kinship Focus Group began with an open discussion around four key questions regarding relative care, Members were asked:

1.) What is it about kinship that we value and believe?

2.) What are current practices issues faced by DCYF regarding kinship?

3.) What should standardized practice look like like statewide?

4.) What are the barriers to kinship care?

It was not surprising to learn that New Hampshire’s child protection staff believe that children who have to be removed from their parents’ care belong with their families. The belief was shared that children who are placed with relatives achieve better permanency outcomes, have more post placement and long-term support, and have better outcomes for reunification. Additionally, workers believed that despite the challenges inherent in some families; being with relatives has better outcomes for reunification. Many state and federal agencies use the terms kin and relative interchangeably. While many were broadening their definition of kin to include a non-relative with a “family like” bond or fictive kin, it seemed in NH we were still using the kinship.

One reason for this was to lessen confusion for the field and the public regarding relative placements for children in state custody. When children enter placement in NH they can immediately be placed with a relative and then referred to the relative to get a foster care license. Approval must be granted and local and police and central registry checks are performed as a temporary measure to provide children with an immediate and safe placement. Relatives are advised of the benefits of obtaining a license however the majority of relative placements in NH choose to receive financial benefits from a TANF Child Only Grant (formerly referred to in NH as Relative Payee). In fact out of 145 relative care homes serving children in state custody, only 36 of them are licensed foster homes.

When placing children in care in NH we value and believe that relationships they have with non-relatives, commonly referred to as “kith”. This is the preferable choice for children entering placement when a relative is not available. However NH’s child placing policy and rules do not allow for a child to remain in a non-relative home unless the family and home has an approved foster care license. Our former kinship care policy included in its definition people who were unrelated to the child but had a “family like” bond. However staff did not understand why this population was included in policy if they were unrelated to the child and had a “family like bond”. This is the preferable choice for children entering placement when a relative is not available. However NH’s child placing policy and rules do not allow for a child to remain in a non-relative home unless the family and home has an approved foster care license. Our former kinship care policy included in its definition people who were unrelated to the child but had a “family like” bond. However staff did not understand why this population was included in policy if they were not given the same consideration as relatives in terms of their availability for placement.

When revising our policy, we used the definition of relative from NH RSA 169:C, the child protection statute which states: Relative means parent, grandparent, brother, sister, stepparent, step-siblings, uncle, aunt, niece, nephews or first and second cousins of the child per. [169-C:3 Definitions. XXVI.]

To simplify the process of relative care for the field it was important that our definitions aligned with the specified definition for relative used by the Division for Family Assistance (DFA), NH’s Economic Assistance Program, when issuing Temporary Assistance to Needy Families (TANF) Child Only Grants. In this way, a worker can be confident when placing a child with a relative as defined in policy that the family can be referred to TANF to receive benefits to assist with their financial expenses.

Some inconsistency remains in the economic assistance policies as, TANF definitions for relatives remain broader than NH definitions allow. For instance under NH RSA 169:C, a second cousin is included in the definition of relative. However according to RSA 167:3, XXIII which

is the definition used by TANF; second cousin is not included. Therefore a second cousin who has been approved for placement would have to become a licensed foster home in order to receive financial compensation for the relative child in their care.

Another factor in NH’s policy decision to use the word “relative” in place of “kin” was the cultural recognition of the term “kin,” which seemed to be a term not easily recognized by the populace of this state. It seemed on a professional and personal level, this writer was constantly explaining the job responsibilities of a Kinship Specialist, whereas the general public and families far more broadly the terminology of Relative Care Specialist.

“Kin is a more cultural term and not intrinsic to the northeast” was a common sentiment shared with committee members. “I have never been referred to as kin by anybody” and “in NH we don’t refer to our relatives as kin, they are just relatives,” were other statements frequently heard.

Within DCYF, while some expressed we should remain consistent with federal language and Kinship terminology, the majority thought we should use the NH term “relative”.

After getting the ultimate approval from Director of DCYF, Maggie Bishop, who was in agreement, saying, “I don’t have kin, I have relatives.” the use of the word “Relative” over “Kin” became official for NH Policy.

Although the initial reaction from the field was one of surprise, once explained, the overall feedback has been that “it makes sense” for us. “Relative” is the most culturally appropriate language for the right for the community and children in care.

This past summer I was invited to speak to a support group of relative caregivers and when I explained that my title recently changed from Kinship Specialist to Relative Care Specialist, several members of the group said, “Thank you”.

Training is now underway to provide our field staff with skills necessary to engage in practice that reflects our new and improved policy. The Relative Care Program in NH will continue collaborative efforts to inform practice, to support the field and, in the end, to ensure that families are valued and served in a way that respects their culture and beliefs while ensuring child safety.

Janet Kohlhase-Purdy currently serves part-time as Relative Care Specialist for NH Division for Children, Youth and Families. She has 18 years experience in child welfare. She can be reached at NH DCYE, 129 Pleasant St. Concord, NH 03301 (603) 271-7338.
**Who was at the Chinese Buffet?**

By Mary Santos

A young teen slid into the banquet bench at the landmark Chinese restaurant, his social worker of many years greeted him. As he glanced around at the decades-old décor and suddenly said: “I was here once a long time ago, with my family. I remember Uncle Buck telling all us kids to ‘belly up to the buffet.’” The worker scratched on a napkin and wondered how long it had been since the young man had dined with someone directly related to him.

Following natural disasters such as hurricanes and earthquakes, organizations like the Red Cross know the importance of reconnecting separated family members as soon as possible. Relief workers recognize that a family’s best chance for recovery lies with one another. The Chinese culture and certain faiths, such as the Church of the Latter Day Saints, respect and encourage a strong appreciation for one’s ancestors. So if “the typical American child living in unrelated foster care has one to three hundred living relatives,” how does a social worker go about finding them? Thankfully, only a very small percentage of kids spend the majority of their lives in a system initially designed for the “temporary safeguarding” of children. But years pass, multiple moves are made and family connections are lost. Young adults begin to wonder to whom he or she belongs. Many question if anyone from their past ever truly cared about them?

During the fall of 2008, two particular Massachusetts Department of Children and Families’ area offices collaborated to develop a Foster Care Search System that became their “legal” parent. While they share their knowledge of the foster care system from a child’s eye view they also give us their views from an adult perspective. Three messages echoed through each chapter. The first was that no one listened to them – whether it was reporting the abuse, reporting problems in the foster home or asking them what they wanted or needed – no one asked!

Rosalind Folman expressed the second message best, “Foremost, the foster care experience UNDERMINES children’s sense of belonging. Belonging is a basic human need that when unmet prevents children from achieving a sense of self-worth...the repeated disruptions in all their social networks are not okay. What they need – no one asked! And, in some cases, a teen could truthfully be told, that yes, someone did care about, and want you.

The group generally focused on older children in the foster care system that became their “legal” parent. While they share their knowledge of the foster care system from a child’s eye view they also give us their views from an adult perspective. Three messages echoed through each chapter. The first was that no one listened to them – whether it was reporting the abuse, reporting problems in the foster home or asking them what they wanted or needed – no one asked!

Rosalind Folman expressed the second message best, “Foremost, the foster care experience UNDERMINES children’s sense of belonging. Belonging is a basic human need that when unmet prevents children from achieving a sense of self-worth...the repeated disruptions in all their social networks are not okay. What they need – no one asked! And, in some cases, a teen could truthfully be told, that yes, someone did care about, and want you.

The third message clearly articulated concerns about leaving the foster care system with no survival skills. Foster youth are well aware of their odds for success once they leave foster care – but no one provided them the necessary tools to make it. These eleven had to find the drive within them in order to become the successes they are today.

Maurice Webb concludes his chapter by saying, “Perhaps it is time for the decision-makers to listen to those of us who have survived the system and utilize our input to fix what too long been broken...by including the voices and insights of survivors...the child welfare system might just advance its mission of helping young people grow past difficult situations by learning from those of us who have surmounted seemingly impossible odds.”

This book is one to be read and taken to heart by everyone who finds themselves in a position to speak for the needs of foster children – whether a CASA volunteer, program staff, foster care worker, judge or legislator. Our greatest successes will come only when we listen to each child and step up to meet that child’s needs.

**Growing Up in the Care of Strangers**

The Experiences, Insights and Recommendations of Eleven Former Foster Kids

Waln K. Brown                 John R. Seita

For ordering information contact:  
Dr. Rosalind Folman by calling 248-554-0899 or visit their website at www.fosterkidslives.com

11
DCYF Director Bishop receives national recognition

At the 17th National Conference on Child Abuse and Neglect held on April 2, 2009, Maggie Bishop, DHHS Director of the Division for Children Youth and Families (DCYF), was named a New Hampshire recipient of the Administration on Children, Youth and Families Commissioner’s Award. This award is given to individuals who are outstanding champions of children and families and dedicated to continued collaborative efforts on their behalf.

Bishop, who has been the Director of the New Hampshire Division for Children, Youth and Families for four years, has had a varied and diverse 30 year career in child welfare. Her work has ranged from direct child welfare services to supervising and administering programs within the state human services agency. Ms. Bishop has shown herself to be a visionary with her drive to improve practice in the areas of prevention, family support, and training for field staff. Ms. Bishop is tireless in her pursuit of permanency, safety, and well-being for all children through bold, unwavering leadership as she builds committed partnerships with the communities of New Hampshire. Ms Bishop greatly values the benefits of ongoing and progressive training for staff, which in turn provides for the best available services to the families of New Hampshire. Her commitment to field staff has enabled her to keep a vibrant awareness of daily practice. Ms. Bishop is a hands-on administrator who does not hesitate to speak directly with field staff, providers or families about case issues. This approach has offered staff a real sense of connection to her efforts to improve and modernize child welfare practice in the state of New Hampshire.

Maggie Bishop is known for her firm commitment to improving and promoting best practice and achieving positive outcomes for children and families. The people of New Hampshire are fortunate to have such a determined and strong individual in this role, continually striving for excellence in the field of child welfare.

Congratulations Maggie!

A “one on one” with Julie Sweeney Springwater

Questions and Answers with CWLA Board Chair, Julie Sweeney Springwater

What is your background in child welfare?

I became involved with CWLA more than 20 years ago while an administrator with the Massachusetts Department of Social Services. I came on to the board as a representative of the New England region about five years ago and was later elected as vice chair. This past April, I was elected as chair of the board. One of the perspectives I bring to CWLA is that of directing a regional membership association of public child welfare agencies, the New England Association of Child Welfare Commissioners and Directors. I worked primarily in the public sector, but the association is housed at Judge Baker Children’s Center, which is a nonprofit mental health organization that houses a therapeutic day school and the DCF after-hours CPS emergency response program. I also run a certificate program in Human Service Management at Boston University’s School of Social Work, where I’ve been teaching for 12 years.

What do you see as the board’s most important strengths and responsibilities?

It’s important for people to know that CWLA’s board is very representative of its membership. Many of us are directors or CEOs of member organizations, and we’re there to represent the entire membership. The fact, when the bylaws were written a few years ago, a change was made so that regional representatives became voting members of the board. Prior to that they were ex officio members. It changes the nature of the board in a very way—when you have people who bring the perspective of the work that occurs on a day-to-day basis with children and families all over the country.

We have a responsibility to members and the children and families that CWLA serves to make sure that the organization is financially stable; that is part of the intergenerational responsibility of any nonprofit board. We also have a responsibility to be strategic by regularly looking at where we want to go and how we’re going to get there. Executing that strategy is an interactive process between the staff and the board. Boards also need to be generative, which is really about trying to understand everything that is going on in the environment around you—data, information, trends—and then formulating a strategy based on the “sensemaking”, if you will, that a board does.

