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Birth Parent Participation in Foster Care Placement Planning: Relationship to Discharge Outcomes

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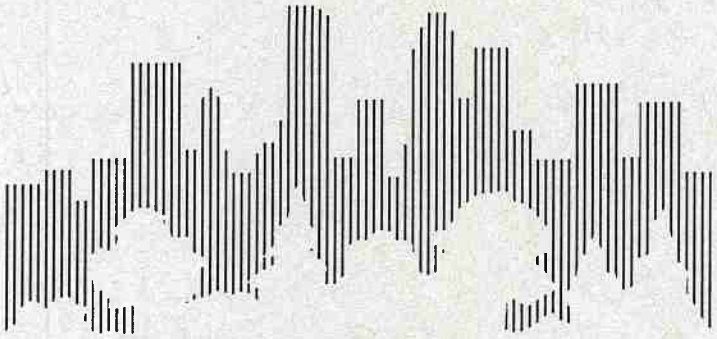

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MASTERS IN SOCIAL WORK THESIS

Karen A. Hulteen

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CERTIFICATE OF APPROVAL

This is to certify that the Master's Thesis of:

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Dedication

This thesis is in dedicated:

- to the memory of my mom, Anna Mae Johnson, who modeled life-long applied learning, and graduated Summa Cum Laude at age 48. She created and taught the self-worth curriculum to homeless men at the Salvation Army Adult Rehabilitation Center.

- to my dad. Major Robert Johnson, who lives and models the value of service far better than his daughter.

Acknowledgments

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Curt Paulsen, thesis reader and gifted professor, whose ideas about grace and accountability I incorporate daily into my practice with youth and families.

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John Hulteen Sr., my husband and hero, soul-mate and sounding board, best friend and cheerleader, whose faith and encouragement kept me growing, grounded, and

focused.

God, who blessed me that I may bring blessings to others and who calls me to serve Him by serving His children.

Abstract

Birth Parent Participation in Foster Care Placement Planning:

Relationship to Discharge Outcomes

This thesis reports results of a quantitive investigation of existing records measuring association between the independent variable of birth parent attendance at placement planning meetings and the dependent variable of discharge outcomes of youth exiting treatment foster care.

Karen A. Hulteen

April 1998

Prior studies have found a positive relationship between contact of birth family and foster children and reunification, as well as with children's well-being, adjustment, and development during and after foster care. Law requires and research validates social work practice which places children in the least restrictive, most normative living situation possible to meet their needs. Examining records of 188 youth discharged from treatment foster care from Human Service Associates from January 1, 1995 to December 31, 1996, this investigation discovered that birth parent participation in placement planning meetings and quarterly reviews, one indicator of birth family involvement, was related to discharge of those youth to less restrictive settings. Given practical, systemic, and

interpersonal barriers to birth family involvement, the study concludes with guidelines for encouraging parental partnerships in planning for youth in treatment foster care.

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I. INTRODUCTION

Within the context of a private, non-profit social service agency, with offices in the three states of Minnesota, South Carolina, and Texas, this study investigates the relationship between birth parent participation in foster care planning meetings and discharge outcomes for youth who exited foster placement during a two year period. Human Service Associates (HSA) licenses special services foster homes for youth with serious emotional and behavioral problems. Historically, HSA has had a strong commitment to maintaining the connections between children in out-of-home placement and their birth parents and extended family. Indeed the value of birth family involvement in treatment planning is articulated in the agency's mission statement and guiding principles, and measured as part of its annual goals. The number one outcome objective listed on HSA's 1995-1996 Review of Program Goals was, "A family member or significant adult in the youth's life will attend planning and review meetings 60% of the time, as reported by the Information System." Yet achievement of this objective has consistently fallen short of hoped-for outcomes. In one of the last full fiscal years of measurement, from July 1, 1995-June 30, 1996, family participation in placement planning remained in the low 20th percentile in the first, second, and fourth quarters, with 32.9% achievement during the third quarter. Even if the agency factors out those parents whose rights have been or are in the process of

being legally terminated or whose direct involvement is impossible due to incarceration, geographic distance, or death, non-achievement of this goal has been a matter of concern. Both empirical research and theory support the value of birth family involvement with children in foster care, one measure of which is participation in the placement planning of those children.

Past studies have found a positive relationship between visitation and reunification, as well as with foster children's well-being and development during and after care. I will summarize findings of research which uphold the importance of maintaining birth family involvement, as well as report rare contradictory evidence which challenges some key assumptions.

This study focuses on youth discharged from treatment foster care, which falls mid-way on the continuum of child welfare services. Children enter this system through a variety of access points. Families in situational, financial, or emotional distress may voluntarily seek and request assistance. Children with mental health issues may be referred for therapeutic support and intervention. Youth adjudicated delinquent for criminal offenses may be mandated to service through Juvenile Corrections Departments. Children at risk for abuse or neglect may be reported to child protection units for investigation of maltreatment.

Whatever the avenue of entry to the child welfare system, the first approaches to remediation after assessment are generally family-based preservation services which support and bolster the primary family system. In

addition to practical and financial assistance, family preservation utilizes community-based services which may include access to counseling, in-home therapy, day treatment, mentoring, temporary child-care, regular respite, even a crisis nursery if a parent is feeling overwhelmed. If a child is deemed vulnerable to imminent harm or poses danger to others, temporary removal from home often occurs. In the event of out-of-home placement, the first choice of placement resource is a close or extended family member, known as kinship foster care, honoring a child's natural and familiar ties. If relatives are unavailable, unwilling, or unsuitable to assume temporary care for a child separated from the primary family, licensed foster parents, ideally reflecting the cultural and/or tribal affiliation of the child, are selected as secondary placement resources. Children in treatment foster care, the population studied in this investigation, require a higher level of supervision and structure than youth in standard foster care. They are often referred with mental health diagnosis, histories of emotional, physical, and sexual abuse, and multiple placements, including institutionalization. Specialist foster care providers are "professional parents," who receive training in clinical pathology and interventions, attachment theory, child development and discipline. They work in close collaboration with agency staff, therapists, special educational personnel, psychiatrists, and other members of the treatment team, including, ideally, the birth family members.

HSA has a visionary commitment to maintaining children in family

settings, as family remains the best agent for the socialization, teaching, and nurture of youth. Law requires and research validates social work practice which places children in the least restrictive, most normative living arrangement possible to meet their needs. Historically, children raised in the institutions and orphanages of our nation's recent past often grew up in sterile, impersonal settings, deprived of emotional warmth. Such deprivation diminishes the capacity for making meaningful connections and contributions. For those children who are not safe in their own homes - or when their parents' overwhelming life circumstances or choices interfere with their capacity to care for their children - therapeutic foster care can provide a humane and normalizing alternative for their temporary care. Further, treatment foster care is less costly than residential or institutional care, at the same time it does a better job of raising children.

However, for some youth who cannot tolerate the intimacy of family life or who pose serious threats to others, more restrictive placement alternatives serve a purpose on the child welfare service continuum. Group homes and shelters, where many youth live and are supervised by multiple non-residential care-givers who come and go on rotating shifts, offer the first level of non-family-based placement. Residential treatment centers provide containment and structure for youth unable to be maintained in family settings. Hospitalization, both short-term and long-term, offers protection and medical monitoring, particularly for youth who threaten or inflict self-harm. Finally, jails, detention centers, and correctional training camps

incarcerate youth who require confinement in a secure locked facility as a consequence for serious criminal activity or for the safety of others.

Another placement alternative considered after voluntary or court-ordered termination of parental rights is adoption, where a child becomes legally part of a adoptive family. Although adoption historically meant severing all contact with biological families, open adoptions, with varying degrees of communication and access between the adoptive and birth families, are sometimes regarded as useful, particularly for older adopted children. Foster parents are frequently approached as potential adoptive resources for youth in care, honoring mutual attachments made during foster placement. Treatment foster care may also be utilized as an interim transitionary placement, preparing a child for permanency with an adoptive family.

Most research about birth family involvement has measured visitation frequency in a general foster care population. This study measured one indicator of familial involvement, attendance at placement planning meetings and quarterly reviews, and compared that indicator with discharge outcomes for youth in treatment foster care. I sought to discover if there was a relationship between the two variables: parents' attendance at planning meetings and the settings where youth moved after leaving treatment foster care. Within this unique foster care population and format, this investigation asked the question, "Is parental attendance at placement planning meetings and quarterly reviews (as an indicator of involvement) associated with children moving to less restrictive settings after

leaving treatment foster care?"

