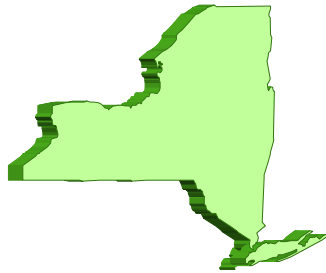


New York
Mental Hygiene Institute



Rensselaer County
Foster Care Enrichment Team
Report

April, 2004

How the Rensselaer County Foster Care Enrichment Team Improved Their County's Foster Care Placement System

Summary

The Rensselaer County Foster Care Enrichment Team (FCET) is an interagency effort initiated in 1999 by Rensselaer County to reduce the number of foster care placements for a child requiring foster care. One of the measures used to evaluate the quality of a county's child foster care program is the number of unintended changes for child placed in foster care. In Rensselaer County, unplanned foster care child placement disruptions decreased significantly from 21 out of 167 (22.6%) in 1999 to 3 out of 176 placements in 2,000 (1.8%) (see Figure 1). Rensselaer County has maintained this dramatic improvement over the last two years with disruption percentages of 1.8% in 2001, which placed the county first in the State, and 2.7% in 2002, which placed the county fourth in the State. This paper describes the steps Rensselaer County took with FCET to achieve these impressive changes in the number of disruptions experienced by children in the Rensselaer County child foster care program. Specifically the paper provides details on how FCET was used to develop a team of people and services from the Department of Social Services (DSS), the Department of Mental Hygiene (DMH), the Department of Health (DH), and private child caring agencies as well as the foster care workers and foster parents to provide for the needs of children placed in foster care.

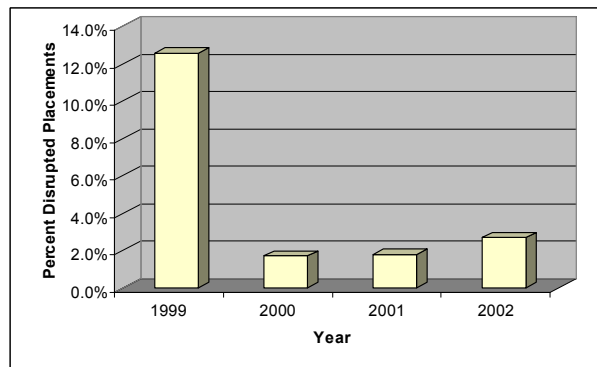


Figure 1. Percent of Child Placement Disruptions in Rensselaer County, NY

Background

In recognition of the harmful effects of unintended family changes on a foster child, federal and state child welfare officials have established a stability rating indicator. The indicator is the percentage of children in foster care (1) who have had two or fewer placements and (2) who have been in foster care for less than one year. Other measures of foster care quality used by New York State are not covered in this report. The national benchmark that all child welfare programs are expected to attain has been set at 86.7 percent. New York State surpasses the national standard. In fiscal year 1999 New York State achieved 88.9 percent, and in 2001 New York increased its performance to 91.6 percent. Rensselaer County went from a ranking of 30th in child placement stability in 1999 to a ranking in the top four child welfare districts in the State for the last three years (see Appendix A for a table with the child foster care disruptions rates for each of the NYS Social Service Districts for the year 2002).

Table 1. New York State Ranking of Child Placement Stability from 1999-2002¹

Year	NYS Stability Rating	Rensselaer County Stability Rate	Rank in NYS for Rensselaer County
1999	88.9%	87.4	30 th
2000	90.8%	98.3	3 rd
2001	91.6%	98.2	1 st
2002	91.4%	97.3	4 th

In 1999 the Rensselaer County child welfare leadership decided to take action to improve foster care and improve the county's child placement stability rating. They knew that unexpected changes in living conditions are not good for the foster children and often result in more intensive levels of care, longer lengths of stay in foster care, and greater cost for the county.

As part of an ongoing effort to improve children's services in the county through increased collaboration among child welfare, mental health and other child service agencies, the county directors of mental health and child welfare decided to use a collaborative strategy for reducing the number of disrupted child foster care placements. Based on a hypothesis that a collaborative process results in better decision-making and therefore in more effective and timely provision of services and fewer unplanned disruptions, an interagency group was formed in 1999 involving the county Department of Mental Hygiene (DMH) (child and adolescent mental health unit), the Department of Social Services (DSS) (foster care unit), the Department of Health (DH) and other

¹ From the New York State annual data submissions to the National Child Abuse and Neglect Data System

relevant private providers. The group has met regularly since then to review the cases of children recently placed in foster care and children in care at risk of disruption.

