Caregiver Core Training – Participant Manual

Welcome to Caregiver Core Training. There are a variety of reasons why you may have decided to attend this class. Some of you want to foster children, some are relatives wanting to care for a family member, and others have the intention to adopt, or to provide respite. Regardless of your reasons, what you all have in common is that you are willing to open your hearts and homes to a child, or children, in need of caregiving. Therefore, this training is designed to provide families with a foundation to begin the process of acquiring the knowledge and skills you will need to be a caregiver for children who have been removed from their homes due to child abuse and neglect.

The 24-hour Caregiver Core Training is made up of 8 sessions, with a break in the middle for a field experience.
Overview

Sessions 1-4
The first four sessions are designed to help you understand the Child Welfare System: its rules and language and your role as part of the team surrounding and supporting the children in care. Sessions 1-4 also includes cultural considerations and how race/ethnicity and culture can influence how we connect with children.

Field Experience
Between Session 4 and Session 5 participants have the opportunity to learn outside the classroom by choosing an activity that will give them more awareness of the experience of children within the system or of the role of a caregiver for children in the system.

Sessions 5-8
The second set of four sessions focuses primarily on understanding a basic framework for parenting children in out-of-home care. These sessions cover attachment, trauma, grief and loss; their connection to behavior and how to manage it; and communication and crisis management. The training concludes with the nuts and bolts of getting your family and home ready, as well as the voices of former foster youth and caregivers.

Completion of Caregiver Core Training
It is not our expectation that you will be perfect caregivers by the end of this training. Caregiver Core Training represents just the beginning of your educational process. It is our hope that by the end of these classes, you have enough information to make a decision about whether this role is right for you and your family, and that you have enough information to get started. Once you are licensed, you will be required to complete 36 hours of Continuing Education in your first 3 years (12 hours/year), 30 hours during the following 3-year cycle, and 24 hours per 3-year cycle from that point forward.

We encourage you to begin taking your next trainings while you wait for your license to be completed, which will likely take 90 days, and longer in some areas. Up to 12 hours can count toward your requirements before you are licensed. Once you are licensed, you can carry up to 12 hours over into your next licensing cycle.

We strongly encourage you to deepen your knowledge and skills through additional training because it will help prepare you for your journey, and once you have a child placed in your home, it will become more challenging to schedule your time.

Thank you for being here, for participating and for taking the time to learn together.
Acknowledgments

The Caregiver Core Training curriculum was designed, reviewed, and revised by a committee and active group of people over the course of several years, and two versions. We want to graciously thank the following individuals for participating in one or more revisions.

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- Julie A. Kerr, Foster and Adoptive Parent, Co-Trainer with the Alliance for Child Welfare Excellence
- Kids in the House
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- Mississippi: Administrative Office of Courts
- Native American Family, Children and Family Services: Extending our Families Through Unity
- New Mexico: Resource and Adoptive Family Training (RAFT), Southwest Institute for Family and Child Advocacy, NMSU School of Social Work and CYFD Protective Services
- Ohio Child Welfare Training Program, Pre-Service Courses for Foster, Adoptive and Kinship Caregivers
- Tennessee: Parents as Tender Healers (PATH), Department of Children Services, Resource Parent Development
- Washington State Department of Social and Health Services

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- Alberta Family Wellness Initiative: “Brain Builders”
- Championship Newsletter: “Growth Mindset: A Study on Praise and Mindsets”
- Children's Administration, WA DSHS: “Birth Parents” and “Check Yourself”
- Dir. John M. Chu: “Silent Beats”
- Circle of Security International: “Circle of Security (Connection and Support)”
- College Success Foundation: “Foster Care to College”
- Josh Shipp Productions, LLC d/b/a Brilliant Partners: “Every Kid Is ONE Caring Adult away from Being a Success Story”
Acknowledgments, Continued

- Jillian Lauren and Kristen Howerton: “$#!+ People Say to Foster Parents” and “#$%@ People Say to Transracial Families”
- Dir. Nathaniel Matanick, Heschle Video Production: “ReMoved”
- National Center on Shaken Baby Syndrome: “The Period of PURPLE Crying”
- National Council of Juvenile and Family Court Judges: “Bringing Our Children Home”
- Zero to Three: “Zero to Three”
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Caregiver Core Training – Participant Manual

Session 1: Introduction to the Child Welfare System

This session will focus on an Introduction to the Child Welfare System. We will define child abuse and neglect, talk about how kids come into care and the intake process, what goes on inside of the mind of a social worker as they make their decisions, legal authority, court, a concept called concurrent planning and the necessary requirements before a child is eligible for adoption.
Session 1: Introduction to the Child Welfare System

Topics covered in Session 1

- Introduction to Class
- Life of a Case – Intake through Permanency
- The Experience of Separation from the Child’s Point of View
- Life of a Case – Legal Authority and Concurrent Planning
- $#!+ People Say to Foster Parents

Competencies covered in Session 1

CCW101-01  Awareness of the foster care system, including but not limited to, the primary goals of Child Welfare Services and the Indian Child Welfare Act.

CCW101-02  Awareness of a child’s journey through care based on legal/judicial processes and Child Welfare agency policies and procedures.

CCW101-03  Awareness of the process and procedures for investigating allegations about foster care rule violations or maltreatment of children in foster care (DLR-CPS).

CCW101-04  Awareness of the laws that define Child Abuse/Neglect.

CCW101-05  Awareness of how and when to report critical incidents to Children’s Administration and/or seek emergency assistance through 911 if a child is injured, seriously ill, or in danger etc.

CCW102-04  Awareness of the primary goals of child welfare services, and the types of services that can help abused and neglected children and their families.

CCW103-02  Awareness that reunification is the primary goal of Child Welfare Services.

CCW103-04  Awareness that adoption may become an option for the caregiving family.

CFAM131-04  Awareness of the risk factors that may contribute to Child Abuse/Neglect.

Begin Session 1
Beliefs and Attitudes Survey  
Children & Families in the Child Protective Services System

This is not a test and there will not be a grade. This quick survey is intended to focus our thinking on our beliefs and attitudes about the children and families in the child protective services system. Take a moment to respond to the following statements. When you agree, check the box for “Agree”; if you don’t know, aren’t sure or cannot commit, select the box for “Not sure”; and if you disagree, select the box for “Disagree”.

Foster children will be easy to please because they will be relieved to be in a safe home.  
Agree □  Not sure □  Disagree □

Providing a foster home is a way to rescue a child from a difficult situation.  
Agree □  Not sure □  Disagree □

Parents who abuse their children do not love them.  
Agree □  Not sure □  Disagree □

Fostering a child is a good way to adopt a child.  
Agree □  Not sure □  Disagree □

Most children who go into foster care never go home.  
Agree □  Not sure □  Disagree □

Most children come into foster care because their parents physically abuse them.  
Agree □  Not sure □  Disagree □

Foster parents can provide a better life for a foster child than the child’s parent can.  
Agree □  Not sure □  Disagree □

Parents that abuse their children have to prove themselves to get their child back.  
Agree □  Not sure □  Disagree □

Parents of children in foster care are really different from most people in the community.  
Agree □  Not sure □  Disagree □

I have a lot in common with the children and the parents in the foster care system.  
Agree □  Not sure □  Disagree □

Parents should earn the privilege of visiting their children in foster care.  
Agree □  Not sure □  Disagree □
Caregiver Training
Depth of Knowledge and Skills

**You are encouraged to take up to 12 hours of CCE between the time you submit your application and you receive your license, as these hours will carry over to your first 3-year licensing period. Additionally, you may carry 12 hours of CCE from one licensing period over to the next licensing period.**

**During the first 3-year licensing period, you must take at least one training from each category, and at least one of these must be culturally-based.**
Training Passport: Caregiver Core Training

It is the participant’s responsibility to bring this Training Passport to all sessions. Trainer will date and initial to verify participant’s attendance. Participants must complete Sessions 1-4 before continuing to Sessions 5-8. When all of the Sessions and the Field Experience are complete, a Certificate will be issued.

Name: 
Address: 
Phone Number: 
Email Address: 

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<th>Date</th>
<th>Session</th>
<th>Trainer’s Signature</th>
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<td>4: Cultural Connections and Advocacy</td>
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<td>Field Experience:</td>
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<td>8: Getting Ready and the Effects on the Caregiving Family</td>
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History of Child Welfare

1853  **Children’s Aid Society of New York County**: first type of “foster care” evolved. Not foster care for abused and/or neglected children; foster care for orphans and children of poverty whose parents could not afford to keep them.

1854  **Orphan Trains began**: Orphan children were escorted to the Midwest on “orphan trains” to be adopted.

Although many children found loving families, there were also many who were “adopted” by families just to be used as an unpaid hired-hand, and were never seen as members of the family.

1874  **Case of Mary Ellen: first recorded case of child abuse/neglect**
Mary Ellen was frequently mistreated by her caregiver. Neighbors were concerned and told a local visiting nurse. When the nurse saw her, she had bruises, cuts, lacerations, torn clothing and matted hair. However, there were no laws to protect children, or that made mistreating a child a crime even though it, it was a crime to mistreat animals. An attorney for the Society for the Prevention of Cruelty to Animals argued Mary Ellen’s case in court, seeking safety and shelter for her under the anti-animal cruelty laws. This was the beginning of legal protection for children.

1875  **New York Society for the Prevention of Cruelty to Children was formed**
The first organization of its kind; founded due to the publicity of the case of Mary Ellen.

1877  **Charity Organization Society**: “Friendly visitors” were the forerunners of modern day social workers

They tended to be ladies of social status who visited poor families in an attempt to help them (though rarely financially)

1881  **Anti-Cruelty Act**: prohibited certain forms of child maltreatment
1887 US policy shifted from physical genocide of Native Americans to cultural genocide. “Kill the Indian, and save the man” (Capt. Richard H. Pratt, 1892, on the education of Native Americans.)

The federal government attempted to “Americanize” Native Americans through the education of Native youth. By 1900, thousands of Native American children were placed in boarding schools around the US in an attempt to “Americanize” them by denying them their cultural ties.

1935 Social Security Act: shifted the emphasis from “rescuing” children from poverty stricken families to keeping them at home by providing financial support to low-income families.

1959 – 1967 The Indian Adoption Project: attempted to assimilate Native children into the mainstream culture through the widespread use of adoption. Native children were removed from their parents, families and tribes, and placed with Caucasian families for adoption.

1962 Dr. Kempe wrote about the “battered child syndrome”
Brought the issue of child abuse out in the open.

1964 First CPS unit (to investigate allegations of child abuse and neglect) was formed in New York
Prior to this, there were generic social workers. After Dr. Kempe’s description of battered children, it was decided that some social workers would specialize in working with families of child abuse.

1969 Washington state created its first CPS units; a mandatory reporting law was enacted.

1978 Congress passed the Indian Child Welfare Act (ICWA): increased tribal control over state foster care placements of Indian children to decrease the placement of Indian children outside of their native culture.
History of Child Welfare, Continued

1986  **On-going training for licensed foster parents in Washington State is offered**
This was in direct response to the 1985 passage of a bill that forbade the spanking of children in the foster care system. On-going training for all licensed foster parents is now a requirement. There are classes offered on all kinds of subjects specific to the children you are parenting and designed to best help you.

1987  **Training for Washington state CA social workers is mandated**
Formalized training existed prior to this; however, it was voluntary, and sometimes discouraged by supervisors who needed the workers in the field.

1988  **Washington State passes a Permanency Planning law**
Understanding that children need permanence, and that foster care is impermanent, and should be short-term and goal-oriented, this law was passed to set standards for how long children should remain in care before other permanent options, like adoption, were pursued. (Note: these actual time-frames have changed many times, and will be discussed later).

1994  **Multi-Ethnic Placement Act (MEPA):** federal legislation that states that race cannot be the sole factor in determining the placement and/or adoptive decision for a child.

1997  **Adoption and Safe Families Act (ASFA):** federal legislation to establish the goals of safety, permanence and well-being for all children in the child welfare system. For the first time in US history, this law set common outcome objectives for all child welfare. Sort of a federal Permanency Planning law. This law is intended to ensure that children across the country do not enter the foster care system and then remain wards of the state until they age out at 18. All children deserve a family. If they cannot be reunified with their own family within the specified timelines than other options are pursued.

1999  **Foster Care Independence Act (Chafee Act):** provides funds to states to assist youth and young adults (ages 16 - 21) aging out of the foster care system to make a smoother and more successful transition to living independently.

Referred to in our state as the “Independent Living Program,” this was act was designed to ensure that young people involved in the foster care system get the tools they need to make the most of their lives.
History of Child Welfare, Continued

2000  **Child and Family Services Review (CFSR):** provides a framework in which states are evaluated on outcomes that are set by the federal government. Standardized some areas of the foster care system throughout the country.

2013  **Extended Foster Care Program in Washington State:** provides on-going foster care from age 18 to 21 for dependents of the state who are enrolled in school (high school, GED, vocational school or college) or a program designed to remove barriers to employment.
Washington State WAC 388-15-009
Definitions of Child Abuse and Neglect

**Child abuse or neglect:** “the injury, sexual abuse, or sexual exploitation of a child by any person under circumstances which indicate that the child’s health, welfare, or safety is harmed; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child.” An abused child is a child who has been subjected to child abuse or neglect as defined by this definition.

**Physical abuse** means the non-accidental infliction of physical injury or physical mistreatment on a child. Physical abuse includes, but is not limited to, such actions as:
- Throwing, kicking, burning or cutting a child
- Striking a child with a closed fist
- Shaking a child under age three
- Interfering with a child’s breathing
- Threatening a child with a deadly weapon
- Doing any other act that is likely to cause (or does cause) bodily harm greater than transient pain or minor temporary marks; or which is injurious to the child’s health, welfare or safety

**Sexual abuse** means the intentional touching, either directly or through the clothing, of the sexual parts of a child; or allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in touching the sexual parts of another for the purpose of sexual gratification (of the person, the child or a third party).

**Sexual exploitation** includes, but is not limited to, such actions as allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in: prostitution; the production or transmission of pornography; or sexually explicit, obscene or pornographic activity as part of a live performance for the benefit or sexual gratification of another person.

**Negligent treatment** or maltreatment means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the consequences to the child of such magnitude that it creates a clear and present danger to the child's health, welfare, or safety. Negligent treatment or maltreatment includes, but is not limited to:
- Failure to provide adequate food, shelter, clothing, supervision, or health care necessary for a child's health, welfare, or safety. Poverty and/or homelessness do not constitute negligent treatment or maltreatment in and of themselves
Definitions of Child Abuse and Neglect

- Actions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child
- The cumulative effects of a pattern of conduct, behavior or inaction by a parent or guardian in providing for the physical, emotional and developmental needs of a child's, or the effects of chronic failure on the part of a parent or guardian to perform basic parental functions, obligations, and duties, when the result is to cause injury or create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child

Child Abandonment: A parent or guardian abandons a child when the parent or guardian is responsible for the care, education, or support of a child and: leaves the child without the means or ability to obtain one or more of the basic necessities of life such as food, water, shelter, clothing, hygiene, and medically necessary health care; or forgoes for an extended period of time parental rights, functions, duties and obligations despite an ability to exercise such rights, duties, and obligations. (Incarceration of a parent or guardian does not constitute abandonment in and of itself).
Adoption

Introduction
In 2013 there were 1316 adoptions of children in custody of Washington State's Department of Social and Health Services (DSHS), with more children still awaiting adoptive homes.

The purpose of the adoption program is to meet the permanency needs of children who are in the care and custody of DSHS. DSHS strives to find safe and stable families that can best meet the needs of the child.

Questions to Ask Yourself
Thinking about adoption is the beginning of the process. Below is a list of questions to help prepare yourself.

- Do I want to adopt a boy or girl?
- What age of child am I looking for?
- Am I interested in adopting a sibling group?
- Would I consider adopting a sibling group in order to get the age of child I am interested in?
- Would I be willing to have on-going contact (open communication) with a child's birth parents?
- Could I parent a child who may have been sexually abused, physically abused and/or neglected?
- Could I parent a child that has an on-going medical issue, may be developmentally delayed, or diagnosed with a developmental disability?
- Could I parent a child who may have been exposed to drugs and alcohol in utero?
- Does the ethnicity of the child I adopt matter?
- How does my extended family feel about adoption?
- If I did adopt a child of a different ethnicity than myself how would my family feel?
- How am I going to handle adoption-related questions that my child may ask?
Adoption, Continued

Responsibilities

<table>
<thead>
<tr>
<th>Foster Parents</th>
<th>Adoptive Parents</th>
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<tr>
<td>• Provide daily care and nurturing of children in foster care.</td>
<td>• Provide permanent homes and a lifelong commitment to children into adulthood and beyond.</td>
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<td>• Advocate for children in their schools and communities.</td>
<td>• Provide for the short-term and long-term needs of children.</td>
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<td>• Inform the children's caseworkers about adjustments to the home, school, and community, as well as any problems that may arise, including any serious illnesses, accidents, or serious occurrences involving the foster children or their own families.</td>
<td>• Provide for children's emotional, mental, physical, social, educational, and cultural needs, according to each child's developmental age and growth.</td>
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<tr>
<td>• Make efforts as team members with children's caseworkers towards reunifying children with their birth families.</td>
<td>• May become certified as a foster family and accept children who are not legally free for adoption, but whose permanency plan is adoption.</td>
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<td>• Provide a positive role model to birth families.</td>
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<td>• Help children learn life skills.</td>
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Open Communication

Open communication agreements allow contact between the adoptive parents and birth parents. In some instances there is also contact allowed between birth parents and the adopted child. The frequency of contact is negotiated and communication may include letters, e-mails, telephone calls, or visits. It is important to note that even in an open adoption, the legal relationship between a birth parent and child is severed. The adoptive parents are the legal parents of an adopted child.

The goals of open adoption are:

• To minimize the child's loss of relationships
• To maintain and celebrate the adopted child's connections with all the important people in his or her life
• To allow the child to resolve losses with truth, rather than the fantasy adopted children often create when no information or contact with their birth family is available
Adoption, Continued

Types of Children
Children available for adoption through DSHS reside in foster care or relative care and are unable to be reunited with their birth parents. Children placed in out-of-home care may have been abused (physical/sexual) and/or neglected. As with all children, the children in out-of-home care:

- Range in age
- Include both boys and girls
- May be part of a sibling group (2 or more)
- Represent diverse ethnic and cultural populations
- May have medical, mental and/or physical health issues
- May have developmental delays
- May have developmental disabilities
- May have been exposed to drug and alcohol use/abuse

Types of Adoption

Private adoption
The children available for adoption from private adoption agencies are:

- Healthy infants and young children
- Children from other countries
- Special needs children
- Children placed in foster care

Independent adoption
The children available for adoption from independent adoption agencies are:

- Healthy infants
- Step-children
- Children from other countries
- Relative adoptions
- Other non-agency placements

Adoption Issues
Adopted children may grow up not knowing many things that others take for granted. For instance, who their birth parents are, who they look like. Are their parents right or left-handed? These are often unanswered questions that leave blanks in the history of their life.
Adoption, Continued

Adopted children often have mixed feelings about who they are. They may wonder:

- Who are my birth parents?
- Did my birth parents love me?
- Did I do something wrong?
- Why didn't my parents keep me?
- Was I a bad child?
- If I was good would you have kept me?
- What do my birth parents look like?
- Who do I look like?
- Where did these feet come from?
- How come I have red hair and no one else in the family does?
- How come my siblings seem to grasp things quickly and I can barely get my homework done?
- If you can choose to have me then you can choose to get rid of me.
- Who do I really belong to?
- Who am I?

These questions and feelings are part of the child's lifelong developmental process. Adoptive parents need to address these issues with their children.

Talking to Your Child about Adoption

You may have mixed feelings about telling your child they were adopted. Some families choose not to tell their child, while others go to the extreme of letting them know on a continual basis. Research indicates that the best solution is a combination of the two extremes.

Children who are adopted, even infants and young children, have an intrinsic sense that there is something different about them. From infancy on, they experience feelings of grief and loss over parents they did or did not know. Your child needs to know that they were adopted, but not make it a central focus. Children need to know that they are loved unconditionally, and you aren't going to leave them. They need their feelings validated and to know that it is okay to grieve the loss of the unknown.

Because adoption is a lifelong developmental process, adoption issues never completely go away. For example, the adult adoptee preparing to start a family may experience pangs of uncertainty about an unknown medical history. It is because of this that adoptees should know that they were adopted in a thoughtful and planned manner. What a five-year-old needs to know about adoption is different from a 12-year-old.
Adoption, Continued

The following book provides an eye-opening look at developmental stages from infancy to late adulthood:

- **Being Adopted: The Lifelong Search for Self**, By David M. Brodzinsky Ph.D., Marshall D. Schechter M.D., Robin Marantz Henig

### Cost

Many people who consider adoption are concerned with the financial costs associated with the adoption process and the many services which children with special needs may require.

The costs of adopting a child from the public foster care system are typically kept to a bare minimum and may be eligible for reimbursement. Incurred costs are generally limited to:

- Attorney fees
- Adoption home studies (if completed by someone other than DSHS)

Private adoption ranges from $4,000 to $40,000.

### Resources Available to Provide Families with Financial Assistance

#### Adoption Subsidy

Families adopting special needs children through the public welfare system may qualify for adoption subsidy, a negotiated monthly cash payment provided to adoptive families to help pay for some of the expense involved in raising a child with special needs. See the [Adoption Support Program](https://www.dshs.wa.gov/CA) at www.dshs.wa.gov/CA.

#### Non-Recurring Adoption Expense Reimbursement

Before finalizing the adoption of a child with special needs from the public child welfare system, families may apply for reimbursement of adoption costs. Maximum reimbursable costs are $1500.00 per child. See [Adoption Support Program](https://www.dshs.wa.gov/CA).

#### Medicaid

All children participating in the [Adoption Support Program](https://www.dshs.wa.gov/CA) are eligible to receive medical and dental services through Medicaid.

#### Federal Tax Credit

You may be able to take a tax credit of up to $10,160 for qualifying expenses paid to adopt an eligible child. The adoption credit is an amount that you subtract from your tax liability.
Adoption, Continued

To find information about tax rules and changes to those rules, you can link to the Internal Revenue Website at www.irs.gov for information about the IRS Adoption Taxpayer Identification Number, and for Publication 968 on the Adoption Tax Credit and Tax Exclusion.

Employer Benefits

Many employers provide a range of benefits for families who adopt (including paid or unpaid leave when a child arrives in the home, reimbursement of some portion of adoption expenses, assistance with adoption information and referral services, etc.). Corporate human resource departments will provide employees with information if benefits are available.
Financial Assistance

While foster parents must have a regular source of income to meet their families' needs, financial assistance is available to help with the costs of caring for a foster child.

Foster Care Reimbursement

Foster care maintenance payments are intended to assist licensed foster parents in meeting the needs of the foster child in their care. A basic rate payment (Level 1) is paid to all foster parents for costs related to food, clothing, shelter, and personal incidentals. In addition, there are three levels of supplemental payments (Levels 2, 3 and 4) which are paid to foster parents who care for children with varying degrees of physical, mental, behavioral or emotional conditions that require increased effort, care or supervision that are above the needs of a typically developing child.