How will CWLA use its leadership position to help members in the coming decade?

What is unique about CWLA is that it has members from both the public and nonprofit sectors. A critical part of being a leadership organization is to hear those voices from both private and public organizations and to be able to formulate positions on what will create the best outcomes for children and families. Building on the relationships we have, and helping them connect to each other is a critical aspect of our leadership role in the coming years. One of my pet peeves is reinventing the wheel. CWLA values networking among members to share challenges and lessons learned so that the limited resources we have are not utilized to duplicate work efforts or to repeat similar mistakes.

I think members can really turn to CWLA to learn from other members; we can all be stronger by building solid relationships with each other.

In addition to building public-private partnerships, we recognize that child welfare operates in a continually shifting environment. In order to continue to be a leadership organization, you need to foster dialogue not only between member agencies, but also between the variety of stakeholders who play a role in the field. This includes a broad spectrum of people who work with children and families, because many families have complex needs.

We have a responsibility to members and the children and families that CWLA serves to make sure that the organization is financially stable; that is part of the intergenerational responsibility of any nonprofit board. We also have a responsibility to be strategic by regularly looking at where we want to go and how we’re going to get there. Executing that strategy is an interactive process between the staff and the board. Boards also need to be generative, which is really about trying to understand everything that is going on in the environment around you—data, information, trends—and then formulating a strategy based on the “sensemaking”, if you will, that a board does.

How will CWLA use its leadership position to help members in the coming decade?

What is unique about CWLA is that it has members from both the public and nonprofit sectors. A critical part of being a leadership organization is to hear those voices from both private and public organizations and to be able to formulate positions on what will create the best outcomes for children and families. Building on the relationships we have, and helping them connect to each other is a critical aspect of our leadership role in the coming years. One of my pet peeves is reinventing the wheel. CWLA values networking among members to share challenges and lessons learned so that the limited resources we have are not utilized to duplicate work efforts or to repeat similar mistakes.

I think members can really turn to CWLA to learn from other members; we can all be stronger by building solid relationships with each other.

In addition to building public-private partnerships, we recognize that child welfare operates in a continually shifting environment. In order to continue to be a leadership organization, you need to foster dialogue not only between member agencies, but also between the variety of stakeholders who play a role in the field. This includes a broad spectrum of people who work with children and families, because many families have complex needs.

Best served by a variety of systems. The integration of mental health, juvenile justice, domestic violence, substance abuse, education, and other areas is a critical issue this field faces today. CWLA can be a convener of people from all child- and family-serving organizations, bringing them together to have strategic conversations during this tremendously challenging time. The economic situation has been difficult for many agencies and states facing cutbacks, but stressful times often can produce very creative solutions. CWLA wants to help the field find these solutions.

We can leverage these private-public conversations in our work on Capitol Hill. Having knowledge from both sides of the child welfare field is a great strength, particularly on a national level. It brings a strong and credible voice to the advocacy positions that CWLA takes, which can create positive changes for children and families.

Emily Shenk is the Editor in Chief for Children’s Voice and Managing Editor at Child Welfare League of America. She can be reached at 703-412-4162. This article was originally published in Children’s Voice, January/February 2010, www.cwla.org/voice.

The Malden Magic squared off against a mighty opponent January 31st at the Stoneham Arena, “The Magic” is a hockey team comprised of members of the Massachusetts Department of Children and Families workers and community individuals in the Malden area often play for acompanionship, this was one such game. The game featured “The Magic” against the Melrose Senior Pride and Selected Bruins Alumni and attracted several hundred supporters to benefit the North Suburban Family Networks. The Magic are well known for using their love of hockey to raise funds for foster children, win or lose, their fans continue to support them.

Sunday evening’s game was a lively, hard fought, up and down affair, with goals being exchanged, from start to finish. The Magic held a two goal lead, late in the third period, until Bruins Legend Rick Middleton (Nifty), took over, and scored three goals in the last ten minutes. With less than a minute left in the game, Middleton’s third goal brought the magic to the 7-7 tie. Though Magic goalie Reggie, thought he had Middleton tied up, going to the net, “Nifty” with his old tricks was able to beat, Reggie and Ryan Patti, with a shot to the upper right hand corner of the net.

The Magic, will put this loss behind them immediately, and prepare to play in their favorite charity game, which benefits DCF foster children. Come and cheer them on as they face off against the Medford Police Friday, March 19th at 7pm., Friday, March 19th at 7pm They face off at the Laconia Rink in Medford. This is hosted, for the 3rd year in a row, by Medford Youth Hockey and is a great family night out for a great cause. For ticket information or to make contributions to the third game, please contact Malden DCF office at 781-388-7100.

Please see “Save the Date” on page 24.

Julie Sweeney Springwater

Common Ground, February 2010

New England News

Congratulations Maggie!

Maggie Bishop

12
Young adult involvement in Vermont’s Youth in Transition (YIT) Grant

By Vanessa Lang

A long with the opportunity and promise of receiving a six year Substance Abuse and Mental Health Services Administration (SAMHSA) grant to improve systems of care for Vermont’s youth in transition (ages 16-21) with serious emotional disturbance, comes the responsibility of involving young adults in all aspects of the systems change efforts. As we complete the initial planning year, we have begun to reflect upon how young adults have been involved so far.

Since February, 2009, Vermont’s twelve Agency of Human Services regions have been performing needs assessments, soliciting information from stakeholders, and creating strategic plans to improve systems of care for transition-aged young adults. In general, the task of involving young adults in this process proved to be quite challenging. The course that most regions took was information gathering through focus groups, in the hopes that some of the material garnered could be used to inform local planning efforts. Facilitators, inquired into the participants’ experiences with schools, jobs, families, and the myriad of services they may have received. Young adults from across Vermont voiced the many obstacles and difficulties they face, ranging from finding a stable place to live and transportation to fears of being stigmatized by seeking mental health services or economic assistance. A young person from southern Vermont said, “I know there are services out there, but I don’t know what or where they are.” This sentiment was echoed by countless young people throughout the state. A young person who dropped out of a central Vermont school said of his experience, “I had a one-on-one aide that helped, but it made me feel dumb.” Hearing and reading these comments has been stunning, making it clear why and how very great the need is to improve our state and regional care for this population.

The collection of pages quoting and summarizing these young people’s accounts of their experiences with the State of Vermont’s services should be the bellwether of this project because they hold the greatest knowledge about what helps them. They know their world.

While holding focus groups to ask young people what they need is an excellent step to involving them in systems change, it cannot end there. The engagement of young people must go beyond focus groups, so that we can continuously hear and include a greater diversity of young adults and viewpoints. Most regions are now planning to create young adult councils and advisory boards as a way to encourage and help young adults gain a sense of competence, usefulness, and empowerment. Involving young adults is the most important piece in improving systems to better meet their needs; the successful implementation of the Youth in Transition (YIT) grant depends upon it.

To promote increased young adult participation, we recommend the use of the “youth guided pyramid”, below. Really doing so could lead to a strong young adult voice woven throughout Vermont’s organizations, communities, and systems!

For more information contact Vanessa Lang, Statewide Young Adult Coordinator at vlang@vfcnh.org or (802) 595-5159.

My Declaration

Living without you
Is like trying to breathe with no air-
It’s like the truth without the dare
It’s like having church with no prayer
You see-it just doesn’t seem right-
Cuz at the end of the night
Who’s gonna hold me tight?
I mean-don’t get it twisted-
Cuz at the end of the night
You see-it just doesn’t seem right-
It’s like having church with no prayer
Who’s gonna hold me tight?
Because if I don’t utilize it-
You see-there are services out there, but I don’t know what or where they are.
This sentiment was echoed by countless young people throughout the state. A young person who dropped out of a central Vermont school said of his experience, “I had a one-on-one aide that helped, but it made me feel dumb.” Hearing and reading these comments has been stunning, making it clear why and how very great the need is to improve our state and regional care for this population.

The collection of pages quoting and summarizing these young people’s accounts of their experiences with the State of Vermont’s services should be the bellwether of this project because they hold the greatest knowledge about what helps them. They know their world.

While holding focus groups to ask young people what they need is an excellent step to involving them in systems change, it cannot end there. The engagement of young people must go beyond focus groups, so that we can continuously hear and include a greater diversity of young adults and viewpoints. Most regions are now planning to create young adult councils and advisory boards as a way to encourage and help young adults gain a sense of competence, usefulness, and empowerment. Involving young adults is the most important piece in improving systems to better meet their needs; the successful implementation of the Youth in Transition (YIT) grant depends upon it.

To promote increased young adult participation, we recommend the use of the “youth guided pyramid”, below. Really doing so could lead to a strong young adult voice woven throughout Vermont’s organizations, communities, and systems!

For more information contact Vanessa Lang, Statewide Young Adult Coordinator at vlang@vfcnh.org or (802) 595-5159.

My Declaration

Living without you
Is like trying to breathe with no air-
It’s like the truth without the dare
It’s like having church with no prayer
You see-it just doesn’t seem right-
Cuz at the end of the night
Who’s gonna hold me tight?
I mean-don’t get it twisted-
Cuz at the end of the night
You see-it just doesn’t seem right-
It’s like having church with no prayer
Who’s gonna hold me tight?
Because if I don’t utilize it-
You see-there are services out there, but I don’t know what or where they are.
This sentiment was echoed by countless young people throughout the state. A young person who dropped out of a central Vermont school said of his experience, “I had a one-on-one aide that helped, but it made me feel dumb.” Hearing and reading these comments has been stunning, making it clear why and how very great the need is to improve our state and regional care for this population.

The collection of pages quoting and summarizing these young people’s accounts of their experiences with the State of Vermont’s services should be the bellwether of this project because they hold the greatest knowledge about what helps them. They know their world.

While holding focus groups to ask young people what they need is an excellent step to involving them in systems change, it cannot end there. The engagement of young people must go beyond focus groups, so that we can continuously hear and include a greater diversity of young adults and viewpoints. Most regions are now planning to create young adult councils and advisory boards as a way to encourage and help young adults gain a sense of competence, usefulness, and empowerment. Involving young adults is the most important piece in improving systems to better meet their needs; the successful implementation of the Youth in Transition (YIT) grant depends upon it.

To promote increased young adult participation, we recommend the use of the “youth guided pyramid”, below. Really doing so could lead to a strong young adult voice woven throughout Vermont’s organizations, communities, and systems!

For more information contact Vanessa Lang, Statewide Young Adult Coordinator at vlang@vfcnh.org or (802) 595-5159.
Learning Session 3 of the New England Breakthrough Series Collaborative (BSC) on Safety & Risk Assessment occurred in Nashua, NH in late October 2009 and was a great success by all accounts!

Ever since the beginning of this Collaborative, many people have been wondering about what concrete ‘stuff’ would come of all the PDSAs, conference calls, measures and meetings they’ve been part of. At this Learning Session, it seems like folks started to feel like they were beginning to see the fruits of their labor.

This is only the second BSC that has been purposefully extended to four sessions, and we are using that ‘extra time’ to help our 22 teams develop a more in-depth approach to “spread”. We worked with agency leadership in each of the 6 New England states to map the overall priorities of each agency before we met in Nashua. During this Learning Session team members got the chance to conceive of the ways that their work could be united with the direction of their agency by considering the idea of a Throughline—a framework (like a practice model) that describes a state’s existing priorities and helps staff to envision the direction and context that their work ought to take.