The New York State Office of Mental Health (OMH) provided funding to the New York State Mental Health Institute to assess the ongoing work of the Rensselaer County Foster Care Enrichment Team (FCET) as a model program other interested communities could choose to replicate. This funding supported an initial comprehensive review of FCET in 2002 and 2003 by Pat O'Connor, Ph.D. a private consultant. This study dated April 2003 is titled *Assessment of the Rensselaer County Foster Care Enrichment Team: A Model Program*. Dr. O'Connor gathered her information by reviewing 73 foster care case records; interviewing foster parents, child welfare workers, and members of the FCET team; as well as attending the FCET meetings over a nine-month period (See Appendix B). In addition, OMH funding supported a brief one-year follow-up study described in this paper. This study was completed in the fall of 2003 by Carl Valentine, a private consultant. Mr. Valentine gathered information for this study in interviews with FCET team members and in a review of Dr. O'Connor's study.

Characteristics of Successful Foster Care

When a child is placed in foster care, he or she typically becomes part of a different family. Such a drastic change is necessary when the child's own home presents deficiencies so serious that it cannot provide the child with minimally adequate social, emotional, and physical care. During placement in foster care, the child experiences not only separation from his or her own family (except for visits) and adjustment to a new family, but also a change of location, a change of school, and a change of peer and sibling groups. Because these changes can damage a child's sense of stability, a public child-welfare agency uses foster care only as a last resort after every effort has been made to keep the home intact for the child and to keep the child in the home. Another important goal of the child foster care system is to reunify each child with his or her parent or caretaker.

A key characteristic of a good foster care placement is one that permits the child to remain in the same home during the entire period of foster care. If a child must be removed from one foster home and placed in another, the child will experience the emotional burden of repeated separation and change. Each change reactivates, and hence reinforces, previous separation and rejection experiences and can have the following negative effects on the child:

- Confirms for the child that he or she is unacceptable to others.
- Increases the child's lack of trust in parental figures.
- Increases the incidence of emotional problems and therefore increases the possibility of failure of subsequent placements.
- Reduces the child's chances of successful reunification with his or her parents.

When there are disruptions in the placement of a child or unexpected moves, the child is often moved to a more restrictive level of care, e.g., therapeutic foster care, group or institutional care, and in some instances inpatient hospitalization. Each of these options is more costly than family foster care for the community's child welfare program.

Description of FCET

Rensselaer County is one of several counties in the Capital District Region of New York State. It has one middle-sized city, Troy, and two smaller urban areas, Rensselaer and Hoosick Falls. Rensselaer County is designated as a Unified Services County for the delivery of mental hygiene services; and as a result, the human services agencies collaborate quite well

For over twenty years the county, due to this designation, has received more favorable State financing in exchange for the county taking partial financial responsibility for its citizens requiring care in State mental hygiene facilities. As a result of this fiscal incentive to minimize the use of State facilities, the county's public and private human service agencies have together developed community-based care and interdependence and cooperation. These relationships were fostered over time by regular meetings involving the County Commissioner of Mental Hygiene and other agencies serving mental hygiene clients.

The Foster Care Enrichment Team (FCET) began as a direct response to a large number of unplanned disruptions to children placed in the Department of Social Services foster care system. The negative consequences to the involved children and the excessive costs to the Department of Social Services pointed to the need for intervention. In late 1998, using a collaborative model familiar to leadership in the community, approximately six individuals representing the county departments of Mental Hygiene (DMH), Social Services (DSS), and Health (DH) as well as local private child-placing agencies met to explore alternatives to the existing system. Over the next several months, FCET was developed with representatives from the three county departments (DMH, DSS, and DH), and several local private organizations involved in the care of foster care children.

To support this initiative, the Mental Hygiene Director was successful in obtaining two small grants:

- A grant from the State Office of Mental Retardation and Developmental Disabilities to support a clinician who would split her time between two functions: (1) supporting FCET and (2) working with children under five at risk of developmental disability and their families

- A grant from the State Office of Mental Health to support a set of activities including:
 - A part time clinician to work with foster parents
 - Clinical consultation to assist with adoptions
 - Funding to support an annual foster parent enrichment day
 - A therapeutic visitation room at DSS
 - Assistance in the recruitment of foster parents
 - Development of therapeutic tools for working with foster children requiring mental health services.