<table>
<thead>
<tr>
<th>AGE OF CHILD</th>
<th>BASIC</th>
<th>LEVEL II (includes Basic Rate)</th>
<th>LEVEL III (includes Basic Rate)</th>
<th>LEVEL IV (includes Basic Rate)</th>
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<tr>
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<td>$1,085.51</td>
<td>$1,364.30</td>
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<tr>
<td>6 to 11 Years</td>
<td>$683.00</td>
<td>$860.92</td>
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<tr>
<td>12 &amp; Older</td>
<td>$703.00</td>
<td>$880.92</td>
<td>$1,226.51</td>
<td>$1,505.30</td>
</tr>
</tbody>
</table>

Child Care Costs

Payment for child care during a foster parent’s work hours is available for caregivers with part time or full time employment. If the family is a two parent caregiver family, child care is covered when both parents are employed and working out of the home simultaneously leaving no caregiver at home to care for the child.

Medical and Dental

Every foster child receives medical and dental coverage while in foster care.
Financial Assistance, Continued

Clothing Vouchers for Children in Out of Home Care (Licensed and Un-Licensed)

$200 clothing vouchers will be authorized for children placed by Children’s Administration at initial placement whether the child is placed in a licensed foster home or with an unlicensed caregiver. Additional clothing vouchers up to $200 may be authorized, not to exceed one time per year after initial placement, when there is an exceptional clothing need. Examples of an exceptional need include:

- The child’s clothing being destroyed
- A significant growth spurt
- A medical condition that requires additional clothing

Exceptional clothing needs can be approved if there is no other local community resources available and the need cannot be met through the clothing allowance provided in the monthly foster care payment (for those licensed). (See above)

Foster Care Respite

Respite care is the temporary, time-limited relief for substitute parenting of a child. Respite care can be arranged in advance or on an emergency basis.

It is the policy of Children’s Administration (CA) to provide paid respite services to licensed Relative Caregivers and Foster Parents of children in paid CA foster care. This policy also provides paid respite services to include unlicensed Relative Caregivers of CA placed children when placements are at risk of disruption.

Respite care that is provided outside of the child’s caregiver’s home must be provided by licensed Foster Parent(s) or licensed child care provider(s) only. Licensed child care providers can only be utilized if the respite care is for less than 24 hours.

Unlicensed respite providers can provide respite services in the child’s caregiver’s home only.

Retention Respite:

- Is intended to provide regular, monthly breaks from the responsibilities of foster parenting. It can be saved for scheduled vacations or can be used for emergency situations (such as an illness or death of a family member)
- Is awarded on a monthly basis at a rate of two days per month
- Is authorized in daily units only – not hourly or half-day units
- May be “banked” to a maximum of 14 days to be used all at once (However, it is encouraged that Foster Parents use respite as it is earned.)
Financial Assistance, Continued

Newly licensed foster parents have a 30 day waiting period from the first eligible child placement before accruing respite.

A foster family must provide foster care to one or more children at least 20 days in a month to earn respite for that month.

Relative Guardianship Assistance Program (RGAP)

The federal Fostering Connections to Success and Increasing Adoptions Act of 2008 aided states in establishing a subsidized program for relative guardianships of dependent children in out-of-home-care.

RGAP is:

- A program that offers subsidies to licensed relatives of a dependent child who has resided in the relative’s home for 6 consecutive months
- A permanent plan option if return home and adoption have been ruled out
- Not a permanent plan for children who are already legally free
- Available for children placed with an eligible sibling (For example, one is placed with a licensed relative; a half-sibling enters care, who is not related to the relative caregiver.)

If a child is considered Indian (as defined by the Indian Child Welfare Act manual) a subsidized guardianship may occur if:

- The tribe(s) is involved and requesting a subsidized guardianship
- The tribe is involved through concurrent or exclusive jurisdiction

An RGAP contract is individually negotiated between CA and the relative guardians. The contract may include:

- A monthly subsidy (not to exceed the amount of a foster care payment)
- Non-recurring costs (up to $1,500 per child) to finalize the Relative Guardianship plan
- Medical coverage

When a guardianship is established, CA will dismiss the dependency and no longer provide case management our other services.
Acronyms and Definitions

**AA (Area Administrator):** Social worker reports to a supervisor; supervisor reports to the AA; the AA reports to the Regional Administrator.

**AAG (Assistant Attorney General):** The legal representative of the State in court hearings related to dependency petitions and TPR petitions.

**ADD (Attention Deficit Disorder)**

**ADHD (Attention Deficit/Hyperactivity Disorder)**

**Alcohol Effected Infant:** A child aged birth through 12 months who was exposed to alcohol in utero and may demonstrate physical, behavioral or cognitive signs which may be attributed to alcohol exposure.

**Allegation:** A formal accusation made regarding alleged abuse and/or neglect of a child.

**Alliance for Child Welfare Excellence:** A program through the University of Washington, School of Social Work, that provides training for foster parents, adoptive parents and relative caregivers.

**BCCU (Background Check Central Unit)**

**BRS (Behavior Rehabilitation Services):** A comprehensive program of positive behavioral support and environmental structure in a supervised group or family living setting. Resources are designed to modify a child’s behavior or to appropriately care for a child’s intensive medical condition. Services are tailored to each child’s needs and offered in the least restrictive setting possible.

**Bi-polar Disorder:** A mental health condition characterized by mood swings between mania and depression.

**Becca Bill:** A Washington state law related to truancy and mandatory school attendance.

**CA (Children’s Administration):** The cluster of programs within DSHS responsible for the provision of child welfare, child protection, foster care licensing and other services to children and their families.

**CA/N (Child Abuse and Neglect)**
Acronyms and Definitions, Continued

**CASA (Court Appointed Special Advocate):** A representative appointed by a Judge to speak on behalf of an abused or neglected child in court. The CASA uses information from meetings with the child and caregiver, and case staffings, to present the best interest of the child in court.

**CCE (Caregiver Continuing Education):** Training or education required of licensed caregivers.

**CCT (Caregiver Core Training):** Training required prior to becoming a licensed foster parent.

**CFWS (Child and Family Welfare Services):** A program of CA. CFWS social workers provide ongoing case management to children who are dependents of the Court, or whose families voluntarily accept such services.

**CHET (Child Health and Education Tracking):** A screening and assessment program of DCFS. The CHET program screens all children within the first 30 days of initial placement out of home. The screening looks at a child’s total well-being, including physical health, development, education, emotional/behavioral issues and connections to family and community.

**CHINS (Child in Need of Services)**

**CPA (Child Placing Agency):** A private agency licensed and contracted by the state to certify foster homes. CPAs offer licensing services, case management and placement services.

**CPS (Child Protective Services):** A program of CA. CPS social workers investigate allegations of abuse and/or neglect of children in their own homes.

**CPT (Child Protection Team):** An advisory group of community members who meet to provide consultation and recommendations on cases where there is a risk of serious harm to the child and/or where there is dispute over the appropriateness of out-home-placement.

**CRC (Crisis Residential Center):** A secure or semi-secure facility, with three to four staff members for every eight children or youth, that provides structured group care for children and/or youth.

**CSO (Community Services Office)**

**Case Manager:** Employed by a CPA, the Case Manager may recruit, assess, train, certify, monitor and support foster families. Case Managers partner with DCFS social workers to ensure safety, stability and well-being of children while in foster care. Generally, only foster homes certified by a CPA will have a Case Manager assigned to their foster child.
Acronyms and Definitions, Continued

**DCFS (Division of Children and Family Services):** The division of CA that provides the CPS, CFWS and FAR programs.

**DDA (Developmental Disabilities Administration)**

**DEL (Department of Early Learning)**

**DLR (Division of Licensing Resources):** The division of CA that provides the foster care and group care licensing programs.

**DLR/CPS (Division of Licensing Resources/Child Protective Services):** A program of DLR that investigates allegations of abuse and/or neglect within licensed facilities.

**DOH (Department of Health)**

**DSHS (Department of Social and Health Services):** This department oversees CA (including DCFS and DLR) as well as many other programs (including DDA and JRA).

**Dependency:** The status of a child in the foster care system whose parents’ rights have not been terminated. A child becomes a dependent of the state when a Judge declares sufficient findings pursuant to RCW 13.34.232.

**Drug Affected Infant:** A child aged birth through 12 months who was exposed to drugs in utero and may demonstrate physical, behavioral or cognitive signs which may be attributed to drug exposure.

**EAP (Educational Advocacy Program)**

**ECEAP (Early Childhood Education and Assistance Program)**

**EPSDT (Early and Periodic Screening, Diagnosis and Treatment):** A Federal program for preventive health care of children and youth served by Medicaid (Provider One). The physical/well-child examination helps find health problems early and enables the child to receive timely treatment.

**FAR (Family Assessment Response):** This program is an alternative response for lower-risk reports of child maltreatment, acknowledging that not all families need an investigation as an intervention. The FAR social worker connects families to services, concrete supports and resources in the community, without taking the children from the home.
Acronyms and Definitions, Continued

FASD (Fetal Alcohol Spectrum Disorder): A medical diagnosis of physical, behavioral or cognitive symptoms in a child or adult that can be attributed to pre-natal exposure to alcohol.

FPAWS (Foster Parent Association of Washington State)
FP (Foster Parent)
FPS (Family Preservation Services)
FTDM (Family Team Decision Meeting): An FTDM occurs whenever a placement decision must be made. Participants may include birth parents, the child, relatives, family friends, caregivers, community members and service providers, along with the social worker and supervisor.
FAMLINK: The case tracking and family information system used by CA.
GAL (Guardian ad Litem): A representative appointed by a Judge to speak on behalf of an abused or neglected child in court. The GAL uses information from meetings with the child and caregiver, and case staffings, to present the best interest of the child in court.
Group Home: A licensed, 24-hour staffed facility that provides basic needs and supervision, as well as therapeutic services required for the successful reunification of the child to the family, or the achievement of an alternate less restrictive living arrangement.
Guardian: A person or agency appointed by the Court to care for and supervise a child. The Guardian has legal rights to the custody of that child. Foster parents are not legal guardians of a dependent child.
ICPC (Interstate Compact on the Placement of Children)
IEP (Individual Education Plan)
ILS (Independent Living Services) or ILP (Independent Living Program): A program to assist youth age 16 years or older in preparing to live on their own after leaving care.
ITEIP (Infant and Toddler Early Intervention Program)
IV-E (Four E): A Federal funding stream for child welfare services
Acronyms and Definitions, Continued

**JRA (Juvenile Rehabilitation Administration):** A division of DSHS. JRA is the criminal court system for juveniles.

**LICWAC (Local Indian Child Welfare Act Committee):** An advisory group of local tribal members who provide consultation for developing culturally appropriate service plans, oversight to ensure compliance with ICWA and recommendations that support the preservation of Native American families.

**Legally Free:** The legal status of a child whose biological parents have either voluntarily relinquished their rights or who have had their parental rights terminated by a Judge.

**MLR (Minimum Licensing Requirements):** The minimum requirements which must be met to become a licensed or certified foster parent under WAC 388-148.

**OCD (Obsessive Compulsive Disorder)**

**ODD (Oppositional Defiant Disorder)**

**OFCL (Office of Foster Care Licensing)**

**PICC (Pediatric Interim Care Clinic)**

**PTSD (Post Traumatic Stress Syndrome)**

**RA (Regional Administrator):** Oversees the administration of a Division (DCFS, DLR, etc.) within a specified region.

**RAD (Reactive Attachment Disorder)**

**RCW (Revised Code of Washington):** Washington state laws.

**R-GAP (Relative Guardianship Assistance Program)**

**RSO (Registered Sex Offender)**

**Referral:** A text of allegations made of CA/N, or a violation of the MLRs.

**Relinquishment:** A legal action that terminates the legal rights of parents via their consent and signature, thereby making the child legally free for adoption.

**Respite Care:** Short term care for a foster child that is provided by another foster parent or an approved respite provider. Respite care may last from a few hours to several days.
Acronyms and Definitions, Continued

SBC (Solution Based Casework)

SVP (Supervised Visitation Program)

SW (Social Worker)

**Shelter Care**: The legal status of a child upon entering into foster care and prior to the Disposition Hearing that declares the child a dependent of the state.

**Staffed Residential Home**: A licensed home providing 24-hour care for six or fewer children or youth. The home may employ staff to care for the children or youth.

**Staffing**: A team meeting involving social workers and supervisors, the child’s GAL or CASA, legal parents and their attorneys, and caregivers. The meetings are held to discuss the child and his/her care, as well as the requirements for reunification.

**TANF (Temporary Aid to Needy Families)**

**TPR (Termination of Parental Rights)**: A legal action that terminates the legal rights of parents, thereby making the child legally free for adoption.

**Visitation**: The time scheduled for a visit between a foster child and his/her legal parent(s), guardian(s) or sibling(s).

**WAC (Washington Administrative Code)**: The interpretation of the RCW.

**WIC (Women and Infant Children)**: A program that provides services and nutritional supplements to needy children age 5 and under. All children in out-of-home care are eligible for WIC.
Concurrent Planning

Washington State strives to achieve four possible permanency plans for children:

- **Reunification**: this is the number one goal. In coordination and collaboration with families, address the issues that brought the children into care and reunite the family.
- **Adoption**: If reunification is not possible, the next best option for children is adoption, as this provides a permanent connection to a family.
- **R-GAP**: Relative Guardianship Assistance Program for relative caregivers and caregivers of Native American children, when adoption is not possible or preferable.
- **Third party custody (or Another Planned Permanent Living Arrangement)**: This is the least desired permanency option.
- There are some cases where legal permanency is not possible and a child has to remain in DCFS’s care, however, even in those cases the priority is on connecting every child with adults who will remain permanent supports to them throughout their lives.

Some things to keep in mind about Concurrent Planning:

- Foster parents must understand that the initial placement is considered a “foster placement.”
- Foster parents must understand that the placement does not imply that adoption will occur, or even that the child will remain in the home of foster family during the course of reunification.
- Foster parents are expected to support reunification efforts.
- Foster parents must recognize that reunification efforts may include multiple visits with either or both birth parents, as well as visitation with other relatives (e.g., grandparents, siblings, etc.).
- Foster parents may be asked to adopt the child if the child becomes legally free for adoption.
- Foster parents may encounter emotional challenges as the child “moves through the system” and permanency plans change, or do not.
- Foster parents may need additional support from other team members as plans change or new plans emerge.
Dependency Timeline and Schedule of Case Staffings
Licensing Process Road Map

Please see the Appendix for this material.
Indian Child Welfare Act

A federal law passed in 1978 that declares:

“the policy of this nation to protect the best interests of Indian children and to promote the stability and security of Indian tribes and families.”

In enacting the ICWA, Congress recognized:

- A long history of wrongful removal of Indian children from their homes
- From the tribal perspective, a child is a sacred and precious resource that belongs to the entire Tribe.
- The tribe has a direct interest in its children.
- The tribe is entitled to notice as a party to the case.

The purpose of the ICWA is to:

- Preserve and strengthen Indian families and Indian culture
- Establish “federal standards for the removal of Indian children from their families” and “placement in foster or adoptive homes which will reflect the unique values of Indian culture”

Foster and adoptive preference under the ICWA:

1. Extended family as defined by the child’s Tribe
2. Other members of the Tribe
3. Other Indian families
In the last session we covered an overview of the child welfare system from intake to permanency. We talked about how and why kids come into care, the decision making process of a social worker, legal authority, court timelines and the possibility of Tribal involvement, and we emphasized the concepts around concurrent planning and where the foster parent, the relative and the adoptive parents fit into the system. This session will build on our last one and focus in on working as a member of the team.
Session 2: Working as a Member of the Team

Topics covered in Session 2

- Working as a Member of the Team
- Communication
- The Role of Caregivers
- Confidentiality
- Prudent Parenting

Competencies covered in Session 2

**CCW102-01** Awareness of the individuals’ roles on the child welfare team: Caregiver; Social Worker; agency staff; CPA staff; CASA/GAL; attorneys; and judge.

**CCW102-02** Awareness of the need for effective communication and engagement with the child welfare team.

**CCW102-05** Awareness of the need to support the case plan regardless of Caregiver’s own feelings and perceptions.

**CCW104-01** Awareness of how/when to obtain assessments, treatment, and services for children in care including services related to health, mental health, developmental delays, and other issues.

**CCW104-02** Awareness of the need for supporting children in their regular school settings: opportunities for involvement in school activities; awareness of special education services and accommodations.

Begin Session 2
The Child Welfare Team

**Biological (or legal) parents:** The parents who conceived or sired the child and/or who are legally considered responsible for the child.

**Foster Parents/Relative Caregivers/Fictive Kin/Suitable Others:** A person willing and able to care for children on a short term, temporary basis in order to provide safety for the child while reunification with the biological family is pursued. This caregiver may become the permanent placement for the child if biological parents are unable to reunify.

**Social Worker:** Employed by CA/DCFS. Engages the birth/legal family in the development of a case plan which outlines the steps that must be taken for the child to return home. Arranges services for the child and family with various community agencies and service providers. Visits the child, birth family and the foster family regularly. Coordinates the visitation schedule. Makes recommendations to the Court regarding services for the child and family, visitation schedules and permanent plans. Reports on the status and progress of the child and family. Overall manager of the child and family record. When reunification is to occur, SW coordinates a Transition plan with the foster parents and others involved in the case.

**Contracted Service Providers:** For example, a Child Placing Agency Case Manager. Employed by Private Child Placing Agency or “CPA.” CPA’s recruit, assess, train, certify, monitor and support foster families. CPA Case Managers partner with state social workers to ensure safety, stability and well-being of children while in foster care. CPA Case Managers prepare foster families for child transitions and placements; visit children and foster families on a regular basis; provide case management; facilitate access to services; oversee court ordered parent/child visitation; attend shared planning meetings; report on child’s progress within family; make recommendations for additional assessments or services for child or family; assist foster family to support child’s permanency goals of reunification, guardianship or adoption.

**GAL (Guardian ad Litem) or CASA (Court Appointed Special Advocate):** Appointed by the Court to represent the child’s best interest (in other words, to tell the Court what is best for the child). Meets with the child, foster parents and others. Prepares reports to the court about how the child is doing and makes recommendations to the Court about what is in the child’s best interest.

**Native American Tribe:** The tribe, as an entity, can be a legal party to the case and may wish to claim full jurisdiction, therefore managing the case in Tribal Court. This is a matter of legal citizenship. In many situations, the case is heard in State Court and the tribe is an actively involved party to the case.
The Child Welfare Team, Continued

**Attorney for the youth:** If the child is 12 or over, the Court will appoint an attorney to represent the child’s wishes. (Note this may be different than the child’s “best interest.”) Meets with the child, helps him/her to understand his/her rights, and represents his/her wishes in Court.

**Juvenile Court and Judge:** Decides whether or not abuse or neglect occurred and whether the child can safely remain at home. Decides if the child will become a Dependent of the Court. Monitors the case and will order family to comply with the Service Plan. Holds hearings and reviews to make sure that the child is safe and that the family is complying. If parents are not complying, or when progress is insufficient, the judge can order an alternate permanent plan such as adoption or guardianship. Juvenile Court is not designed to punish parents and does not deal with criminal charges.
Serena

Circumstances in Which Serena Comes into Care
Serena is 9 years old and has been in foster care for the past 2 months. After several years of sporadic drug use, her mom had a near-fatal overdose. Serena came home from school one day and found her mom unconscious on the couch. She used her mom’s cell phone to call 911 and saved her mother’s life. Serena has disclosed that sometimes her mom forgot to feed her. Also, there were some nights when her mom left her alone all night and she put herself to bed and got herself to school in the morning.

Serena and her mother emigrated from Vietnam when Serena was 18 months old.

The whereabouts of Serena’s father are unknown.

Foster Parents
Serena has been living with the same foster parents since she came into care 2 months ago. Most of the time, Serena seems happy, gets along well with the other kids and enjoys family activities. However, after visits with her mom, she is angry and aggressive. She often refuses to eat dinner, saying she isn’t hungry, and has trouble settling down for bed. The foster parent tries to talk to her about the visits with her mom, but she cries, and won’t say anything. Aside from her responses to visits, she has no difficult behaviors. The foster parent finds it odd that when bathing, Serena washes her underwear in the tub and hangs it over the edge to dry for the next day. The foster parent also recently found a stash of food hidden in her closet.

Serena is currently in 3rd grade, but has been struggling in school since entering foster care. The teacher has reported to the foster parent that she has difficulty focusing, and lashes out at her teacher or other students. Some days she seems agitated and anxious, and it is very hard for her to complete in-class assignments on these days. She is falling behind in her school work.
Serena, Continued

What do I know about this situation?

What are my assumptions about this situation?

Are my assumptions true?

What information do I need?

What information do I share with the team?
4313. Partnering with Out-of-Home Caregivers

Purpose
Support out-of-home caregivers* as important and respected team members who have a vital role in meeting the individual needs of children.

*Caregivers include: Foster parents, relatives, and suitable persons.

Laws
RCW 74.13.332 Rights of Foster Parents
RCW 74.13.333 Rights of Foster Parents Complaints Investigations Notice
RCW 13.34.260 Foster Home Placement Parental Preferences

Policy
1. Out-of-home caregivers have the right to be treated with respect and be supported in their responsibilities for the protection, daily care, and nurturance of the child in their home to maintain the health and safety of the child.
2. Out-of-home caregivers may participate as members of the child's treatment team with valuable input about the child's behavior, school and medical status, response to parental visits, and growth and development.
3. Out-of-home caregivers must always be valued and supported in their responsibility to record and share information with the social worker or other agency/community staff working on behalf of the child; i.e., schools, therapists, and SSI facilitators.
4. Out-of-home caregivers must never be intimidated, threatened, or discriminated against when the caregiver complains, provides information, assists, or participates in any part of a complaint process.

Procedures
1. Invite the Caregiver to participate in the development of the service plan for the child, assist in family visitation (if appropriate) and model effective parenting behavior for the parent(s).
2. Discuss the child's communication plan per 43022: Outside Communication for Children in Out-of-Home Care Policy with the caregiver.
3. Invite the Caregiver to participate in shared planning meetings per 4413: Placement Services and 45303: Procedures.
4. Include the Caregiver in court hearings per 5760: Fact Finding and Dispositional Hearings.
5. Confirm therapeutic foster care and group/rehabilitative care providers are providing additional therapeutic service as defined in their DSHS contracts.
4313. Partnering with Out-of-Home Caregivers, Continued

Resources

A Relative’s Guide to Child Welfare Services
Building a Future for Washington’s Children – Foster Care Improvement Plan

Suggested Practice Tips

1. It is important to create both the perception and reality that Caregivers and social workers are working together in complementary roles to mutually assure that the best interests of the child are achieved.

2. Based on experience, some Caregivers may perceive their role is viewed by social workers as secondary to Children's Administration. We are partners in making decisions that are in the best interest of the child and need demonstrate the respect and value each other's perspectives.

3. Respectful communication is critical to creating good partnerships. We need to work together as a team to plan the best outcomes for children in out-of-home care.

4. Decisions regarding the child and his/her placement in the home will be made with careful consideration to the child's needs and with respect to the connection that has developed between the child and the Caregiver.
Family Team Decision Meetings

The purpose of a Family Team Decision Meeting (FTDM) is to encourage families to assist in placement decisions, and to involve a broad representation of people to share in the decision making process. The goal is to develop a plan that will provide the safest and most appropriate placement for children while preventing unnecessary moves and continuing family involvement.

An FTDM includes the social worker, the social worker supervisor, biological parents, child aged 12 and over (when appropriate), relatives, other family supports (friends, clergy, etc.), caregivers (such as foster parents), community partners, service providers and the Guardian ad Litem (GAL) or Court Appointed Special Advocate (CASA).