Up to this point we had operated like a normal BSC, encouraging people to shamelessly borrow...
ideas from other jurisdictions, encouraging talk between teams to help promote cross-pollination, and guiding teams through spread that was mostly confined to their home offices. During this Learning Session we took new and exciting steps. First, we brought the Commissioners and Directors of all of the state agencies to the Learning Session. Secondly, we assembled State Teams, comprised of all the teams and leadership from a given state. Finally, we had multiple State Team Meetings, giving everyone a particular state the chance to meet with each other and their agency’s leadership. This extended intrastate planning time allowed the states to plot their courses forward into statewide Spread. This was unprecedented as most BSCs have only one team from a given state, and most upper-level leaders are rarely given the chance to spend such substantial time hearing directly from all levels of their workforce.

The early results are very encouraging and it looks to us like every state has some promising practices that should be able to start spreading statewide before we conclude our BSC in April. Each of the states is in a different place with their preparation to spread, but they have all made astounding progress! We’re looking forward to seeing how far these practices will get over these last few months!

By Anthony Barrows

Keeping participants engaged
Moving forward…

Connecticut DCF builds statewide capacity for treating traumatized children and adolescents

By Marilyn E. Cloud, Jason M. Lang, and Robert P. Franks

Project description

The Connecticut Department of Children and Families (DCF) continues its third year of sponsored by the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Learning Collaborative. This initiative was created to improve statewide access for eligible children to trauma-specific, evidence-based treatment at community outpatient clinics.

It is well-documented that many children and adolescents have histories of trauma exposure. A national U.S. Department of Justice survey from 2009 indicated that over 60 percent of children were directly or indirectly exposed to violence within the past year. In Connecticut, behavioral health providers estimate that 50 to 80 percent of the children they serve have experienced sexual abuse, physical abuse, domestic violence, community violence, or other traumas. While most children exposed to a trauma do not require treatment, some will develop posttraumatic stress reactions that adversely impact their daily functioning, particularly those exposed to severe, multiple, or chronic traumas. These reactions most often include symptoms of depression and posttraumatic stress disorder (PTSD), including re-experiencing (flashbacks/nightmares), avoidance (related to the trauma), and increased arousal (hypervigilance, difficulty concentrating).

Fortunately, an effective treatment for traumatic stress symptoms in children, TF-CBT, has been developed.

DCF selected TF-CBT for statewide dissemination because it is one of the best scientifically-supported interventions for child traumatic stress, including five completed randomized clinical trials, and has been designated as a Model Program by SAMHSA. TF-CBT is a 16 to 20 session family-centered therapy for children ages 4 to 18 who have significant behavioral or emotional problems related to traumatic life events, even if they do not meet full diagnostic criteria for PTSD. Children and parents/caregivers learn knowledge and skills to process the trauma, manage distressing thoughts, feelings, and behaviors, and enhance safety, parenting skills, and family communication and support.

Dissemination strategy

Connecticut is one of the first states to utilize the Learning Collaborative methodology on a statewide level to disseminate TF-CBT. Historically, efforts to spread evidence-based practices, primarily through traditional didactic trainings, have had limited success. There are multiple, complex challenges that thwart transferring what is learned through scientific research to the real world of practice. Barriers include insufficient funding, limited training time for clinicians, little or no follow-up consultation, clinician resistance, limited buy-in from administrators, lack of data measuring progress and outcomes, and institutional, state, or federal policies that impede adoption.

A learning collaborative approach differs from traditional training in several important ways. Developed by the Institute for Healthcare Improvement, it is an adoption and improvement model that consists of a twelve-month period of intensive learning and change, utilizing a data-driven continuous quality improvement model. Staff from various positions participate, including administrators or senior leaders, clinical supervisors, clinicians and a family partner who represents the perspectives of families receiving treatment. Having multiple agencies participate together creates a rich learning community where successes are shared across sites. The team address barriers to implementation at multiple levels.

Through creative use of federal Mental Health Block Grant Funds and a competitive procurement process, DCF selected the Child Health and Development Institute/Connecticut Center for Health and Human Service Practice (CHDI/CEEP) to serve as the Coordinating Center. Their primary functions are to plan, manage and evaluate the TF-CBT Learning Collaborative. During the three years of this initiative (2007 through 2010), 16 clinics have, or are currently participating in a learning collaborative. The clinics receive financial support from DCF to offset some of the expenses incurred.

Implementation process

The CHDI/CEEP provides project staff, secures expert faculty, and consults with the National Child Traumatic Stress Network. Project staff provide: initial site visits to assess organizational readiness; selective follow-up site visits to address targeted clinic issues; extensive training on assessment and standardized measures; facilitation of 3 to 4 in-person learning sessions and monthly consultation calls; management of measures and implementation (metric) data across sites; training and support for family partners; management of senior leader, supervisor and family partner learning tracks; management of an intranet site for posting questions/answers and sharing tools; and liaison activities with site coordinators, faculty, and other partners. A TF-CBT Fellowship Program offers advanced training for 6 high performing clinicians, who serve as co-trainers with faculty, facilitate monthly consultation calls, and are becoming in-state TF-CBT experts and champions.

Data

The use of data to improve practice is fundamental to the learning collaborative model, and includes client data (measures) and agency-level implementation data (metrics).

Measures

Therapists are required to use the UCLA Posttraumatic Stress Reaction Index (PTSD-R) and the Short Mood and Feelings Questionnaire (SMFQ) or Child Depression Inventory (CDI) with each client and his/her caregiver. These measures are administered pre-treatment, every three months, and at discharge. A client satisfaction survey is also administered to caregivers every three months and at discharge. These data are used for assessment and evaluation of potential TF-CBT cases, to measure client progress over time, and to drive treatment/discharge decisions. Symptom data are shared with clients and caregivers regularly during treatment to discuss progress. Each clinician receives a computer-generated summary of each assessment in a format that is easy to read and share with families.

Metrics

Clinicians complete monthly metrics over the course of the year to assess, evaluate, and promote the implementation of TF-CBT at each agency. Metrics include data about each clinician’s experience assessing cases for TF-CBT, TF-CBT caseload, supervision, skill/competency in the TF-CBT components, and information about each case they see, including caregiver involvement, number of sessions, and use of various TF-CBT components.

Cross-system collaboration

To further support successful implementation, efforts were made to advance a statewide trauma-informed system of care, particularly by disseminating TF-CBT knowledge and developing strategies for cross-system collaboration between child welfare workers and outpatient clinicians. Too often these professionals work in closed systems, characterized by limited information-sharing and sparse ongoing communication. Workers are often unaware of the status of treatment, even though they may transport the child to weekly therapy appointments. Trauma histories are not routinely shared. There may be multiple, conflicting plans of care. Through the TF-CBT Learning Collaborative, training was provided at DCF Area Offices that have participating TF-CBT clinics within their region. Training included an overview of child traumatic stress and TF-CBT, guidelines for DCF staff to identify appropriate referrals, and treatment expectations. This resulted in a common language and shared understanding across disciplines. Relevant client information is shared at the time of referral, trauma histories are documented and shared by the involved parties, and there is ongoing dialogue throughout the course of treatment.

Continued on page 22
By Sue Hubert

Child welfare and domestic violence

“Accurate identification of domestic violence can create an appropriate framework for intervention.”

Over the last twenty years we have watched how DCF and communities have integrated available research about the overlap of domestic violence and child abuse. Because of specialized child witness programs and work on trauma informed care we have an enormous amount of information about the potential negative impact on children who witness domestic violence. Children can develop traumatic responses from witnessing one of their parents being abused, whether or not they themselves were physically injured during an assault either by accident and/or because they try to intervene to protect a parent. New therapeutic interventions and trauma specializations have developed to meet the very specific needs of these children. Considerations of access and safety are woven into therapy approaches and the work that is done helps parents better grasp the impact witnessing the abuse has had on their children. I am sure that many children’s lives are safer because of this information and work. It is vital that we continue to support and develop of some important interventions. There have also been some unintended outcomes of the work we have done in highlighting the importance of identification of domestic violence.

We never want to underestimate the danger a child may be in but there are things about children and their communities that have an impact on their safety. A significant amount of research supports the findings that although children can be negatively impacted by witnessing domestic violence, not all children who do so are traumatized or physically in danger. In fact, considerable research points to the presence of resiliency factors that can mitigate the negative impact of witnessing violence on children. It depends on the specifics involved in the situation we are calling “domestic violence” but also the nature and extent of the impact varies depending on some other aspects of a child’s life. For example:

• How often the violence happens
• How long the violence has been happening
• The severity of the violence
• Developmental stage of the child
• Availability of supports to the child and family
• The child’s own resources
• The child’s perception of the events
• Parents’ protective capacity
• Their support system

Domestic violence and children’s resilience

Children’s individual coping skills, the specifics of the situation around them and the supports they have in their community all play a part in their resilience. There is a great deal of information about what contributes to the impact domestic violence has on a child and also what contributes to building a child’s resiliency. These are factors like:

• Parent availability and extended family support
• Creativity, hobbies, extra curricular activities
• The development of healthy coping skills
• A child’s connection to their community
• Having positive, supportive adult role model
• Availability of safe havens
• Modeling healthy interactions

Gathering information about these areas of a child’s life and identifying specific impact on each child is vital to a full assessment of a situation. This can lead child welfare workers to be actively involved in building resilience in children’s lives. Even though we know a great deal about children’s resiliency, how they survive and thrive despite such circumstances, this is not often a primary part of the conversation.

Progress and problems in identifying “domestic violence”

There has been success in identifying domestic violence in child welfare cases, and such work is an integral part of clinical case practice at DCF. The DCF DVU has provided consultation and trainings that support staff in identifying “red flags” and build strategies for different approaches when talking to battered women. Individuals and office managers have taken leadership roles in further developing staffs’ skills in this area. Knowledge has been integrated about how to gather information from multiple sources to identify risks and patterns of domestic abuse so that we do not simply rely on individual disclosures. The domestic violence provider community has been very successful at raising the issue as a social/community concern that needs to be identified and addressed.

These are all good things, but we always need to be cognizant of unintended consequences that may develop as change occurs. As this field of work has developed the language of “domestic violence” has become more comfortable for people. The phrase, “domestic violence” is often used as if those two words tell us something specific about a family. Then it elicits the most fearful, dangerous images of what “could” happen, what has happened and how we might be held responsible if “it” happens again.

Making assumptions from a place of fear or lack of information can be very dangerous. We may under identify very high risk situations as well as over identify situations that do not, or should not, rise to the level of state child protection involvement. Without specifics we may also miss identifying the best and most useful interventions and services for a family. Domestic violence can encompass a wide range of behaviors, risk and danger. Like all other issues that families deal with there cannot be a “standard” response but rather there must be one tailored to the specific needs being present.

The accurate assessment of the specific risk domestic violence poses is necessary to determine:

• if CPS needs to be involved at all
• the specific level of risk is to the child(ren)
• the specific impact to the child(ren)
• the most appropriate services for the child(ren) and other family members for the best possible outcome;
• the safest and most effective approach with this family.