Operations and Meetings of the Foster Care Enrichment Team

Over nearly five years of operation, the Foster Care Enrichment Team (FCET) has evolved to its present efficient and effective level of operation based on feedback from members, on insight gained through day-long retreats, and on recommendations growing out of the extensive study completed by a team of researchers led by Pat O’Conner. Throughout this period FCET has met biweekly, usually for the fully planned 90 minutes.

Over time, membership has been restructured, reducing the average number of persons attending meetings to a core group of ten. Three FCET members are from the DSS Foster Care Unit, three are from county DMH, two are from private foster care providers, Vanderhyden Hall and Jewish Family Services, one is a client advocate and one is a foster parent liaison. The remaining persons, largely representing other local private sector service providers and the Health Department, remain part of FCET but only attend when invited.

The mental health worker hired by Rensselaer County DSS to support the foster care unit prepares for the FCET meeting by reviewing with the Foster Care Unit Supervisor the cases of children to present at the upcoming FCET meeting, preparing an agenda, structuring the case presentations, and notifying foster care case workers and other key individuals of the meeting agenda.

Meetings begin on time because participants call if they are going to be late for the meeting or if they will not be able to attend the meeting. There is an average of about four cases presented at each meeting, and most of these cases are new placements. The Foster Care Unit Supervisor, in discussions with her staff, determines whether for these cases there are factors that could lead to disruption if not addressed early in the foster care placement.

The meetings are facilitated by the mental health worker assigned to the foster care unit or in her absence, by the Foster Care Unit Supervisor. Moving the role of facilitation from the Supervisor to the mental health worker has freed the Supervisor to become actively involved with the discussions concerning particular children. Meetings are held at the DSS office rather than the original meeting location at the DMH office. Because of the location, foster care caseworkers can easily participate for that period of the meeting dealing with children in their caseload. Often the children being reviewed are newly placed and only known to the Transition Worker but not yet known to the foster care caseworker who assumes long-term responsibility for them while they remain in foster care. Caseworkers or foster parents concerned about a particular foster child may also refer children for review by the FCET.

The Transition Foster Care worker presents new cases. If the child is new to the FCET, a mental health assessment of the child, the foster home and the natural family is generally requested along with a physical health assessment. The mental health assessments are completed within the following two weeks by the mental health worker assigned to the foster care unit and by another mental health worker serving on the FCET who is familiar with the workings of the foster care system. The Department of Social Services contracts with Dr. Malone, a private physician in the community, to complete both a developmental and physical assessment. The findings from these assessments are presented at the next FCET meeting and help guide recommendations.

The mental health worker assigned to the Foster Care Unit prepares the minutes of each FCET meeting. The minutes help clarify who is responsible for various recommended follow-up actions and provides a means of tracking children discussed by FCET over time.

This past summer the mental health assessment component was not functioning well because of confidentiality issues raised by new federal guidelines. Now that DSS and DMH have signed an agreement concerning client confidentiality, assessments are being completed more quickly and enhancing the FCET discussions and recommendations. Updates on previously presented cases are provided when deemed appropriate by the Foster Care Unit Supervisor.

Regularly, but not at every meeting, administrative and training issues are discussed such as the following:

- Particular professional difficulties in accessing some part of the system
- The need to include a representative from another provider in a follow-up discussion of a particular child
- The need for new or modified services to address a service gap
- The need for improved communication among FCET member-providers

- Training presentations on issues relevant to FCET

An example of FCET operating in a policy and program development role was FCET identifying the need to increase the number of therapeutic foster care beds in the county. DSS responded by issuing a request for proposals (RFP) to provide eight new therapeutic foster care beds. FCET was enlisted by DSS to review six proposals submitted for this RFP. The Commissioner acted upon the recommendations developed by the FCET.

Start-Up Factors That Led to the Success of FCET as Identified in the Pat O'Connor Study of FCET.

In Pat O'Connor's study FCET members noted four critical start-up factors for the team. In Carl Valentine's study, the FCET members reiterated that these factors contributed to the success of the team

1. Support from key county officials and local providers

Three county officials, the County Executive and the DSS and DMH Commissioners were willing to support the search for alternative strategies to address the problem of excessive numbers of unplanned disruptions among children in foster care. Similarly, directors of local provider agencies supported the initiative by permitting staff to be involved in developing the new model. County staff and local providers collaborated and established an essential group of stakeholders needed for FCET success.