An FTDM is held for all decisions in the following circumstances:

- **Initial Placement:** Within 72 hours of an emergency placement. The purpose of the FTDM in this situation is to decide if:
  - The agency must file for dependency and continue placement of the child
  - The child can remain at home with a safety/service plan in place
  - The child should be voluntarily placed by parent(s) with a safety/service plan in place

- **Change of Placement:** Prior to child being moved from one placement to another, to decide if:
  - The child can remain in the current placement with additional supports and/or services
  - The child must move to another placement, then: why, where, when and with what services in place

- **Reunification/Other Permanency Plan:** A FTDM is held prior to reunification/transfer of legal custody to decide if:
  - The child can safely return home
  - An alternative plan is required if the child cannot return to the family home
# Information Sharing Quick Reference

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<thead>
<tr>
<th>What</th>
<th>When</th>
<th>Who Is Responsible</th>
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<tbody>
<tr>
<td><strong>Child Information / Placement Referral (DSHS Form 15-300)</strong></td>
<td>Prior to or soon after initial placement (within 24-72 hours)</td>
<td>Social Worker, Placement Coordinator</td>
</tr>
<tr>
<td></td>
<td>When the child changes placement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When new information is known about the child’s needs</td>
<td></td>
</tr>
<tr>
<td><strong>Shared planning meetings</strong></td>
<td>Within 72 hours, where available (FDTM sites only)</td>
<td>Social Worker</td>
</tr>
<tr>
<td>bring individuals together to share information, plan and inform decisions regarding children and families.</td>
<td>Within 30 days, 180 days (6 months), 9 to 11 months, every 12 months thereafter</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advance notice (5 days) given to caregivers unless emergent.</td>
<td></td>
</tr>
<tr>
<td><strong>Caregiver Staffing Notice Form (DSHS 15-311)</strong></td>
<td>Within 5 days of receiving report and recommendations</td>
<td>Social Worker</td>
</tr>
<tr>
<td>if written notification is provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recommendations and reports resulting from all assessments and screenings</strong></td>
<td>5 days prior to moving when the child has been in the home at least 90 consecutive days</td>
<td>Social Worker</td>
</tr>
<tr>
<td><strong>Moving notice</strong></td>
<td>10 days prior to Dependency hearings</td>
<td>Social Worker</td>
</tr>
<tr>
<td></td>
<td>10 days prior to Dependency hearings or 60th day of placement episode, 180th day of placement, 6 month intervals</td>
<td></td>
</tr>
<tr>
<td><strong>Court Hearing Notice-ISSP Cover Letter form (DSHS 15-319)</strong></td>
<td>10 days prior to Dependency hearings</td>
<td>Social Worker</td>
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<tr>
<td><strong>Individual Service and Safety Plan (ISSP) (DSHS 15-209)</strong></td>
<td>10 days prior to Dependency hearings or 60th day of placement episode, 180th day of placement, 6 month intervals</td>
<td></td>
</tr>
</tbody>
</table>
| **Supervision Plan** (DSHS 15-352) | Developed with the caregiver, the Supervision Plan is required for any youth identified as SAY or PAAY.  

The Supervision Plan is developed and provided prior to or soon after initial placement (within 24-72 hours)  

When the child changes placement  

When new information is known about the child’s needs | Social Worker |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and Safety Visits</strong></td>
<td>Monthly social worker visits, not to exceed 40 days between visits</td>
</tr>
</tbody>
</table>
Notice of Hearings to Caregivers

Please see the Appendix for this material.
1. When a child is in out-of-home care, the social worker must complete or update the report to the court in the following timeframes.
   a. The first report to the court is due no later than 10 working days before the dependency Disposition hearing or by the 60th day of the placement episode of a child (whichever date occurs first). The second report to the court is due by the 180th day of placement, and periodically thereafter at six month intervals.
   b. If the report to the court is completed earlier than required, the next report to the court is due no later than six months from the date of the last one completed.
   c. The report to the court shall include screening results and case plans to address the child/youth's multiple needs.

2. The report to the court must be submitted in the following situations:
   a. For all court disposition, permanency planning, and review hearings.
   b. To obtain approval to place a child in Behavior Rehabilitation Services, formerly called group care.
   c. For Shared Planning and administrative reviews.
   d. For citizen reviews.
   e. For tribal or Local Indian Child Welfare Advisory Committee (LICWAC) staffing, as appropriate and as defined in the ICW Manual.

3. The report to the court must be developed after consulting, in person if possible, with the parents of the child, and, if developmentally appropriate, with the child. Following completion of the case plan, the social worker's supervisor must approve and sign each report to the court. The social worker must provide a copy of the report to the court to the parent(s) if the parent(s) whereabouts are known.

4. The child's report to the court contains information that is important for the child's caregiver to know so that the caregiver can provide appropriate care to the child. The child's report to the court must be shared with the child's foster parent, relative caregiver, or preadoptive parent(s).

5. Document in the Court Report for an incarcerated parent the following:
   a. How the parent participated in case planning
   b. What treatment services and resources are available in the facility that meet the parent's individual needs
   c. Visitation schedule or reasons why visitation is not appropriate with the incarcerated parent

6. The child's caregiver must preserve the confidentiality of information contained in the child's court report. A social worker who becomes aware of a breach of confidentiality must discuss this with the caregiver, the social worker's supervisor, and the licenser. The social worker and supervisor may decide to use another strategy to provide the caregiver with all information pertinent to providing appropriate care for the child. The social worker must document the alternate strategy for sharing information in the child's electronic record.
43091. Court Report, Continued

Effective Date Initial: Revised: 10/20/2013 Approved by: Jennifer Strus, Asst. Secretary
Caregiver’s Report to the Court

Child’s Name: __________________________________________________________________________

Legal Case Number: ___________________________________________________________________

Hearing Date: __________________________________________________________________________

County with Legal Jurisdiction: ___________________________________________________________________

Caregiver Name/Person providing information: ___________________________________________________________________

Child’s Assigned Social Worker: ___________________________________________________________________

Please return Caregiver Report Form (via e-mail, US Postal Service or in-person) to the child’s assigned social worker and/or guardian ad litem.

Topics:

1. Child’s strengths, hobbies, gifts, talents, participation in extra-curricular activities/events:

2. Child’s social interaction with caregiver family, peers and siblings:

3. Child’s school progress and adjustment:

4. Child’s physical health (state results of medical and dental appointments):
Caregiver’s Report to the Court, Continued

5. Child’s emotional health and well-being (counselor or therapist appointment schedule):

6. Child’s adjustment to caregiver family and caregiver family expectations:

7. Child’s visits with parent(s) and sibling(s):

8. Your view on the needs of the child:

9. Your thoughts on how these needs can be addressed:

10. Your thoughts on Department’s case plan:
11. Other child/case specific information you wish the Court to consider:

Caregiver's Signature:  
Signature Date:  

Caregiver's Printed Name:
Tips for Communicating with Your Social Worker

How to communicate with your worker:

- Use Email rather than the phone whenever possible.
- In the Subject Line Identify if the email is:
  - FYI/Information Only
  - Urgent, meaning a response is needed by the end of the day
  - Not urgent but need an answer by______
- Email is not always secure so use a case number or initials of the child or both. Do not use the child’s name or specific identifying information in the email.
- Keep your emails short and to the point.
- Use bullets whenever you can. It will help the social worker scan through and quickly assess what action is needed.
- Report the facts rather than your opinion.
  - I observed the child; the child stated; the teacher reported…
  - I need; I am requesting; may I have permission to…

What to do if your social worker does not respond within your timeframe:

- Send a follow up email with the previous email attached or try a phone call at that point.
- Always give the worker the benefit of the doubt.
- If there’s still no response email the supervisor (keeping the worker included). Since you have the last email you sent the social worker in your email folder forward the email string and state something like, “I know Sandy must very busy. I need help resolving the following things…. Are you able to assist? I need this by the end of the week if at all possible…. Thank you.”
- If that doesn’t work (which is rare), email the Area Administrator (keeping the supervisor and the worker included).
- If that doesn’t work (which is extremely rare), email the Regional Administrator (keeping the supervisor, worker and Area Administrator included).
Sample Emails

Sample Secure Emails

From: Audi, Robert C (DHS/CSE)
To: Arthur Fernandez
Subject: Secure Email
Date: Saturday, October 31, 2015 2:28:09 PM

New secure email message from State of Washington

You've received a secure email message related to business with the State of Washington. To view it, select Open Message.

The secure message expires on Nov 30, 2015 @ 10:28 PM (GMT).

Do not reply to this notification message; this message was auto-generated by the sender's security system. To reply to the sender, select Open Message.

If selecting Open Message does not work, copy and paste the link below into your Internet browser address bar.
https://sendsecure.m88security.com/s/e2b=dts_wa&m=ABOVGXHvfFLbwGpbVe3yd8ep&c=ABDAmNahf0OZH-o8SeP27sOWS&em=sarl300%40uw%2eedu

Register Account
Enter your email address and a password to register and begin sending and receiving secure messages.

Email Address
sar300@uw.edu
Password:
Retype Password:

Password Rules
Passwords must be at least 15 characters in length and need all of the following conditions:
• Contains both alphabetical and numeric characters
• Contains both uppercase and lowercase characters
• Contains at least one special character, such as #, @, %, 
Passwords cannot match email address.

For customer support, email Washington Technology Solutions (security service desk) at service-security.service@state.wa.us or call 1-800-231-5007, 711 or 629-5469.
This site is secured with digital assurance, meaning the data of the organization and government by Terms of Service
User indicates you have reviewed and accepted the Service Conditions you have indicated you to accept the Service

CCT V2.1 Revised 12/1/2016
Sample Emails, Continued

Sample Emails

To: frstname.lastname@dhs.wa.gov
Cc: myself@home.com
Subject: #1567845 B.H. - FYI

Social Worker,

FYI

- On 11/5 the school called to report that B.H. left class angry and was found in the bathroom curled up on the floor crying.
- On 11/6 we made a plan with the school counselor, the teacher and B.H.
  - B.H. has been provided with an "urgent counselor pass".
  - When B.H. feels out of control then he may give the pass to the and go down to the counselor for support.
  - He will return to class when he feels back in control.

Thank you,
Foster Parent

See more about: firstname.lastname@dhs.wa.gov.
Sample Emails, Continued

Social Worker,
Observation:
- On 11/2, after visitation, I observed B.H. to have had a screaming fit lasting approximately 20 minutes. He was also rubbing his eyes and yawning in between crying and screaming.
- A similar pattern happened following visitation on 10/10; 10/15; 10/18
- On non-visit days B.H. typically naps between 11am-1pm

Request:
- Please consider adjusting the visitation time to later in the afternoon or earlier in the morning
  - Benefits:
    - easier transition for B.H.
    - more pleasant visit for parents

Response respectfully requested by:
- 11/8/15
  - Next visit is scheduled for 11/10/15

Thank you,
Foster Parent
I Feel / I Need

1. The social worker has asked me to attend a Family Team Decision Meeting (FTDM) where the child’s family will be present.
2. The child in my home shared with me about his/her day at school for the first time.
3. The social worker is expecting that parent-child visits will be done in my home.
4. My social worker kept me up to date on court progress, even with hard-to-hear news.
5. The visitation schedule that has been set for the baby in my care is during nap time.
6. We attended a local cultural activity and felt welcomed.
7. The social worker has given my home phone number to the biological parents.
8. We took our adopted daughter to her biological sister’s birthday party so she could see her biological family.
9. The child in my home is taken out of school twice a week for visits with parents.
10. The biological mom asked my advice and I was able to help.
11. I emailed the social worker about which doctor and dentist to take the child to, but I have gotten no response.
12. I met the birth family and we truly connected in talking about what we wanted for the child in my home.
13. I took the child to the doctor and they asked for MY insurance information.
14. The social worker promised to do a task that I requested, and did that and more!
15. The social worker told me that a new child would be brought to my home at 6:00 p.m.; it is now 10:00 p.m. and the child still has not arrived.
16. I received a new 3-year-old child placed in my home, and she came with no clothes, except a man’s T-shirt that she was wearing.
17. I haven’t received my payment for foster care.
18. A child who has been in my home for several months is leaving to be reunited with his family.
I Feel / I Need, Continued

19. I did not receive a placement packet or any papers for the child that was placed with me.

20. The social worker assumes that I will transport the child to visits, but my schedule just doesn’t allow it.

21. The school is calling me every day and is threatening to expel the child in my care.

22. The demands of caregiving are far greater than I ever expected.
Foster Parents’ Rights and Responsibilities, State of Washington

- The RIGHT to be treated with consideration and respect by agency staff;
- The RIGHT to a supportive relationship with the agency;
- The RIGHT to receive timely reimbursement for children placed in their care;
- The RIGHT to receive training as members of the child’s professional team;
- The RIGHT to receive notice of and be present at all shared planning meetings;
- The RIGHT to give input into decisions regarding the child in their care and to be treated as a valued member of the team in developing case plans for the child;
- The RIGHT to a clear explanation or description of their role as foster parents and the role of the child’s family and the agency;
- The RIGHT to give and receive timely pertinent information about the child placed in their care;
- The RIGHT to be informed of any grievance procedures or access to any appeals process should they wish to appeal the agency’s policy, regulation, or plan for a child in their care;
- The RIGHT to continue their own family patterns and traditions;
- The RIGHT to refuse to accept a child into their family if they feel they cannot meet the needs of the child or the placement may affect the well-being of the foster family;
- The RIGHT to be notified of any Court Hearing or Administrative Review, concerning a child in their care;
- The RIGHT to be present and heard in all court proceedings involving a dependent child in their care;
- The RIGHT to submit a written Caregivers Report to the Court regarding the child in their care, for any Review Hearing or Permanency Planning Hearing;
- The RIGHT to be included in the permanency consideration for the child who is in the foster family’s care;
Foster Parents’ Rights and Responsibilities, Continued

- The RIGHT & RESPONSIBILITY to advocate for children in their care;
- The RESPONSIBILITY for the day-to-day care and nurturance of the child;
- The RESPONSIBILITY to inform the agency of any changes in the child’s life and in the foster parent’s household;
- The RESPONSIBILITY to respect a child’s biological family, traditions, culture and values;
- The RESPONSIBILITY to help a child placed in their care maintain regular and on-going contact with siblings not in the same placement;
- The RESPONSIBILITY to gain further knowledge and expertise regarding the care of children by attending on-going foster parent training;
- The RESPONSIBILITY to work cooperatively with agency staff as professional members of the child’s team; and
- The RESPONSIBILITY to ensure a child’s safety, health and well-being needs are met.
Caregiver Guidelines for Foster Childhood Activities

Please see the Appendix for this material.
So far we’ve looked at an overview of the child welfare system from intake to permanency to understand the process and the experience. We have also focused in on working as a member of the team supporting the child. In this session we will concentrate on working with birth families.
Session 3: Working with Birth Families

Topics covered in Session 3
- Green / Blue Family
- “Zero to Three” Video
- The Continuum of Partnering with Birth Families
- Visitation Perspectives
- Birth Parent Voices

Competencies covered in Session 3
CCW102-03  Awareness of the importance of being involved and involving biological families, in case planning and working towards reunification.

CCW103-02  Awareness that reunification is the primary goal of Child Welfare Services.

CFAM135-02  Awareness of the importance of preparing a child for placement transitions.

CFAM136-01  Awareness of the need to interact with children and their families in a culturally responsive and appropriate way.

CFAM137-01  Awareness of the importance of children’s relationships with families, including the importance of fathers as parents.

CFAM137-02  Awareness of caregiver’s role in visitation to be positive and supportive of child’s family contact; making the child available for visits.

CSELF181-02  Awareness of the need to not interfere with the permanency plan for a child.

Begin Session 3
Trash Bag Activity

Directions
Imagine you are Serena and you are at home and police and people come to your house and tell you that you will have to leave your home and come with them. You have 5 minutes to take whatever you want with you but it has to fit in this bag:

How did it feel to fill this bag?

What did you bring?

What did you have to leave behind?
Video Themes
Zero to Three

First relationships:

Attachment, trauma, and brain development:

Repairing relationships between birth parents and children:

The role of the foster parent:
## Engaging Families

The type of contact that is arranged between caregivers and birth families is planned in conjunction with the social worker, to enable contact that is in the best interest of the child, as well as ensuring safety for all. The continuum includes:

<table>
<thead>
<tr>
<th>No Direct Contact</th>
<th>Limited and Public Contact</th>
<th>Frequent and Private Contact</th>
<th>Mentoring the Birth Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Send photos of the child to the parents; ask for pictures of the parent</td>
<td>Take child to visits</td>
<td>Host visits in your home</td>
<td>Welcome parents into your home</td>
</tr>
<tr>
<td></td>
<td>Talk with parents at the visit</td>
<td>Attend visits at the parents’ home</td>
<td>Coordinate and discuss discipline efforts</td>
</tr>
<tr>
<td></td>
<td>Refer to the child as “your child” when speaking with parents</td>
<td>Support child’s transition back to the family</td>
<td>Attend parenting classes with parent</td>
</tr>
<tr>
<td>Prepare child for visit</td>
<td>Encourage phone calls between parent &amp; child</td>
<td>Assist in planning child’s return to birth family; support family reunification efforts</td>
<td>Advocate for needed services for the family and provide assistance in obtaining services</td>
</tr>
<tr>
<td>Remember child’s family in prayers or other family rituals</td>
<td>Ask for parents’ advice</td>
<td>Involve parents in farewell activities</td>
<td>Support and encourage birth family’s involvement in treatment programs</td>
</tr>
<tr>
<td>Request cultural info from the family</td>
<td>Ask questions of the parent</td>
<td>Attend training to learn about mentoring birth parents</td>
<td>Provide feedback to parents on parenting skills</td>
</tr>
<tr>
<td>Share copies of school papers &amp; report cards</td>
<td>Attend meetings where the parent is present</td>
<td>Assist parents with transportation to and from visits or other appointments</td>
<td>Model and teach parenting skills in your home</td>
</tr>
<tr>
<td>Share child’s artwork</td>
<td>Reassure the parent of the child’s love</td>
<td>Participate in recreational and/or cultural activities with the child and family</td>
<td>Provide respite care for birth parents after the child returns home</td>
</tr>
<tr>
<td>Exchange letters and cards</td>
<td></td>
<td></td>
<td>Serve as a support for the family after child returns home</td>
</tr>
<tr>
<td>Speak positively about the child’s family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learn about child’s family, community &amp; culture</td>
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</tbody>
</table>
Visitation Information

Planning for Visits
The foster care team must plan and prepare for family visits. You will be told whether visits are supervised or unsupervised, where the visits will take place, how often visits will take place, and how long each visit will last.

Visits are generally supervised in the beginning. Supervision may continue if:

- There is concern for the safety and protection of the child.
- There is concern that the parent might leave with the child.
- The parent is unable to manage the child’s behavior.
- Termination of parental rights is being pursued.
- The social worker wished to observe a visit.
- The Court orders continued supervised visits.

Frequency and Length of Visits
The first visit needs to occur as soon after placement as possible, preferably within 72 hours. Although there is a wide variation in visit plans, visits are generally offered once or twice a week, for one to two hours per visit. Infants may have more frequent visitation to ensure that they develop attachments with their biological parents. When reunification is the goal, the visits may increase in length and frequency over time. Before a child returns home, there should be extended visits, including overnight stays.

When the plan calls for termination of parental rights, the department still has a continuing obligation to arrange parent-child visits. These visits will probably be supervised. It is important to have a final visit, or good-bye visit, that coincides with the termination, or relinquishment, of parental rights.

Location of Visits
- **The agency:** This is where many supervised visits occur. It is easy for the social worker to observe, and it is a controlled setting. However, the visit rooms sometimes feel cold or impersonal. Children or parents may be uncomfortable and may dislike the lack of privacy.
- **Neutral spot:** A visit may occur at a park, the mall, or a local swimming pool or restaurant. These settings may be less emotionally charged than some other options. However, as the setting is quite public, there is a lack of privacy.
Visitation Information, Continued

- **Relative’s home:** A visit in a relative’s home can help maintain the kinship ties of the child, and may be a more comfortable spot for the child and parent. However, sometimes parents feel criticized or rejected by the family. On occasion, the extended family is not safe for the child.

- **Foster home:** A visit at the caregiver’s home can satisfy the parent’s curiosity about how and where the child is living, and will be less disruptive to the child. However, the parent’s may not be comfortable visiting their child in someone else’s home. In addition, the caregivers may be uncomfortable having the biological family in their home.

- **Parents’ home:** As reunification draws near, visits will be moved to the parents’ home. Both the parent and child may feel more comfortable with a visit at the parents’ home. However, if problems with housing or housekeeping have not been resolved, this may be unsafe for the child. In addition, the child may not be adequately protected or supervised by the parents.

**Caregiver Responsibility**

It is the responsibility of the caregiver to have the child available for visits. Many caregivers choose to transport the child to and from visits, and some agree to supervise visits. Neither of these is required of you, but may be in the best interest of the child. You and the other team members will decide your role in visitation.
Family Visitation in Child Welfare

Please see the Appendix for this material.
**Sibling Visits and Contacts**

Sibling contact is crucial for maintaining sibling relationships and supporting the well-being of children while in care.

<table>
<thead>
<tr>
<th>What is the definition of a sibling?</th>
<th>A sibling is considered to be a child’s:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Birth sister or brother</td>
</tr>
<tr>
<td></td>
<td>• Adoptive sister or brother</td>
</tr>
<tr>
<td></td>
<td>• Half-sister or half-brother</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which siblings require a visit/contact?</th>
<th>All siblings living together at the time of removal and not placed together. Even when the sibling is . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Legally free</td>
</tr>
<tr>
<td></td>
<td>• An adult</td>
</tr>
<tr>
<td></td>
<td>• Not in care</td>
</tr>
<tr>
<td></td>
<td>• In a pre-adopt placement</td>
</tr>
<tr>
<td></td>
<td>• Living out of state</td>
</tr>
<tr>
<td></td>
<td>• Aged out of care</td>
</tr>
<tr>
<td></td>
<td>• Hospitalized</td>
</tr>
<tr>
<td></td>
<td>• Born after placement and a relationship exists</td>
</tr>
<tr>
<td></td>
<td>• In detention (JRA)</td>
</tr>
</tbody>
</table>

| What qualifies as a visit/contact? | • A visit is a face-to-face or in-person visit.                                                  |
|                                   | • A contact can be telephone, skype, text, e-mail or postal mail.                               |

| How many visits/contacts are required? | • A minimum of two visits or contacts per month until a permanent plan has been finalized |
|                                       | • Sibling visits are still required when parent/child visits are cancelled or not occurring. |

| When are sibling visits/contacts not required? | • Sibling is born after placement and no prior relationship exists |
|                                               | • Step-sibling                                                   |

Remember, the minimum amount of contacts or visits for siblings is two per month. However, with social worker approval, caregivers may agree to more than this. Caregivers can be reimbursed for their mileage costs when transporting children to visits with siblings.
Visitation Perspectives

Step into the shoes of each role.