Obviously we never want to underestimate the danger a child may be in but without specifics about level and type of violence being used,
The unmet needs of foster parents

By Paula Stahl, Stefi Rubin, and Lulie Munson

Children’s Charter, a division of The Key, Inc, is an outpatient trauma speciality clinic located in Waltham, MA. Its sole purpose is to provide specialized psychological services to children, adults and families who have been victimized by trauma. Children's Charter/Key is the state’s largest provider of outpatient trauma-focused services for children. We offer a comprehensive array of specialized clinical services: individual, family, and group treatment; parent consultations; psychopharmacological intervention; Expressive Arts Therapy; EMDR; and community training and consultation. Additionally, we offer four Specialized Programs: Project “GIFT”, a mental health service for children and adults who are dealing with issues related to loss and illness; and the “Three-Legged Stool” Foster Parent Partnership Program, a consultation service for foster parents.

The “Three-Legged Stool” Program recognizes these complex relationships in its work with foster/kinship families.

The “Three-Legged Stool” Program recognizes these complex relationships in its work with foster/kinship families.

Children’s Charter/Key has had a long-standing partnership with the Massachusetts Department of Children and Families (DCF), providing consultation and treatment for children and families served by their agency, as well as consultation and training for workers. Over the past twenty-four years, some of the most difficult cases have been those where a child or children have been removed from their parents’ care due to severe, chronic abuse and neglect and then placed either in institutions or in foster homes. Moreover, we have treated children who enter the foster care system or are in kinship placements following the murder, overdose, or suicide of a parent. These children are frequently separated from their siblings and placed in homes and communities that are unfamiliar to them. Statistics from DCF show that the number of children under the age of 18 in foster placements in Massachusetts in 2005 neared 11,000. The largest group of children was between the ages of 12-17 years. Over the next several years, this number is likely to increase as the DCF protective model shifts children from residential settings into community-based foster homes.

Not surprisingly, foster children present with multiple challenges. They often display symptoms of Post Traumatic Stress Disorder (PTSD), such as nightmares, hypervigilance, flashbacks, anxiety, and difficulty concentrating. The children may be emotionally dysregulated, aggressive, withdrawn, depressed, and/or lack the skills to self-soothe. Depending on their age, they may also struggle with bedwetting or soiling. Frequently, children in the foster care system present with difficulties connecting to caregivers; a disorganized attachment style is commonly seen in these children. With limited preparation, foster parent(s) can be overwhelmed by the ongoing issues that arise as they attempt to parent these children; this can lead to the decision to terminate the arrangement, leading to multiple placements and rejections for the children. Worse still, some of these children end up in institutionalized care, with little or no hope of ever being part of a family. Even when a child is adopted, his or her early history of trauma can create barriers that leave both the parent(s) and the child feeling defeated. As Bill Frenzel from the Pew Commission on Foster Care stated, “The nation’s foster care system is unquestionably broken.”

Overall, there are few available interventions for foster parents. Additionally, there is limited funding and flexibility available to create intervention that meets foster families’ varied needs due to narrowly defined outcomes and fragmented care. Recognizing the need for intensive, comprehensive support for foster parent(s), in 2005 Children’s Charter/Key developed the “Three-Legged Stool” Program with DCF’s Arlington area office with whom we have maintained a successful partnership for the past twenty-four years. The “Three-Legged Stool” Program’s target population is foster parent(s) caring for children with significant trauma histories and attachment difficulties. The structure of the program is to pair each foster parent with a Senior Children’s Charter/Key Clinician and a DCF Social Worker to form a partnership that provides consultation, support, and clinical services for the foster parent(s).

How it works

The “Three-Legged Stool Program” serves: Children: a wide range in terms of status of the child’s or children’s cases, court proceedings, and permanency planning. Ages: preschoolers through late adolescence.

Caretakers: foster parents, kinship families, guardians, pre-adoptive, and adoptive parents; many work full time while a few have been in transitional or temporary, and during their time as foster parents; families are defined as both traditional and alternative.

Duration: range from six meetings to as long as three years

Referrals: closed referrals from DCF area offices

Capacity: twenty-five foster families

Clinicians: licensed clinicians with a minimum of ten years clinical experience in trauma

There are several important partnerships formed within the “Three-Legged Stool” Program. When a child is placed in foster/kinship care, the birth family forms a new relationship with the foster family and vice versa. Both families undergo a reconfiguration. They also have different relationships and responsibilities as determined by DCF.

The “Three-Legged Stool” Program recognizes these complex relationships in its work with foster/kinship families. For instance, when a child is removed from his/her birth family, and during their placement in foster care, the child often experiences mixed emotions, given the loss of the familiar birth family and the joining into the new foster family. In turn, new kinds of communication need to be created between the birth and foster families (e.g. phone calls and scheduling visits). One role of the “Three-Legged Stool” Program clinicians is to provide guidance around ways to facilitate communication so as to preserve the child’s best interests. Furthermore, the child’s placement in foster/kinship care generates new relationships among the child’s previous and current teachers, the child’s community resources (e.g. afterschool programs) and the child’s health and mental health providers.

Presenting Behavior

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Sexualized Behavior</td>
<td>1. Preoccupation with private parts 2. Excessive masturbation</td>
</tr>
<tr>
<td>B. Conscience Development</td>
<td>“Cruel” behavior-name calling, swearing, smiling, smiling when saying something</td>
</tr>
<tr>
<td>C. Affect Regulation</td>
<td>Impulsive; yelling; meltdown</td>
</tr>
<tr>
<td>D. Preoccupation with aggression, monsters in play, violent dreams</td>
<td></td>
</tr>
<tr>
<td>E. “Center of Attention”- competitive, argumentative</td>
<td></td>
</tr>
<tr>
<td>F. Roles/Relationship Confusion</td>
<td></td>
</tr>
<tr>
<td>G. Anxiety related to Permanency</td>
<td></td>
</tr>
</tbody>
</table>

Through the Trauma Lens

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. “Selling”</td>
<td>Attaches different meanings, private behavior that is public and lack of understanding of appropriateness.</td>
</tr>
<tr>
<td>B. Development interrupted</td>
<td>No anxiety following cruel behavior; project blame onto others; difficulty recognizing feelings in others (empathy).</td>
</tr>
<tr>
<td>C. No capacity for attunement/module affect 1-12 months</td>
<td></td>
</tr>
<tr>
<td>D. Mastery/Re-Doing</td>
<td>Hypervigilance</td>
</tr>
<tr>
<td>E. Negative Attention</td>
<td>Reinforcing, scarce resources</td>
</tr>
<tr>
<td>F. No family template; chaos and role reversal</td>
<td></td>
</tr>
<tr>
<td>G. No safety; “adults come and go”.</td>
<td></td>
</tr>
</tbody>
</table>

Continued on following page
NH promotes the use of evidenced based treatment in children and youth affected by trauma

By Erica G. Ungarelli

The NH Division for Children, Youth and Families (DCYF) has been progressively looking towards the use of evidenced based practices in our treatment milieu. DCYF has incorporated language concerning the use of evidenced based and informed practices into our certification rules as a way to encourage our provider community to stay abreast of the best practices in treating children in the child welfare system. Using this language in our certification practices spotlights that this population of children and youth have unique needs that must be addressed. Specifically, DCYF sought the use of a highly effective modality for treating trauma in children.

In this time of reduced funding for services, the Division recognized that engaging in the implementation of any evidenced based treatment could be an expensive proposition for our providers. In order to encourage the use of an evidenced based model, NH DCYF has used Child Abuse Prevention and Treatment Act (CAPTA) funds to sponsor a training for our private providers. DCYF’s Senior Psychiatric Social Worker, Christine Gerhardt, in collaboration with the Division’s Bureau of Quality Improvement, developed the idea of using these funds to purchase training and consultation for our providers in an evidenced based trauma focused treatment. The Center for Professional Excellence in Child Welfare at the University of New Hampshire provided logistical and coordination support to the effort.

Trauma Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), developed by Judith Cohen, Anthony Mannarino and Esther Deblinger, is an empirically supported therapeutic treatment program for children and families exposed to traumatic life events. For this reason, DCYF chose to encourage the use of this highly evidenced based treatment modality and spread access to it for children and families throughout NH. In October 2009, DCYF sponsored in-depth training in the use of TF-CBT, for DCYF’s certified private therapists, as well as Residential Care and Individual Service Option (ISO) providers. This training was offered at no cost to those who attended.

The training

The two-day training provided an intensive review of all the TF-CBT treatment components, with a specific focus on clinical implementation strategies. DCYF was able to accommodate 100 people in this training. There was not an empty seat in the auditorium. DCYF was also able to use state funds to purchase Continuing Education Units for practitioners who participated in this training.

Dr. Kay Jankowski and Dr. Erika Ryan presented the training. Erika Ryan, Ph.D., is a licensed psychologist and maintains a private practice in Middletown, RI. She earned her Ph.D. from the University of North Carolina Greensboro and completed a postdoctoral fellowship in child maltreatment at the CARES Institute, where she remained as a staff psychologist for several years. Dr. Ryan has authored articles and chapters on the topic of child abuse and trauma-focused treatment and has provided trainings and consultations to other mental health providers on both a local and national level.

Kay Jankowski, Ph.D., an Assistant Professor in the Department of Psychiatry at Dartmouth Medical School, is a clinical psychologist who specializes in the treatment of children, adolescents, and adults who have been traumatized, and suffer posttraumatic symptoms. She provides training and consultation to providers in New Hampshire and elsewhere in best practices for treatment of trauma related disorders in children and adolescents. She also conducts research on treatment models for PTSD in adolescents, and provides direct clinical services.

We did not stop there. A limited number of participants were provided an opportunity to sign up for a forty-week consultation group with either of the presenters. These groups will allow participants to use real cases to learn the clinical application of TF-CBT. The cost for the consultation groups was shared evenly between DCYF and participants. Currently, 17 providers are participating in the consultation group.

The objective of this training and consultation is to increase the number of providers who are proficient in the treatment of trauma in children. As we know children who experience trauma may exhibit behaviors that can impact their ability to be successful in a family, in school and in every aspect of their life. By effectively treating the trauma, we hope to see children achieve their permanency goals and possibly shorten the amount of time it takes to reach them. In the end, our goal is to have a number of providers across the state, and in various service areas, that are able to provide this effective form of treatment to our children and youth who have experienced trauma.

The organization and funding for this training was truly a cross-agency collaboration. The training and ongoing consultation groups would not have been possible without the support and efforts from the Division’s Clinical Services Unit, the Bureau of Quality Improvement, the Bureau of Organizational Learning, and the Division’s Fiscal and Provider Relations Unit.

Erica G. Ungarelli is the Bureau Chief for the Bureau of Well-Being for NH DCYF. Erica has worked for the Division for Children, Youth and Families for 13 years. She may be contacted at 129 Pleasant St. Concord, NH 03301. (603) 271-7298.

From previous page

Components of the “Three-Legged Stool” Program include the following:

1. Home visits to familiarize clinicians with the home environment and to implement specific parenting strategies for times when the child may be most challenging and dysregulated including meal times and bed times. Goals for the foster children often include increased capacity to tolerate transitions, increased ability to self-soothe, and demonstrate faster recovery time when dysregulated.

2. Office visits focus on Psyco-education on the impact of trauma on conscience development, attachment, and affect regulation; the neurobiology of trauma and its impact on development; and the relationship between trauma and shame-based behavior.

3. 24-hour telephone emergency service is available with the goal of “holding the foster parent” when a child is experiencing a “meltdown” and offering practical strategies to deescalate the episode.

4. Psycho-Pharmacological Consultation with a child psychiatrist who specializes in trauma.

5. Attendance at school meetings with foster parent(s) as trauma experts to advocate for special services under the Federal/State guidelines of “Emotional Impairment”.

6. Attendance at DCYF meetings with foster parent(s) as an advocate and support for the foster parent(s) concerns and questions.