2. Previous success in the community with the process of collaboration

The people involved in the start-up of the FCET were generally known to each other. In this relatively small county, networks among providers are fairly well established and easy to build upon. Thus, people and organizations that had a history of working together undertook the definition of the FCET structure and its functions. For example, the DSS and DMH Commissioners had collaborated on several successful initiatives prior to the formation of FCET

3. In-kind funding from key agencies

FCET was undertaken without added funding to cover the cost of planning and implementation. Organizations supporting FCET allowed key staff to spend time developing and implementing FCET. This commitment remained in place during the first two years of FCET before there was evidence of success, and this commitment continues today. The core group is now ten people, who can call upon a broad array of specialists without requiring them to attend every meeting.

4. Leadership provided by the DMH Director of Children's Services and the DSS Foster Care Unit Supervisor

The DMH Director of Children's Services had been central in developing other collaborative efforts. Her vision of the possibility of a collaborative strategy to deal with the disruption problem and her experience in helping to lead similar cross-agency initiatives set a positive tone for the work of the FCET planning process. The Foster Care Unit Supervisor was willing to tackle the problem and take the risks of using a collaborative strategy and of opening the foster care placement process to recommendations from outside players, namely the Departments of Mental Hygiene and Health and a set of private providers. Her major goal was to improve foster care services in the county. Because of her enthusiastic support, her overworked foster care workers accepted the FCET review, which was another step added to the already complex and highly structured foster care process.

Factors that Contributed to the Successful Operations of FCET as Identified in the Pat O'Connor Study of FCET.

1. Early and ongoing focus on process

In order for FCET to succeed, the FCET team had to resolve a number of basic questions: How would a child-specific case be brought to the FCET? Who would present it? Where should the FCET meeting be located? How would recommendations be made? Who would take responsibility for ensuring access to the necessary resources? Who should be participating in the FCET meetings? How could confidentiality constraints on sharing child specific information be overcome? How would FCET members know if their recommendations had been successful in averting foster care disruptions?

As indicated in the description of the FCET process above, these questions were initially addressed by the FCET workgroup and continue to be revisited in FCET meetings and occasional FCET retreats.

2. Sufficient time to build collaborative culture

To develop any new team, particularly one that requires disparate parties to collaborate, adequate time and attention are needed. The FCET members have come to trust and respect one another's knowledge and experience.

3. Recognition of commonalities and differences in perspectives

When Pat O'Connor, the system evaluator, observed FCET meetings in 2002, she noted that representatives from DSS and DMH had difficulty communicating. Ms. O'Connor helped improve communication by developing client flow charts with the FCET for both the DSS and DMH systems.

Members were not only willing to participate in the process of constructing each of the flow charts (initially completed outside the FCET meetings), but also to explain the workings of their respective systems until they were certain that the other FCET members understood. Equally, they were willing to learn about the other's system to ensure their own understanding. The FCET discussions of the flow charts ensured that both the DSS and DMH foster care system functions were clear to everyone.

As became clear in the discussions, each system operated on very different premises and constraints:

a. **DSS.** The foster care system is encumbered with legal mandates focused on the safety of the child, timelines addressing reunification or freeing the child for adoption, court oversight, and a need for specific mental health interventions responding to court orders and tight timelines with severe sanctions when specific goals are not achieved.

b. **DMH.** The DMH child and adolescent services focus on voluntary participation by clients and regularly experience service waiting lists resulting from demands that exceed capacity to provide service. Clients choosing to participate in DMH treatment work toward particular goals, but timelines are general and driven by individual readiness to move on rather than by externally imposed timelines. Even if therapy is part of a treatment plan ordered by court action, the participants must be willing to engage in the therapeutic process.

4. Access to crisis mental health and behavior modification services

Most disruptions of foster care placements result from a crisis in the foster home or in school. If these crises can be avoided or quickly addressed when they do arise, the placement can often remain intact. In addition to the crisis support services available through behavioral health staff assigned to the foster care unit, and the DMH Child and Adolescent Unit, two crisis respite beds are available from Vanderhyden Hall, a private child-placing agency located in Rensselaer County, which has participated in the FCET process from its inception. DSS and DMH each support one of those crisis respite beds.