<table>
<thead>
<tr>
<th></th>
<th>Child</th>
<th>Birth Parent</th>
<th>Foster Parent/Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What am I feeling?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What do I fear?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What do I want?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Last class we talked about working with birth parents for the benefit of the children in our care. We covered the importance of visitation as well as the various ways visitation can happen. In addition, we heard the voices of birth parents who had successfully reunified and we found empathy for their experiences. This session will focus on the importance of the connections that children bring into care: their cultural, ethnic and racial heritage – and our own. We will work on how to have courageous conversations about our different backgrounds and experiences. In addition, we will cover disproportionality and some of the groups who are most likely to be involved in the child welfare system, including Native American and LGBTQ youth.
Session 4: Cultural Connections and Advocacy

Topics covered in Session 4
- Race, Ethnicity and Culture
- Understanding Disproportionality
- Native American Children
- LGBTQ Youth
- Advocacy
- How We Interpret Behavior
- Keeping Cultural Connections

Competencies covered in Session 4

CFAM134-01  Awareness of the need to encourage everyone in the home be respectful; provides appropriate nurturing and empathy to children.

CFAM136-01  Awareness of the need to interact with children and their families in a culturally responsive and appropriate way.

CFAM136-02  Awareness of the importance of helping children resolve issues related to race, ethnicity and culture.

CFAM136-03  Awareness of the mandate to keep Indian children connected with their cultural heritage and tribes.

CFAM136-04  Awareness of the need to seek deeper knowledge and develop skills for interacting with families from diverse cultures.

CFAM136-05  Awareness of the key issues faced by refugees or immigrants.

CFAM139-14  Awareness that some children may question their sexual identity and that some may be gay lesbian, bisexual or transgendered.

Begin Session 4
Race

“Race is a socially constructed system of categorizing humans largely based on observable physical features (phenotypes) such as skin color and on ancestry.

There is no scientific basis for or discernible distinction between racial categories.

The ideology of race has become embedded in our identities, institutions and culture and is used as a basis for discrimination and domination.”

This quote comes from the seminal work of Omi and Winant, Racial Formation in the United States: From the 1960s to the 1990s.
The Cultural Iceberg

Like an iceberg, the majority of culture is below the surface. When one first enters into another culture, one is usually first interacting with only the top 10% – literally, the tip of the iceberg! Sometimes people make assumptions or develop ideas about another cultural community without really understanding the internal or deep characteristics that makes up the majority of that culture’s values and beliefs.

Adapted from Indiana Department of Education: Office of English Language Learning and Migrant Education
Disproportionality in the Child Welfare System

Disproportionality is happening throughout the system: kids from certain ethnic and racial backgrounds are more likely to enter, more likely to stay and less likely to get adopted. And this is happening locally. Comparing 2015 Census data for Washington State and children in the care of DCFS as of March 31, 2015, you can see the over-representation or under-representation of children.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>% of Total Population in Washington State</th>
<th>% of Children in Foster Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>1.9%</td>
<td>13%</td>
</tr>
<tr>
<td>Asian</td>
<td>8.2%</td>
<td>2%</td>
</tr>
<tr>
<td>African-American</td>
<td>4.1%</td>
<td>7%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12.2%</td>
<td>24%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>80.7%</td>
<td>53%</td>
</tr>
</tbody>
</table>
Bringing Our Children Home, Video Recap

1. What new information did you learn about the history of Indian Child Welfare?

2. What was the pain expressed in this video tied to?

3. What do children need while in cross-cultural placements to mitigate the potential consequences?

4. What principles can we apply for all children who are placed cross culturally?
Supporting LGBTQ Youth in Care

Take some time for the following self-assessment:

- Do you recognize, and can you set aside any beliefs, prejudices or fears that you may have?
- Can you allow the youth’s concerns to take center stage?
- Will your conscious and unconscious motivations and expectations about sexual identity affect your parenting?
- What motivated you to become a caregiver?
- What qualities did you think you needed to be a good caregiver?
- Do you have realistic expectations about the children in care?
- Are you able to separate your goals and expectations from the realities of the child in your care?

Do you understand and believe that:

- Being LGBTQ is not “just a phase.”
- Sexual orientation and gender identity are the result of complex genetic, biological, and environmental factors.
- LGBTQ youth are no more likely than other youth to be mentally ill or dangerous.
- LGBTQ identity cannot be changed.
- There are many religious groups that embrace LGBTQ people.
- LGBTQ youth are like other youth.
  - They may have been affected by trauma and loss.
  - They require acceptance and understanding.
  - They need to understand that your home is welcome to all differences, including race, ethnicity, disability, religion, gender and sexual orientation.

Caregivers Must Create a Welcoming Home for Youth

ALL youth need:

- Nurturing homes
- A safe place to process their feelings of grief and loss
Supporting LGBTQ Youth in Care, Continued

- Freedom to express who they are
- Structure to support them in becoming responsible, healthy adults

Feeling good about one’s sexual identity is one of the most critical challenges of adolescence.

As caregivers there are some simple steps that we can take to enhance the lives of children who are trying to negotiate adolescence and who may also be struggling with sexual identity. These children have experienced the same losses, and traumas that have brought other youth into care. In addition to the stressors unique to LGBTQ youth, including homophobia or transphobia and their need to evaluate the safety of their communities, schools, social networks, and homes in order to decide whether to disclose their LGBTQ identity, when, and to whom. As caregivers we must be aware and willing to listen, understand, and assist these youths to become happy, healthy adults.

Whether or not a youth in care openly identifies as LGBTQ:

- Make it clear that slurs or jokes based on gender, gender identity, or sexual orientation are not tolerated in your house. Express your disapproval of these types of jokes or slurs when you encounter them in the community or media.

- Display “hate-free zone” signs or other symbols indicating an LGBTQ-friendly environment (pink triangle, rainbow flag, etc.).

- Use gender-neutral language when asking about relationships. For example, instead of “Do you have a girlfriend?” ask, “Is there anyone special in your life?”

- Celebrate diversity in all forms (books, movies, materials, celebrities).

- Let youth in your care know that you are willing to listen and talk about anything.

- Support the youth’s self-expression through choices of clothing, jewelry, hairstyle, friends and room decoration.

- Insist that other family members include and respect all youth in your home.

- Allow youth to participate in activities that interest them, regardless of whether these activities are stereotypically male or female.

- Educate yourself about LGBTQ history, issues and resources.
Supporting LGBTQ Youth in Care, Continued

If a youth in your care discloses his or her LGBTQ identity, you can show your support in the following ways:

- When the youth discloses his or her LGBTQ identity to you, respond in an affirming, supportive way.
- Understand that the way people identify their sexual orientation or gender identity may change over time.
- Use the name and pronouns (he/she) that the youth prefers. If you are not sure, ask.
- Respect the youth’s privacy. Allow him or her to decide when to come out and to whom.
- Avoid double standards: Allow your LGBTQ youth to discuss feelings of attraction and engage in age-appropriate romantic relationships, just as you would a heterosexual youth.
- Welcome your youth’s LGBTQ friends or partner at family gatherings.
- Connect your youth with LGBTQ organizations, resources, and events. Consider seeking an LGBTQ adult role model for your youth, if possible.
- Stand up for your youth when he or she is mistreated.
- Be prepared to advocate for your youth. To do that you must fully understand the youth’s rights. Please watch for and take part in special topic classes on LGBTQ youth.

Bullying and harassment at school are everyday experiences for many LGBTQ youth. Negative remarks about sexual orientation or gender identity can be common from other students, and even faculty or staff. School harassment can have a devastating consequence for the youth’s education and general well-being. Absenteeism and dropout rates are higher and grade point averages lower among LGBTQ youth who are experiencing harassment at school.

It is important to be comfortable with any and all gender identity and/or sexual orientations a child might have (even if you are unaware of them) prior to inviting them into your home.
Keeping Cultural Connections – Scenarios

Scenario 1
Iesha is a 12-year-old African-American girl. She grew up with her biological mother in a poor part of town. She and her mother were very close and spent weekends doing girl stuff like painting nails and doing hair. Iesha loved it when her mom would spend hours braiding Iesha’s hair. Iesha and her mother attended the Baptist church where some of Iesha’s friends also attended. Iesha went to the public school down the street where she would talk to many of her neighbors as she passed them on her way to and from school. Even though Iesha and her mom didn’t have much, they had each other.

Iesha’s mom passed away unexpectedly. Because Iesha doesn’t have any other family, she was placed in a foster home until a permanent placement could be found. Eventually a family came forward that wanted to adopt Iesha. The mom, dad and 3 children (all older than Iesha) live in an upper middle class neighborhood. Iesha has been enrolled in a private school where she has to wear a uniform and her grades begin to drop. The family attends the Catholic Church, eats strange food (compared to what Iesha is used to) and does not allow Iesha to talk to the neighbors. The family does not know their neighbors and they don’t want the neighbors involved in their business. The children in Iesha’s new home are not interested in trying any foods that Iesha likes. They think Iesha’s food sounds horrible. Iesha misses her old school and the Baptist church.

How can the adoptive parents keep Iesha connected with her culture? How could her foster parents advocate for her?

Scenario 2
Michael, 5 years old, and his older sister Victoria, 7 years old, are members of the Quinault Indian Nation. They grew up with their mother in a single-parent home in Tribal housing on the Quinault Reservation. The children have a close relationship with their maternal relatives, as they have grandparents, auntsies and uncles who occasionally provide care and supervision when their mother is at work. The children participated in Tribal events on the reservation, attending Pow-Wows and Community Gatherings, and the family regularly attended Shaker church services.

The father is a member of the Yakama Nation and lives in Olympia. He has not had contact with the children since Michael was born. However, Michael and Victoria know their paternal relatives who live in Tacoma and on the Yakama Reservation. The children visit the Yakama Tribe and their paternal relatives monthly.
Keeping Cultural Connections – Scenarios, Continued

The children are involved in drumming, singing, and dancing. Victoria excels in fancy dancing and looks forward to Pow-Wow season. Michael also enjoys going to Pow-Wows, and mostly stays by the drum circle and sings with the group every chance he gets.

The children were removed from their mother’s care because of substance abuse issues. Although there are a lot of family members who helped raise the children thus far, no one was available to take in Michael and Victoria. The children were placed into foster care and in separate homes. Michael was placed in a home in Aberdeen and Victoria was placed in a home in Chehalis.

Since the children were removed, the mother has not complied with court orders and has not communicated with the Tribal Child Welfare program. Some Tribal staff sees the mother in the local area, but has not been successful in maintaining connection with her.

Michael has adjusted well in his Aberdeen home, but frequently asks about his mother and the rest of the family, and gets extremely emotional about missing his “Grandpapa.” The child explained that his grandfather taught him how to drum and sing.

Victoria has struggled in her Chehalis home. She reports not having any friends in school and deeply misses her family, especially Michael. While passing by Capitol Lake in Olympia, Victoria said that she likes looking over the water because it reminds her of home.

How can the foster parents keep Michael and Victoria connected with their culture? How could their foster parents advocate for them?

Scenario 3

Janae is a 17-year-old girl who identifies as male. Janae came into care after extreme physical abuse at home in Seattle. Janae’s parents refused to accept Janae as male, or use the name “Jay,” as Janae requested. Janae ran away from home and was picked up by the police a week ago. Janae has been placed in a foster home in Tacoma that has no previous experience with children whose gender identity does not match their physical body. The foster parents don’t know what to do to help or support Janae. Janae has not opened up to them yet. However, at Janae’s old school, Janae had a strong connection to the guidance counselor, who was a strong ally. In addition, Janae, had connected to Gay City in Seattle and was involved in programming there.

How can the foster parents keep Janae connected with his/her culture? How could the foster parents advocate for Janae?
Caregiver Core Training – Participant Manual

Field Experience

Between Session 4 and Session 5, you have the opportunity to learn outside the classroom by choosing an activity that will give you more awareness of the experience of children within the system or of the role of a caregiver for children in the system. This document provides suggestions for your field experience, organized by region.
Field Experience Suggestions

Region 1

Videos

Articles

Occasional Support Groups
Note that there are very few active support groups in Region 1.

Region 2

Foster Parent Support Groups
All groups are open to those considering relative care, foster care and/or adoption.

For a list of support groups in your area visit Fostering Together:
http://fosteringtogether.org/support-groups

Muckleshoot Field Experience
Various social services are offered to assist individuals achieve self-sufficiency. Services offered include general assistance, federal LIHEAP, community services block grants, family violence prevention, social services, case management and referrals.

If you are interested, please contact Cynthia Orie:
(253) 876-3396
39015 172nd Ave SE
Auburn, WA 98092

Daybreak Star Cultural Center Field Experience
The Daybreak Star Cultural Center is a Native American Cultural Center in Seattle, Washington, described by its parent organization United Indians of All Tribes as “an urban base for Native Americans in the Seattle area.” Daybreak Star Indian Cultural Center is located on 20 acres (81,000 m²) of Seattle’s Discovery Park in the Magnolia neighborhood.

If you are interested, please contact Thaidra Alfred:
(206) 829-2229

Visit Treehouse and Tour the 2100 Building
Treehouse is a non-profit organization serving foster children and their families. It is housed in Seattle at 2100 24th Avenue South in what is commonly referred to as “the 2100 Building.” This
facility is also home to The YMCA Independent Living Program, The Mockingbird Society and many other organizations that serve children in care. They are currently scheduling tours on Mondays at 4:30, Wednesday at 11:30 and a floating time on Friday's (depending on request and schedules).

To set up a tour, contact:
Michelle McBreen
Treehouse Intake Coordinator
(206) 267-5130
referrals@treehouseforkids.org

Attend “Dependency 101”
Dependency 101 is a two-hour class designed to educate bio parents about the dependency system and help them learn to navigate it.

Youth Service Center (Juvenile Court) in Seattle, Room 203: 1st Wednesday of every month from 3:00pm to 5:00pm and the 3rd Thursday of every month, from 11:30am to 1:30pm.

The Maleng Regional Justice Center in Kent: 2nd Wednesday of every month from 11:30am to 1:30pm.

Call (206) 477-2566 for more information.

Website: http://kingcounty.gov/courts/JuvenileCourt/dependency/parentsforparents.aspx

Observe a Hearing in Dependency Court
Dependency court hearings are open to the public.

King County Dependency Court located is in the Seattle Downtown King County Superior Court (2nd Floor E201). Hearings are Monday-Thursday from 8:30am to 12:00 pm and from 1:30pm to 4:00pm.

516 3rd Ave Seattle, WA 98104
(206) 477-2310

Attend a Meeting on House Bill 1624
Engrossed Substitute House Bill (ESHB) 1624 was passed by the House of Representatives and the Senate on April 20, 2007. This bill requires regional and statewide quarterly meetings between Children’s Administration (CA), foster parents, and the Foster Parent Association of Washington State (FPAWS).

To find out more, visit http://www.fpaws.org/content/cafpt-1624-2013-roster
Attend a Mockingbird Hub Meeting

The Mockingbird Family Model (MFM) is an award-winning, innovative – yet intuitively old-fashioned – model for foster care delivery. In every MFM 'constellation,' six to ten families live in close proximity to a licensed foster care family – a Hub Home – who provides assistance in navigating bureaucracy, peer support, social activities and respite care. Each Hub (located in Everett, Kirkland and South Seattle) holds monthly meetings. Every other month they hold “Project Leadership Team” Meetings with community stakeholders.

To learn more about attending a meeting, contact:
Degale Cooper
Mockingbird Society Director of Family Programs
(206) 407-2133
degale@mockingbirdsociety.org

Contact the CASA/ GAL Program for a Conversation and Observation of Family Treatment Court

Court Appointed Special Advocates (CASA) is a national association in the United States that supports and promotes court-appointed advocates for abused or neglected children in order to provide children with a safe and healthy environment in permanent homes.

In Seattle (at the King County Superior Court), contact:
Luis Galvan
Luis.Galvan@kingcounty.gov

Meet with an Experienced Foster Parent

Contact an experienced foster parent from one of the resources below and talk to them about their experience.

### Mockingbird Hub Home Providers

<table>
<thead>
<tr>
<th>Hub Name</th>
<th>Constellation Location</th>
<th>DSHS Office</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cathy &amp; Kevin Apgar</td>
<td>Marysville</td>
<td>Smokey Point</td>
<td><a href="mailto:K_C@frontier.com">K_C@frontier.com</a></td>
</tr>
<tr>
<td>Diana Hardwick-Smith</td>
<td>Shoreline</td>
<td>King West</td>
<td><a href="mailto:Diana.hardwick@gmail.com">Diana.hardwick@gmail.com</a></td>
</tr>
<tr>
<td>Mary &amp; Gerald Donaldson</td>
<td>Kirkland</td>
<td>King East</td>
<td><a href="mailto:thedonaldsonscare@comcast.net">thedonaldsonscare@comcast.net</a></td>
</tr>
<tr>
<td>Liz &amp; Stephen Wisham</td>
<td>Carnation</td>
<td>King East</td>
<td><a href="mailto:LizW@occ.org">LizW@occ.org</a></td>
</tr>
</tbody>
</table>

Or contact:
FPAWS
(The Foster Parents Association of Washington State)
View Online Short Film “ReMoved”
Write a 1- or 2-page paper about your thoughts and observations of this film. Meet with others in class who have picked this option and have a one-hour discussion about the film. Consider the topics listed below when viewing the film.

- Domestic Violence
- Differences in foster homes
- Abuse & Neglect
- Parentified children
- Trauma
- Separation of siblings
- Why children come into care
- Behavioral triggers

This is only an option for participants who have not yet seen the film.

To find the video, search Youtube or visit http://vimeo.com/73172036

Office Moms & Dads Field Experience
Office Moms & Dads is a practical way to support local child welfare social workers and also care for children who have recently been removed from their home. Office Moms & Dads provides a caring adult who can care for, sit with, and entertain a child or sibling group while a social worker works hard to find a foster care placement for them.

For more information, please contact:

West Seattle/ White Center
Mandy Neil
OMDKingWest@gmail.com
westseattleomd@gmail.com

Bellevue
Janae Jones
Janae.jones@dshs.wa.gov
Region 3

Lewis County
Local foster parent liaison contact for Lewis Co:
Rachelle Ireton
(360) 957-9574
Rachelle-Ireton@olivecrest.org

Fostering Together
www.fosteringtogether.org

Suggestions:

- Contact a foster parent you already know and have a discussion about their experience as a foster parent.
- Contact your local foster parent liaison with specific questions regarding foster care. Find the liaison serving your area: http://fosteringtogether.org/about/staff/regional/
- Use the Fostering Together website to find and attend Foster Parent Support groups http://fosteringtogether.org
- Check out the Lewis County Foster Parent Association (LCFPA). Connect with other licensed foster parents. Attend monthly meetings. Check the LCFPA out on Facebook.
- Explore the Foster Parent Association of Washington website: http://www.fpaws.org
- Attend a court hearing at Juvenile Court.
  Lewis Co. District Court
  345 W. Main St.
  Chehalis, WA 98532
  (Fourth Floor)
  Hearings begin at 10:00 AM on Thursdays.
- Check into the requirements and roles of a CASA/GAL:
  http://www.casaforchildren.org/site/apps/kb/cs/contactsearch.asp?c=mtJSJ7MPIsE&b=5331473&raw=
- Spend a few hours with a foster family you already know and interact with the children.
Foster parent must be present at all times.

- Learn about local resources for foster children using google or the DSHS website.
- Visit or contact a local child-placing agency to get more information about what they offer for foster parents.
- Learn more about the Passport to College program:
  http://www.collegesuccessfoundation.org/wa/supports-and-scholarships/passport
- Learn more about Independent Living Skills for teens: http://independence.wa.gov/
- Observe a Children’s Administration Foster Parent Team (1624) meeting:
  http://fosteringtogether.org/resources/1624-2/
- Learn more about Tribal Foster Care:
  http://fosteringtogether.org/foster-care/greatest-need/native-american/
- Explore the Treehouse for Kids website: http://www.treehouseforkids.org/
- Check out the Head Start/ECEAP program in your area: https://wsaheadstarteceap.com/
- Attend a Dependency 101 class. Find out when the next class in your community is offered by visiting http://familyess.org/ or contacting:

  Tonia Morrison
  Tonia@familyess.org
  (877) 813-2828

Potential foster parents and caregivers are welcome to attend. Please do not comment or ask questions during the class.

- Learn more about “Camp to Belong” ( http://www.fosterfamilyconnections.org/ ) and the “Royal Family Kids Camp” ( http://royalfamilykids.org/ )
- Learn more about being a relative caring for children:
  https://www.dshs.wa.gov/CA/fos/relatives-caring-for-kids
- Attend a Kinship Care Support Group.

  Centralia College Campus
HFL Building (brick house on the corner of Rock St. and Centralia College Blvd.)
2nd and 4th Monday of each month, 6:00pm to 8:00pm

For more information and to register for the support group, please contact:
Family Education & Support Services (FESS)
(877) 813-2828
Lynn@familyess.org

• Watch the video about Kinship Caregivers:
  http://youtu.be/4-53OUoghd8

• Explore the Kinship Care website: http://dshs.wa.gov/kinshipcare

• Watch the movie “Closure” on Netflix.

• Attend an information session regarding Amara’s Sanctuary program:
  https://www.amaraparenting.org/programs-initiatives/emergency-sanctuary/

• Watch the Mandatory Reporting Video on the Mandatory Reporting Toolkit eLearning.
  As a caregiver you are a mandated reporter of child abuse and neglect. Learn more about the reporting process in this video: http://allianceforchildwelfare.org/

• Attend an Alliance Continuing Education Class or watch a training video.
  Look for Alliance trainings in your community:
  https://allianceforchildwelfare.org/course-schedule
  For training videos, go to: https://allianceforchildwelfare.org/content/training-videos

• Attend a free training for foster parents/relative caregivers through Coordinated Care:
  http://www.cenpaticou.com/foster-care-edu/caregiver-training/

• Check The National Child Trauma Stress Network (NCTSN) website and complete one of the trainings from the website.
  http://www.nctsn.org
  http://www.nctsn.org/resources/audiences/parents-caregivers#q2

• Check out the ifoster website: Life changing resources for children and youth:
Check out the FosterClub website: https://www.fosterclub.com/

Read the Caregiver Connection monthly newsletter:
https://www.dshs.wa.gov/ca/foster-parenting

Take a free 1-day Fetal Alcohol Spectrum Disorder training for community professionals and students. For details about this training and on how to register, please go to:
fasdpn.org/htmls/1-day-train.htm

Read one of the following books:

- A Different Home: A New Foster Child’s Story by Kelly and John DeGarmo
- Maybe Days: A Book for Children in Foster Care by Jennifer Wilgocki and Marcia Kahn Wright
- A Child’s Journey Through Placement by Vera Fahlberg.
- Twenty Things Adopted Kids Wish Their Adoptive Parents Knew by Sherrie Eldridge
- How to Talk So Kids Will Listen & How to Listen so Kids Will Talk by Faber and Mazlish

**Pierce and Kitsap County**

Local foster parent liaison contacts:

**Pierce County**
Erika Thompson
(206) 406-2398
Erika-thompson@olivecrest.org

**Kitsap County**
Jeanie Johns
(360) 265-3398
Jeanie-johns@olivecrest.org

Fostering Together
www.fosteringtogether.org
Suggestions

- Contact a foster parent you already know and have a discussion about their experience as a foster parent.

- Contact your local foster parent liaison with specific questions regarding foster care.
  Find the liaison serving your area: http://fosteringtogether.org/about/staff/regional/

- Use the Fostering Together website to find and attend Foster Parent Support groups
  http://fosteringtogether.org

- Attend a court hearing at Dependency Court (Mon-Thurs is best.)
  Pierce Co.
  Remann Hall
  5501 6th Ave
  Tacoma
  Kitsap Co.
  Kitsap Juvenile Court
  1338 SW Old Clifton Rd
  Port Orchard

- Check into the requirements and roles of a CASA/GAL: http://dev.wacasa.org

- Spend a few hours with a foster family you already know and interact with the children.
  **Foster parent must be present at all times.**

- Learn about local resources for foster children using google or the DSHS website.