7. Foster parent problem solving group that meets bi-monthly.

8. Family treatment for foster families to address the stress of parenting traumatized children on the marital relationships and impact on siblings.

An important part of our work with foster parent(s) is to support a shift in their perspective and responses to behaviors commonly seen in children with complex PTSD. These children struggle with regulation and the need for control. We work together to “shift the paradigm” and to help foster parents to view foster children’s presenting behaviors through a trauma lens; this shift interrupts the all too human response to these challenging behaviors: personalization - demonization - disconnection, which can lead to a disrupted placement. Figure 1, on the previous page illustrates this approach.

In the 4 years that we have offered the “Three Legged Stool” Program, we have served eighty families and experienced only two disrupted placements; this program dramatically illustrates the value of offering foster parent(s) a setting (a time/”respite”) in which to air concerns, seek perspective, clarify roles, problem-solve, and find resources. The core of our program is relational. We give voice to what these children often cannot. Representing the child, we attune with, validate, and appreciate their foster parents. Most importantly, we hold the vision and the belief in the foster parents’ capacity to create homes for these, our most vulnerable children.

Paula Stahl, Ed.D., is the Founding Director of Children’s Charter. She developed the “Three-Legged Stool” Program.

Stefi Rubin, Ph.D, is an Associate Professor of Child and Family Studies at Wheilehock College. She is a Clinical Psychologist at Children’s Charter/Key and a Clinician for the “Three-Legged Stool” Program.

Lulu Munson, LICSW, is the Co-Author of “In Their Own Words” a sexual abuse handbook for teenage girls. She is a Clinical Social Worker at Children’s Charter/Key and a Group Leader for the “Three-Legged Stool” Program.

They may be reached at Children’s Charter/Key, 77 Runford Ave, Walplitham, MA. 02453 or by phone at (781) 894-4325.
An organizational response to the impact of primary and secondary traumatic stress

By Michael J. Schultz

In an era marked by corruption, inequity and violence, the field of human services can be fertile ground for learning, justice and hope. The dialectic between helper and traumatized client is inherently ambiguous and potentially a source of great understanding and compelling stress, often wrought with blurred boundaries, identity confusion and a haunting sense that one can never do enough. For most professionals operating in the complex world of child welfare, the “work” is a calling and “way of being,” and one that impacts all aspects of our lives and relationships. These resonances between the personal, professional and organizational are the source of both insight and error.

During the past three decades there has been a growing body of literature and research across disciplines indicating that the cognitive, interpersonal, physiological, psychological and spiritual effects of trauma extend beyond those directly affected (Bride, 2007; Figley, 1995; Pryce, Shackelford & Pryce, 2007; van Dernoot Lipsky, 2007). Secondary Traumatic Stress is becoming viewed as an occupational hazard of providing direct services to traumatized populations. Ask any child welfare or human service professional that is called upon to educate, protect and support susceptible clients experiencing severe and pervasive abuse, neglect, violence and trauma — and they are likely to tell you that this work changes them in very profound ways.

What is Secondary Traumatic Stress?

Secondary Traumatic Stress (STS) is the result of exposure to trauma experienced by others, generally within a workplace context. Symptoms of STS are often indistinguishable from those found in individuals as a response to a traumatic event they experienced directly, and have been known to be as severe and intensive as Post Traumatic Stress Disorder (PTSD). Although each person’s response is usually unique and dependent on their life circumstances and support network, acute or chronic symptoms of STS can include: “constant fatigue or illness; cynicism; irritability; reduced productivity; persistent anger; despair; sadness; episodes of re-experiencing the event; nightmares; anxiety; fear of certain persons or situations; and, overall feelings of helplessness, hopelessness and powerlessness” (Collins and Dohn, 2009). Like child welfare workers, professional colleagues from other fields exposed to trauma, such as emergency response workers, firefighters, healthcare workers, law enforcement officers, and military personnel have been shown to experience STS and PTSD as a result of their work.

“The greatest enemy of truth is not the lie — deliberate, contrived, and dishonest — but the myth — persistent, pervasive and unrealistic…”

John F. Kennedy, Commencement Address, Yale University

Nested within an increasingly volatile and uncertain economic and social context, child welfare, related human services organizations and businesses throughout the country are being asked to “do more with less.”

The dialectic between “helplessness, hopelessness and powerlessness” and the need for helplessness, hopelessness and powerlessness (Collins and Dohn, 2009). Like child welfare workers, professional colleagues from other fields exposed to trauma, such as emergency response workers, firefighters, healthcare workers, law enforcement officers, and military personnel have been shown to experience STS and PTSD as a result of their work.

“The greatest enemy of truth is not the lie — deliberate, contrived, and dishonest — but the myth — persistent, pervasive and unrealistic…”

John F. Kennedy, Commencement Address, Yale University

Understanding our adopted teens

By Diane Dexter

adolescence can be a difficult time for many families. Children who grow up under the best of circumstances often challenge their parents’ authority, values, and rules. This is normal development. “Because I said so” are the words many parents swore they would never say, but find themselves so exasperated by their once loving, reasonable, and approachable children that they are the only words left to say.

Adoption affects children in many ways. It adds another layer to normal child development. Children who are adopted have had a significant loss regardless of their age at the time of adoption. For some children this primary loss becomes apparent in early adolescence when the youth’s job is to push their parents away and begin challenging all that he or she has been taught. “Question Authority” becomes their motto.

Pre-teens in the general population often “hope” they are adopted as this explains why their parents are so disappointing. Our teens, often confused about birth parents that are cool, always say yes, and never cause embarrassment. Both situations represent normal child development where the child may fantasize about birth parents that are cool, always say yes, and never cause embarrassment. Both situations represent normal child development where the child may fantasize about birth parents that are cool, always say yes, and never cause embarrassment.

Left unresolved, this trauma can affect a child’s development in much the same way soldiers returning from war describe how surreal their life feels back home.

Trauma and adolescence

Parenting a child through adolescence can become very complicated when compounded with normal adolescent development and the primary loss of being adopted. When a child’s early life includes multiple placements with various caretakers, years spent in an orphanage, being born drug affected, or abused and neglected early in life, the foundation for a challenging adolescence is laid. Each one of these issues adds another level of trauma that the child will have to work through at some point in his or her life.

The longer the trauma remains unresolved, the greater the impact. The more moves a child in foster care experiences, the greater the feeling of loss and not belonging. Losing one’s parents, even the most abusive parents, can shake a child’s sense of self worth. Left unresolved, this trauma can affect a child’s development in much the same way soldiers returning from war describe how surreal their life feels back home. This unresolved trauma often results in our children being diagnosed by school psychologists or therapists as ADHD, ODD, OCD, PTSD, BPD or RAD. Many of us are parenting “alphabet soup” kids who have progressed along the alphabet of diagnosis as they have grown older.

Trauma and adolescence

Parenting a child through adolescence can become very complicated when compounded with normal adolescent development and the primary loss of being adopted. When a child’s early life includes multiple placements with various caretakers, years spent in an orphanage, being born drug affected, or abused and neglected early in life, the foundation for a challenging adolescence is laid. Each one of these issues adds another level of trauma that the child will have to work through at some point in his or her life.

The longer the trauma remains unresolved, the greater the impact. The more moves a child in foster care experiences, the greater the feeling of loss and not belonging. Losing one’s parents, even the most abusive parents, can shake a child’s sense of self worth. Left unresolved, this trauma can affect a child’s development in much the same way soldiers returning from war describe how surreal their life feels back home. This unresolved trauma often results in our children being diagnosed by school psychologists or therapists as ADHD, ODD, OCD, PTSD, BPD or RAD. Many of us are parenting “alphabet soup” kids who have progressed along the alphabet of diagnosis as they have grown older.

Trauma and adolescence

Parenting a child through adolescence can become very complicated when compounded with normal adolescent development and the primary loss of being adopted. When a child’s early life includes multiple placements with various caretakers, years spent in an orphanage, being born drug affected, or abused and neglected early in life, the foundation for a challenging adolescence is laid. Each one of these issues adds another level of trauma that the child will have to work through at some point in his or her life. The longer the trauma remains unresolved, the greater the impact. The more moves a child in foster care experiences, the greater the feeling of loss and not belonging. Losing one’s parents, even the most abusive parents, can shake a child’s sense of self worth. Left unresolved, this trauma can affect a child’s development in much the same way soldiers returning from war describe how surreal their life feels back home. This unresolved trauma often results in our children being diagnosed by school psychologists or therapists as ADHD, ODD, OCD, PTSD, BPD or RAD. Many of us are parenting “alphabet soup” kids who have progressed along the alphabet of diagnosis as they have grown older.
Understanding our adopted teens
From previous page

but the parents’ authority to be the parents was undermined by encouraging them to become social workers. Many of these youth became orphaned a second time as their adoptive family could not reclaim their role as the parent. The bond between adoptive parent and youth often did not have enough time to form, even though within the very process intended to help them. Too many youths were successful in splitting the parents and social workers, resulting in families stopping to remain whole.

The adoptive families had become the “problem.” For the social workers, the disappointment that life was not smooth sailing after the adoption was a painful experience. How could the adoptive little four year old I placed with you become the troubled teen I see today?

Workers were certain the families must have been doing something wrong. The age of, “go forth and be a happy adoptive family” had ended as we learned more about brain development, fetal alcohol and drug addiction on the unborn, neglect and attachment and genetic profiles that can be hereditary. Vermont had to find a way to reach the adoptive/child youth teams by all avenues that drove them to releasing custody of their teen.

In 1996, with the help of an Adoption Opportunity Grant, the Vermont Adoption Consortium began. The idea was to bring together these various support agencies and community mental health and licensed adoption agencies to create a collaborative system of care around adoptive families. The thinking behind this idea was to create an environment where the natural cross-pollination of experts could grow.

Working together to provide support

In the beginning the Consortium had to create a language of understanding, a philosophy of how to work with families, “raising a child not born to them” and a set of standards to which we could all agree. One of the first standards was that families should not have to release custody of their teen to the state in order to access residential treatment. We also agreed that the entire burden of supports to these families could not rest solely on community mental health or the school systems. We used grant funding to educate ourselves about how to work with these families. We used the families to help design a service they needed and worked for them.

Today, an agency staff provides adoption competent supports in family’s homes, attend school meetings, sit on treatment teams, and helps access appropriate adoption competent therapists. The most important service is something we call adjusted parenting. This helps adoptive parents understand the child’s trauma history or genetic pre-dispositions and how their parenting style impacts that history positively or negatively. They help families modify how they see their teen in foster care, in a residential facility or out of their home for some other reason. The adoption displacement rate (when youth leave the adoptive family prior to their 18th birthday for any reason) appears to be about 8.3%.

Vermont has also made improvements to the front end of the Child Welfare System. Families that come to adopt a foster child are advised to be proactive in establishing relationships with community service providers. We advised them to connect with the Youth Service Bureaus, run away youth programs, Community Mental Health Centers, schools guidance office, and the Vermont Adoption Consortium.

During the adoption finalization process, we connect families adopting older youth or very troubled children with community providers to establish a written coordinated service plan. This helps the family to be on the radar of community providers, establishes the need for services and gives a written plan to follow if needed. It helps to cut down the need to go through this process when a crisis erupts.