The substantial involvement of DMH has been central to the success of FCET. Data presented in the O'Connor study indicated that more than half of the children reviewed had mental health issues and 36 of 43 active cases reviewed documented individual and/or family therapy. Assignment of a mental health worker to the foster care unit by DSS and the provision of mental health services for foster care parents by DMH has facilitated timely and useful assessments which have contributed to the quality of the recommendations resulting from the FCET process and facilitated access to mental health services.

The hiring of the mental health worker by the DSS child welfare office has facilitated the use of MH services by the child welfare workers. Mental health services always seemed to be difficult for the child welfare worker to access – they were always at least a phone call away – at the wrong time, in the wrong place, or provided without an understanding of the child welfare process. Now child welfare workers are comfortable asking for advice and consultation from their mental health worker and from the mental health worker assigned by DMH to work with the DSS foster care unit. These mental health workers have facilitated access to mental health services for children in foster care, their families, and their foster families.

5. A sense of success in the work of the FCET

The members of the FCET team who were interviewed felt FCET was worthwhile and should be continued. They also wanted a way to determine the effectiveness of FCET. The most compelling evidence became available in fiscal year 2001 after FCET had been operating for two years. The statistics showed that in fiscal year 1999, 21 children in care less than one year had more than two foster care placements, while in fiscal year 2000, just three children in care less than one year had more than two placements. This sign of success refocused the FCET members' energies on the work of the FCET and particularly on sharing the success with those who could facilitate systemic change. The evidence of success ensured the commitment of the FCET members, giving them a sense of pride in their participation and of importance of their contributions.

Recommendations for Improving FCET

Nearly all of the recommendations identified in the Pat O'Connor study of FCET have been incorporated in the current functioning of FCET. One area requiring further consideration concerns the involvement of foster parents and biological parents in FCET discussions. Most of the FCET members interviewed explicitly recognized the importance of the participation of the foster parents and the biological parents of the children, both to increase the likelihood of stability and to facilitate permanency for the children. Both types of parents are already invited to participate in the State-mandated Service Plan Reviews occurring every six months. The Service Plan Review provides an opportunity for all participants to assess the progress of the biological parents on court-mandated goals while FCET has a more limited fundamental goal, the stability for the children in foster care. A second area concerns a tracking system to better inform the

FCET about case outcomes, e.g., the effectiveness of their recommendations in stabilizing placement.

1. Develop strategies to involve foster parents in the FCET process.

There are a number of questions to answer regarding foster parents:

- a. How can the current foster parent liaison on FCET be most effective? Should this person try to present the foster parent point of view in the discussions of each child reviewed by the FCET as she currently tries to do, or should her energies be directed at involving foster parents directly when children in their care are being reviewed?
- b. How can foster parents become informed about the role of FCET? To be effective, foster parents would need to understand that the FCET is designed to increase their effectiveness and success as foster parents.
- c. How can the time in the FCET meetings be most effectively used if foster parents attend? Clearly the direct involvement of foster parents during discussions of children in their care would both strengthen the discussion about the particular child and ensure that the foster parent understands the recommendations growing out of the discussion. As a result, the foster parent could help implement the recommendation more effectively. But attendance by foster parents at the FCET when a child in their care is being reviewed would mean that about four foster parents would need to be present at various times during each FCET meeting.
- d. What are the alternatives to foster-care parent attendance at FCET meetings?
 - Foster parents could participate by conference call from their home so they could better contribute to the discussion and learn first hand about recommendations and next steps.
 - Foster parents could receive minutes of the FCET meetings with names not related to children in their care deleted.
 - Foster parents could meet with an assigned member of FCET to review the recommendations growing out of the FCET discussion.
- e. How would the logistics be handled if foster parents attended the FCET meetings? There would need to be advance communication to allow time for foster parents to arrange their lives so they could attend. Logistic supports would also need to be provided such as child care and occasionally transportation. The cost of child care and other necessary supports would add to the cost of FCET, but it would be a very large step in helping the foster parent to become a more effective member of the treatment team and the foster care process.

2. Develop strategies to involve the biological parents of the foster children.

Currently, the biological parents are represented by a client advocate on the FCET, but this representation has not been central to the FCET process. Biological parents are present for the six-month Service Plan Reviews. The direct involvement of the biological parents in the FCET process would complicate the logistics of the process to the point where its effectiveness would be severely compromised. An alternative might be the convening of a meeting involving biological parents when the FCET determines that such a meeting would be an important component of a plan to stabilize the placement. In most cases biological-parents should be informed of the meeting and the meeting results.