Parental participation and less restrictive discharges are both desirable outcomes sought and measured by HSA. If the two are related, it will provide further support for social worker attentiveness to these agency goals. Examining existing records of agency discharges for two years, from January 1, 1995 to December 31, 1996, and corresponding records of whether birth parents attended the planning and review meetings for those youth prior to discharge, I organized the data on a two-by-two table of each variable, then submitted the frequencies to chi-square statistical analysis.

I approached these research questions as both investigator and practitioner. As a licensing social worker at HSA for nearly ten years, I have developed a profound and heartfelt reverence for the power of parental partnership in planning for children in treatment foster care. A child's sense of identity, significance, and sometimes the capacity for attachment are rooted in this primal parent/child relationship. We whose professional roles include planning for separation of children from their families of origin, practice with laxity if we fail to recognize and respect the energy and influence of that relationship on children in foster care. My hope is that this study will validate in a new way the importance of birth family involvement in planning for their children in out-of-home placement, while demonstrating the need for social worker vigilance in its promotion.

In subsequent chapters, I will review what is already known about the

relationship of birth family involvement and permanency outcomes for youth. In Chapter III, I will describe in detail the methodology used to answer the research question. Chapter IV will report the findings of the study, while Chapter V will interpret them. In conclusion, I will make recommendations for practice and policy which enhance the likelihood of birth family participation in foster care planning.

II. REVIEW OF THE LITERATURE

A. Rationale for Valuing and Promoting Birth Family Involvement

High parental involvement and visitation have consistently been associated with increased likelihood of reunification, considered by law the most desirable, least restrictive permanency outcome (Bullock, Little & Millham, 1993; Davis, Landverk, Newton, & Ganger, 1996; Fanshel, 1975; Hess, 1987; Marsh, 1987; Mech, 1985; Tam & Ho, 1996; Whittaker, 1981). Maluccio and Whittaker (1989) found high parent-child contact to be the best single predictor of positive foster care discharge, often to birth family. Though the positive relationship between parental involvement and reunification was validated in a study of 877 children in care in Hong Kong, Tam and Ho (1996) were surprised to find that siblings placed together were less likely to return home, a discovery which warrants further research. While Hess (1987) summarized consistent findings which linked parent-child visitation with discharge, often to a parent's care, she cautioned about the complexity of factors affecting placement outcomes and questioned whether visitation frequency is an intervening rather than the independent variable. Cantos, Gries, and Slis (1997) warn that frequency of visitation may be indicative of parents who are healthier and better adjusted to begin with, and thus likelier to have their children returned, so causality cannot be assumed.

Most youth in foster care eventually return to some form of their biological families (Bullock, Little, and Millham, 1993). Recognizing that birth parents are the most likely source of permanency for foster children, Fanshel (1981) lamented the neglect of birth family represented by the lack of provision of services which build upon their strengths. He recognized the demoralizing social and personal challenges which contribute to out-of-home placement in the first place. In a similar vein, Fein and Maluccio (1984) asked that diagnostic and treatment orientations be reconsidered to focus on competency rather than pathology.

Parental contact throughout placement may help the youth maintain a factual, balanced view of a parent's strengths and shortcomings-which are inextricably woven with his or her view of self. In describing his own experience as a foster child, Fernando Colõn stated, "A child's experience of biological/familial continuity and connection is a basic and fundamental ingredient to his sense of self, his sense of personal significance, and his sense of identity" (Colõn, 1979, p. 289).

According to Kufeldt, "Inclusive care is necessary to reduce the trauma of separation and loss, provide for continuity, assist the child to make use of the placement experience, and to maintain support systems for the post-placement experience" (1990, p.111). Family contact can preserve positive ties, reassure a child feeling rejected, and help prevent idealization of the absent parent (Kline and Overstreet 1992). "Physical separation---does not guarantee psychological

separation" (Hutchinson, 1972, p. 50), and children may carry idealized delusions about the parent which are magnified by being apart. As Brier Miller stated in her lecture to a Family Practice class at Augsburg College March 1, 1997. "You can take the child out of the family, but you can't take the family out of the child. They are made of the parent who abused them, and therefore must find something likeable about even the abusive parent."

Children in residential care who were less likely to commit major infractions were those visited by parents more frequently (Borgman, 1985). Youth in family foster care who were visited most consistently exhibited fewer externalizing or internalizing behavior problems than those visited infrequently or not at all (Cantos, Gries, and Slis, 1997). The authors point out, however, that the relationship is complicated and cannot be construed as causal.

In adolescents preparing for emancipation from foster care, connections with family may help clarify personal history and integrate past trauma (Carbino, 1990). Positive post-placement well-being across the life-span is associated with emancipated youth who have had contact with family, especially siblings, during foster care (Festinger, 1983). In a longitudinal study in 1978, Fanshel and Shin measured children's adjustment and development by using projective and intelligence testing, and seeking assessments from classroom teachers and caseworkers. They, too, found an association between foster children's well-being and parental involvement, validating its primacy in conscientious social work

practice.

While visitation frequency is one manifestation of family involvement, participation in decision-making for youth in care, as occurs in placement planning meetings, is another indicator of such involvement. A Canadian study describes a model of extended family involvement in placement decisions and fostering arrangements which increased cooperation and understanding, while sometimes expediting the return of children to parents or kin (Burford, Pennell, MacLeod, Campbell, and Lyall, 1996). Based on a New Zealand approach of family group conferencing, 32 multi-problem abusive families were referred to a demonstration project to develop plans in cooperation with authorities which either prevented out-of-home placement, restored children to the care of parents or kin, or approved ongoing non-relative placement with guaranties of contact with the family-of-origin. In all of these cases, the involvement of parents and/or extended family increased compared with the pre-conference degree of involvement. Although preserving or uniting the nuclear family unit was seen as preferable to placement with kin, and kinship care preferable to foster care, reunification was defined broadly to include extended family. In this model of Family Group Decision Making, parents and kin were included as partners with formal helpers and authorities in case planning for the child in substitute care. The authors planned to complete a one-year follow-up to this project, which should provide information about the effectiveness of those family case-plans in achieving permanency.

family case-plans in achieving permanency.

Over years of tracking program outcomes, partnership parenting also increased the likelihood of parents reuniting with their children in Atlanta's Family First Program (Burton and Showell, 1997). Including parents in decision-making for their children not only has measurable pay-offs in reunification efforts, but has value to the child, even if family restoration is not a viable option. Burton and Showell (1997) regarded as important the sense of identity and history parental participation provides, even when reunification is not the case plan.

Unless a parent's participation and implicit consent in placement planning are noted by the child in care, the youth may not be able to make constructive use of the services offered, whatever their quality (Maluccio, 1966.) Peter Smith (1989), in describing the British Kent Family Placement Service, cited parental consultation in the placement contracting process with the child as critical to positive outcomes for youth.

Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, provided congressional support for prevention and reunification services, and championed permanency planning for children, many of whom remained in unnecessarily prolonged out-of-home care, known as "foster care drift." To receive Federal money, states were mandated to create case plans, with timely reviews, which included participation of a child's family of origin and built-in safeguards of access to parental visitation. This law has clearly impacted social work practice,

even though implementation remains underfunded and outcomes mixed. Using financial incentives which promoted practice standards validated by research, PL 96-272 shifted focus from substitute care to the preservation or restoration of families (Pecora, Whittaker, and Maluccio, 1992).

This focus was reinforced more recently by the 1993 Family Preservation Act. Similarly in other countries, partnership with birth families is a key theme in the Children's Act of 1989 (England and Wales), Children's Act of 1995 (Scotland), and Children's Order of 1995 (Northern Ireland) (Berridge, 1996). Law has supported the maintenance of birth family involvement prior to and during foster care placement.

In an apparent contradiction, the Federal Adoption and Safe Families Act, passed in November, 1997, gives top priority to child safety in child welfare decision-making, and consideration of termination of parental rights (TPR) is expedited. It requires that states file a petition to initiate TPR for any child in foster care for 15 of the most recent 22 months, unless the child is in a relative's care or insufficient services have been provided to permit the safe return of the child home. Concurrent or dual-track planning provides a case plan to reunite families at the same time it considers an alternative, adoptive plan, should birth families fail to comply or progress with that case plan. While two simultaneous permanency plans may appear at cross-purposes and be confusing to families, there is value in involving the birth family in designing of the secondary plan,

similar to the process of the Canadian Family Group Decision Making model which invites extended kin to participate in a violence-prevention and/or reunification plan in identified abusive families. Given the urgency of Federal and State timelines, it is critical that birth family be involved in planning right from the start of placement.