As adoptive parents, and professionals we must take the long view when measuring a family’s success in navigating the turbulent waters of youth. Sometimes it is not until the next generation when a family can see how their intervention has made a difference. Slowly we are all beginning to improve the outcomes for the generations to come together. The good news is that in spite of having difficulties during the teen years most adopted people do well in life. Research tells us that adopted youth fare better in life than their counter parts that remain in long-term foster care. Some of the reasons are:

Role in Family is Clear

Adoption offers lifetime membership in a family whereas guardian- ship and LTFC expire at age 18. Being ”just like” a member of the family is not the same as being an entitlement carrying member of the family.

School Performance/IQ

Adoption promotes educational attainment. Parents who are in it for the long haul will go to many lengths to see to it their child graduates high school or goes onto higher education. Educational attainment is associated with social adjustment, health, lower rates of criminal behavior, communication skills and mental health.

Emotional/Developmental Functioning

Children must have a loving relationship with a primary caregiver who is consistent in the care provided. When that does not happen due to an impaired caretaker or multiple moves the child learns not to trust her or his environment and the child turns inward for comfort. The earlier the child in this situation can establish an attachment to a caregiver who can consistently meet the child’s needs help to minimize long-term attachment issues. Overall children in adoptive homes fared better in family adjustment and emotional and developmental functioning than children who remained in foster care drift.

Placement Stability

Adoption disruption rates are significantly lower than that of the number of placements that have that remain in foster care.

Financial Value to the Child

Adopted children benefit financially by the additional resources spent on them by their adoptive families. This includes the use of their adoption subsidy. Because educational attainment is associated with increased income over the course of one’s life, the adoptee benefits by earning higher wages. In the event of the adoptive parent’s death, the child is entitled to any SSA benefits and to inheritance.

Diane Dexter is an adoptive parent of two children age 18, 13 and the guardian for her niece who is now 22 years old. She has worked in the field of social work for more than 30 years. Diane is the adoption specialist in Vermont. She is the idea person behind the Vermont Adoption Consortium and the co-founder and co-director of Project Family. Project Family is Vermont’s permanency planning and adoptive home finders service. It is the voting member of the consortium.
The Diversity Journey 2010: Different Paths, Shared Destiny

Thursday, October 7, 2010
Friday, October 8, 2010

Save the date for Different Paths, Shared Destiny, a two-day conference celebrating diversity and increasing cultural effectiveness.

Radisson Hotel
Manchester, NH

For more information on presenting displays or workshop sponsorship, please call or e-mail:
301-797-3757
kevint@caseyfamilyservices.org

www.caseyfamilyservices.org

Moving forward continued from page 16

Child/family outcomes

To date more than 500 children and adolescents have received TF-CBT, and 160 staff and family partners have been trained. Preliminary analysis of child outcome measures indicates that children completing TF-CBT through Learning Collaborative agencies show clinically significant improvements. Specifically, analysis of the first 60 children completing TF-CBT showed the following:

• 79% had remission of PTSD diagnosis
• Average 56% reduction in PTSD symptom severity
• Average 68% reduction in depression symptom severity

Sustainability

Fostering sustainability is part of the Learning Collaborative approach, and each agency develops a long-term sustainability plan during the training year. To date, all agencies who have completed the training continue to provide TF-CBT, and many have incorporated new clinicians onto the teams and expanded to other practice areas. The senior leaders continue to consult regularly to address shared challenges of sustaining TF-CBT. For example, a current goal is to explore fiscal incentives such as an enhanced Medicaid rate for TF-CBT.

Additional planning is underway to support:
ongoing quality assurance and consultation; data collection of statewide monthly metrics and client measures; maintenance of the intranet site; a statewide TF-CBT roster that identifies trained providers; continuation of the Fellowship Program; and an annual statewide TF-CBT conference.

Marilyn E. Cloud, LCSW is a Behavioral Health Clinical Manager at DCE, Bureau of Behavioral Health and Medicine. She can be reached at: CT DCE, Bureau of Behavioral Health and Medicine, 505 Hudson Street, Hartford, CT 06106, (860) 723-7260, Fax (860) 560-7066, e-mail: marilyn.cloud@ct.gov.

Jason M. Lang, Ph.D. is the Project Coordinator. He is also the Associate Director of the Connecticut Center for Effective Practice, part of the Child Health and Development Institute of Connecticut, Inc. He can be reached at: Child Health Development Institute, 270 Farmington Avenue, Suite 367, Farmington, CT06032, (860) 679-1556, Fax (860) 679-1521, e-mail: jlangan@uchc.edu.

Robert P. Franks, Ph.D. serves as the Project Director. He is also the Director of the Connecticut Center for Effective Practice, part of the Child Health Development Institute of Connecticut, Inc. He can be reached at: Child Health Development Institute, 270 Farmington Avenue, Suite 367, Farmington, CT06032, (860) 679-1521, e-mail: jlangan@uchc.edu.

Robert P. Franks, Ph.D. serves as the Project Director. He is also the Director of the Connecticut Center for Effective Practice, part of the Child Health Development Institute of Connecticut, Inc. He can be reached at: Child Health Development Institute, 270 Farmington Avenue, Suite 367, Farmington, CT06032, (860) 679-1521, e-mail: jlangan@uchc.edu.

Jennifer Miller can be reached at jennifer@childfocus-partners.com or via phone 401-884-1546.

GrandFamilies of America becomes a reality

GrandFamilies of America is a unique, national organization founded in 2006 by Pat Owens and Sharon Olson in response to the ever growing need of resources for relative caregivers on children across our country. After many years of advocacy in both their local communities and respective states, Pat, President and CEO and Sharon, Vice President became respected partners with such renowned organizations as The Children's Defense Fund, Generations United, AARP, The American Bar Association and The Foundation. These partnerships resulted in GrandFamilies of America, the only national organization of its kind giving relative caregivers of children across the country a voice. GrandFamilies of America is made up entirely of volunteers who are either currently caregivers of relative children or have at some time been such. Where support groups for this population exist around the country, GrandFamilies of America connects the dots between states through its large database and real life experiences of its staff and the caregivers who reach out to them for help.

Our goal and objective is to bring together grandparents/relative caregivers of children, to provide them with the education and tools, to enable them to provide 24/7 safety and permanence for the children in their care, while at the same time preserving their family ties and heritage for future generations. We do this through collaboration with these caregivers, child welfare advocates and other organizations and agencies which share our vision. We will dedicate our energy to empowering caregivers to take back control of life altering decision-making from outside sources as it affects their family. It only takes a single thought and/or action to make a difference.

Pat Owens is a mother of seven children, grandmother of 10 and great grandmother of two and is currently raising a grandson. She and her husband (now deceased) were foster parents for 10 years. She is also the founder of Solutions For Children and Caregivers of Maryland which still operates today as a statewide resource for relative caregivers.

Sharon Olson and her husband Greg are the relative caregivers of two of their grandchildren. Sharon is the current President of the Minnesota Kinship Care Association, the voice of kinship care across her state. For more information visit their website at www.grandfamiliesofamerica.org.

other safety/licensing standards, staff must know how to assess kinship caregivers for their commitment to safety, their willingness to help the family work toward reunification, and their interest in other permanency options if reunification is not possible. Assessing caregivers for capacity to maintain safe boundaries with birth parents is particularly important. When kinship caregivers cannot be a placement option for children, staff should be aware of other roles they can play as an on-going family connection for the child.

• Offering Non-safety Licensing Waivers – licensing standards for foster parents were not developed with kinship families in mind. Fostering Connections reaffirms state flexibility to provide licensing waivers for relatives for non-safety standards on a case-by-case basis. Agencies can develop policy to ensure frontline staff, supervisors and managers take full advantage of this opportunity to license kinship families when it is in the best interests of the child.

• Engaging Kinship Caregivers – many agencies are engaging kinship caregivers as mentors for other kin to help them navigate the child welfare system. Kin can also act as co-trainers for kin foster parent trainings as well as participate in trainings to help workers understand the issues they face.

• Collaborating with Community Support Networks – child welfare agencies and private providers can work with aging departments, local and state AARP offices, legal clinics, and organizations that offer support groups to ensure that caregivers have access to a wide range of community support. They can also help to educate other public systems, including schools, TANF agencies, and health care providers about the unique needs of kinship families.

Research confirms that kinship care is good for children. Yet kinship care without the proper supports can threaten even the most stable family arrangements. Agencies that identify and notify relatives when children are involved with the child welfare system, educate caregivers about their options, and embrace the unique nature of kinship care can make important strides to ensure that caregivers have access to a wide range of community support. They can also help to educate other public systems, including schools, TANF agencies, and health care providers about the unique needs of kinship families.
An Organizational Response
continued from page 20

These presumptions often bring about negative feedback loops in which attempts to resolve and help one another lead only to further entrap people in a cycle of repeated traumatic incidents. The only way to avoid this outcome is to acknowledge the capacity of our crucial intervention workers and our capacity as a whole as a rich and multifaceted agency. Interpersonal alliances, coalitions and organizational structures are formed across generation, and change is constant. Some have likened the interpersonally collaboratively managed administration to another as “trying to change a fan belt with the motor running.” That is, the tension between managing the daily crises with imparting a structured action is often characterized by high anxiety, mistrust, and anxiety across each and every level and intentionally exacerbate the traumatic experiences of staff at the time they are in need of healthy personal and professional connections to colleagues, friends and supervisors.

In September of 2005 DCF established a Statewide Worker Support Advisory Board to address the parallel processes between care for clients and the ways in which we treat one another. A training and supervisory training approach assumes that when workers feel appropriately supported, stimulated and appreciated for their contributions and role in the organization, they may become more empathic and sensitive to the client’s needs. The Worker Support Advisory Board has fostered cross-system affiliations and generated stories of hope, collaboration and creativity for staff at each level of the agency. It is designed to provide guidance to local Worker Support Teams in the field.

Local Worker Support Teams (WST) are constructed to address the distinctive qualities and “culture” of the local area, while offering standardized responses to critical incidents and crises impacting the workforce on a statewide level. By and large, the WST are comprised of the following components: clear protocols to manage immediate crises on three dimensions: administrative, case-related, and workplace. Immediately following critical incident debriefing, assessment, and referral for additional services if necessary (Employee Assistance Program, Human Resources, community resources); staff preparedness and examinations of existing direct linkages with supervisory leadership; on-going training and psychoeducation; and, a number of wellness activities designed to expand social supports, enhance morale and encourage team building. The teams are currently operating in all DCF Area Offices and Facilities, as well as other Divisions such as the Hotline and Special Investigations Unit. As the individual teams continue to evolve, we are constantly reminded that “one size does not fit all,” and that each situation calls for an individualized response.

“Experience is not what happens to you, experience is what you do with what happens to you…”

Aldous Huxley

Mary is an experienced social work investigator with more than 15 years in the field, and is the mother of three, daughter, aunt, sister, and baseball coach. Mary currently works as part of the after-hours team of investigators that are routinely called upon to respond to critical incidents that may involve the injury or death of children and family members, sometimes as a result of abuse and neglect. Mary and her colleagues are “on-call” and asked to respond immediately when their “number comes-up,” frequently involving briefings after one hour, and sometimes unexpected interactions or situations Mary has never previously encountered. Their interactions typically require collaboration and interface with emergency rooms, extended family, law enforcement, and other members of the client’s social network, some of which are more cooperative than others. The boundaries of these complicated systems are often in the “eyes of the beholder.”

On one spring evening at about midnight, Mary was asked by her supervisor to verify and prepare for a state foster home. Mary’s supervisor and on-call administrator recognized the multiple dimensions of the situation, and understood that additional support was needed, and she assigned our employee investigator, colleague and father of two young children himself, was assigned the task of coordinating his work with law enforcement and interviewing the foster mother and hospital staff; all conducted while a family was placed in the safety of the foster home. All of these tasks were to be conducted simultaneously with oversight from a supervisor and on-call administrator via the telephone. Mary’s experience as a professional in this powerful scenario is familiar. DCF was coming out of my chest.” As Mary told her story, most of her colleagues were also in tears.