- Visit or contact a local child-placing agency to get more information about what they offer for foster parents.

- Attend a Foster Parent Association meeting. For more info, contact:
  Kitsap Co.
  www.kitsapfostercare.org
  Pierce Co.
  (253) 473-9252
  Foster Care Relative Resource Network
• Learn more about the Passport to College program:
  http://www.collegesuccessfoundation.org/wa/supports-and-scholarships/passport
• Learn more about Independent Living Skills for teens: http://independence.wa.gov/
• Observe a Children’s Administration Foster Parent Team (1624) meeting:
  http://fosteringtogether.org/resources/1624-2/
• Learn more about Tribal Foster Care:
  http://fosteringtogether.org/foster-care/greatest-need/native-american/
• Explore the Treehouse for Kids website: http://www.treehouseforkids.org/
• Check out the Head Start/ECEAP program in your area: https://wsaheadstarteceap.com/
• Attend a Dependency 101 class. Find out when the next class in your community is offered by visiting http://familyess.org/ or contacting:
  Pauline Ross
  Parent for Parent
  rosspm67@yahoo.com
  (253) 722-4789

  Potential foster patents and caregivers are welcome to attend. Please do not identify yourself as a potential foster parent in the class.
• Explore the Foster Parent Association of Washington website: http://www.fpaws.org
• Learn more about “Camp to Belong” ( http://www.fosterfamilyconnections.org/ ) and the “Royal Family Kids Camp” ( http://royalfamilykids.org/ )
• Learn more about being a relative caring for children:
  https://www.dshs.wa.gov/CA/fos/relatives-caring-for-kids
• Connect with the Kinship Navigator for Pierce Co. and visit HopeSparks website:
  Rosalyn Alber
  ralber@hopesparks.org
  http://hopesparks.org/programs-full-width/relatives-raising-children/
• Watch the movie “Closure” on Netflix.

• Attend an information session regarding Amara’s Sanctuary program:
  https://www.amaraparenting.org/programs-initiatives/emergency-sanctuary/

• Watch the Mandatory Reporting Video on the Mandatory Reporting Toolkit eLearning.
  As a caregiver you are a mandated reporter of child abuse and neglect. Learn more about the reporting process in this video: http://allianceforchildwelfare.org/

• Attend an Alliance Continuing Education Class or watch a training video.
  Look for Alliance trainings in your community:
  https://allianceforchildwelfare.org/course-schedule

  For training videos, go to: https://allianceforchildwelfare.org/content/training-videos

• Attend a free training for foster parents/relative caregivers through Coordinated Care:
  http://www.cenpaticou.com/foster-care-edu/caregiver-training/

• Check The National Child Trauma Stress Network (NCTSN) website and complete one of the trainings from the website.
  http://www.nctsn.org
  http://www.nctsn.org/resources/audiences/parents-caregivers#q2

• Check out the ifoster website: Life changing resources for children and youth:
  https://www.ifoster.org/

• Check out the FosterClub website: https://www.fosterclub.com/

• Read the Caregiver Connection monthly newsletter:
  https://www.dshs.wa.gov/ca/foster-parenting

• Take a free 1-day Fetal Alcohol Spectrum Disorder training for community professionals and students. For details about this training and on how to register, please go to:
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• Read one of the following books:
- *A Different Home: A New Foster Child’s Story* by Kelly and John DeGarmo
- *Maybe Days: A Book for Children in Foster Care* by Jennifer Wilgocki and Marcia Kahn Wright
- *Twenty Things Adopted Kids Wish Their Adoptive Parents Knew* by Sherrie Eldridge
- *How to Talk So Kids Will Listen & How to Listen so Kids Will Talk* by Faber and Mazlish

**Grays Harbor and Pacific County**

Local foster parent liaison contacts:

**Grays Harbor County**
Teneille Carpenter
teneille-carpenter@olivecrest.org

**Pacific County**
Niki Johnson
niki-johnson@olivecrest.org

Fostering Together
www.fosteringtogether.org

**Suggestions**

- Contact a foster parent you already know and have a discussion about their experience as a foster parent.

- Contact your local foster parent liaison with specific questions regarding foster care. Find the liaison serving your area: http://fosteringtogether.org/about/staff/regional/

- Use the Fostering Together website to find and attend Foster Parent Support groups http://fosteringtogether.org

- In Grays Harbor, attend a Foster Parent/Relative Caregiver Support Group Meeting.
  Aberdeen Public Library
  5:30-7pm
Contact:
Rhonda Snelling
im2acountrygirl@gmail.com

- Attend a court hearing at Juvenile Court.
  
  Grays Harbor
  Wednesday Mornings at 9am
  103 Hagara St.
  Aberdeen, WA
  Arrive by 8:30 if you want a seat.

  Pacific County
  1st Tuesday of the month at 9am
  300 Memorial Dr.
  South Bend, WA

- Check into the requirements and roles of a CASA/GAL:
  
  http://www.casaforchildren.org/site/apps/kb/cs/contactsearch.asp?c=mtJSJ7MPIsE&b=5331473&raw=

- Spend a few hours with a foster family you already know and interact with the children.
  
  Foster parent must be present at all times.

- Learn about local resources for foster children using google or the DSHS website.

- Visit or contact a local child-placing agency to get more information about what they offer for foster parents.

- Learn more about the Passport to College program:
  
  http://www.collegesuccessfoundation.org/wa/supports-and-scholarships/passport

- Learn more about Independent Living Skills for teens: http://independence.wa.gov/

- Observe a Children’s Administration Foster Parent Team (1624) meeting:
  
  http://fosteringtogether.org/resources/1624-2/

- Learn more about Tribal Foster Care:
  
  http://fosteringtogether.org/foster-care/greatest-need/native-american/
• Explore the Treehouse for Kids website: http://www.treehouseforkids.org/

• Check out the Head Start/ECEAP program in your area: https://wsaheadstarteceap.com/

• Explore the Foster Parent Association of Washington website: http://www.fpaws.org

• Learn more about “Camp to Belong” (http://www.fosterfamilyconnections.org/) and the “Royal Family Kids Camp” (http://royalfamilykids.org/)

• Learn more about being a relative caring for children:
  https://www.dshs.wa.gov/CA/fos/relatives-caring-for-kids

• Connect with the Kinship Navigator for Grays Harbor and Pacific County:
  Eric Nessa
  NessaEM@dshs.wa.gov
  (360) 5382458

• Watch the movie “Closure” on Netflix.

• Watch the Mandatory Reporting Video on the Mandatory Reporting Toolkit eLearning.
  As a caregiver you are a mandated reporter of child abuse and neglect. Learn more about the reporting process in this video: http://allianceforchildwelfare.org/

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  For training videos, go to: https://allianceforchildwelfare.org/content/training-videos

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  http://www.nctsn.org/resources/audiences/parents-caregivers#q2

• Check out the ifoster website: Life changing resources for children and youth:
https://www.ifoster.org/

- Check out the FosterClub website: https://www.fosterclub.com/
- Read the Caregiver Connection monthly newsletter:
  https://www.dshs.wa.gov/ca/foster-parenting
- Take a free 1-day Fetal Alcohol Spectrum Disorder training for community professionals and students. For details about this training and on how to register, please go to:
  fasdpn.org/htmls/1-day-train.htm
- Read one of the following books:
  - A Different Home: A New Foster Child’s Story by Kelly and John DeGarmo
  - Maybe Days: A Book for Children in Foster Care by Jennifer Wilgocki and Marcia Kahn Wright
  - A Child’s Journey Through Placement by Vera Fahlberg.
  - Twenty Things Adopted Kids Wish Their Adoptive Parents Knew by Sherrie Eldridge
  - How to Talk So Kids Will Listen & How to Listen so Kids Will Talk by Faber and Mazlish

Clallam County and Jefferson County
Local foster parent liaison contacts for Clallam County and Jefferson County:

Linda Cortani
(360) 640-0869
linda-cortani@olivecrest.org

Fostering Together
www.fosteringtogether.org

Suggestions

- Contact a foster parent you already know and have a discussion about their experience as a foster parent.
- Contact your local foster parent liaison with specific questions regarding foster care.
Find the liaison serving your area: http://fosteringtogether.org/about/staff/regional/

- Use the Fostering Together website to find and attend Foster Parent Support groups
  
  http://fosteringtogether.org

- Attend a court hearing at Juvenile Court.
  
  Clallam Co.
  
  Clallam County Superior Court
  223 E. 4th Street, Ste. 8
  Port Angeles, WA 98362
  (360) 417-2386

  Jefferson Co.
  
  Jefferson County Superior Court
  1820 Jefferson St.
  Port Townsend, WA 98368
  (360) 385-9125

- Check into the requirements and roles of a CASA/GAL:
  
  http://www.casaforchildren.org/site/apps/kb/cs/contactsearch.asp?c=mtJSJ7MPIsE&b=5331473&raw=

- Spend a few hours with a foster family you already know and interact with the children.

  **Foster parent must be present at all times.**

- Learn about local resources for foster children using google or the DSHS website.

- Visit or contact a local child-placing agency to get more information about what they offer for foster parents.

- Learn more about the Passport to College program:
  
  http://www.collegesuccessfoundation.org/wa/supports-and-scholarships/passport

- Learn more about Independent Living Skills for teens: http://independence.wa.gov/

- Observe a Children’s Administration Foster Parent Team (1624) meeting:
  
  http://fosteringtogether.org/resources/1624-2/

- Learn more about Tribal Foster Care:
http://fosteringtogether.org/foster-care/greatest-need/native-american/

- Explore the Treehouse for Kids website: http://www.treehouseforkids.org/
- Check out the Head Start/ECEAP program in your area: https://wsaheadstarteceap.com/
- Explore the Foster Parent Association of Washington website: http://www.fpaws.org
- Learn more about “Camp to Belong” (http://www.fosterfamilyconnections.org/) and the “Royal Family Kids Camp” (http://royalfamilykids.org/)
- Learn more about being a relative caring for children:
  https://www.dshs.wa.gov/CA/fos/relatives-caring-for-kids
- Watch the movie “Closure” on Netflix.
- Watch the Mandatory Reporting Video on the Mandatory Reporting Toolkit eLearning.
  As a caregiver you are a mandated reporter of child abuse and neglect. Learn more about the reporting process in this video: http://allianceforchildwelfare.org/
- Attend an Alliance Continuing Education Class or watch a training video.
  Look for Alliance trainings in your community:
  https://allianceforchildwelfare.org/course-schedule
  For training videos, go to: https://allianceforchildwelfare.org/content/training-videos
- Attend a free training for foster parents/relative caregivers through Coordinated Care:
  http://www.cenpaticou.com/foster-care-edu/caregiver-training/
- Check The National Child Trauma Stress Network (NCTSN) website and complete one of the trainings from the website.
  http://www.nctsn.org
  http://www.nctsn.org/resources/audiences/parents-caregivers#q2
- Check out the ifoster website: Life changing resources for children and youth:
  https://www.ifoster.org/
- Check out the FosterClub website: https://www.fosterclub.com/
- Read the Caregiver Connection monthly newsletter:
  https://www.dshs.wa.gov/ca/foster-parenting

- Take a free 1-day Fetal Alcohol Spectrum Disorder training for community professionals and students. For details about this training and on how to register, please go to:
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- Read one of the following books:
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  - *Maybe Days: A Book for Children in Foster Care* by Jennifer Wilgocki and Marcia Kahn Wright
  - *Twenty Things Adopted Kids Wish Their Adoptive Parents Knew* by Sherrie Eldridge
  - *How to Talk So Kids Will Listen & How to Listen so Kids Will Talk* by Faber and Mazlish

**Clark and Cowlitz County**
Local foster parent liaison contacts:

Clark County
Kim Glover
(360) 433-7150
Kim-Glover@olivecrest.org

Cowlitz County
Rachelle Ireton
(360) 957-9574
Rachelle-Ireton@olivecrest.org

Fostering Together
www.fosteringtogether.org

Suggestions

- Contact a foster parent you already know and have a discussion about their experience as a foster parent.
• Visit the lobby at the Vancouver or Kelso DCFS office and observe interactions.

• Join other foster parents and social workers at “Dessert Night.” There will be time to socialize and a question-and-answer period. Contact:

  Terisa Rivera
  rivert@dshs.wa.gov

• Contact your local foster parent liaison with specific questions regarding foster care.
  Find the liaison serving your area: http://fosteringtogether.org/about/staff/regional/

• Use the Fostering Together website to find and attend Foster Parent Support groups
  http://fosteringtogether.org

• Learn about the clothing closet resources, foster care night, and what churches have been doing for foster families. Contact:

  Kim Glover
  ankglover@comcast.net

• Attend a court hearing at Juvenile Court.

  Cowlitz Co.
  Cowlitz County Juvenile Court
  1725 1st Ave, Longview, WA 98632
  (360) 577-3100

  Clark Co.
  Family Law Annex
  601 W. Evergreen Blvd.
  Vancouver, WA

• Check into the requirements and roles of a CASA/GAL:

  http://www.casaforchildren.org/site/apps/kb/cs/contactsearch.asp?c=mtJSJ7MPIsE&b=5331473&raw=

• Spend a few hours with a foster family you already know and interact with the children.

  Foster parent must be present at all times.

• Learn about local resources for foster children using google or the DSHS website.
• Visit or contact a local child-placing agency to get more information about what they offer for foster parents.

• Learn more about the Passport to College program:
  http://www.collegesuccessfoundation.org/wa/supports-and-scholarships/passport

• Learn more about Independent Living Skills for teens: http://independence.wa.gov/

• Learn more about the Independent Living Skills program at the Clark Co. YWCA:
  http://www.ywcaclarkcounty.org/site/c.brKRL6NKLnJ4G/b.9240781/k.5482/Independent_Living_Skills_Program.htm

• Observe a Children’s Administration Foster Parent Team (1624) meeting:
  http://fosteringtogether.org/resources/1624-2/

• Learn more about Tribal Foster Care:
  http://fosteringtogether.org/foster-care/greatest-need/native-american/

• Explore the Treehouse for Kids website: http://www.treehouseforkids.org/

• Learn more about the educational resources available in Cowlitz Co. at The Progress Center: http://theprogresscenter.org/

• Check out the Head Start/ECEAP program in your area: https://wsaheadstarteceap.com/

• Explore the Foster Parent Association of Washington website: http://www.fpaws.org

• Learn more about “Camp to Belong” (http://www.fosterfamilyconnections.org/) and the “Royal Family Kids Camp” (http://royalfamilykids.org/)

• Learn more about being a relative caring for children:
  https://www.dshs.wa.gov/CA/fos/relatives-caring-for-kids

• Connect with the Kinship Navigator for Clark and Cowlitz Co:
  Selena Deer
  Selena.Deer@chs-wa.org
  (360) 695-1325 Ext. 4214

• Watch the movie “Closure” on Netflix.
• Watch the Mandatory Reporting Video on the Mandatory Reporting Toolkit eLearning.

As a caregiver you are a mandated reporter of child abuse and neglect. Learn more about the reporting process in this video: http://allianceforchildwelfare.org/

• Attend an Alliance Continuing Education Class or watch a training video.

Look for Alliance trainings in your community: https://allianceforchildwelfare.org/course-schedule

For training videos, go to: https://allianceforchildwelfare.org/content/training-videos

• Attend a free training for foster parents/relative caregivers through Coordinated Care: http://www.cenpaticou.com/foster-care-edu/caregiver-training/

• Check The National Child Trauma Stress Network (NCTSN) website and complete one of the trainings from the website.

http://www.nctsn.org
http://www.nctsn.org/resources/audiences/parents-caregivers#q2

• Check out the ifoster website: Life changing resources for children and youth:

https://www.ifoster.org/

• Check out the FosterClub website: https://www.fosterclub.com/

• Read the Caregiver Connection monthly newsletter:

https://www.dshs.wa.gov/ca/foster-parenting

• Take a free 1-day Fetal Alcohol Spectrum Disorder training for community professionals and students. For details about this training and on how to register, please go to:

fasdpn.org/htmls/1-day-train.htm

• Read one of the following books:

  o A Different Home: A New Foster Child’s Story by Kelly and John DeGarmo
- **Maybe Days: A Book for Children in Foster Care** by Jennifer Wilgocki and Marcia Kahn Wright
- **A Child’s Journey Through Placement** by Vera Fahlberg.
- **Twenty Things Adopted Kids Wish Their Adoptive Parents Knew** by Sherrie Eldridge
- **How to Talk So Kids Will Listen & How to Listen so Kids Will Talk** by Faber and Mazlish

### Thurston and Mason County

Local foster parent liaison contact for Thurston and Mason Co:

Niki Hatzenbuehler
(253) 219-3355
niki-hatzenbuehler@olivecrest.org

Fostering Together
www.fosteringtogether.org

### Suggestions

- Contact a foster parent you already know and have a discussion about their experience as a foster parent.

- Contact your local foster parent liaison with specific questions regarding foster care.
  
  Find the liaison serving your area: http://fosteringtogether.org/about/staff/regional/

- Use the Fostering Together website to find and attend Foster Parent Support groups
  
  http://fosteringtogether.org

- In Thurston Co. attend the Foster Parent Support Group, Lifeline.
  
  Join us at the Hand’s on Children’s Museum for a support group and training program for foster parents. The support group is the 3rd Tuesday of every month from 6:00 pm to 8:00 pm. For more information or if you are planning on attending the support group, please contact:

  Family Education & Support Services (FESS)
  (877) 813-2828
  Marc@familyess.org
• Attend a court hearing at Juvenile Court.

  Mason County Superior Court
  419 N 4th Street
  Shelton, WA 98584.
  Hearings begin at 1:30 PM on Thursdays.

  Family & Juvenile Court
  Law Library
  2801 32nd Avenue SW
  Tumwater, WA 98501
  Hearings begin at 9:00 AM on Fridays.

• Check into the requirements and roles of a CASA/GAL:

  http://www.casaforchildren.org/site/apps/kb/cs/contactsearch.asp?c=mtJSJ7MPIsE&b=
  5331473&raw=

• Spend a few hours with a foster family you already know and interact with the children.

  **Foster parent must be present at all times.**

• Learn about local resources for foster children using google or the DSHS website.

• Visit or contact a local child-placing agency to get more information about what they offer for foster parents.

• Learn more about the Passport to College program:

  http://www.collegesuccessfoundation.org/wa/supports-and-scholarships/passport

• Learn more about Independent Living Skills for teens: http://independence.wa.gov/

• Observe a Children’s Administration Foster Parent Team (1624) meeting:

  http://fosteringtogether.org/resources/1624-2/

• Learn more about Tribal Foster Care:

  http://fosteringtogether.org/foster-care/greatest-need/native-american/

• Explore the Treehouse for Kids website: http://www.treehouseforkids.org/

• Check out the Head Start/ECEAP program in your area: https://wsaheadstarteceap.com/
• Attend a Dependency 101 class. Find out when the next class in your community is offered by visiting http://familyess.org/ or contacting:

  Tonia Morrison  
  Tonia@familyess.org  
  (877) 813-2828

Potential foster parents and caregivers are welcome to attend. Please do not comment or ask questions during the class.

• Explore the Foster Parent Association of Washington website: http://www.fpaws.org

• Learn more about “Camp to Belong” (http://www.fosterfamilyconnections.org/) and the “Royal Family Kids Camp” (http://royalfamilykids.org/)

• Learn more about being a relative caring for children:

  https://www.dshs.wa.gov/CA/fos/relatives-caring-for-kids

• Attend a Kinship Care Support Group, Kinship Conversations

  The Olympia support group is every Tuesday from 6:00 pm to 8:00 pm at the Hands on Children’s Museum in Olympia.

  The Shelton support group is the 3rd Monday of every month from 6:30 pm to 8:00 pm at the Squaxin Island Child Development Center, located at 3851 SE Old Olympic Hwy Ave. Shelton, WA 98584.

  For more information and to register for the support groups, please contact:

  Family Education & Support Services (FESS)  
  (877) 813-2828  
  Lynn@familyess.org

• Watch the video about Kinship Caregivers: http://youtu.be/4-53OUoghd8

• Explore the Kinship Care website: http://dshs.wa.gov/kinshipcare

• Watch the movie “Closure” on Netflix.

• Attend an information session regarding Amara’s Sanctuary program:

  https://www.amaraparenting.org/programs-initiatives/emergency-sanctuary/

• Watch the Mandatory Reporting Video on the Mandatory Reporting Toolkit eLearning.
As a caregiver you are a mandated reporter of child abuse and neglect. Learn more about the reporting process in this video: http://allianceforchildwelfare.org/

- Attend an Alliance Continuing Education Class or watch a training video.

  Look for Alliance trainings in your community:
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  For training videos, go to: https://allianceforchildwelfare.org/content/training-videos

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- Read the Caregiver Connection monthly newsletter:
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  - A Child’s Journey Through Placement by Vera Fahlberg.
- *Twenty Things Adopted Kids Wish Their Adoptive Parents Knew* by Sherrie Eldridge

- *How to Talk So Kids Will Listen & How to Listen so Kids Will Talk* by Faber and Mazlish
Caregiver Core Training – Participant Manual

Session 5: Growing up with Trauma, Grief, and Loss

We started off CCT with an overview of the child welfare system from intake to permanency. We talked about how and why kids come into care; the decision-making process of a social worker; legal authority; the court timelines; and the possibility of Tribal involvement. We also emphasized concurrent planning and where the foster parent, the relative parents, and the adoptive parents fit into the system. We then focused in on the child welfare team and the role of the caregiver, including team meetings, your report to the court and advocacy. In addition, we focused in on the continuum of caregiver involvement with birth families, with topics like visitation and parenting/mentoring the parent. We concluded with a focus on cultural connections and how to keep these connections for children who are in care connected.

For the remainder of CCT, we will primarily focus on the child’s experience in developing attachment and dealing with trauma, grief and loss, and building a basic framework for parenting children in out-of-home care.

This session will cover brain development, exposure to drugs and alcohol in utero, child development, and attachment, ending with an exploration of grief and loss and the essential connections.
Session 5: Growing up with Trauma, Grief, and Loss

Topics covered in Session 5
- Early Child Development
- Attachment
- Trauma, Grief, and Loss

Competencies covered in Session 5

CFAM131-01 Awareness of child and human development across all developmental domains.

CFAM131-02 Awareness that early childhood is a critical window for brain development.

CFAM131-03 Awareness of the effects of poverty, trauma, and maltreatment on development and how children in care, due to genetic factors, may also be at elevated risks of developing health, mental health and/or developmental concerns.

CFAM132-01 Awareness of the child’s need to heal from physical and emotional trauma.

CFAM133-01 Awareness of the dynamics of brain development, relationships and attachments.

CFAM133-02 Awareness that children in out-of-home care may be affected by attachment issues and disorders.

CFAM133-03 Awareness that separation and placement affects early brain development, relationships and attachments.

CFAM133-04 Awareness that relationships with trustworthy, consistent caregivers will have a positive effect of the development of the child’s brain.

CFAM133-05 Awareness that separation, grief, and loss is experienced by children, families, caregivers, and social workers.

CFAM134-10 Awareness of the potential influences/triggers on a child’s behavior including: developmental challenges, behavioral emotional challenges, past abuse, neglect, separation, and placement.