The merit of encouraging birth family involvement in placement planning and decision-making is born of personal and professional experience and substantiated by research which links parental contact with children's well-being while in and after care. In fifteen years of work with foster youth, ten years as a direct care provider and nearly ten years as a foster home licensing social worker, I have never met a child who lacks some sense of connection and loyalty to his or her birth parent, no matter how distant, abusive, neglectful, rejecting, or abandoning that parent may have been. In my observations, foster youth appear protective and defensive of biological family, drawn by some innate blood bond of identity and rootedness, even with histories of hurt, disappointment, betrayal, and loss. This notion is contradicted, however, by a study of 43 children in long-term care and 42 controls in Australia, which found no evidence of a preference to live with birth family, calling into question the primacy of the biological bond, and making a plausible case for permanent foster care for some youth (Gardner, 1996). Living preference, however, may not preclude family loyalty.

Given the preponderance of evidence showing a relationship between high

birth family involvement and positive discharge outcomes, and with children's well-being, it is useful to examine the dynamics which may interfere with parental participation.

B. Impediments to Birth Family Involvement

Practical, systemic, and interpersonal hindrances contribute to the underrepresentaton of birth family on the placement planning team.

Geographic isolation, scheduling, and transportation problems have been cited as obstacles to family involvement (White, 1980, Whittaker, 1981). In a qualitative study seeking to discover supports and barriers to birth parent participation in placement planning, Allison Barno (1994) interviewed an admittedly small sample of birth parents whose children were in foster placement, using a structured questionnaire and open-ended questions, seeking their perspectives about the roles of the foster parent, county social workers, licensing social worker, attorney, therapist, Guardian ad Litem, and themselves. Her final query was regarding advice about what would help the parent in feeling part of the foster care team. Barno identified the therapist as having the most supportive role with these parents, and lack of transportation as a major hindrance to meeting attendance.

Acknowledging these practical barriers, Proch and Howard (1986) suggest that agencies provide transportation, child care and convenient weekend and evening hours to encourage parental involvement. In a group process model for engaging parents of "troubled and troubling youth," Grealish and Hawkins (1989) utilized such practical supports as reminder prompts, babysiting, transportation,

refreshments, and opportunity to visit with their child to successfully maintain parental participation. The group process intervention for birth parents helped even very disturbed families improve enough to reunify with some youth in out-of-home placement.

Systemic barriers to parental participation in foster care planning are both obvious and subtle. Since most birth parents are considered involuntary clients whose children are removed and placed by court order due to neglect, abuse, or abandonment, often related to chemical dependency, mental illness or domestic violence, it is not surprising to find resistance to an agency's overtures to participate in a plan they neither initiated nor welcomed.

Birth parents have been labeled by social services and the judicial system as deficient, and foster care may be seen as a manifestation of that deficiency, implying parental failure. Guilt, shame, and felt inadequacy may lie beneath the veneer of hostility and distrust presented by an angry parent. Charbonneau and Kaplan (1989) describe the social isolation, alienation, sense of powerlessness and helplessness felt by many birth parents who may be suffering from their own childhood traumas of loss, abuse, and neglect. A birth parent's perception of victimization by a controlling system which makes decisions about their lives and that of their children is counterproductive to their participation in placement planning. An adversarial legal and child protection system has judged the parent

"unfit," while the foster parents have been scrutinized, evaluated, trained, and approved by the state as "good" substitute care-givers (Pike, Downs, Emlen, Downs, & Case, 1977). This theme surfaced during the "Rethinking Child Welfare" symposium June 3, 1997, when Esther Wattenberg asked the rhetorical question, "It is possible to have a user-friendly child protection system? How can we create a less fearful system for families who cannot nurture their children?"

Child protection interventions, which may include out-of-home placement to assure children's basic safety, seem inherently adversarial. Other referral sources to treatment foster care include Children's Mental Health Units and Juvenile Corrections. Yet even when children are placed voluntarily by parents due to a child's emotional problems with behavioral manifestations, or because of delinquency adjudication, parents often feel blamed for the child's difficulties (Kagen, Reid, Roberts, & Silverman-Pollow, 1987). It should not come as a surprise that such parents, sensing the reproach and censure of the social service system, may resist or avoid participation in placement planning meetings for their children in foster care.

Interpersonal obstacles to parental involvement may include discouragement by an agency or social worker, conflicts with foster care providers, or children's behavioral regression (White, 1990). Foster parents, who view their role as protecting, nurturing, and providing a corrective experience for a child, are confronted by the real possibility of unpredictable, inconsistent, argumentative, or

knowledgeable of the family's differing lifestyle, and increasingly involved with and attached to the foster child. Litner (1975) describes scenarios which may color the turf of foster care: "They show up at inconvenient times, early, late, or not at all.---They may be critical or drunk. They may unrealistically promise the child anything. They may be sabotaging of the foster parents best efforts. They may treat the foster parents like hired help. They may show up with a different boyfriend or girlfriend each time.---In addition, the visits may result in a temporary worsening of the child's behavior" (pp. 269-270). Parent/child visitation, considered by law a child's right in many states, is often followed by behavioral deterioration (Grealish & Hawkins, 1989). Indeed, treatment foster care agencies prepare providers for the likelihood of a foster child's emotional and behavioral regression following family contact.

Kline and Overstreet (1972) describe the most common maladaptive defenses in the birth parent/foster child relationship:

1. Avoidance - failure to observe planned visitation arrangements or impulsive, unannounced, or surreptitious contact.
2. Reversal of parent-child roles-emotional dependence on the child, with inappropriate confidences, physical seduction, whispered secrets, etc.
3. Hostility, expressed as overt or subtle criticism of child or substitute parents.

3. Hostility, expressed as overt or subtle criticism of child or substitute parents.
4. Competitive triangulation, where parents set up a struggle of divided loyalties between child, self, and foster parents, or self, parent, and agency. Foster children may learn to use this pattern manipulatively, arousing parental guilt and jealousy, which may, in turn, generate the empty promises and sabotage which interfere with resolution of the problems which may have led to placement initially.

Practical, systemic, and interpersonal barriers may contribute to birth family absence at placement planning meetings. Yet most research links birth family involvement with better discharge outcomes for youth in foster care, and with children's emotional well-being, adjustment, and development during and after care. Using existing data from the HSA Information System, I explored whether birth parent attendance at placement planning meetings and reviews for youth in treatment foster care, one indicator of family involvement, is related to an increased likelihood of that youth's discharge to a less restrictive setting. Law requires that youth reside in the least restrictive living situation possible to meet their needs; law also mandates that birth parents have a voice in the development of a clear, timely case plan for their children in out of placement. To my knowledge, no one has ever measured the association between these variables,

both of which are dictated by public policy. I hope this investigation will contribute to the knowledge base and practice standard of social workers who place youth in treatment foster care.

BARRIERS TO PARENTAL INVOLVEMENT

- Adversarial relationship with courts and/or social services
- Feeling judged, blamed for child's difficulties
- Interpersonal conflicts with foster care providers
- Geographic isolation/transportation problems
- Socio-cultural differences
- Overwhelming life circumstances
- Competitive triangulation ➜ divided loyalties

(Barno, 1994; Charbonneau and Kaplan, 1989; Coutley, 1980; Grealish and Hawkins, 1989; Kagen, Reid, Roberts, and Silverman-Pollow, 1987; Kline and Overstreet, 1972; Pike, Downs, Emlen, Downs, and Case, 1997; White, 1980; Whittaker, 1981)

III. METHODOLOGY: RESEARCH DESIGN

A. The Research Question

Many research studies have found a positive association between active birth parent involvement and better discharge outcomes for youth in foster care. Law requires and research validates social work practice which places children in the least restrictive, most normative living situation possible to meet their needs.

Given theoretical and empirical support for maintaining birth family ties with youth in out-of-home care, this study examined the relationship between the independent variable, birth family involvement, and the dependent variable, discharge outcomes for children exiting treatment foster care. One concrete indicator of birth family involvement is participation in decision-making for youth in placement. While most prior studies have measured birth family involvement as visitation frequency, this concept was operationally defined in this investigation as birth parent attendance at placement planning meetings and quarterly reviews. Discharge outcomes were operationally defined as the settings in which children were placed when they left care, identified as more or less restrictive than the treatment foster home. The unit of analysis was the birth parent(s) of youth in treatment foster care.

The research question was, "Does birth parent attendance at placement

planning meetings and quarterly reviews affect the discharge of youth to less restrictive settings?"

Within the context of Human Service Associates, a social service agency with offices in three states, Minnesota, South Carolina, and Texas, the study explored this question by examining records of agency discharges for two years, from January 1, 1995 to December 31, 1996. It then reviewed corresponding records of whether birth parents participated in the planning and review meetings for such youth prior to discharge.