3. Develop a process for assessing the effectiveness of FCET in stabilizing foster care placements and improving outcomes for children involved.

At present there are two ways that information is collected on FCET:

- FCET minutes provide updates of previously discussed cases.
- Data are gathered for the national stability rating indicator. This gross measurement does not directly tie back to the children reviewed by FCET and the extent to which recommendations resulting from this review are implemented.

Data need to be collected that would measure the effectiveness of FCET and that would provide detail on the barriers that FCET recommendations encounter. This information could provide guidance for FCET on the effectiveness of their recommendations and the capacity of the service delivery system to implement them in a timely manner. Resources to undertake such a study might be drawn from a partnership with a local college or university. Under the guidance of a research professor, students could complete this work.

4. Bill federal entitlement programs (Title IV-E or Medicaid) for direct services provided by the FCET process.

Clinical staff assigned to FCET are not billing Medicaid for the direct services provided as a part of the FCET process because their services are supported by State grants. Nearly all children in foster care are Medicaid recipients. If Rensselaer County claimed the mental health services provided as part of the FCET, revenue for the project would be increased, grant funds would be saved, and program administrators would have a better understanding of the extent to which the project could be self-supporting when the grant funds are no longer available.

Savings Realized by the County, by the State, and by the Federal Government as a Result of FCET

National studies of foster care have documented that children who are disrupted from a family foster care placement are often subsequently placed in more restrictive placements such as a group home, child caring institution, or psychiatric hospital. Each of these settings is more costly than family foster care for the county. According to information provided to Carl Valentine in interviews of staff of the Office of Children and Family Services and the Council of Family and Child Caring Agencies, the average cost of family foster care was about \$13 per day and the average cost for purchased private foster care in the capitol district was about \$160/day in 1999.

Data clearly show that Rensselaer County dramatically reduced the number of foster care disruptions from 21 in fiscal year 1999 to just three in each fiscal year 2000 and 2001. If the average length of stay was nine months and the average cost of family foster care was \$13/day and the average cost for purchased care was \$160/day, and it is assumed that children being disrupted from family foster care were placed in purchased private foster care (primarily institutional), FCET's methods resulted in a saving of nearly \$725,000 (18 children x [\$160 - \$13] per day x 274 days per year) for Rensselaer County annually. About one third of this saving was a direct saving to the county, the remainder was reflected in State and federal savings.

Conclusions About the Successes of FCET

The following conclusions about Rensselaer County can be drawn from the evidence obtained during Pat O'Connor's and Carl Valentine's studies:

1. Central to the success of FCET has been the substantial involvement of mental health services. Data presented in the O'Connor study indicates that more than half of the children reviewed had mental health issues and 36 of the 43 active cases reviewed documented individual and family therapy. Foster children and their families in Rensselaer County have benefited from access to mental health services such as timely assessments, crisis services, and consultations.
 - a. Assignment of a mental health worker to the foster care unit by DSS and the provision of mental health services for foster care parents by DMH has facilitated timely and useful assessments. These assessments have contributed to the quality of the FCET recommendations and facilitated access to mental health services and rapid crisis interventions.
 - b. The location of the mental health worker in the DSS child welfare office has improved the relationship of DSS child welfare and mental health services. Now instead of being a phone call away, the child welfare workers can ask advice or obtain consultation from the co-located mental health worker.
2. FCET reduced the number of foster care child placement disruptions.

3. There has been an improved relationship and cooperation between agencies in Rensselaer County, which has helped FCET do its job. DMH and DSS have provided leadership and all FCET participants have provided in-kind funding.
4. Members of the FCET team have recognized their differences and have spent time on understanding the processes of each agency.
5. In Rensselaer County, the cost of foster care has been reduced in the last five years by avoiding expensive specialized care purchased from private providers.

Summary of Recommendations for FCET

1. Strategies need to be developed to involve foster parents and biological parents in the FCET process
2. Data needs to be collected that would measure the effectiveness of FCET and that would provide detail on the barriers that FCET recommendations encounter.
3. Sources of revenue for FCET should be tapped such as billing Medicaid for mental health services for foster care children and their family.