CFAM139-01 Awareness that a child entering care may have special needs: illness or medical condition; developmental delays; emotional and/or behavioral issues; may be medically fragile.

CFAM139-04 Awareness of the possible effects of prenatal drug exposure.

CFAM139-05 Awareness that Fetal Alcohol Spectrum Disorder may impact development.
Session 5: Growing up with Trauma, Grief, and Loss

Competencies covered in Session 5, continued

CFAM139-06  Awareness of the possibility of providing care to children with emotional, behavioral, or thought disorders.

CFAM139-10  Awareness that post-traumatic stress disorder (PTSD) may occur in children of trauma.

CFAM139-11  Awareness of healthy sexual development in children and youth including knowledge of puberty.

CFAM139-12  Awareness that sexual abuse may impact a child’s behavior, thoughts and development.

CFAM139-13  Awareness that some children may have been exposed to domestic violence.

CFAM139-15  Awareness that children placed in care may not possess age appropriate life skills.

CFAM139-17  Awareness that some children, especially children of trauma, may have drug and/or alcohol abuse issues.

Begin Session 5
Child Development

Infancy and Toddlerhood (Birth – 3 Years)

Physical Development

Birth – 1 year
The development of control and mastery over one's own body in both gross and fine motor skills is the infant's primary physical task, culminating toward the end of the first year in walking.

Age 1-2 years
The infant perfects the gross and fine motor skills that emerged during the first year by developing balance, coordination, stability, and an improved ability to manipulate objects.

Age 2-3 years
The child develops increased strength and uses motor skills to master challenges in the environment, such as bicycles, stairs, balls, playground equipment, eating utensils, crayons, and other objects. The child is developmentally ready to master toilet training.

Cognitive Development

Birth – 1 year
Cognition begins with alertness, awareness, recognition, and interest in visual, auditory, and tactile (touch) stimuli. As motor development improves, the infant begins to explore and manipulate objects and develops a rudimentary understanding of his/her properties. Infants develop object permanence (The understanding that objects continue to exist even when they cannot be seen, heard, or touched) toward the end of the first year.

Age 1-2 years
The emergence of symbolic thought is central to cognitive development. This results in the ability to understand and produce language.

Age 2-3 years
Perfection of language skills and the use of language to communicate with others is the principle cognitive task.

Social Development

Birth – 1 year
The most important social task is the development of attachment to the primary caretaker, most often the child's mother.
Child Development, Continued

Age 1-2 years
The child develops affectionate and trusting relationships with other family members and with adults outside the family. The child can also be engaged in simple games and play.

Age 2-3 years
The child develops rudimentary relationships with other children, which are usually characterized by parallel play; that is play in the presence of, rather than in interaction with, other children. Children also begin to imitate social roles at this time. Toilet training represents a significant internalization of social rules and expectations.

Emotional Development

Birth – 1 year
The development of basic trust, a derivative of the positive attachment between the infant and the primary caretaker, occurs during the first year. This is a cornerstone of emotional development.

Age 1-3 years
The primary developmental task involves the development of autonomy, which includes mastery and control over oneself and one's environment. Children develop a rudimentary self-concept, experiencing pride and pleasure at being "good" and embarrassment, shame, and distress at being "bad."

Moral Development
Might Makes Right: Focus on deference to power and an avoidance of physical punishment. The immediate consequence of an action determines its goodness or badness.

Sexual Development
- Sex organs are present.
- Boys experience erections.
- Girls are susceptible to vaginal infections (lack of estrogen causes the walls of the vagina to be thin and dry).
- Both sexes learn the difference between boys and girls.
- Exploration of own genitals is common.
- Curiosity about parents’ bodies is present.
- Gender-role conditioning begins.
- Pleasure is derived from touching, being touched, looking, listening and sucking.
Child Development, Continued

Preschool (3-5 Years)

Physical Development
Most basic gross motor abilities have emerged. Existing skills are practiced and perfected. The child develops mastery in applying motor skills to increasingly challenging and complex situations.

Cognitive Development
Language develops rapidly. Grammar and syntax are refined, and vocabulary increases geometrically. The child uses language as a communication tool. Thinking is concrete and egocentric in nature. Problem solving is illogical and magical thinking and fantasies are prevalent.

Social Development
The child expands social relationships outside the family such as developing interactive and cooperative play skills with peers. The child begins to understand, explore, imitate, and practice social roles. The child learns concepts of "right" and "wrong" and begins to understand the nature of rules. He/she experiences guilt when he/she has done something wrong.

Emotional Development
The preschool child has been described as "on the make." Erikson refers to the child's primary mode of operation during this stage as initiative. The child is intrusive, takes charge, is very curious and continuously tries new things, actively manipulates the environment, and is self-directed in many activities.

Moral Development
The child's beginning to understand "right" and "wrong" leads to self-assessments, affecting the development of self-esteem.

Sexual Development
- Slight increase in size of genitalia occurs.
- Playing “house” and “doctor” is predictable.
- Engaging in exhibition and observation of others’ bodies is common (though not necessarily appropriate).
- The learning of gender roles is continuing.
- Sex words are being used without their actual meaning being known.
- Masturbation is more deliberate.
Child Development, Continued

School Age (6-11 Years)

Physical Development
The child practices, refines, and masters complex gross and fine motor and perceptual-motor skills.

Cognitive Development
Concrete operational thinking replaces egocentric cognition. The child's thinking becomes more logical and rational. The child develops the ability to understand others' perspectives.

Social Development
Relationships outside the family increase in importance, including the development of friendships and participation in a peer group. The child imitates, learns, and adopts age appropriate social roles, including those that are gender-specific. The child develops an understanding of rules which are relied upon to dictate proper social behavior and to govern social relationships and activities.

Emotional Development
The child is industrious, purposeful, and goal directed in his/her activities. He/She is confident and self-directed. The child is developing a better sense of him/herself as an individual, with likes and dislikes and special areas of skill. He/She is capable of introspection. The child evaluates his/her worth by his/her ability to perform. Self-esteem is largely derived from one's perceived abilities.

Moral Development
“You scratch my back, and I’ll scratch yours.” The child does what is necessary, and makes concessions only as necessary to satisfy her own desires. Vengeance is considered a moral duty (for example, “he deserved it!”). Others are valued in terms of their utility – “What can they do for me?”

Sexual Development
- Sex words are being used without their actual meaning being known.
- Sexual exploration by siblings is more likely.
- Modesty/shame is learned.
- Friendship exists mostly with members of the same sex.
- Masturbation continues.
- Gender-role stereotypes are reinforced.
Adolescence (12-17 Years)

Physical Development
Physiological changes at puberty promote rapid growth, the maturity of sexual organs, and development of secondary sex characteristics. The youth must become accustomed to these changes.

Cognitive Development
During early adolescence, precursors to formal operational thinking appear, including a limited ability to think hypothetically and to take multiple perspectives. During middle and late adolescence formal operational thinking becomes well developed and integrated in a significant percentage of adolescents.

Social Development
Social relationships in early adolescence are centered in the peer group. Group values guide individual behavior. Acceptance by peers is critical to self-esteem. Most peer relationships are still same-sex. Young adolescents become interested in sexual relationships, but most contact is through groups. Some youth may begin to experiment with sexual behavior, but many early adolescents are not sexually active with other youth. Social roles are still largely defined by external sources. During middle and late adolescence, values become individualized and internalized after careful consideration and independent thought. Friends are more often selected on personal characteristics and mutual interests. The peer group declines in importance, individual friendships are strengthened, and more youth date in one-on-one relationships. The youth experiments with social roles and explores options for career choice.

Emotional Development
The early adolescent is strongly identified with the peer group. Youth depend upon their peers for emotional stability and support and to help mold the youth’s emerging identity. Self-esteem is greatly affected by acceptance of peers. Early adolescents are emotionally unbalanced with exaggerated affect and frequent mood swings. They are very vulnerable to emotional stress. During middle and late adolescence, identity is more individualized, and a sense of self develops and stabilizes that is separate from either family or peer group. Self-esteem is influenced by the youth’s ability to live up to internalized standards for behavior. Self-assessment and introspection are common.
Moral Development
Right is considered the conformity to the stereotypical behavior and values of one’s society or peers. Child seeks to gain the approval of others. Good behavior is that which pleases or helps others within the group. Peer pressure makes being different the unforgivable sin. Failure to punish is seen as unfair: “If he can get away with it, why can’t I?”

Sexual Development
- Growth of pelvic bones, appearance of pubic hair, budding of breasts and spurt of overall body growth occurs.
- In girls, the increased production of estrogen makes the vagina resistant to bacterial infection.
- Sensitivity exists in talking about sex-related matters.
- In girls, breasts may continue to grow, and menstruation and ovulation become more regular.
- In boys, genitalia grow, sperm is produced and nocturnal emissions (wet dreams) occur.
- Upsurge in hormone production arouses strong sexual feelings in both genders.
- Sexually oriented dreams and fantasies become quite dominant.
- Both genders may masturbate frequently.
- Interest in sexual activity is intense.
- Sexual exploration is normal.
- Birth control and STD prevention may become issues.
- Sexual activity is often started without accurate information.
- Pregnancy and STDs are real possibilities for teens that lack information, or think they are invincible.
- Romantic, intensely involved relationships develop.
- Feelings of guilt often accompany sexual experimentation.
- Gender-role stereotypes are reinforced and exploited by the media.
- STDs and HIV may be transmitted.
- A part of sexual development is the development of sexual identity and orientation.

Adapted from:
RAFT: Relative, Adoptive, Foster Parent Training; New Mexico CYFD Resource Family Pre-Service Training, Version 3.0
Fosterparnts cope: 1993, State University of New York, Research Foundation/CDHS
Lawrence Kohlberg’s Stages of Moral Development:
http://en.wikipedia.org/wiki/Lawrence_Kohlberg%27s_stages_of_moral_development
## Child Development, Continued

<table>
<thead>
<tr>
<th>Ages</th>
<th>Tasks</th>
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| 0 – 18 months      | **Develop a sense of trust**  
This is when the child first learns to trust, through the attachments made to caregivers. This is also the time when the child is the most vulnerable they will likely be in their life and so they are deeply reliant on their caregivers for safety and nurturance. |
| 18 months – 3 years| **Develop a sense of identity as a distinct self**  
The child is learning that he is his own little entity and is seeking some independence to prove it. Child will start dressing himself, feeding himself, and toileting himself. |
| 4 years – 7 years  | **Develop a sense of reality that is distinct from fantasy**  
The child is attempting to sort out what is real from what is not. (For example, a four year old will probably believe in Santa Claus; a seven year old may not.) A very creative time period. Very interested in science (as reality) and the human body. Asks lots of questions. |
| 8 years – 11 years | **Develop a sense of values**  
Children of this age have more role models in their lives (teachers, friends, coaches, parents of friends) and more influences (TV, movies, books, video games). They are beginning to incorporate all of the messages they receive into their own sense of what is right and what is wrong. |
| Adolescence        | **Develop/create a personal identity**  
**Establish independence**  
This stage is marked by ambivalence. The adolescent may practice with various looks (hairstyles and clothing), may be very idealistic and a pursuer of justice, but also be moody and pouty. Frequently at odds with parents over limits, responsibilities and decisions about the future. |
Child Development, Continued

0 – 18 months: Develop a sense of trust
Developmentally appropriate behavior during this stage may include:

- Clingy, needy behaviors
- Infant that wants you right now!
- Inconsolable crying

Parenting choices that will promote healthy development:

- Meet the child’s needs: feed a hungry baby, change a dirty diaper, interact with a lonely baby.
- Comfort and reassure the child when upset.
- Sometimes infants need to cry and they cannot be consoled.

18 months – 3 years: Develop a sense of identity as a distinct self
Developmentally appropriate behavior during this stage may include:

- Temper tantrums (frustration from wanting to do something, but not being allowed, or not having the skills to succeed)
- Bossiness: “I do it!” “Mine!”
- Independence: “No!”

Parenting choices that will promote healthy development:

- Give the child tasks that she can do independently.
- Offer choices.
- Praise independence.
- Give appropriate ways to discharge frustration and anger.

4 years – 7 years: Develop a sense of reality that is distinct from fantasy
Developmentally appropriate behavior during this stage may include:

- Unreliable reporters of the truth
- Persistent questioning

Parenting choices that will promote healthy development:

- Don’t accuse the child of lying; help the child understand the differences between what is real (e.g., home and family) and what is not (e.g., cartoon characters).
- Use their blurred sense of reality in creative ways, e.g., to create interesting and amusing stories and pictures.
- Answer lots of questions; seek out interesting and stimulating books
Child Development, Continued

8 years – 11 years: Develop a sense of values
Developmentally appropriate behavior during this stage may include:

- Pulling away from parents as friends become more important
- Believe all information received from peers is accurate and factual
- Inappropriate language
- May begin to succumb to peer pressure (especially around clothing and hair styles)

Parenting choices that will promote healthy development:

- Discuss role models.
- Discuss TV shows and videos that are viewed.
- Clearly state the reasons for your own values.
- Encourage discussions of moral issues; listen to their questions and statements.
- Ask for their opinions, or their help.
- Encourage activity with friends.
- Encourage sports and other hobbies.

Adolescence: Develop their own identity; establish independence
Developmentally appropriate behavior during this stage may include:

- Tension with the family to establish their independence
- Experimentation (with alcohol, drugs, or sex) as a way to establish their own identity
- Conflict around rules, expectations, etc.
- Pulling away from the family
- Question the authority of parents

Parenting choices that will promote healthy development:

- Maintain open communication with the teen; discuss your values and their rationale.
- Offer a variety of experiences (such as a monster truck show and a ballet) for the child who is seeking their identity.
- Encourage appropriate independent activity (such as doing their own laundry).
- Allow creative identities around hairstyles and clothing; compliment their physical appearance.
- Balance limits and freedom (for example: school is out at 2:15; you must be home by 3:30).
- Let the teen help create the rules; always give your rationale for rules.
Safe Sleep for Babies

- Always place baby on his or her back to sleep, for naps and at night.
- Use a firm sleep surface, such as a mattress in a safety-approved crib, covered by a fitted sheet.
- Avoid wedges, positioners or other products that claim to reduce the risk of SIDS unless prescribed by baby’s doctor.
- Keep pillows, bottles, toys, crib bumpers, and loose bedding out of baby’s sleep area.
- Baby should not sleep in an adult bed, on a couch, in an infant swing or on a chair.
- Don’t sleep with baby in a bed, on a chair or couch – put baby in his or her own bed.
- Room sharing – keeping baby’s sleep area in the same room where you sleep – reduces the risk of SIDS.
- Offer baby a pacifier that is not attached to a string for naps and at night.
- Keep baby warm, but not hot. Dress baby in one layer of clothing more than an adult would wear to be comfortable. Leave blankets out of the crib.
- Follow the health care provider’s guidance on baby’s vaccines and regular health check-ups. Talk with the doctor if you have any concerns about how baby sleeps.
- Give baby plenty of tummy-time when he or she is awake and when someone is watching.
- Do not smoke or allow smoking around baby.
- Place baby’s crib away from draperies and blinds to avoid strangulation by cords.
- Make sure that anyone caring for baby knows about safe sleep practices.

*Based on recommendations from the American Academy of Pediatrics (AAP) Task Force on SIDS.*
The Period of PURPLE Crying

The Letters in PURPLE Stand for

**P**eak of Crying
Your baby may cry more each week, the most in month 2, then less in months 3-5

**U**nexpected
Crying can come and go and you don’t know why

**R**esists Soothing
Your baby may not stop crying no matter what you try

**P**ain-like Face
A crying baby may look like they are in pain, even when they are not

**L**ong Lasting
Crying can last as much as 5 hours a day, or more

**E**vening
Your baby may cry more in the late afternoon and evening

The word *Period* means that the crying has a beginning and an end.
# How Alcohol and Drugs Affect Your Pregnancy

<table>
<thead>
<tr>
<th>Substance</th>
<th>Possible Effect on Mother</th>
<th>Possible Effect on Fetus, Newborn, and Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
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<tr>
<td></td>
<td>• Lack of certain vitamins</td>
<td>• Low birth weight</td>
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<td></td>
<td>• Miscarriage</td>
<td>• Intellectual disability</td>
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<td></td>
<td>• Stillbirth</td>
<td>• Heart problems</td>
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<td>• Learning and behavior problems</td>
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<td></td>
<td>• Fetal alcohol syndrome</td>
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<tr>
<td>Cocaine</td>
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<td></td>
<td>• Seizures</td>
<td>• Low Apgar score</td>
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<td></td>
<td>• Hallucinations</td>
<td>• Stroke</td>
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<td>• Fluid in the lungs</td>
<td>• Deformed reproductive or urinary organs</td>
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<td>(pulmonary edema)</td>
<td>• Sudden infant death syndrome (SIDS)</td>
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<td>• Breathing problems</td>
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<td>• Heart problems</td>
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<td></td>
<td>• Placenta abruption</td>
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<td>• Miscarriage</td>
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<td>• Stillbirth</td>
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<td>Ecstasy</td>
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<td>• Long-term memory problems</td>
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<td>• Effects not known</td>
<td>• Learning problems</td>
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<td>Heroin</td>
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<td>• Preeclampsia</td>
<td>• Seizures</td>
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<td>• Bleeding in the third</td>
<td>• Addiction, withdrawal symptoms after</td>
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<td>trimester</td>
<td>birth</td>
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<td></td>
<td>• Placenta abruption</td>
<td>• Breathing problems</td>
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<td>• Breech birth</td>
<td>• Small size at birth</td>
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<td>• Physical and mental development problems</td>
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<tr>
<td>Inhalants</td>
<td>• Life-threatening</td>
<td>• Low birth weight</td>
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<td></td>
<td>breathing problems</td>
<td>• Problems with how bones form</td>
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<td>• Convulsions or seizures</td>
<td>• Learning problems</td>
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### How Alcohol and Drugs Affect Your Pregnancy, Continued

<table>
<thead>
<tr>
<th>Substance</th>
<th>Possible Effect on Mother</th>
<th>Possible Effect on Fetus, Newborn, and Child</th>
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<tbody>
<tr>
<td>Marijuana</td>
<td>• Preterm labor</td>
<td>• Tremors</td>
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<td>• Easily startled</td>
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<td>• Cranky or fussy</td>
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<td>• Learning problems</td>
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<td></td>
<td></td>
<td>• Attention deficit hyperactivity disorder</td>
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<td></td>
<td>• Depression</td>
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<td></td>
<td>• Substance abuse</td>
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<td>• Leukemia</td>
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<td></td>
<td>• Certain types of cancer</td>
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<tr>
<td>Methamphetamine</td>
<td>• Stroke</td>
<td>• Low birth weight</td>
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<td></td>
<td>• Brain damage</td>
<td>• Heart and lung problems</td>
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<td></td>
<td>• Miscarriage</td>
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<td></td>
<td>• Placenta abruption</td>
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<td>PCP/LSD</td>
<td>• Confusion</td>
<td>• Withdrawal symptoms after birth</td>
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<td></td>
<td>• Delusions</td>
<td>• Learning problems</td>
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<td></td>
<td>• Hallucinations</td>
<td>• Emotional problems</td>
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<td></td>
<td>• Risk of overdose</td>
<td>• Behavior problems</td>
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Fetal Alcohol Spectrum Disorder: A Few Facts

Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These conditions can affect each person in different ways, and can range from mild to severe. They can include physical problems and problems with behavior and learning.¹

**Physical differences can include:** abnormal facial features, such as a smooth ridge between the nose and upper lip (this ridge is called the philtrum), small head size, shorter than average height, low body weight, poor coordination, vision or hearing problems, sleep and sucking problems as a baby, problems with the heart, kidneys or bones.

**Behavior and developmental signs can include:** hyperactive behavior, difficulty paying attention, poor memory, difficulty in school (especially with math), speech and language delays, learning disabilities, intellectual disabilities or low IQ, poor reasoning and judgement skills.

- FASDs are the leading known cause of intellectual disabilities.²
- FASDs effect an estimated 40,000 newborns each year in the United States.³
- FASDs are more common than autism.⁴
- FASD is not just a health care issue. Its primary impact is on schools, foster/ adoptive care, the justice system, and mental health services. Less than 10% of adults with FASD live independently or remain employed.
- The effects of FASDs last a lifetime but people with an FASD can grow, improve, and function well in life with proper support.

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¹ Centers for Disease Control, Diseases and Conditions
² May & Gossage, 2001; The Arc, 2005.
⁴ The Autism Society of America (2009) estimates that there are 24,000 new cases of autism each year in the U.S. Meanwhile, an estimated 870 children are born with FASD in WA each year (1% of all births). An estimated 70,000 individuals with FASD of all ages currently live in WA State.
Please see the Appendix for this material.
Strategies for Parenting Children with Fetal Alcohol Syndrome

- Concentrate on your child’s strengths and talents.
- Accept your child’s limitations.
- Be consistent with everything (discipline, school, behaviors).
- Use concrete language and examples.
- Use stable routines that do not change daily.
- Keep it simple.
- Be specific; say exactly what you mean.
- Structure your child’s world to provide a foundation for daily living.
- Use visual aids, music, and hands-on activities to help your child learn.
- Use positive reinforcement often (praise, incentives).
- Supervise: friends, visits, routines.
- Repeat, repeat, repeat.

Behaviors Related to Attachment Issues

**Poor eye contact:** Eye contact is an act of intimacy and feels threatening to children who are not attached – it feels like a challenge to their independence and separateness. (Note: In some cases, lack of eye contact can be explained in terms of culturally appropriate behavior.)

**Affection on the child’s terms:** This is often about manipulation and control. The child may use affection to manipulate the receiver.

**Deliberately oppositional:** This is about control. It can be used to frustrate caregivers.

**Demanding:** Children may feel their needs are a matter of life or death. This may occur because their needs were not met at one point. Also, the critical problem solving portion of their brain has not fully developed. They may not have the ability to distinguish crisis from priority.

**Destructive:** This is often about control, as well as destroying things that are important to others.

**Chatters non-stop:** This often accompanies lying and being superficially charming. This is often about control and manipulation.

**Superficially charming:** This is a manipulative behavior.

**Lying:** This may be a manipulative behavior, or a way to reconstruct reality for themselves.

**Drawn to horror or gore:** This may be related to how their brain was wired for adrenaline.

**High tolerance for pain, unless the injury is minor:** Often children with attachment issues are disconnected from their emotions and feelings, including physical feelings of pain. They have learned to not seek comfort because there was no one to comfort them.

**Setting family members up for failure:** This is about control and confirmation that no one can/will meet their expectations.

**Stealing:** This behavior is often seen in children who have not had their basic needs met in the past. They believe that since no one cared for them in the past, that will happen again; therefore, they fend for themselves.

**Incongruent affect**

**Poor social interactions**

**Poor ability to maintain relationships**
Behaviors Related to Attachment Issues, Continued

Lack of empathy

Little remorse for harming others

Difficulty with sleep

Control issues

**Triangulation:** This is a controlling behavior; the child seeks to divide and conquer.
Attachment Continuum

Secure → Anxious → Ambivalent → Disorganized → Unattached

Secure

- Needs are consistently met
- Strong, secure attachment with one or more caregivers

Anxious

- Have been attached in the past, but frequently left alone or with strangers
- Clingy and needy
- Fear of abandonment

Ambivalent

- Have had previous attachments, but may have been punished for expressing needs
- Hide behind a mask of detachment

Disorganized

- Never learned the appropriate signals to send
- Stuck at random behaviors
- Look and act out of control
- Can’t regulate emotions

Unattached

- Reactive Attachment Disorder
Strategies for Promoting Healthy Attachments

Respond to the Attachment Cycle

- Be available and responsive when the child needs something.
- Allow and encourage expressions of feeling.
- Respond to the child when s/he is hurt or injured.
- Help child cope with feelings about family visits, birth family, struggles, frustrations, etc.
- Share excitement with the child over achievements.