Using data collected on the agency's computerized Information System, the list of coded cases was arranged as follows:

CASE NUMBER	SUBJECT (IDENTIFIED BY CODED I.D.)	NEW RESIDENCE	DISCHARGE REASON	STATE	MOM PRESENT?	DAD PRESENT?	IF NOT PRESENT, REASON FOR ABSENCE

After narrowing the study population of total discharges to those where birth parent attendance was possible or reasonable, I organized the findings into a 2 X 2 table with both variables measured as dichotomous.

DISCHARGE OUTCOMES	BIRTH PARENT ATTENDANCE YES	NO
LESS RESTRICTIVE SETTING		
MORE RESTRICTIVE SETTING		

Less restrictive discharges, as identified on the agency Information System form #5, included placement of a child in the birth parent's home, a relative's home, another foster home with less intensive structure and supervision, or independent living. More restrictive discharges included placement in a group home, residential treatment, hospital, shelter, jail, detention, training school or camp.

I then determined whether birth parent attendance at placement planning meetings for youth in treatment foster care, one important indicator of family involvement, is related to an increased likelihood of that child's discharge to a less restrictive setting.

B. Subjects

The population examined by this study were youth discharged from treatment foster care and their parent(s), whose participation in placement and review meetings was surveyed. Foster care was defined as removal of a child, age 0-18, from the home of biological family and placement in the home of a state-licensed substitute care-provider, known as a foster parent. Children served in treatment foster care are usually referred with mental health diagnoses, histories of multiple placements, including institutional care, and often, histories of emotional, physical, and/or sexual abuse and profound neglect. Specialist "professional" foster parents receive training in crisis intervention, clinical pathology and therapeutic responses, attachment theory, child development and discipline. As key members of a multi disciplinary treatment team, they collaborate with HSA staff, therapists, medical and school personnel, as well as the youth and birth family members. Treatment foster care providers have regular access to consultation, support, and supervision in implementing achievement of the goals listed on the placement plan generated by the treatment team. It is within this unique population that the research question regarding birth parent participation in planning meetings and children's discharge outcomes was explored.

From the total population of 725 youth discharged from treatment foster care for the two-year period of 1995-1996, I narrowed the study population to 188

children, based upon the criteria of the possibility or reasonable likelihood of meeting attendance by parent(s). Using the Information System list of discharged youth, identified by code, and the corresponding report of birth parent attendance or absence from planning meetings, I eliminated from the study population the following categories:

1. Parents whose rights had been, or were in the process of being legally terminated.
2. Parents whose contact was prohibited by court-order, county case plan, or official restraining order.
3. Parents whose whereabouts were unknown or whose location prevented involvement in meetings (e.g. out-of-country, out-of-state, incarceration, in-patient hospitalization, etc.).
4. Parents whose physical or mental health hindered attendance.
5. Parents who are deceased.
6. Parents for whom the reason for absence was recorded as "not involved."

While the last criterion of parental exclusion from the study population could raise questions about the study's validity, I had no choice but to eliminate that category, as I had no way to investigate the reasons for noninvolvement. Conceivably, those reasons could fit any of the other categories of elimination. Because this study used existing records of families whose identities were protected by data privacy policy, I could only access data which the Information

System has already collected. Individual social workers fill in a blank where the IS6 Form asks "reason Mom or Dad absent." With an open-ended response, rather than a list of standardized, mutually-exclusive reasons, the category "not involved" becomes meaningless for purposes for this study, as there was no way to ask staff for its case-specific explanation without breaching confidentiality. I would recommend that HSA revise the 1S6 Placement Team Meeting Report form to include a list of reasons for absence, which forces a meaningful choice. Eliminating ambiguity in the tool itself would enhance its usefulness in future research.

I also eliminated from the population those youth discharged to an adoptive home, another less-restrictive setting, as there was a presumption of death or termination of parental rights (TPR) for these children. Both TPR and death of parent were already categories excluded from the list of discharged youth.

Another small group dropped from the study population were those youth whose discharge setting was listed as "unknown" or "other," usually because of runaway status, as the level of restrictiveness was likewise unclear. When a child was discharged from treatment foster care to another foster home, I presumed a less restrictive, more traditional level of foster care, if that child's placement goals had been met while in care.

I predicted the remaining population of 188 discharged youth was large enough and representative enough to collect meaningful information and make

useful observations and conclusions.

C. Instrumentation

The tools used to collect data for this study were Information System Forms 5 and 6, respectively known as the Discharge Form and Placement Team Meeting Report (see Appendix A and B). The information recorded on these tools was then entered into the computerized Information System at the agency's National Office, from which this study's two-year report was generated. This investigation used two sets of data already collected, and sought to discover if a relationship existed between the two, namely birth parent attendance at planning meetings and discharge outcomes for youth exiting care.

Data coding error can occur at the point of filling out the IS5 and IS6 forms, particularly if a social worker is relying solely on memory at the time of entry. Error may occur at the point of recording, coding, and typing the data for computer input. It is less likely to be an issue when retrieving the data for a comparative report. Whenever an instrument has an open-ended response opportunity, there is the possibility of subjective, idiosyncratic answers, subject to the interpretation of either respondent or reader of the answer. As in the case of the response"not involved" as a reason for parental absence, there appears to be a flaw in the tool itself in terms of providing meaningful or sufficient information. Because this study used existing records of past discharges, reported on the IS forms, there was no way to discover the meaning of such a response.

In this study, the two variables were dichotomous and nominal. In placement planning meetings and reviews, birth parent attendance either has or has not occurred, mutually exclusive and exhaustive categories. Such a measure is fairly straightforward and not likely to be recorded incorrectly, especially if the information is entered at the time of the meeting. While discharge outcomes could be ranked from most to least restrictive, such rankings could be subjective depending upon the individual youth or family circumstances, of which I had no knowledge. In this investigation, I identified the outcome as more or less restrictive than treatment foster care. I made no quantitative comparison of the value along a continuum, merely noting the direction of restrictiveness as compared with the treatment foster care setting from which a youth was discharged.

D. Procedures

Because this study used existing records, with subjects identified only by code, access to such information entailed seeking and securing authorization from the agency's Chief Executive Officer verbally and in writing. After approval by the Institutional Review Board, the list of discharged youth was analyzed according to discharge category, as well as the corresponding list of parental attendance or absence from the planning meetings for those youth. I met with the agency Financial Director, who oversees the Information System, and retrieved the computerized reports on which the investigation depended. The data entered into the Information System originated from the IS5 and IS6 forms submitted by agency social workers at the three state offices, then forwarded to the national office. The IS forms report information about discharge settings and reasons, and placement planning meetings and reviews, respectively, as they occurred over the two-year time frame the study examines. From the total population of 725 discharges, I then narrowed the study population to 188 youth by the system of elimination described earlier.

E. Organization

Having identified each discharge according to whether the subsequent living arrangement was more or less restrictive, I then organized the report of parental attendance according to whether it did or did not occur. Excluding from the population those discharged youth where parental participation is impossible or unrealistic or where reasons for absence were ambiguous and meaningless for this study, I analyzed the relationship between the two variables statistically in order to answer the research question. Using the same computerized Information System reports, a modified list of starred subjects was submitted to data analysis by the Paradox software built into the data base of HSA's Information System. Using Chi-Square, a statistical test of association between variables, I calculated whether the difference between expected frequency and actual observed frequency in each cell was large enough that it was not likely the work of chance. While Chi-Square does not prove causation, it does reveal patterns or clustering of values of variables. The larger the study population, the more reliable this test of association becomes in ruling out the alternative explanation of chance. With 188 discharges, this process revealed whether youth whose birth parents attended their planning meetings were statistically more likely to be discharged to less restrictive settings than those youth whose parents were not in attendance.

F. Protection of Human Subjects

Discharged youth and their parents were identified only by code, so subjects remained anonymous and information confidential, protecting data privacy. At no time did I have access to actual names, identifying information, or discharge files, so there was no direct contact with subjects, who had, by definition, left the agency. Data collected and analyzed were kept in the locked file cabinet in my home office until project completion. Since subjects were unidentified, there was no need for informed consent. Use of anonymous data, derived from existing agency records, greatly reduced risk to study subjects.

G. Strengths and Limitations of Study

This investigation focused on youth discharged from treatment foster care, which may be qualitatively different from the general foster care population. Therefore, the findings may not be generalizable to the foster care population as a whole. I hope to build upon prior research which found a correlation between parental contact and youth returning home, considered the most normative, least restrictive setting in most cases.