One of Mary’s colleagues remarked that “it feels like there is one heartbeat in this room, the single sense of guiding us from perspective to perspective.”

During the winding course of my work over the past several years in conjunction with colleagues and peers, these kinds of stories and illuminations abound on a weekly basis, and likely resonate across state-line and jurisdiction. These are stories that unify us as child welfare professionals and human beings trying to make differences in our client’s narratives, and to make the world a “good enough place” for us all.

Coping with Work-Related Stress: From Information to Transformation

The Connecticut DCF has been building a multi-tiered systemic approach to addressing STS in conjunction with the National Child Traumatic Stress Network (NCTSN) and through use of the Child Welfare Training Toolkit designed to ground child welfare staff on the impact of trauma on children, families and professionals. To supplement the trauma training and local support teams, the DCF Special Review and Staff Support Division and Training Academy came together to develop and deliver trauma-informed training for front-line staff and supervisors to address critical workforce needs related to STS, PTSD, and organizational burnout. Twelve full-day seminars were held from July 2008-December of 2008 that included a pre-conference session attended by all fourteen DCF Area Offices, all four Facilities, and several Divisions (Adoption and Foster Care, Hotline, Juvenile Services, Legal, Quality Improvement, Special Investigations and Support). Participation was voluntary. In January of 2009, a qualitative Summary of Findings was provided to all DCF staff, and placed on the DCF Intranet. The Summary provides a description of the seminar, substantive feedback from participants, an analysis of the information, and recommendations for continuing development of family-centered, culturally competent and trauma-informed policies, programs and practices throughout the Department (The Summary is available upon request).

The stress seminars have been refined and modified based on staff feedback and recommendations received from the seminars. Mary is coming out of my chest.” As Mary told her story, most of her colleagues were also in tears.

During the past decade, the workforce crisis in child welfare has received much attention and meaningful study with regard to recruitment and retention, burnout, lack of supervisory support, workload issues, and training; with less attention on the impact of STS on the workforce and organizations as a whole. Promising programs, practices and research are emerging across the country, with mounting awareness that thoughtful and respectful efforts to ground our field in practices that have reverence for our mission and the courage to accept our social and ethical responsibilities with unrelenting conviction.

“Build it, and they will come…” —The Field of Dreams

Child welfare workers will inevitably encounter trauma and secondary stress. The heart and soul of effective and respectful child welfare practice under these circumstances lies in the integrated role of social and ethical responsibility to one another. A resilient workforce must experience a sense of agency, a feeling of support, of systems that have reverence for our mission and the courage to accept our social and ethical responsibilities with unrelenting conviction.

References may be obtained upon request.

Quotations in Sequence

Aldous Huxley, Author (1894-1963).


Margaret Mead, Anthropologist (1901-1978).

Michael Schultz, Ed. D. is the DCF Director of Special Investigations. A licensed psychologist and family therapist with more than thirty years in the field. He can be reached at (860) 569-5034 in Hartford, or by email at schultz@ct.gov.


Common Ground, February 2010

Michael Schultz, Ed. D. is the DCF Director of Special Investigations. A licensed psychologist and family therapist with more than thirty years in the field. He can be reached at (860) 569-5034 in Hartford, or by email at schultz@ct.gov.

References may be obtained upon request.
Moving forward

Twenty years ago we did not see domestic violence as a child protection concern. Now in Massachusetts, human service providers, teachers and police are all very aware of the dangers this poses to children and actively file reports to CPS when they know of domestic violence in families. We have moved forward but we must be careful not to assume that child protection is the answer to the social problem of domestic violence. Reporting a domestic violence situation to CPS is a tool for our communities, not an intervention for families and we need to partner closely with communities to truly create a safety net for families. MA DCF has taken significant steps to engage communities in creating safety for families.

MA DCF has initiated the new Integrated Casework Practice Model (ICPM) which establishes the framework, expected outcomes, and underlying core values for our involvement with children and families. With a focus of being strength based this model standardizes our approach to casework practices to ensure that children and families and their natural support systems are actively engaged and empowered in decision-making processes that promote safety, permanency, and well-being. Also incorporated is an extended screening period and differential response which provides for cases screened in to be assigned either for CPS Investigation or a CPS Assessment. This model gives an excellent framework to apply domestic violence principles, identify strengths and protective factors and gather a more full and accurate assessment of situations.

In 2008 MA DCF printed a brochure entitled, “Promising Approaches: Working with Families, Child Welfare and Domestic Violence”. This publication provides a framework for mandated reporters to create family centered approaches when domestic violence is identified, offer guidance to assist mandated reporters in considering the impact domestic violence has on children, identify the most helpful interventions and assess if/when child welfare should be involved. This year the MA DCF revised their mandated reporters guide to include this information. Both of these documents can be found on their mandated reporters guide to include this information.

As we move forward the DCF DVU is working with administrators and DCF staff to create specific tools and tips for social workers to use as they initiate the new case practice model in domestic violence cases. We continue to learn from the community and from the child welfare system how to best serve the families we are involved with and it is with great enthusiasm and expectation that we move into this next phase for DCF.

Sue Hubert is a Manager in the DCF Domestic Violence Unit. She has been doing domestic violence work for the past 24 years and a member of the DCF Domestic Violence Unit for 15 of those years. She may be reached at (617) 748-2334.

Interrupting the link between secondary traumatic stress and trauma is a matter of ensuring that workers are not stuck holding toxic emotions.

The next phase of the initiative is now in process. Participants are continuing the efforts that they have begun in their regions and area offices—educating supervisors and workers about secondary traumatic stress, training supervisors to facilitate unit meetings and debriefs, figuring out the right structures and processes. They have also begun the process of synthesizing what they have learned, and combined with research into what other agencies are doing, developing frameworks to share across the agency more generally. Working groups have focused on debriefs and coping groups, unit meetings and group supervision, cultivating a culture of trust, and involving managers, staff diversity, and working with groups and not just individuals affected by painful events.

The next phase of the initiative is now in process. Participants are continuing the efforts that they have begun in their regions and area offices—educating supervisors and workers about secondary traumatic stress, training supervisors to facilitate unit meetings and debriefs, figuring out the right structures and processes. They have also begun the process of synthesizing what they have learned, and combined with research into what other agencies are doing, developing frameworks to share across the agency more generally. Working groups have focused on debriefs and coping groups, unit meetings and group supervision, cultivating a culture of trust, and involving managers, staff diversity, and working with groups and not just individuals affected by painful events.

The knowledge collected and disseminated by these working groups, led by our participants, will create the foundation for engaging the agency more generally in the process of preventing and intervening in secondary traumatic stress.

William Kahn is Professor of Organizational Behavior at Boston University School of Management, where he has taught since receiving his Ph.D. in Psychology from Harvard University. His research focuses on caregiving organizations, which include child welfare organizations, health care systems, treatment centers, schools and religious organizations. Author of Holding Fast: The Work of Child Welfare Organizations published by Brunner-Routledge in 2005. Professor Kahn can be contacted by email at wkahn@bu.edu or by phoning 617.353.2680.

Common Ground, February 2010

25

Trauma
Celebrate being a grandparent

and it was a different period of time. My own
to remind myself that they were two different girls
when she entered 6th grade. I remembered my
School. The upcoming teens years really fright-
therefore was up on what was going on in her little
played a game. As a rule, she called her daily and
right-frontal lobe injury prevented her from being
that she made numerous bad choices and that her
both times it was unsuccessful. It was difficult see-
During this time, we tried unification twice but
soccer, Brownies/Girl Scouts and play dates.
rent child rearing issues. Sue was also busy with
weeks but I want to scream doing it totally on my
daughter’s godfather recently broke his wrist and
thing that is consistent about me...my grand-
“Some days I think that exhaustion is the only
in a “perpetual state of exhaustion. Commenting
ents are concerned about themselves.
many grandparents are
and unrecognized
They worry about the future of their family.
Many grandparents are dealing with difficult sons
and daughters who have mental illness, addictions or are incarcerated. To think of
how to help. It is essential to think that the rights of absentee parents come before the rights of grandparents who are providing a stable home for their grandchildren. This is exacerbated by the guilt and shame when some feel they failed as par-
ents. As one said, “It’s far too painful. There is joy, energy and hope with my granddaughter but with my daughter there is still a lot of pain.”
Grandparents are also faced with a double generations gap issue. The "grandparents"
gble to bond with children who are 35 to 60 years younger, to participate as caregivers in the lives of young people whose experiences and values differ greatly from their own.

The issues are not simply child welfare issues any more than they are elder services issues.
While the Commission will require time to form its final recommendations, and to garner support for the resources to support these families, several needs are already apparent.
First, grandparents need clear and understand-
ables and counselors related to their roles, and
the children’s needs. They need direction, unbiased information as well as guides and mentors to help
them navigate a system that can be intimidating.
Second, grandparents raising their children’s children need legal information and help about the
definition of their legal status and recognition that their voluntary commitment,
born out of love does not alter the hard and prag-
matic facts of raising someone else’s children. Adoption, while a noble ideal may not be a viable solution to every case, especially where it results in financial hardship and further alienation from ones own child.
Third, grandparents need access to mental health, health care and other services for them-
se, to address isolation, and many other need,
placed on the back burner when caring for your
children’s children.
Fourth, they need places to go for personal sup-
port and peer support especially from others who are living with the same challenges and fears.
Finally, based on the comments of many, they
need the various systems with which they interact, to interact with each other and help problem-solve
real issues for both the children and the caregiver.

Celebrate being a grandparent

continued from page 6

Too often the experience is perceived as no system
being willing, as one grandfather said, “to hold on to
the hot potato”.
Grandparents and older kin caregivers rep-resent a growing resource for children in need of lov-
ing, stable homes. They represent a resource upon
which the child welfare system is increasingly
reliant. According to the Urban Institute, “while
child welfare agencies traditionally refer to fos-
ter parents having no relation to the children in
their care, over the past 15 years agencies have increasingly relied on relatives. Today, both by
mandate and in practice, in almost all child welfare
organizations consider kin to be the first placement choice”.[R. Green, “Foster Children
Placed With Relatives Often receive Less
Government Help,” 2003]
Our conclusion is that like so many other “real
world” problems, issues facing grandparents and
other older kin caring for children do not fit neatly
into one department or jurisdiction. The issues
are not simply child welfare issues any more than they
are elder services issues. The needs of older kin are
every bit as real as those of children, and the cre-
ation of a safe and stable home requires that the
needs of both be addressed. The solutions are not to be found in one department or jurisdiction, but
rather collaborations between the various pub-
lic sector agencies like DCF and Elder Affairs,
and community based service providers like Family Continuity, where resources can be directed toward
the whole family.

Kerry J. Rickford has been a Youth Development
Specialist with UMASS Extension (Barnstable County since 1994. In 2009 Governor Deval Patrick
appointed Kerry to the M.A Commission on the Status of Grandparents Raising Grandchildren where she cur-
rently serves as Chair. She and her husband, Richard, are the parents of 5 sons, and the grandparent
guards of Kyleigh and Jared. Kerry can be reached via email at grandparents@capcoalition.com.
Earl N. “Skip” Stuck is the Executive Director of
Family Continuity Programs Inc., a family service
agency operating programs and services in over 200 communities throughout Eastern and Central Massachusetts. Skip
can be reached via email at stuck@familycontinuity.org or by calling 508-862-0273.