Initiate Positive Interactions to Give Children Positive Messages about Themselves

- Play games with them.
- Ask them to teach you something new.
- Give hugs or other comfortable forms of physical affection.
- Go for a walk or a bike ride.
- Compliment a strength or skill they have.
- Express affection verbally.
- Encourage their efforts.
- Encourage positive discussions of birth family relationships.

Create a Sense of Belonging

- Do things to show that the child is wanted and belongs.
- Display the child’s photograph.
- Include the child in family photographs.
- Provide a space that is “all their own” and encourage child to personalize it.
- Include the child in family trips and gatherings.
- Post art work on the refrigerator.
- Tell the child that you are happy s/he is with your family.
- Encourage the child to have pictures of the birth family.
Children and Sexual Abuse

What is child sexual abuse?

Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer. Sexual abuse can include both touching and non-touching behaviors. Touching behaviors may involve touching of the vagina, penis, breasts or buttocks, oral-genital contact, or sexual intercourse. Non-touching behaviors can include voyeurism (trying to look at a child’s naked body), exhibitionism, or exposing the child to pornography. Abusers often do not use physical force, but may use play, deception, threats, or other forms of coercion to engage children and maintain their silence. Abusers frequently employ persuasive and manipulative tactics to keep the child engaged. These tactics—referred to as “grooming”—may include buying gifts or arranging special activities, which can further confuse the victim.

Who is sexually abused?

Children of all ages, races, ethnicities, and economic backgrounds are vulnerable to sexual abuse. Child sexual abuse affects both girls and boys in all kinds of neighborhoods and communities, and in countries around the world.

Statistics

- 1 in 4 girls are sexually abused as a child.
- 1 in 6 boys are sexually abused as a child.
- 90% of childhood sexual abuse is committed by a family member or family friend.
- 70% of victims are under 17 years of age.
- 20% of victims are younger than 8 years of age.

How can you tell if a child is being (or has been) sexually abused?

Children who have been sexually abused may display a range of emotional and behavioral reactions, many of which are characteristic of children who have experienced other types of trauma. These reactions include:

- An increase in nightmares and/or other sleeping difficulties
- Withdrawn behavior
Children and Sexual Abuse, Continued

- Angry outbursts
- Anxiety
- Depression
- Not wanting to be left alone with a particular individual(s)
- Sexual knowledge, language, and/or behaviors that are inappropriate for the child’s age

Why don’t children tell about sexual abuse?

There are many reasons children do not disclose being sexually abused, including:

- Threats of bodily harm (to the child and/or the child’s family)
- Fear of being removed from the home
- Fear of not being believed
- Shame or guilt

What can you do if a child discloses that he or she is being (or has been) sexually abused?

If a child discloses abuse, it is critical to stay calm, listen carefully, and never blame the child. Never question the child. Thank the child for telling you and reassure him or her of your support. Please remember to call for help immediately.

If you know or suspect that a child is being or has been sexually abused, please call the Childhelp® National Child Abuse Hotline at 1-800-4-A-CHILD (1-800-422-4453) or visit the federally funded Child Welfare Information Gateway at: http://www.childwelfare.gov/responding

If you need immediate assistance, call 911.
Children and Sexual Abuse, Continued

How can you help protect children from sexual abuse?

• Teach children accurate names of private body parts.

• Avoid focusing exclusively on “stranger danger.” Keep in mind that most children are abused by someone they know and trust.

• Teach children about body safety and the difference between “okay” and “not okay” touches.

• Let children know that they have the right to make decisions about their bodies. Empower them to say no when they do not want to be touched, even in non-sexual ways (e.g. politely refusing hugs), and to say no to touching others.

• Make sure children know that adults and older children never need help with their private body parts (e.g. bathing or going to the bathroom).

• Teach children to take care of their own private parts (e.g. bathing, wiping after bathroom use) so they don’t have to rely on adults or older children for help.

• Educate children about the difference between good secrets (like surprise parties, which are okay because they are not kept secret for long) and bad secrets (those that the child is supposed to keep secret forever, which are not okay).

• Trust your instincts! If you feel uneasy about leaving a child with someone, don’t do it. If you’re concerned about possible sexual abuse, ask questions.

Children are most often sexually abused by someone they know and trust.

The best time to talk to your child about sexual abuse is now.
The Impact of Abuse and Neglect on Development

Developmental Delays
As you consider children/youth in your home and children/youth that may join your family, keep in mind:

- Children/youth impacted by abuse or neglect often have significant developmental delays in one or more areas of development.
  - Some delays are caused by genetics.
  - Some are the result of prenatal exposure to drugs or alcohol.
  - Some are the result of poor prenatal care or from situations in which children lived after birth.
  - Some delays are the direct result of trauma, abuse, and neglect.

As a result, many children/youth in substitute care will have developmental delays.

Consequences of Abuse and Neglect on Physical Development

- Chronic malnutrition of infants and toddlers results in growth retardation, brain damage, and potentially, mental retardation.
- Direct blows to the head can create swelling of brain tissue, and subdural hematomas (pools of blood in the brain) that destroy brain tissue and can result in brain stem compression and herniation (abnormal protrusion of an organ), blindness, deafness, mental retardation, epilepsy, cerebral palsy, skull fracture, paralysis and coma.
- Injury to the hypothalamus and pituitary glands in the brain can result in growth impairment and inadequate sexual development.
- Less severe but repeated blows to the head can also result in equally serious brain damage. Pressure inside the skull leads to a decrease in oxygen supply to the brain, and involved nerve cells die. This type of injury may be detectable only with a CT scan, and, in the absence of signs of trauma, may go unnoticed.
- Blows or slaps to the side of the head over the ear can injure the inner ear mechanism and cause partial or complete hearing loss.
- Shaking can result in brain injury equal to that caused by a direct blow to the head. Additionally, bones in the neck and spine can be injured, resulting in a collapse of the vertebrae. Spinal cord injury can result in paralysis. Internal injuries can lead to permanent physical disability or death.
- Medical neglect, as in withholding treatment for treatable conditions, can lead to permanent physical disability, such as hearing loss from untreated ear infections, respiratory damage from pneumonia or chronic bronchitis.
The Impact of Abuse and Neglect on Development, Continued

- Neglected infants and toddlers have poor muscle tone, poor motor control, exhibit delays in gross and fine motor development and coordination, and fail to develop and perfect basic motor skills. Since most of an infant’s cognitive development is facilitated by motor involvement with the environment, physical delays contribute to cognitive delays as well.

Consequences of Abuse and Neglect on Cognitive Development

Absence of stimulation interferes with the growth and development of the brain. Generalized cognitive delay or mental retardation can result.

- Brain damage from injury or malnutrition can lead to mental retardation.
- Maltreated infants are often apathetic and listless, placid or immobile. They often do not manipulate objects or do so in repetitive, primitive ways. They are often inactive, lack curiosity, and do not explore their environments. Maltreated infants may not master even basic concepts such as object permanence and may not develop basic problem-solving skills.
- Abused and neglected toddlers typically exhibit language and speech delays. They fail to use language to communicate with others, and some do not talk at all. This represents a cognitive delay that can also affect social development including the development of peer relationships.

Consequences of Abuse and Neglect on Social Development

Maltreated infants may fail to form attachments or reciprocal connectedness to primary caregivers.

- Maltreated infants often do not appear to notice separation from the parent and may not develop separation or stranger anxiety. Infants and toddlers may willingly go to anyone and show equal pleasure in the presence of strangers and close family. This lack of discrimination between strange and familiar people is one of the most striking characteristics of abused and neglected children/youth.
- Maltreated infants are often passive, apathetic, and unresponsive to others. They may not maintain eye contact with others, may not become excited when talked to or approached, and often cannot be engaged into vocalizing (cooing or babbling) with an adult. These infants may not develop nonverbal communications that attract and hold and adult’s attention.
The Impact of Abuse and Neglect on Development, Continued

- Abused or neglected toddlers may not develop play skills and often cannot be engaged into reciprocal, interactive play. Their play skills may be very immature and primitive. This can affect their relationships with other children/youth.

Consequences of Abuse and Neglect on Emotional Development

Abused and neglected infants often fail to develop basic trust. This will impair the development of healthy relationships.

- Maltreated infants are often withdrawn, listless, apathetic, depressed, and unresponsive to the environment.
- Abused infants often exhibit a state of frozen watchfulness, remaining passive and immobile but intently observant of the environment. This is a protective strategy in response to a fear of attack. It is as if the infant is on guard.
- Abused toddlers may feel that they are bad children. This has a pervasive effect on the development of self-esteem.
- Punishment (abuse) in response to normal exploratory or autonomous behavior can interfere with the development of healthy personality. Children may become chronically dependent, subversive or openly rebellious.
- Abused and neglected toddlers may be fearful and anxious or depressed and withdrawn. They may also become aggressive and hurt others.

RAFT: Relative, Adoptive, Foster Parent Training, New Mexico CYFD, Resource Family Pre-Service Training, Version 3.0
The Impact of Trauma on the Brain

Each year in the United States alone, there are over three million children that are abused or neglected. These destructive experiences impact the developing child; increasing risk for emotional, behavioral, academic, social and physical problems throughout life. The purpose of this article is to outline how these experiences may result in increased risk by influencing the development and functioning of the child’s brain.

The Brain

The human brain is an amazing and complex organ. It allows us to think, act, feel, laugh, speak, create and love. The brain mediates all of the qualities of humanity, good and bad, yet the core mission of the brain is to sense, perceive, process, store, and act on information from the external and internal environment to promote survival. In order to do this, the human brain has evolved an efficient and logical organization structure.

The brain has a bottom-up organization. The bottom regions (i.e., brainstem and midbrain) control the most simple functions such as respiration, heart rate and blood pressure regulation while the top areas (i.e., limbic and cortex) control more complex functions such as thinking and regulating emotions.

Brain Development

At birth, the human brain is undeveloped. Not all of the brain’s areas are organized and fully functional. It is during childhood that the brain matures and the whole set of brain-related capabilities develop in a sequential fashion. We crawl before we walk, we babble before we talk.

The development of the brain during infancy and childhood follows the bottom-up structure. The most regulatory, bottom regions of the brain develop first, followed in sequence by adjacent but higher, more complex regions.

The process of sequential development of the brain and, of course, the sequential development of function, is guided by experience. The brain develops and modifies itself in response to experience. Neurons and neuronal connections (synapses) change in an activity-dependent fashion. This “use-dependent” development is the key to understanding the impact of neglect and trauma on children.
The Impact of Trauma on the Brain, Continued

These areas organize during development and change in the mature brain in a "use-dependent" fashion.

The more a certain neural system is activated, the more it will "build-in" this neural state -- what occurs in this process is the creation of an "internal representation" of the experience corresponding to the neural activation. This "use-dependent" capacity to make an "internal representation" of the external or internal world is the basis for learning and memory. The simple and unavoidable result of this sequential neurodevelopment is that the organizing, "sensitive" brain of an infant or young child is more malleable to experience than a mature brain. While experience may alter and change the functioning of an adult, experience literally provides the organizing framework for an infant and child.

The brain is most plastic (receptive to environmental input) in early childhood. The consequence of sequential development is that as different regions are organizing, they require specific kinds of experience targeting the region’s specific function (e.g., visual input while the visual system is organizing) in order to develop normally. These times during development are called critical or sensitive periods.

Traumatic Experiences and Development

With optimal experiences, the brain develops healthy, flexible and diverse capabilities. When there is disruption of the timing, intensity, quality or quantity of normal developmental experiences, however, there may be devastating impact on neurodevelopment and, thereby, function. For millions of abused and neglected children, the nature of their experiences adversely influences the development of their brains. During the traumatic experience, these children’s brains are in a state of fear-related activation.

This activation of key neural systems in the brain leads to adaptive changes in emotional, behavioral and cognitive functioning to promote survival. Yet, persisting or chronic activation of this adaptive fear response can result in the maladaptive persistence of a fear state. This activation causes hyper-vigilance, increased muscle tone, a focus on threat-related cues (typically non-verbal), anxiety, behavioral impulsivity -- all of which are adaptive during a threatening event yet become maladaptive when the immediate threat has passed.
The Impact of Trauma on the Brain, Continued

This is the dilemma that traumatic abuse brings to the child’s developing brain. The very process of using the proper adaptive neural response during a threat will also be the process that underlies the neural pathology, which causes so much distress and pain through the child’s life. The chronically traumatized child will develop a host of physical signs (e.g., altered cardiovascular regulation) and symptoms (e.g., attention, sleep and mood problems) which make their lives difficult.

There is hope, however. The brain is very plastic meaning it is capable of changing in response to experiences, especially repetitive and patterned experiences. Furthermore, the brain is most plastic during early childhood. Aggressive early identification and intervention with abused and neglected children has the capacity to modify and influence development in many positive ways.

The elements of successful intervention must be guided by the core principles of brain development. The brain changes in a use-dependent fashion. Therapeutic interventions that restore a sense of safety and control are very important for the acutely traumatized child. In cases of chronic abuse and neglect, however, the very act of intervening can contribute to the child’s catalogue of fearful situation.

Investigation, court, removal, placement, re-location, and re-unification all contribute to the unknown, uncontrollable and, often, frightening experiences of the abused child. Our systems, placements and therapeutic activities can diminish the fearful nature of these children’s lives by providing consistency, repetition (familiarity), nurturance, predictability and control (returned to the child). Yet the poorly coordinated, over-burdened and reactive systems mandated to help these children rarely can provide those key elements.

Prevention and Policy

What we are as adults is the product of the world we experienced as children. The way a society functions is a reflection of the childrearing practices of that society. Today, we reap what we have sown. Despite the well-documented critical nature of early life experiences, we dedicate few resources to this time of life. We do not educate our children about development, parenting or about the impact of neglect and trauma on children. As a society we put more value on requiring hours of formal training to drive a car than we do on any formal training in childrearing.
The Impact of Trauma on the Brain, Continued

In order to prevent the development of impaired children, we need to dedicate resources of time, energy and money to the complex problems related to child maltreatment. We need to understand the indelible relationship between early life experience and cognitive, social, emotional, and physical health. Providing enriching cognitive, emotional, social and physical experiences in childhood could transform our culture. But before our society can choose to provide these experiences, it must be educated about what we now know regarding child development. Education of the public must be coupled with the continuing generation of data regarding the impact of both positive and negative experiences on the development of children. All of this must be paired with the implementation and testing of programs dedicated to enriching the lives of children and families, as well as programs to provide early identification of, and proactive intervention for at-risk children and families.

The problems related to maltreatment of children are complex and they have a complex impact on our society. However, there are solutions to these problems. The choice to find solutions is up to us. If we choose, we have some control of our future. If we, as a society, continue to ignore the laws of biology, and the inevitable neurodevelopmental consequences of our current childrearing practices and policies, our potential as a humane society will remain unrealized. The future will hold sociocultural devolution – the inevitable consequence of the competition for limited resources and the implementation of reactive, one-dimensional and short-term solutions.

Alarm Systems in the Brain

The alarm systems of those who have experienced multiple traumatic events or severe neglect in infancy are triggered with regularity. The reaction is often a behavior related to fear or rage. The behavior can be primitive in nature (aggression, yelling, etc.) as the primitive part of the brain is activated, not the frontal cortex (which is associated with problem solving, verbalizing emotions, etc.).

People who have experienced trauma can be triggered easily by people, smells, and scenarios that look and feel similar to the traumatic event or persons involved in the incident. For example, a low flying plane in New York may provoke biological reactions (heart palpitations, hyper-vigilance, and/ or shallow breathing) in those persons who witnessed, heard, or saw the 9/11 tragedy. A child or youth who has been traumatized may react with aggression to a request or person that he/she may misperceive as threatening. His/her body may respond in a variety of ways: increasing agitation or increased numbing out (remember fight, flight, and freeze).
The Impact of Trauma on the Brain, Continued

The brain has billions and billions of neural pathways. We learn by watching and experiencing. What we learn, in repeating actions over and over, whether it is considered to be a good behavior or bad behavior, is a connection made in the brain. For instance, how did we learn to say “Thank You”? Many of us cannot remember the process that our caregivers used to teach us. We must have practiced over and over and were probably given verbal reminders, and either positive or negative reinforcing statements, each time an event occurred in which a “thank you” was required. For many of us, it is automatic.

For children who experienced inconsistent parenting, neglect, or multiple caregivers during their formative years, they may not have received collaborative communication or quality repetitive behaviors from parents. Therefore, many of the social actions that children exhibit, who were not traumatized, are not displayed or understood by children who had early trauma.

Bruce D. Perry, M.D., Ph.D. and John Marcellus, M.D. The ChildTrauma Academy http://www.childtrauma.org/
The Impact and Effects of Trauma

The level of child trauma is dependent on several factors. Sometimes it is these factors that dictate whether or not someone has PTSD. However, the experience of trauma is relative and cannot be judged as more or less as someone else’s level of trauma.

The impact of a potentially traumatic event depends on several factors including:

- The child’s age and developmental stage
- The child’s perception of the danger faced
- Whether the child was the victim or a witness
- The child’s relationship to the victim or perpetrator
- The child’s past experience with trauma
- The adversities the child faces following the trauma
- The presence/availability of adults who can offer help and protection

Children/youth who have experienced trauma will often experience ongoing effects in multiple areas of their lives. Below are examples of some of these potential areas of impact:

- **Cognition**: Ability to problem solve, memory, comprehension, etc.
- **Social Interactions**: Ability to trust, maintain relationships, reciprocate friendship and/or love.
- **Self-regulation**: Ability to monitor mood, behavior and emotion with any consistency. Many children who have primary attachment trauma come into care with dysregulated behavior.
- **Perception of the world**: When a child has experienced trauma, the world and people in it, can seem scary and unpredictable.
- **Issues of Attachment**: Children who are neglected in utero or in early infancy are at risk for attachment difficulties.

**Effects of Trauma Exposure**

- **Attachment**: Traumatized children feel that the world is uncertain and unpredictable. They can become socially isolated and can have difficulty relating to and empathizing with others.
- **Biology**: Traumatized children may experience problems with movement and sensation, including hypersensitivity to physical contact and insensitivity to pain. They may exhibit unexplained physical symptoms and increased medical problems.
The Impact and Effects of Trauma, Continued

- **Dissociation:** Some traumatized children experience a feeling of detachment or depersonalization, as if they are “observing” something happening to them that is unreal.

- **Behavioral control:** Traumatized children can show poor impulse control, self-destructive behavior, and aggression towards others.

- **Cognition:** Traumatized children can have problems focusing on and completing tasks, or planning for, and anticipating future events. Some exhibit learning difficulties and problems with language development.

- **Self-concept:** Traumatized children frequently suffer from disturbed body image, low self-esteem, shame, and guilt.

- **Mood regulation:** Children exposed to trauma can have difficulty regulating their emotions as well as difficulty knowing and describing their feelings and internal states.
# Essential Connections

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## Understanding How a Child Responds to Loss

<table>
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<tr>
<th>Age</th>
<th>How the Child Sees and Reacts to Loss</th>
<th>Possible Effects of Loss</th>
<th>What You Can Do</th>
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</table>
| **Infant** 0-1 years | - Has no concept of permanent loss  
- Cries, frets and shows other signs of being unhappy                                               | **Now**  
- Sense of security and trust in adults could be undermined  
- Regression to an earlier stage of development: e.g. clings more to adults  
  **Later**  
- Grows up feeling that the world owes him/her  
- Trouble trusting others  
- Learning problems                                                     | **Keep up the same routines the child has had:** e.g. feeding, bathing.  
**Record information so that it will be available to the child when he/she gets older.** |
| **Toddler** 1-3 years | - May see loss as irreversible  
- May cry or appear uninterested in food, toys, and activities                                           | **Now**  
- Regression to an earlier stage of development, may begin to wet  
- May stop talking or not start talking when most children his/her age begin  
- May become too dependent or to independent  
  **Later**  
- Develops a need to be always in control  
- Has trouble learning to be aware of his/her own needs  
- Has problems developing appropriate relationships with others | **Keep routines the same:** e.g. meals, bath, bed every day at the same time.  
**Say things like, “it’s OK to miss your Mommy and Daddy. I know it must hurt.”**  
**Don’t pressure the child to do things he/she was doing before the loss:** e.g. giving up the bottle, eating with utensils, potty-training.  
**Prepare the child for moves.** |
# Understanding How a Child Responds to Loss, Continued

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<td><strong>Preschool</strong></td>
<td>- Knows that a loss has happened, but often sees it as temporary</td>
<td><strong>Now</strong></td>
<td>• Encourage the child to express his/her feelings through play.</td>
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<td>3-5 years</td>
<td>- Is very curious and may ask sensitive questions with matter-of-fact manner</td>
<td>- May feel that he/she caused the loss by thinking “bad things” or “wishing things would</td>
<td>• Provide ways for the child to remember the people and places he/she is separated from.</td>
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<td></td>
<td>- May feel abandoned</td>
<td>- change” – magical thinking</td>
<td>• Reassure the child that you will take care of him/her.</td>
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<td>- Has trouble understanding “good vs. bad”</td>
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<td><strong>Later</strong></td>
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<td></td>
<td>- Blames himself/herself for the loss</td>
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<td>- Has problems developing a positive self-image</td>
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<td><strong>Grade School</strong></td>
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<td>6-12 years</td>
<td>- Now understands that a permanent loss cannot be reversed</td>
<td><strong>Now</strong></td>
<td>• Encourage the child to talk about his/her feelings and don’t be judgmental.</td>
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<td>- Often feels responsible for the loss, may see it as punishment for something he/she has done or thought</td>
<td>- Lack of energy to do things</td>
<td>• Give the child clear information about the loss to reduce his/her feelings of responsibility and/or guilt.</td>
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<td>- Often hides his/her feelings about the loss, carrying on as if nothing has happened</td>
<td>- Chronic grief</td>
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<td>- Feels vulnerable and different from others</td>
<td><strong>Later</strong></td>
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<td>- Ongoing problems in school, including difficulty making friends</td>
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<td>- Problems knowing right from wrong</td>
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| Adolescence  | • Understands that a permanent loss cannot be reversed  
• Does not blame himself/herself as much for the loss  
• Learns to understand how this loss will affect his/her in the future |                                                                                          | • Be open and honest when the youth asks questions.  
• Encourage him/her to talk about his/her feelings.  
• Be available, but allow the youth time alone.  
• Involve the youth, whenever possible, in making decisions. |
| 13-18 years  |                                                                                                    | Now  
• May feel hopeless, out of control, different from others  
• May have school problems, including choosing friend who are “troublemakers”  
• May show fear, unhappiness, anxiety, denial or trouble getting close to others |                                                                                          |
# How to Keep Youth Connected

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**What groups do they belong to?**

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### 4. Their Meaningful Role

**What do they do that gives meaning to their life?**

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### 9. Culture

What is culturally important to them?

### 10. History

How do they know about their past?
In the last class, we discussed brain development, exposure to drugs and alcohol in utero, child development, and trauma and attachment, ending with an exploration of grief and loss and the essential connections.