While this study found a relationship between birth parent attendance at planning meetings and quarterly reviews and less restrictive discharge outcomes, such a positive correlation cannot be construed as causal. Many intervening variables can - and hopefully do - contribute to discharge outcomes for youth leaving treatment foster care. Examples of these variables include:

- quality and quantity of therapeutic services a youth receives (which could be measured by the numbers of appointments, numbers of service providers, such as psychiatrist, therapist, special educational staff, etc.).
- foster care placement itself (which could be measured by stability/duration of stay, implementation of home-based intervention plans, skills of "professional parents" and licensing social worker, etc.).
- choices and behaviors of the child (which could be measured by academic standards, such as credits earned, grades assigned, activities, etc., charting law-

abiding or criminal behaviors, assessment of youth's ability to access and utilize community support networks, legal, recreational, financial, and transportation resources, etc.).

No reputable treatment foster care agency would control for these potential intervening variables by withholding or denying such services, which are considered standard in therapeutic foster care. Individual variations in the skills and strengths of children and parents are also givens. One would have to test the research hypothesis in a control population where services and competencies were comparable and essentially equal, with one group having birth parent involvement and another lacking parental participation, in order to minimize the impact of intervening variables. Treatment foster care presumes the provision of comprehensive, community-based services individualized to meet a child's needs.

Another limitation of the study is the ambiguous term "not involved" when offered as the reason for parental non-attendance. I would recommend that HSA amend the IS6 form to define more precisely the explanations of parental absence. Despite this challenge, I expected the remaining population of 188 discharged youth to be large enough to establish confidence in my findings.

IV. FINDINGS

One exciting revelation of this study was that HSA's success in achieving birth parent attendance in treatment planning was far better than indicated by earlier measures, after eliminating categories where parents were unable or unlikely to attend. Future studies should systematically factor out parents whose participation is prohibited, impossible, or unreasonable when assessing agency outcomes.

Seventy-five percent (n=141) of the study population (N=188) had birth parent participation in their placement planning meetings and quarterly reviews, and 25% (n=47) did not.

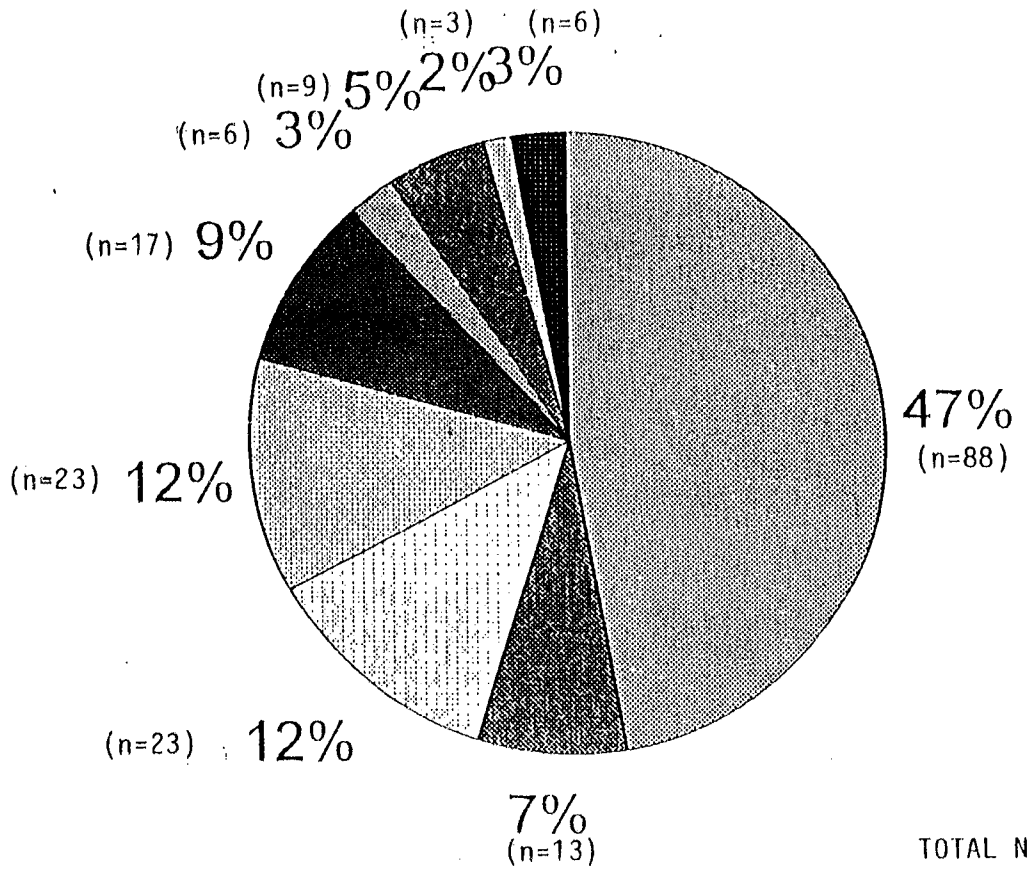
Of 188 youth discharged from treatment foster care during the two-year study period, 22% (n=41) were placed in more restrictive settings, while 78% (n=147) were moved to less restrictive settings.

As summarized on Figure 1, Discharged Clients' New Living Arrangements, of the 188 study subjects, 3% (n=6) were confined in jail, juvenile detention centers or correctional training camps, 5% (n=9) were transferred to residential treatment, 3% (n=6) were placed in group homes or foster homes with more structure and supervision, 9% (n=17) were dispatched to shelters or considered runaways, and 2% (n=3) were hospitalized. Each of these discharge categories is considered more restrictive than treatment foster care. Of those youth

discharged to less restrictive settings, 47% (n=88) were returned to the birth parent's home, 7% (n=13) were placed with relatives, 12% (n=23) were transferred to another foster home with less intensive supervision and structure, and 12% (n=23) were transitioned to independent living.

Reunification is considered the least restrictive, most normative and desirable permanency outcome in most cases. With nearly half the study population having been reunited with birth parents, it is notable that 64 of the 88 youth who returned home had their parent(s) present at their placement planning or review meetings. By contrast, only 24 of the 88 youth where family restoration occurred did not have such parental participation. Often the reasons cited for parental absence were transportation difficulties or conflicts with work schedules.

Figure 1. **Discharged Clients' New Living Arrangements**



Less Restrictive :

47%	Parent's Home
7%	Relative's Home
12%	Independent Living
12%	Another foster home

More Restrictive :

9%	Shelter/Runaway
3%	Group Home
5%	Residential treatment
2%	Hospital
3%	Jail/detention/trainining

Submitting the collected data to the Chi-square test, I found a small, but statistically significant association between birth parent attendance at foster care planning meetings and the subsequent discharge of youth to less restrictive living arrangements upon leaving treatment foster care, which supports the effectiveness of therapeutic placement. As summarized on Table 1, Observed and (Expected) Frequencies - Birth Family Participation in Foster Care Planning: Relationship to Discharge, the observed frequency of 115 less restrictive discharges associated with birth parent participation exceeded the expected frequency of 110. The Chi-square statistic rounded to 3.8, with a probability value rounded to .05 allows me to reject the null hypothesis that such a relationship could be attributed merely to chance. While such a finding must be interpreted cautiously and cannot be considered as causal, it supports the predicted positive relationship between birth parent attendance at their children's placement planning meetings and the subsequent discharge of those youth to less restrictive living situations.

TABLE 1. OBSERVED AND (EXPECTED) FREQUENCIES- BIRTH FAMILY PARTICIPATION IN FOSTER CARE PLACEMENT PLANNING: RELATIONSHIP TO DISCHARGE

DISCHARGE OUTCOMES	BIRTH PARENT ATTENDANCE YES	BIRTH PARENT ATTENDANCE NO	
LESS RESTRICTIVE	115 (110)	32 (37)	147
MORE RESTRICTIVE	26 (30)	15 (10)	41
	141	47	X2 = 3.8 N = 188 P = .05

V. CONCLUSIONS AND RECOMMENDATIONS

This study sought to discover whether a relationship existed been birth parent participation in their children's placement planning meetings and quarterly reviews, and the discharge of their children to less restrictive settings. Of 188 youth who left treatment foster care in the two-year study period of 1995-1996, 115 children who had parental attendance moved to less restrictive living arrangements upon discharge, compared with 32 children who did not. Though parental attendance is only one indicator, and arguably not the most important measure of birth family involvement, the findings appear to support results of prior studies which associated parent/child visitation, another indicator of involvement, with reunification, considered the least restrictive discharge outcome. (Bullock, Little & Millham, 1993; Davis, Landverk, Newton, & Ganger, 1996; Fanshel, 1975; Hess, 1987; Marsh, 1987; Mech, 1985; Tam & Ho, 1996; Whittaker, 1981).