Resources
Department of Elder Affairs: www.mass.gov/elders, see “Grandparents Raising Grandchildren Resource
Guide” or call 617-727-7730
Department of Children and Families: www.mass.gov/dcf or 1-617-748-2000
Family Continuity: www.familyccontinuity.org or Information line at 1-866-219-3320

Placed With Relatives Often receive Less
placement choice”. (R. Green, “Foster Children
Placed With Relatives Often receive Less
Government Help,” 2003)

It is with great sorrow that we announce the death
of Brenda Davies, the Senior Leader for the
Malden, MA BSC Team. Brenda died on Thursday, January
14 after a short illness. The following
was taken from her obituary:
Brenda had a Masters degree from Simmons University, was a
superb shot with a pistol and a brilli-
ant pianist; she held a private
pilot’s license and had oodles of fun
and enjoyment with her horse
Penny and her two beloved cats,
Bella and Sam. She will be greatly
missed by her family and many,
much friends.
As you can see, Brenda lived life
to the fullest. She was passionate
about many things including the
work of her dedicated team, the
Malden Rickettars, are
doing in the BSC. Her passing leaves
a gap that will be very difficult
to fill. Our deepest sympathy goes out
to all who knew her.
Fostering connections continued from page 9

the truth is there’s been another child welfare system, much older than the one that most of us work in, that has been successfully taking care of kids’ families for generations.”

In the past, “stranger foster care” was favored, but now relatives are generally considered the first placement of choice. “We define kin very, very broadly so that fictive kin and blood relations are all within the same definition,” said Mary Gambon, Associate Commissioner Massachusetts Department of Children and Families. “We all of a sudden found out that the families were really always there all along. We just hadn’t looked hard enough.”

The secret seems to be exploring options carefully. “You have to listen to what the kids have to say. You have to listen to families,” said Kevin Savage, Administrator of Rhode Island’s Department of Children, Youth and Families. “Listen to the voices of relatives: they know their strengths and weaknesses. Listen to the youths,” agreed Ms. Purdy.

Roger Desrosiers, program specialist at New Hampshire’s Department of Health and Human Services, agreed about the broad definition of family. “You begin to realize family is who the children define as members of their family and not what stereotypes might appear from the perspective of a bureaucrat like me. We very much support kinship care. We realize that outcomes are much better for kids.”

There are many benefits to relative care. “We learned really quickly that by inviting family in to care for family members, we did a better job of placing children in ethnically, racially and culturally matched families,” said Ms. Gambon. “It was a much better match for these children. Their experience in terms of day to day living was much better.” Mr. Savage found the same results in Rhode Island. “The goals are obviously much better.” Mr. Savage found the same results in Rhode Island. “The goals are obviously much better.” Mr. Savage found the same results in Rhode Island. “The goals are obviously much better.”

“Involving families in the process of making decisions in this particular state increased relative placements from 19 percent to 45 percent. They were able to avoid placements in foster care and move kids out of foster care by engaging families in that process,” said Arlene Lee, senior associate, Center for the Study of Social Policy.

Improving Fostering Connections

The roundtable identified several areas where the implementation of Fostering Connections could be improved: specifically data collection, collaboration and economic resources.

There is a fundamental lack of data, particularly about children in informal arrangements. “Our data deficiency needs to improve throughout all the states,” said Janet Kohlase Purdy, relative care specialist of New Hampshire’s Division of Health and Human Services.

Catherine Walsh, deputy director of Rhode Island’s Kids Count, explained that collecting better data “allows us to have the urgency you need to make decisions quickly and make things happen, but it also gives you the ability to take a longer-term view on things.”

Many forms of collaboration were discussed during the roundtable: from working together on advocacy to building bridges between families including foster parents, kinship relatives, and others. At the other end of the spectrum, the need to develop consortiums to encourage agencies to work together and to promote integration to improve access to resources across systems was discussed. As Karina Jimenez Lewis, senior policy associate with the Casey Foundation’s Center for Effective Family Services and Systems, put it, “There needs to be better connection, better integration and better access of resources across all the systems that support these families and children.”

There are many pressing economic issues, but the TANF (Temporary Aid to Needy Families) grants and waivers were mentioned most frequently. “The TANF grant is a fundamental piece of support for these families that are struggling,” Ms. Jimenez Lewis said. “So there’s a question of whether these grants are reaching the population that they intend to serve, and whether enough of the relative caregivers are really accessing those benefits they’re entitled to.” Ms. Walsh added that other aspects of funding need to be addressed. “There’s a federal financing reform piece that needs to happen in terms of how they federal money flows to that states,” she said. “But we’re all challenged about how to most effectively use the state dollars that we have and how we fund things at the state level.”

In addition to child welfare financing reform, Ms. Nesbit stressed the importance of prevention.

“Every day matters!”

As the meeting ended, Ms. Butts exhorted the delegates to stay focused: “Be sure to take action as a result of today. Stay connected and take advantage of the resources that exist,” she said. “Think about what we can do to move forward and what we can do today. Because every day matters!”

Sania Metzger, Esq. is Director of State-Level Child Welfare Policy Reform for the Annie E. Casey Foundation. Lee Mullane is Director of Communications for Family Services and Supports, the Annie E. Casey Foundation. You can contact Sania at 203-401-6930 or via email at smullane@aecf.org. Lee Mullane can be reached at 203-401-6932 or lmullane@afe.org. Photos courtesy of Susan Warner/Casey Family Services
Regional Round-Up

Massachusetts

Community Program Innovations

For a schedule of upcoming programs go to www.communityprograminnovations.com.

For additional information call Carol Stevens at 978-968-2781 or email cstevens@communityprograminnovations.com.

Friday, March 5, 2010
Getting Dads Involved: Building the Connection Between Dads & Their Children
Wednesday, March 10, 2010
Providing Beyond the Fence: Challenges in Home-Based and Wrap-Around Care

Friday, March 19, 2010
Psychotropic Medication for Childhood & Adolescent Disorders

Anger, Rage & Trauma: Talking to Kids About Difficult Things

Center For Family Connections

Cambridge, MA 617-547-0099 (800) KINNECT E-mail: cff@cffc.org

Massachusetts Adoption Resource Exchange

www.mareinc.org for more information.

Regional Adoption Informational Meetings

Arlington Stephanie Peckel, 781-641-8276
Multi-Cultural Worcester Barbara Fird, 508-929-2143,
Lowell Mike Wilson, 978-275-6800
Boston 617-989-9211.
Brockton Kelly Lounds, 508-894-3781.
Plymouth Michael Johnson, 508-732-6306,
Ongoing Adoption & Foster Care Informational Meetings

Please visit www.mass.gov/dss for a schedule of Meetings or call 1-800-KIHS-508 (545-7508).

Family Therapy Training Boston Spring Workshops

www.familytherapytrainingboston.com

Certificate Program starting September 2010
Contact Liz  liz@familytherapytrainingboston.com or phone at 617-924-9255.

Rhode Island

RICORP offers a variety of programs for adolescent youth, go to www.RICORP.net for more info.

Suicides For Kids Program:
Providing new or slightly used suitcases for children in residential placement
For more information call Jim Harris at 401-431-0555

YES!
After Care Services for Young Adults for more information contact Madeline at 401-497-3545

Green Safe Life Skills Center for Adolescents providing real life training on becoming self sufficient and living independently.
For more information on the Green Safe Life Skills Center, or to make a referral, please call 401-431-0557

Vermont

Reporting Child Abuse & Neglect Training for central Vermont mandated reporters of child abuse/neglect contact Kim Revoir at 802-479-4260 (kim.revoir@ahs.state.vt.us)

Reporting Elderly &/or Disabled Abuse training call DAIL at 241-4365

Vernon Leadership Development Opportunities through the Summit for State Employee Development

www.vermont pesso nella d.org/employee/training.php

Vermont Training Links:


Call Don Mandlekorn at 802-479-7594 or email Don.Mandlekorn@ahs.state.us

For statewide or non-central VT training

Call 802-241-2131 or email fed.ober@ahs.state.us

in Every Issue

National Child Welfare Data and Technology Conference

Hyatt Regency Bethesda — more info www.ncwced.org

National Child Welfare Work Institute:
Leadership Academy for Supervisors, an on line training national project for supervisors in public, private and tribal child welfare agencies.
To find out more or to apply go to www.ncwwi.org

COMMON GROUND

Daniel Kids
4203 Southpoint Blvd., Jacksonville, FL 32216 (904) 296-1055 Email: info@danieldkids.org for information on upcoming conferences

Center for Family Representation, Inc.

CFR is based in New York, for more information call 212-691-0950 or visit their website at www.cfrinc.org to download their latest newsletter.

National Resource Center for Youth Services
Visit their website at www.nrcys.on.ca

National Foster Youth Advisory Council
Visit www.scanfayr.org for more info.

Child Welfare League of America

702-412-2400 or visit their website at www.cwla.org.

Child Welfare Gateway

Protecting children and strengthening families, go to www.childwelfare.gov for updates on information, services, and resources.

Recently released books

Dad, Me, and Muhammad Ali: A Father and Son Story

Felix Rodriguez, recently awarded Mom’s Choice Award. To learn more go to www.dadandmali.com.

Growing up in the Care of Strangers: Stories and insights of eleven former foster children

To order: Dr. Rosalind Folman 218-534-0899 or on their website at www.fosterkidsalive.com

The application of the gained knowledge can be both practical and theoretical. It is our goal to create change in our agencies that will lead to better outcomes for the children and families we serve.

Sometimes it is through policy that change is attempted and other times it may be a chance at the practice level that due to its success becomes widespread. Not many may begin at the executive or direct service level of an agency, and usually requires common elements such as leadership support, strong communication methods, and shared values.

This issue of COMMON GROUND seeks to highlight examples of the use of various change initiatives/methods that are occurring in the field of child and family services.

One innovative methodology is represented by the Breakthrough Series Collaborative (BSC). First introduced to the field of child welfare in 2000 by Casey Family Programs in collaboration with the Institute for Health Care, a BSC seeks to engage an entire agency in the change process. As explained by Agosti and Morrill in their February 2007 monograph Promising Practices and Lessons Learned from The MA Department of Social Services BSC on Adolescent Permanency, all BSCs “focus on energizing an entire organization from high level administrators to youth to resource families to community partners in the change process”.

This process is unique in its team approach to testing new ideas and strategies in a continual and rapid fashion and sharing what is learned with the other teams participating in the same BSC.

to Date Collaboratives have addressed Improving Health Care for Foster Children, Supporting Kinship Care, Recruiting and Retaining Resource Families, Addressing the Disproportionate Representation of Children of Color in the Child Welfare System, Differential Response and Permanency for Youth. Currently the New England States are participating in a BSC on Safety and Risk Assessments. This editor knows firsthand about the lessons that may be learned from participating in a BSC.

COMMON GROUND seeks articles that highlight lessons learned by participants in any of the above Breakthrough Series. It is our hope to continue to help “spread” their learning to others.

We also invite articles from other change initiatives which may be occurring in your agency, your network and your community. Please consider contributing an article that addresses any of the questions above or one of your choosing.

Articles should be submitted to Dunna Conner/aphra via email at dconner@labc.harvard.edu or by mail to:

Dunna Conner/Aphra
75 Parker Hill Ave., Boston, MA 02120

For questions or information on Common Ground articles or to subscribe to Common Ground, contact Dunna Conner at 617-278-4275.