Summary of a General Procedure for Developing an FCET Process in a County

1. Seek enthusiastic leadership from such individuals as the DMH Director of Children's Services and the DSS Foster Care Unit Supervisor. This leadership is vital to the success of any team.
2. Develop a team of stakeholders from the county Department of Mental Hygiene (DMH), Department of Health (DH) and Department of Social Services (DSS), and local private child placement agencies to explore alternatives to the existing system. This team will work best if these groups have worked together collaboratively in the past. If collaboration and relationships need improvement, seek outside help.
3. Obtain funding and support from sources such as the following
 - A grant from the State Office of Mental Retardation and Developmental Disabilities to support a clinician who would split her time between two functions: (1) support of the FCET and (2) work with children under five at risk of developmental disability and work with their families
 - A grant from the State Office of Mental Health to support a set of activities such as the following if they are needed:
 - A part time clinician to work with foster parents

- Clinical consultation to assist with adoptions
 - Funding to support an annual foster parent enrichment day
 - A therapeutic visitation room at DSS
 - Assistance in the recruitment of foster parents
 - Development of therapeutic tools for working with foster children requiring mental health services.
- Organizations supporting FCET by allowing key staff to spend time developing and implementing FCET.

4. The FCET meetings should have the following general characteristics:

- a. **Agenda Preparation.** The mental health worker who supports foster care services reviews with the Foster Care Unit Supervisor the cases of children to present at the upcoming FCET meeting, prepares an agenda, structures the case presentations, and notifies foster care case workers and other key individuals of the meeting agenda. Most of the four cases presented at each meeting are new placements. The Foster Care Unit Supervisor, in discussions with staff, determines whether for these cases there are factors that could lead to disruption if not addressed early in the foster care placement.
- b. **Timing.** Biweekly meetings of the FCET team should be held, usually for the fully planned 90 minutes. Meetings should begin on time, and participants should call if they are going to be late or if they will not be able to attend the meeting.
- c. **Facilitator.** The meetings should be facilitated by the mental health worker assigned to the foster care unit or in her absence, by the Foster Care Unit Supervisor. Moving the role of facilitation from the Supervisor to the mental health worker frees the Supervisor to become actively involved with the discussions concerning particular children.
- d. **Location of Meetings.** Typically the meetings should be held at the DSS office. Because of the location, foster care caseworkers can easily participate for that period of the meeting dealing with children in their caseload. Typically the children being reviewed are newly placed and only known to the Transition Worker but not yet known to the foster care caseworker who assumes long- term responsibility for them while they remain in foster care. Caseworkers or foster parents concerned about a particular foster child may also refer children for review by the FCET.

- e. **Agenda.** The Transition Foster Care worker can present new cases. If the child is new to the FCET, a mental health assessment of the child, the foster home and the natural family is generally requested along with a physical health assessment. The mental health assessments should be completed within the following two weeks by the mental health worker assigned to the foster care unit and by another mental health worker serving on the FCET who is familiar with the workings of the foster care system. The Department of Social Services needs to have completed both a developmental and physical assessment during the initial two week period. The findings from these assessments can be presented at the next FCET meeting and help guide recommendations.

Regularly, but not at every meeting, administrative and training issues can be discussed such as the following:

- Particular professional difficulties in accessing some part of the system
 - The need to include a representative from another provider in a follow-up discussion of a particular child
 - The need for new or modified services to address a service gap
 - The need for improved communication among FCET member-providers
 - Training presentations on issues relevant to FCET
- f. **Minutes.** The mental health worker assigned to the Foster Care Unit prepares minutes of each FCET meeting. The minutes help clarify who is responsible for various recommended follow-up actions and provides a means of tracking children discussed by FCET over time.
- g. **Client Confidentiality.** Be sure there is an agreement concerning client confidentiality among participating organizations.
5. Take time to build a collaborative culture. Recognize commonalities and differences. Develop flow charts showing how each part of the system works. Take time to talk about how each service system works.
 6. Obtain access to crisis mental health and behavior modification services. Most disruptions of foster care placements result from a crisis in the foster home or in school. If these crises can be avoided or quickly addressed when they do arise, the placement can often remain intact.
 7. Develop strategies to involve foster and biological parents in the FCET process.
 8. Develop a process for assessing the effectiveness of FCET in stabilizing foster care placements and improving outcomes for children involved.