While parental presence alone is probably not the best manifestation of parent/child connections, attendance at planning meetings is information HSA collected in 1995 and 1996. A recent addition to the Information System, Form #10, the Kinship Involvement Form, (Appendix C) is commendable for its inclusiveness in measuring other representations of birth family involvement. It does not limit the definition of family contact solely to parental contact, and counts

the number of contacts in each of the following categories:

- care provider consultation with parent,
- contact mandated by court or county case plan,
- family therapy,
- HSA meetings,
- letters/cards,
- phone calls,
- visits,
- school meetings and functions,
- others.

The IS #10 is completed by the care provider and submitted with the monthly report of the child's problems and progress in meeting placement goals. Tracking multiple indicators of birth family involvement will provide a far more comprehensive picture of those connections than recording parental meeting attendance alone. A suggestion for further research would be to seek the relationship between these categories, types, and numbers of contacts and subsequent discharge outcomes, after HSA has accumulated at least a year's worth of data. The creation of the Kinship Involvement Form demonstrates HSA's commitment to maintaining the connection between children in treatment foster care and their families-of-origin. I look forward to the first summary reports generated via the collection of this data.

In addition to the statistical association between birth parent participation in placement planning and less restrictive discharge outcomes, the value of such involvement is supported by the theorists who link family continuity and contact with a child's sense of personal identity and significance (Colõn, 1979; Hutchinson, 1972). A child's perception of a parent's strengths and shortcomings is likelier to be realistic if contact is regular. One routine and timely occasion for such contact is the quarterly review meeting. I have witnessed a child's demeanor brighten at the arrival of a parent at a quarterly placement review, some even verbalizing, "She cared enough to come!" Others have wept, acted out behaviorally, or made limp excuses for a invited parent's absence in varying expressions of hurt, disappointment and anger. For better or worse, most foster children appear to measure their own worth in part by their parent's involvement in their lives, of which planning meeting attendance is one indicator.

Just as past research has studied children's well-being, development and adjustment during and after care in relationship to visitation, it would be interesting to see if the independent variable in this study, birth parent attendance in placement planning and review meetings, was similarly associated with positive outcomes other than discharge, such as achievement and completion of treatment goals. A suggestion for further study might be testing the association between the numerous indications of familial contact listed on HSA's Kinship Involvement Form, including planning meetings, and foster children's emotional and cognitive

development, using the same projective and intelligence tests employed by Fanshel and Shin (1978) in one of the few longitudinal studies of youth in foster placement.

Implications for Social Work Practice

Given the importance of including birth family in foster care planning and decision-making, reinforced and further validated by this study, I propose several policy and practice guidelines for increasing and sustaining birth family participation in placement planning.

1. Articulate its value in agency mission statement, literature, and staff orientation, and measure staff performance by outcomes.

At the agency level, several management components which contribute to effective service delivery include:

A) "articulating a clear organizational mission and program philosophy" and

B) "specifying measurable performance criteria and worker appraisal methods." (Pecora, Whittaker, & Maluccio, 1992, p. 431).

An agency seeking to promote birth family involvement must state that mission, and concretely track its success in meeting that mission. HSA's encouragement of family participation in contracting meetings for youth in care is reflected in its repeated and ongoing support of this value in formal public relations literature, at staff and team meetings, in agency orientation and in the training series for foster families. That focus has generated such innovative

programs as Whole Family Placement, where vulnerable children, often with child protection issues, are placed with their parents in a foster home, and care providers assume a teaching, modeling, mentoring, coaching, and supportive role with the entire family system. Another innovation is the addition of the more recent Family Preservation/Restoration Program.

The value is reinforced by a staff performance appraisal standard which awards up to 20 out of 100 points for 80% attendance of birth family at placement planning meetings and reviews, and subsequent recommendations for team and individual raises are based partially on this measurable goal. Yet monetary incentives and recognition have not alone changed outcomes. A staff inservice, within the confines of a mandatory staff meeting which assures maximum attendance, could summarize the research which demonstrates the value of birth family involvement, including results of this study, based on actual agency data. Understanding the reasons for the goal seems likelier to generate staff diligence in its achievement, even if it creates more work for social workers and care providers. The fact that this investigation found a positive association between parental participation and less restrictive discharge outcomes, both of which are HSA goals, should accentuate the value of staff attentiveness to their attainment.

Consistent with the practice guidelines of staff orientation and foster parent education, I would gladly share the findings of this research with my co-workers and care providers, perhaps even assist in teaching the pre-service seminar on Co-

parenting. I anticipate arguments from staff and foster parents about those exceptions in treatment planning, when a child has been so traumatized and psychologically damaged by abuse that contact is clearly detrimental to the child. In most of these cases, parental involvement will have been therapeutically restricted by court order, county case plan, or legal restraining order. Yet given the theoretical foundations which link family connection with a youth's sense of identity, attachment, and personal significance, I would argue that contact is almost always eventually desirable, if for no other reason than to integrate past history. Recent examples from my practice include a young woman, who after 44 placements, many of which were institutional, has recently reconnected with her biological mother and half-brothers, despite TPR when the child was three years of age. Despite the pain of rejection and abandonment due to her mother's chemical dependency and mental illness, there is a hunger and longing to establish a relationship with her birth mother, with the backdrop of security and support from her extraordinary foster family. Another adolescent female has participated in therapeutically supervised amends sessions with her biological father, despite a 20 year court-ordered "No Contact" mandate, after suffering years of incest from early childhood. Coming to terms with her historical and current relationship with her father, while enjoying the protection, safety, and nurture of her permanent foster family, will prepare her for healthy adulthood more effectively than the total severing of contact imposed legally when criminal sentencing occurred. This

father is now a faithful participant in his daughter's and son's quarterly placement reviews, and maintains regular communication with the foster family who cares for his children.

2. Articulate its value to customer agencies.

Be clear that a commitment to involving birth family is part of the package a referring agency is purchasing when it contracts for services to foster children. I have occasionally met with resistance from county social workers who view birth family members as "the bad guys" from whom children need protection and isolation. White (1980) identified discouragement by an agency and/or social workers as one of the barriers to birth family participation, and some county workers, often with large, overwhelming case-loads, view family involvement as "messy," complicating case management and generating more work. Again, education about the current and long-term benefits of birth family involvement to foster children may be useful.

3. Include, invite, and orient birth family to agency and foster home at preplacement meeting.

After an extensive process in which the presenting needs of a referred child

are matched with the skills, education, and experience of professional parents, a preplacement visit is scheduled, usually in the therapeutic foster home. Peter Smith (1989), in describing Kent Family Placement Services, recommends arranging for birth family to meet their foster family prior to placement, perhaps having them tell the youth about the proposed placement, in the spirit of enlisting parental support and consultation in the placement process. Ideally, the birth parent should be invited to attend the preplacement meeting simultaneously with the child. It is here that the social worker can orient the parent to the agency's philosophy and mission, which champions their "sense of mattering," as well as to the specific home being considered for placement. An authentic, welcoming, nonjudgmental stance at this meeting can establish an atmosphere and attitude of mutuality, the groundwork for an ongoing reciprocal relationship throughout placement. MacDonald (1992) describes the first meeting, where "the placement worker joins with the family by being neutral, normalizing, and non-blaming---informs them she is there to discuss their future and the future of their child.---All meetings are described to them as part of the agency's protocol planning for the placement of children, establishing the context for parents as one of 'not therapy'" (p. 7). Since preplacement meetings are often a "get-acquainted" opportunity for all, interviewing the parent about their view of their child's strengths and needs validates their sense of being the "expert" on their own child (Johnson, 1986). A clear public statement about the importance of parents' participation as integral

members of the treatment team affirms the prominence of their role and responsibility. If confident of basic literacy, the social worker can invite the birth parent to actually fill out parts of the information-gathering forms and assessment tools, as well as sign parent/guardian permission statements which helps define the relationship as "reciprocal rather than power-based" (Fahleberg, 1991, p.340). Including the birth parent in the preplacement visit establishes the foundation for a pattern of shared decision-making and "parental participation as part of the team working together for the child's well-being" (McFadden, 1980, p. 69), which reinforces their "rights to and concern in the child" (McFadden, p. 75).

With the urgency imposed legally by both Federal and state timelines which dictate initiation of a petition to terminate parental rights (TPR) after a child has been in placement 15 of the most recent 22 months, it is essential that birth parent inclusion is sought immediately at the onset of placement. Concurrent planning simultaneously provides both a reunification strategy and adoptive proposal, should reunification efforts fail. Birth family input to the design of either permanency plan is critical to successful implementation and is likelier to elicit parental cooperation rather than resistance. The preplacement and initial placement planning meeting is a timely, logical forum for such discussion. I hope that county agencies will exercise restraint and discretion in moving too hastily to TPR, as individual family circumstances are considered. Although the positive intent of the Adoption and Safe Families Act is to assure safety, minimize long-term emotional

harm, and expedite secure, permanent placement of children, there is a paucity of skilled adoptive resources, particularly for youth represented in the treatment foster care population. Indeed, some of HSA's referrals are children from disrupted adoptive placements.

Given the acceleration of the process of child removal to TPR imposed by well-intended laws, inviting parents to preplacement and planning meetings is even more imperative, given theoretical support and empirical findings which proclaim the importance of birth family involvement to less restrictive discharge outcomes.

4. Identify and build upon strengths.

Birth parents have often been labeled by social services as deficient, and foster care is seen by them and others as a manifestation of that deficiency. Diagnostic and treatment orientations which reinforce family strengths rather than focusing on pathology are central themes in sound social work practice. Pecora, Whittaker, and Maluccio (1992) champion preservation of family ties, viewing parents and other family members as "partners and resources in the helping process" (p.338), rather than dwelling on deficits. Family strengths should be identified at intake and listed prominently on the placement plan. Concentrating on competency is a good way to engage a reluctant family in creation of a plan which

builds on those identified strengths. To the credit of HSA, the agency intake form and placement plan clearly ask that individual and family strengths be noted, and used as the foundation for intervention. The agency is in the process of fashioning an assessment tool and placement plan which is even more respectful of the strengths perspective. (See Appendix D.)

5. View birth family members as full contributing team members in placement planning meetings and quarterly reviews.

McFadden (1980), in her manual for training families who serve foster children, lists concrete suggestions and ways to include birth family in shared decision-making regarding their child. Collaboration facilitates a sense of joint ownership of the plan, and enhances the likelihood of vestedness in its achievement. Publicly reinforcing with verbal acknowledgment birth parents' participation in and compliance with their piece of the placement plan, calling attention to even small increments of success, hoping that the benefits of such will become inherently reinforcing over time, may shape competency which leads to second-order change. Having the parent sign off on a contract they helped generate places a seal of collusion and support, which is noted by the child.

6. Assure access by choosing convenient time, place, and date, and provide

transportation if needed.

In a qualitative study seeking to discover supports and barriers to birth family participation, with an admittedly small sample of interviewees, Allison Barno (1994) identified lack of transportation as a practical obstacle to meeting attendance. Transportation needs and work schedule conflicts were often cited as reasons for parental absence on HSA's IS6 Form. If unavailable, a social worker can personally pick up a birth parent, arrange for a case aide or foster parent to do so, or request cab vouchers or bus tokens. While arranging meetings around a parent's time-table may conflict with the schedules of physicians, therapists, school personnel, psychiatrists, and social workers who may work more traditional hours, accommodating parents' timing needs is one way to enunciate their importance to the team. Likewise, choosing a neutral site for planning meetings which is accessible by public transportation provides an antidote to social services offices where the turf is tinged with unequal power. I have occasionally scheduled review meetings in the parent's own home, from 5:30-8:30 p.m. with children, therapist, county social worker, Guardian ad Litem, HSA staff, and care providers all assembled in the birth family's living room, a powerful symbol of affirmation. Since Barno's limited 1994 study identified therapists as professionals whom parents regarded as supportive, it might be wise to schedule a review in the office of the therapist who has provided individual and family counseling to the family-

of-origin. In a group process model for engaging parents of "troubled and troubling youth," Grealish and colleagues (1989) utilized such practical supports as "reminder prompts, transportation support, babysitting support, refreshments, opportunity to visit with their child" in maintaining parental attendance and participation (p. 49), all of which are useful tools in assuring access and providing incentives for family involvement.

7. Broaden definition of family

In the absence of an available or willing parent, identify with the youth an extended family member or significant community person with whom the child feels a connection to represent family at the meetings where placement plans are generated. In their vision of networks which nurture, support, and endure throughout the life course, McFadden and Downs (1995) define family continuity as the new paradigm in permanency planning, and include grandparents, aunts and uncles, siblings, and kith or fictive kin, non-relatives such as friends, neighbors, or godparents as part of that network who have emotional significance to a child. Using a genogram or life-book may be useful in this process of identification. To HSA's credit, the new IS10, Kinship Involvement Form, tracks contacts with the "youth's family of origin-or person who functions in that role from the youth's extended family, community or support network," a far more inclusive definition

of family than only parents.

Congruent with research and placement priorities defined by law, extended family should always be considered first for foster care resources, even for disturbed youth. Fein and Maluccio (1984) found that children discharged from relative's homes were doing better than those from non-kin or residential placement, underscoring the value of kinship care for temporary or permanent child placement.

8. Identify community resources and supports for family.

Related to the strengths perspective and expansion of how family is defined, do an ecomap with the child and birth family to discover where natural supports exist, a snapshot in time of where energy is generated and expended. Often friends, volunteers and informal community resources can assist with practical matters such as transportation, which if lacking, interfere with access to planning meetings. Ideally, informal supportive relationships between the birth and foster family will be voluntarily maintained beyond the formal out-of-home placement (Lewis and Callaghan, 1993). In my experience as a foster care provider, the best indication of a successful parental partnership was when the birth parent of a youth who had left my care continued to call for suggestions, favors such as child-care, or just to share news of her son's progress after returning home.

9. Provide initial and ongoing foster parent training and support of co-parenting.

Since the primary focus of a licensing social worker's function is to provide support to and consultation with the care providers, this is also the principal way in which a worker can impact the goal of parental participation in team meetings. For instance, HSA mandates 36 hours of pre-service training prior to and during the first year of licensure, and a full day is devoted to working cooperatively with the biological family of youth in care, underscoring its significance. However, translating this value into practice can be challenging, as foster parents, who view their role as protecting, nurturing, and providing a corrective experience for a child, witness the disappointment, hurt, and betrayal a foster youth experiences when unpredictable, inconsistent, or undermining behavior of a birth parent occurs.

HSA prepares providers for the likelihood of emotional and behavioral regression following family contact or following the let-down of missed visitation. When foster parents become frustrated, even demoralized, about the short-term impact of parental contact -or its absence - on youth-in-care, the concepts of perspectivism and reframing are useful. In consultation, a social worker can remind foster families that the subjective realities of parents with children in care are colored and filtered through their life experiences-just as are the perspectives

of the foster care providers. Reframing the behavior of the child and family as functional, in that it maintains homeostasis, even if destructive or pathological, helps the provider recognize the purposefulness of otherwise baffling conduct. If the maladaptive patterns identified by Kline and Overstreet (1972) in Chapter 2 can be reframed as learned, internalized, functional, characteristic dynamics in family relationships, which served a purpose within the family system, foster parents are less likely to be blaming or judgmental, which is clearly detrimental to forging a co-parenting partnership on behalf of the child in placement. Where a child has been scapegoated as the "identified patient" within the family of origin, removal may upset the family structure and dynamic and force corresponding changes within the family system, or shift focus to a new scapegoat as equilibrium is unbalanced by placement. Training and consultative support help foster care providers identify and respond to behavioral and interactional patterns within the family systems of their own family and the birth family of the child in foster placement.

10. Create parental partnerships by identifying and addressing triangulation.

Though this may be a part of parent support and consultation, the incidence of triangulation in foster care is so common it warrants its own practice guideline. Rowan (1976) warns against the risks of forming "unholy alliance" (p. 22) by

taking a child's side against the parents when summarizing a family's social history. Similar dynamics when foster families align with youth in care may set in motion a destructive pattern of competition, counterproductive to birth family involvement. Triangulation is almost inevitable in the foster care system. In Fernando Colõn's rich analysis of his own experience in foster care, he states, "Bowen's work with family system triangles, Nagy's work with family loyalties, and Minuchin's work with current familial/contextual arrangements all have applicability here" (p. 265). Recognizing and intervening with triangulation and competition are part of the social worker's role. When effective in their elimination, achievement of the goal of birth family participation is enhanced. If a social worker and foster family can give permission and support for both relationships, it "reduces the conflict of loyalties that often stand in the way of the child's use of surrogate parenting" (Kline and Overstreet, 1972, p. 179). The social worker can model and encourage parental partnerships, promoting effective teamwork, in which the differential roles of all parties are clearly spelled out and understood. Johnson (1986) defines parental partnerships as a "share the care" philosophy, where foster parents "supplement, not supplant" the role of the birth parent in care of the child (p. 46). If birth parents are members of the team which creates the placement plan, and have a meaningful contribution and stake in that plan, triangulation is minimized.

11. Solicit birth family feedback regarding the placement process.

Effective child welfare practice should include some system of collecting and analyzing program evaluation data (Pecora, Whittaker, & Maluccio, 1992). HSA should and does solicit information from birth families about their satisfaction with the services they and their child received during foster placement. If parental participation has been consistent throughout care, seeking such a response at a discharge planning meeting by using a simple survey, with opportunity for comments, would diminish the poor return rate when such follow-up questionnaires are sent by mail. Since a knowledge gap exists in those birth family's reasons for not participating, it would be instructive to practice to find a means to learn of the "whys" associated with family members who choose not to be involved in placement planning. Perhaps a financial incentive for participation in an interview by someone not directly employed by or aligned with the agency might help a placing facility get some sense of how such parents view their role and treatment within the foster care system. For example, in a qualitative study of four birth parent's perspectives on the placement experience, Ruth Broman Burns (1993) interviewed four mothers about the difficulties they encountered with social worker attitudes, visitation problems, and foster parent conflicts. Getting feedback and suggestions for improving the placement process from birth parents of children in foster care should provide useful insights into practice standards which

promote parental participation.

POLICY AND PRACTICE GUIDELINES WHICH ENHANCE BIRTH FAMLY PARTICIPATION

Broaden Definition of Family

Solicit birth family feedback

Build upon Family Strengths

Articulate value to customer agencies

Articulate value in agency mission statement, literature, and staff orientation. Measure staff performance by outcomes.

Provide initial and training and consultation regarding co-parenting

Identify community resources and supports

Invite and include birth family in Preplacement meeting; orient family to agency and foster home.

View family as full, contributing team members in planning/ contractual ongoing foster parent meetings

Create Parental Partnership; Identify and address triangulation

Assure access by choosing convenient time, place, date. Provide transporation if needed

VI. SUMMARY

Despite the limitations of this study - the uncertainty of generalizability of findings from treatment foster care to a general foster care population, the impact of significant intervening variables on discharge outcomes, and the ambiguous explanation for parental absence "not involved," which may have skewed or compromised the findings - there was statistically significant support for the research hypothesis.

Birth family involvement in placement planning for youth in care is linked with better discharge outcomes and associated with children's well-being and development during and after care. This study found a positive relationship between parental attendance in placement and review meetings for youth in treatment foster care and their subsequent discharge to less restrictive settings. While the statistical difference was not large, it may have meant all the difference in the world to the child whose parent participated in their treatment planning! Practice guidelines for increasing and sustaining family participation flow logically from both theoretical concepts and research data. Conscientious social work practice must be attentive to maintaining the meaningful involvement of foster children's birth family in shared decision-making and parental partnerships, whatever the permanency plan.

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Appendix A

IS5: DISCHARGE FORM PAGE 1

Instructions: This form is to be submitted by the supervising worker upon discharge of a person from the HSA program.

HSA State Program MN

Person's Name _____ Date of Birth _____

Date of Discharge _____

Name of Care Provider at time of Discharge: _____

Person/family discharged from HSA will live (check one):

_____Parent's home
_____Adoptive home
_____Another foster home (Agency Name: _____)
_____Group home
_____Independent living
_____Residential treatment
_____Hospital
_____Shelter
_____Jail/detention/training school/Camp
_____Relative's home
_____Unknown

Reason for discharge (check one):

_____Placement Goals Met
_____Requested of care provider (Reason for request:)
_____Request of referral agency (Reason for request:)
_____Request of person (Reason for request:)
_____Runaway
_____Court Action
_____Lack of Funding
_____Inappropriate for program (Reasons:)
_____Team Decision
_____Family completed its case plan
_____Hospitalization
_____Arrested/detained by corrections authority
_____Unable to be maintained in the community

FORM COMPLETED BY _____

DATE _____

DATE ENTERED: _____ INITIALS: _____ REVISED: December 15, 1994

Appendix B

IS6:PLACEMENT TEAM MEETING REPORT PAGE 1

Instructions: This form is to be completed after each placement planning or quarterly review meeting.

Check one: ____*Placement Planning Meeting* ____*Quarterly Review Meeting*

1. HSA state program _____ 2. Meeting date _____

3. Name of person/family placed _____

4. Date of Birth _____

5. Name of care provider(s) _____

6. Has there been a change in the person's/family's HSA placement since the last report?
   ____No
   ____Yes (Date _____;
   former HSA provider's home _____
   _____)

7. Meeting location:

   ____ Provider's home
   ____ Natural parent home
   ____ School
   ____ HSA office
   ____ Other (Where? _____)

8. Attending meeting?

	Yes	No
Natural/Adoptive/Legal/Step mother	___	___
Natural/Adoptive/Legal/Step father	___	___
Care provider #1	___	___
Care provider #2	___	___
Legally responsible social worker	___	___
HSA social worker	___	___
Youth placed	___	___
School personnel	___	___
Other service provider	___	___

9. Reason N/A/L/S father could not attend: _____

10. Reason N/A/L/S mother could not attend: _____

11. Total number participants _____

IS6:PLACEMENT TEAM MEETING REPORT PAGE 2

12. Who chaired meeting?
___ HSA social worker
___ HSA care provider
___ Natural parent
___ Legally responsible agency worker
___ Person placed

13. Permanency Plan:
___ None (date by which plan will be developed: _____)
___ Natural parents
___ Relatives
___ Adoption
___ Foster care by another agency until emancipation
___ Foster care by HSA until emancipation
___ No change from previous plan

14. Date permanency plan was set _____

15. Month/year for next review _____ / _____

FORM COMPLETED BY _____

DATE _____

DATE ENTERED: _____ INITIALS: _____ DATE REVISED: December 15, 1994

IS 10 - KINSHIP INVOLVEMENT FORM Appendix C

Instructions: Foster care provider should complete this form each month and attach it to the Monthly Foster Care Reports. Please indicate the number of contacts in each applicable category that the youth's family of origin - or person who functions in that role from the youth's extended family, community or support network - has with the youth. IF THIS IS A WHOLE FAMILY PLACEMENT, there is no need to fill out this form.

---

1. Social Worker: _____ 2. State: __ MN __ SC __ TX

3. Month/Year: /

4. Youth/Family Name:_____ 5. Date of Birth: _____

6. Program: ___ Youth ___ RTA ___ ROP ___ WFP ___ Med

7. If contact was made, please check one of the following choices:

___ Care provider consultation with parent

___ Contact mandated by court or county case plan other than above:

Specify: Contact mandated:

Other specification:

___ Family therapy

___ HSA meetings

___ Letters (including birthdays & holidays)

___ Phone calls (including birthdays & holidays)

___ Visits (including birthdays & holidays)

___ School meetings and functions

___ Other

8. If no contact was made, please check one of the following choices:

___ No contact due to court or county order

___ No contact initiated by parent

___ No contact initiated by youth ___ No contact initiated by HSA

FORM COMPLETED BY: _____ DATE: _____

DATE ENTERED: _____ INITIALS: _____ REVISED: August 1, 1997

Appendix D

YOUTH/FAMILY INFORMATION SHEET

NAME: *DATE:* *CASE#:*

HSA BELIEVES THAT YOUTH/FAMILIES HAVE STRENGTHS AND ARE VALUED MEMBERS/PARTNERS OF THE PLANNING TEAM. HSA SERVICES SUPPORT GROWTH IN THE AREAS OF BELONGING , KNOWING, BECOMING AND GIVING. HSA WILL HELP YOUTH/FAMILIES GROW IN THESE AREAS AND CONTRIBUTE TO THEIR COMMUNITY.

WHAT IS THE ISSUE THAT CURRENTLY CONCERNS THE YOUTH/FAMILY?

WHAT HAS THE YOUTH/FAMILY TRIED, TO RESOLVE THIS ISSUE? - INDICATE YOUTH/FAMILY STRENGTHS.

WHAT DOES THE YOUTH/FAMILY WANT THINGS TO BE LIKE?

HOW WILL THE PARENTS , SIBLINGS AND OR EXTENDED FAMILY BE INVOLVED IN THE PLACEMENT?

WHAT BARRIERS EXIST TO THEIR INVOLVEMENT?

WHAT PLAN IS THERE TO ADDRESS THESE BARRIERS?