In this session, we will continue to provide a basic framework for parenting children who are in out-of-home care. This is not a full parenting class, but rather a basic framework infused with principles and concepts that will be key as you go on to increase your knowledge and skills. We will focus on understanding behavior as a way that children express their needs, and finding ways to meet their needs and change problematic behaviors.
Session 6: Understanding and Managing Behaviors

Topics covered in Session 6

- Understanding the Needs That Drive Behavior
- Effective Discipline
- Positive Discipline and Behavior Intervention Model
- Behavior Activity

Competencies covered in Session 6

CFAM133-06  Awareness of the need to help children adjust to caregiver’s home.

CFAM134-02  Awareness of the need to provide structure and predictability for a child who has been maltreated.

CFAM134-03  Awareness of the goals of behavior management and appropriate discipline techniques.

CFAM134-04  Awareness of behavioral expectations appropriate for the age, capability and cultural background of each child; the importance of setting limits for children; the state law and policy prohibiting corporal punishment by foster parents.

CFAM134-10  Awareness of the potential influences/triggers on a child’s behavior including: developmental challenges, behavioral emotional challenges, past abuse, neglect, separation, and placement.

CFAM139-07  Awareness that children in care may have strong emotions including anger and rage.

CFAM139-08  Awareness that mental health issues may be present in children in out-of-home care.

CFAM139-15  Awareness that children placed in care may not possess age appropriate life skills.

Begin Session 6
### Three Hungry Children

#### My Kids Are Hungry...What Do I Do?

<table>
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<th>Behavior</th>
<th>Response</th>
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<td><em>What would I do?</em></td>
<td><em>How might people react to me?</em></td>
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Choices

**Brea – 5 years old**
Very dirty and smelly, and resistant to taking a bath

**Cassia – 3 years old**
Does not want to go to sleep

**Danny – 13 years old**
His room is a complete disaster.

**Ali – 8 years old**
You have asked him to turn off the video games and he has not followed through.

**Briston – 6 years old**
At a family gathering, he suddenly drops his pants and starts masturbating.
Skill vs. Will

If a child in your home is “mis-behaving,” it’s worth taking the time to look at their behavior and deconstructing what’s really going on.

Does the child know how to:
1. Ask for help
2. Identify their own feelings
3. Recognize the feelings of others
4. Set goals
5. Raise a complaint
6. Express anger
7. Play with other children
8. Recognize when they are hungry or tired

Is the child capable of:
1. Controlling their emotions
2. Controlling their behaviors
3. Being empathetic

These are skills that can be learned!

Source: Jane Nelsen, www.positivediscipline.com

Common missing skills include:
- Difficulty in handling transitions, shifting from one mind-set or task to another
- Difficulty mustering the energy to persist on tasks that are challenging, effortful or tedious
- Difficulty doing things in a logical sequence or prescribed order
- Poor sense of time
- Difficulty reflecting on multiple thoughts or ideas simultaneously
- Difficulty maintaining focus for goal-directed problem-solving
- Difficulty considering the likely outcomes of consequences of actions (impulsive)
- Difficulty considering a range of solutions to a problem
- Difficulty expressing concerns, needs, or thoughts in words
- Difficulty understanding what is being said
- Difficulty managing emotional response to frustration so as to think rationally
- Chronic irritability and/or anxiety significantly impede capacity for problem-solving
• Difficulty seeing the “grays” (i.e. concrete, literal, black-and-white thinking)
• Difficulty deviating from rules, routine, original plan
• Difficulty handling unpredictability, ambiguity, uncertainty, novelty
• Difficulty shifting from original idea or solution; difficulty adapting to changes in plan or new rules; possibly perseverative or obsessive (with the numerous moves, children may have experienced frequent and complicated changes in house rules, expectations, etc.)
• Difficulty taking into account situational factors that would suggest the need to adjust a plan of action
• Inflexible, inaccurate interpretations/cognitive distortions or biases (e.g., “Everyone’s out to get me,” “Nobody likes me,” “You always blame me,” “It’s not fair,” “I’m stupid,” “Things will never work out for me.”)
• Difficulty attending to and/or accurately interpreting social cues; poor perception of social nuances
• Difficulty starting conversations, entering groups, connecting with people; lacking in other basic social skills
• Difficulty seeking attention in appropriate ways
• Difficulty appreciating how one’s behavior is affecting other people; often surprised by others’ responses to his/her behavior
• Difficulty empathizing with others or appreciating another person’s perspective or point of view
• Difficulty appreciating how one is coming across or being perceived by others

From Lost at School: Why our Kids with Behavioral Challenges are Falling Through the Cracks and How We Can Help Them. By Ross W. Greene p. 287
Five Criteria for Effective Discipline

Effective discipline:

1. Helps children feel a sense of connection
2. Is mutually respectful and encouraging
3. Is effective long-term
4. Teaches important social skills and life skills
5. Encourages children to discover how capable they are
Effective Discipline Techniques

- Choices
- Reflective Listening
- Building Self-Concept
- Problem-Solving
- Rules
- Modifying the Environment
- Consequences: Natural and Logical
- Time Out and Time In
Time Out and Time In

The intent of time out or time in is to:

- Calm down
- De-escalate
- Regain self-control

Steps in Implementing Time Out or Time In

- Take time to gain your own composure.
  - Sometimes it is the parent that needs the time-out, not the child! If this is the case, then take it.
  - Calming yourself first makes it more likely that a time-out or time-in imposed by you is not done to punish the child but rather to teach appropriate calming behaviors.
  - In addition, it is appropriate role-modeling for children to see what responsible adults do when they need to calm down.
- Give the child an opportunity to change or stop the behavior.
  - Sometimes children don’t know that a behavior is inappropriate or unacceptable. Pointing out the undesired behavior, and giving them a chance to change or stop the behavior gives the child the opportunity to act responsibly.
- Decide if this child, in this situation, will calm down more quickly with a time-out or a time-in.
  - Choose the technique that will be most effective in helping the child to calm down, de-escalate and regain control.
- Rename the time-out or time-in.
  - Some children may have memories of time out that involved being locked in a closet, tied to a chair, or left alone for hours. Giving the techniques a new name, such as “thinking time,” may immediately alleviate fear and anxiety.
  - Another example is the “good energy chair.” You may choose a chair in the house that is the “good energy chair.” Whenever anybody feels as if they are filled with “bad energy” (anger, frustration, hatred, etc.), they may sit in the good energy chair and take deep breaths of good energy until they begin to feel better.
- Encourage soothing and calming activities
  - Most people have their own strategies for calming down and self-soothing. So do some children. Think of how this child self-soothes or calms and allow that activity and/or experience to help the child de-escalate.
Some children will de-escalate more quickly with their favorite stuffed animal; some may de-escalate more quickly if they are allowed to write in a journal or read a book.

Very kinesthetic children may need to be active to calm down. For example, they could use large muscles to run, jump rope, or shoot hoops, or they could use small muscles to play with Legos or Play-Doh.

Some children will need to be taught how to calm down.

- Have the child begin with deep breaths or belly breaths. The child may lie on the floor on their back and breathe into their belly enough to make it rise and fall.
- Remember, the intent is to teach children how to calm themselves, not to punish them for bad behavior.

Ignore the child’s behavior while in a time-out or time-in.

- Unless the behaviors are threatening or dangerous, ignore them. Especially ignore whining and complaining.

When the child is calm, end the time-out or time-in.

- When the child is calm, the goal has been achieved and the time-out or time-in is over.
  - Setting a timer at this point would be counter-intuitive.
- Praise the child for regaining self-control.

Talk about the situation that led to the time-out or time-in.

- “What happened?” Ask the child to explain the circumstances that caused the escalation and lack of control. Look for triggers and point them out to the child.
- “What will you do next time?” This helps the child to problem-solve and future-plan.
Problem-Solving

1. Encourage children to talk about the problem. Use reflective listening and other communication skills to help the child discuss the troubling situation.

2. Brainstorm alternatives with the child. Encourage the child to think of many ideas and solutions. Do not censor or judge their ideas.

3. Allow the child to choose a solution. During this process the caregiver can offer information and ask questions to help the child determine the appropriateness of their previously generated ideas.

4. Obtain a commitment. Ask the child when and where and how they will act on the solution they chose.

5. Evaluate the results. Meet with the child again to ask how it went, offer support and praise the child for their efforts.
Logical Consequences

1. Your children leave their toys and books all over the house. Which of the following would be a logical consequence?
   a. You tell the children that any toys that they don’t pick up, will be picked up by you and put away until Saturday.
   b. You don’t let them have any dessert on days when their toys are not picked up.
   c. You leave the toys for days and days, with the hope that somebody will get sick of the mess and do something about it.
   d. Put the kids in a time-out while you pick up the toys.

2. Upon returning from a shopping trip with a six-year-old, you find that she has a pocket full of candy that you didn’t buy. Which of the following would be a logical consequence?
   a. Take the candy away from her and give it to the other kids.
   b. Tell her she cannot have dinner.
   c. Take something that belongs to her so that she can see how it feels.
   d. Return to the store with her and have her pay for the candy with her own money.

3. An 11-year-old in your home has a difficult time getting his homework done. You have established a homework hour, but he doodles, fools around with the other kids and generally wastes the hour. Which of the following would be a logical consequence?
   a. Take away his weekend privileges.
   b. Let him know if it is too distracting for him to sit and work with the other kids, then you will find him a quieter place to do his homework.
   c. Give him extra chores to do.
   d. Let him flunk.
Modifying the Environment

- Planning:

- Organizing:

- Enhancing:

- Soothing:

- Structuring:

- Childproofing:

- Adolescent-proofing:
Behavior Intervention Model

1. Name the offending behavior.

2. State the expectation.

3. Teach the appropriate behavior.

4. If appropriate, encourage the child to make reparation.
How to Intervene in Sexual Behaviors

Strive to teach appropriate behavior, not punish or shame for the inappropriate behavior.

- Neutralize the behavior in your own mind. Don’t think of this as a “sexual” behavior, but as just another generally inappropriate behavior.
- Use words that describe the behavior as “not okay” or “against the rules,” instead of words that are judgmental (such as “gross” or “nasty”).
- Don’t expect that the child will know that their behavior is inappropriate.
- Understand that this behavior may be related to past hurt and trauma, and that the child needs modeling, guidance and limits.
- Stay calm, and use simple and direct words to set limits and teach appropriate behavior.

Patricia Ryan’s 4-Step Model of Intervention:

1. **Stop the behavior.** Tell the child to stop that specific behavior; remove the child’s hand; separate the children; ask them to pull up their pants; etc.

2. **Define or name the behavior.** Describe specifically and clearly what the inappropriate behavior is. Instead of “Stop that” or “Don’t do that,” say “You are touching Anna’s private parts and that’s not okay.”

3. **State the house rule or expectation for this behavior.** Don’t lecture, but state calmly and matter-of-factly, with as few words as possible, what the expectations are. For example, “We don’t touch our private parts in public.”

4. **Re-direct the child by teaching the appropriate behavior.** Let the child know what you expect him or her to do next. Praise the child when s/he does what you have asked.

And…notify the social worker if you are concerned about sexual behaviors.
Understanding and Managing Behaviors

Practice Scenario A: Amber

Amber is a 4-year-old who has been enrolled in Head Start for the past year. She had a rough first year of life. Her mother has been an alcohol and substance abuser for many years and she left Amber unattended for hours at a time when she was just an infant. It is unknown if mom used drugs or alcohol during her pregnancy.

Amber came to live with relatives when she was 12 months old. The relatives have had Amber since then and plan to adopt her. They have been very consistent in their parenting practices and immediately took Amber to be evaluated by early childhood specialists. Because the evaluation showed delays, Amber has been receiving services for 3 years.

Amber plays well with other children, is described as sweet, has great eye contact, and seeks attention and affection just like other children. Amber occasionally gets upset and may yell or throw a stuffed animal. When the caregiver intervenes, she calms down fairly quickly and is able to regain control.

Strategies:
Understanding and Managing Behaviors, Continued

Practice Scenario B: Brandon

Brandon is a 5-year-old boy who has been in foster care for two years. He has lived with the same foster family since he came into care for medical neglect. He has three siblings who were placed in foster care for a short time, but have been successfully reunited with their parents.

Brandon was born with a cleft palate and a congenital heart defect. His parents did not follow through with recommended medical services. It is reported that they “just didn’t seem to connect with him”. They were very uncomfortable with his medical conditions. Brandon has been hospitalized five times for corrective surgeries, each time being away from the foster home for one to two weeks. Although Brandon maintained contact with his families (foster and birth) during the hospitalizations, he still had to re-adjust each time he returned to the foster home.

Brandon struggles with making friends, and prefers to play by himself. He doesn’t shy away from physical affection, but he rarely initiates it. He has poor eye contact. Although not intentionally aggressive, he shows little remorse when his actions hurt others. The permanency plan is for Brandon to return to his birth family. He currently has weekly visits with them.

Strategies:
Understanding and Managing Behaviors, Continued

Practice Scenario C: Calisha
Calisha is a 9-year-old girl who has lived with four different foster families since coming into care at age five. Calisha is in the 4th grade, receiving special education services for learning disabilities and behavioral difficulties. Little is known of Calisha’s prenatal development and early childhood, except that the family moved frequently and she was often left home alone for extended periods of time. Calisha’s record states that she was found wandering around the neighborhood in dirty clothes, asking neighbors for food.

Calisha has lived with her current foster family for the past 12 months. It took her a long time to adjust to the household expectations and family routines. Calisha often reacts to requests to brush her teeth, or get ready for bed, with yelling, slamming of doors and sometimes tantrums that last 30 minutes or more. When Calisha gets angry, she goes to her room and isolates herself for two or three hours.

Calisha seems closer to her foster father and sometimes allows him to hug her, but she rarely initiates contact. Calisha is not close to her foster mother or the other children in the home. Calisha sometimes purposely initiates arguments with family members or takes toys from the other kids and hides them or breaks them. She has difficulty with honesty.

Strategies:
Understanding and Managing Behaviors, Continued

**Practice Scenario D: Dominic**

Dominic is 13 years old. His mother died following his birth, and his father has had ongoing mental health problems. As Dominic has grown older, his father has depended on him more and more. He doesn’t allow Dominic to have friends over, play sports, or leave the home except to go to school. Dominic’s father has told him for many years that he is responsible for his mother’s death.

Dominic stayed after school last week to attend a Science Fair meeting. His father came to the school looking for him, and began to verbally abuse him in front of the teachers and other students. Dominic fell to the ground in a fetal position, crying, and refused to talk to, or leave with, his father. Dominic was placed in a psychiatric hospital unit for two days, and then placed in foster care.

Dominic’s father is currently hospitalized. Dominic is very quiet at the foster home – he won’t speak unless spoken to, and spends most of his time alone in his room. He is shy, depressed and appears much younger than his 13 years. He refuses to come to family meals or join in with any activities. He rarely expresses any emotion, including a reaction to physical pain. He likes to watch violent TV and movies, and draws pictures involving blood and gore.

**Strategies:**
In the last session, we focused on parenting children in out-of-home care using effective techniques that disciplined rather than punished them. We discussed the fact that children express their needs through behaviors and that to change behaviors we must meet the underlying needs.

In this session, we will start with information about the legal requirements around caregiving and how to understand the regulations so you can abide by them. Then, we will return our focus to caring for youth through effective communication. We will also discuss a few more techniques you can use with youth in your care, especially in crisis moments. We will end the session by hearing from former foster youth.
Session 7: Communication and Crisis Management

Topics covered in Session 7

- Licensing and Minimizing the Risk of Allegations
- The Power of Language in Managing Behavior
- Disclosures
- Crisis Intervention
- Finding the Fun and Self-Care
- Youth Panel

Competencies covered in Session 7

CCW104-03 Awareness that children placed with a caregiver may disclose new information related to CA/N not known to social worker.

CFAM134-02 Awareness of the need to provide structure and predictability for a child who has been maltreated.

CFAM134-03 Awareness of the goals of behavior management and appropriate discipline techniques.

CFAM134-07 Awareness of the importance of supervision of children in the caregiving home.

CFAM134-09 Awareness of how to manage crisis/severe behavior problems in the home: aware of agency policy on physical restraint of children in care; aware of actions to take when children are out of control.

Begin Session 7
Understanding WACs

**WAC 388-148-1515**

How often must I feed children?

1. You must provide all children a minimum of three meals in each twenty-hour period.
   You may vary from this guideline only if you have written approval from the child’s physician and social worker.
2. The time interval between the evening meal and breakfast must not be more than fourteen hours.

**Scenario**
The child in your care has skipped a class at school three days in a row. You have just found out on the third day. You are so upset with the child that you tell her she must go straight to bed after school and that she is not welcome to have dinner with the family. Will this action result in a licensing violation?

**WACs around Medication**

**WAC 388-148-1565**

How must medications be stored?

1. Prescription and over the counter medications must be kept in a locked container.
2. Internal and external medication must be stored separately.
3. Human medication and animal medication must be kept separate and in locked containers.

**WAC 388-148-1570**

Who may access stored medications?

Only you or another authorized care provider (such as a respite provider) is allowed to have access to medications for a child in your care except as noted in WAC 388-148-1580.

**WAC 388-148-1575**

What are other requirements for medications?

1. You must keep a written record of all prescription medications and the dates given for the children in care. This list must go with the child when a child leaves your home.
2. You must notify the child’s DSHS worker of changes in prescribed medications.
Understanding WACs, Continued

(3) You must give prescription and over the counter medications as specified on the medication label or as prescribed by persons legally authorized to prescribe medication. This includes herbal supplements and remedies, vitamins, or minerals.

(4) You must give children non-prescription medication according to product instructions and seek medical advice regarding possible interactions with a child’s other prescription and non-prescription medications.

WAC 388-148-1580
Can children take their own medications?

(1) You may permit children under your care to take their own medicine as long as:
   (a) They are physically and mentally capable of properly taking the medication; and
   (b) You obtain and keep written approval by the child’s DSHS worker in your records.

(2) When a child is taking their own medication, the medication and medical supplies must be kept locked or inaccessible to unauthorized persons.

WAC 388-148-1585
Can I use medication for behavior control?

You must not use medication for behavior control, unless prescribed for that purpose by a physician or another person legally authorized to prescribe medication.

WAC 388-148-1590
Can I choose to give prescribed medications, including psychotropic medication?

(1) You must not start or stop giving a child’s prescribed medication without approval from the child’s physician.

(2) In addition to the physician, you must coordinate starting or stopping a child’s psychotropic medication with the child’s social worker to determine what consent is needed. The social worker may need to obtain consent from the child age thirteen and older, the parent, or the court.

(3) You must not give medications to a child that has been prescribed for someone else.
Understanding WACs, Continued

WAC 388-148-1595
Can I accept prescription medication from a child’s parent or guardian?

(1) The only medication you may accept from the child's parent, guardian, or responsible relative is medicine in the original container labeled with:
   (a) The child’s first and last name;
   (b) The date the prescription was filled;
   (c) The medication's expiration date; and
   (d) Readable instructions for administration (manufacturer's instructions or prescription label) of the medication.

(2) You must notify the child's DSHS worker when you receive a new prescription from a child's parent or guardian before giving it to the child.

Scenario
Your foster daughter who is 11 years old was diagnosed with Attention Deficit Hyperactivity Disorder at the age of 9 and has been prescribed Adderall to be taken twice daily. She has been taking this medication for the 3 months that she has been in your home. Today, she refused to take the medication and informed you that she is not going to take it again.

Can you simply stop giving her the medication? What should you do and who should you contact?
FACT Sheet – Frequently Asked Questions – Foster Home Specific

Caregiver Reporting Matrix

Please see appendix for this material.
Family Guidelines for Safety and Minimizing Your Risk of Allegations

Secure accurate information upon placement of the child.

- Ask why the child is being placed.
- Ask about behavior problems that are known.
- Ask about history of abuse.
- If the child is known to have been sexually abused, set up a safe and protective environment for the child and for your family.

Keep a copy of, fully understand, and comply with, the Supervision Plan that you are given at the time of placement.

Make sure your behavior is above reproach.

- Do not spank or use any physical punishment.
- Never engage in aggressive horseplay or teasing.
- Avoid suggestive or sexual language, swearing, comments, whistles, and things that may be misinterpreted or are ambiguous.
- Keep touches appropriate:
  - Kisses on the cheek
  - Short side hugs
  - No lap-sitting for older children
- Make sure every family member’s comfort level with touching, hugging, and kissing is respected.
- Avoid playful touch, such as play fighting and tickling.
- Help children learn the importance of privacy.
- Keep adult sexuality private.
- Be aware of and limit sexual messages received through the media.

Use the Rule of Three.

- If a child has a history of sexually acting out, do not leave the child alone with another child or adult. Have three people in the room at all times.
- If the child has a history of false allegations, when possible, do not be alone with the child for a long period of time. Have three people in the room at all times.
Family Guidelines for Safety and Minimizing Your Risk of Allegations, Continued

Be clear about house rules, including rules around dress, privacy and touching.

- Set, explain and maintain clear, firm, concise rules on dress, privacy, touching, boundaries, language and behaviors.
- Take special caution around bathroom, bedroom and dressing issues.
- Supervise and monitor children’s play.
  - Keep doors open while children are playing.
- Put the foster child in their own bedroom, if at all possible.
- Leave doors open and be within earshot of another parent/child if you need to talk or be with the child in his or her own room.
- Develop comfort with language about sexual boundaries:
  - With friends
  - At school
  - In the community
  - In your home

Address issues when they happen.

- If you are open and transparent, children will learn that everything can be talked about.
- Keep the lines of communication open.

Partner for help and support.

- Actively participate as a team member.
- Participate in training.
- Schedule regular breaks for yourself.
- Use respite and other supports.
- Monitor your own emotions and stress and seek help when you need it.

Documentation

- Keep a daily log in a ledger book or other bound book.
- Begin a new page for every day and start the page with the date.
- List positive and negative information about how each day has gone.
- List all parties present.
- List facts, not your opinions.
Family Guidelines for Safety and Minimizing Your Risk of Allegations, Continued

- When there is room left at the bottom of any page, cross out any blank lines, sign and date.

Record any sexual acting out in writing and send a copy of the report to the social worker and therapist (if applicable) and keep a copy for your records.
Examples of Documentation

June 3, 2016 (Friday)

Today was a very good day. I dropped Cindy off at school this morning at 7:00 am, and I picked her up from school at 2:45 pm. She had quite a bit of homework, so she began working on it directly after school. She remained at the kitchen table working until 5:00 pm. As soon as her homework was completed, she asked if she could help with dinner and began setting the table. We had dinner, she watched television for a couple of hours and then she went up to bed.

My husband and both of my sons were at home with us all evening.

It was a great day with no issues!!

RMG 6/3/16

June 4, 2016 (Saturday)

Cindy got up today at about 9:30 am and helped me with some light housework. At about noon she advised me that she was going to a party at Jeff’s house which starts at 7:00 pm. I explained that this was the first I had heard of this and that I do not know who Jeff is, where Jeff lives or what kind of a party this is. I explained to her that based on my lack of information and the lack of pre-planning for such an event, that it was not going to be possible for her to go to the party.

Cindy appeared to be angry, told me that this was all “bullshit,” that she would go to a party if she wanted and that she did not care what I said about it. She went to her bedroom and slammed the door. She refused to come out of her room when I knocked on her door and asked her to come and speak with me. She did not come out of her room for dinner, and did not try to leave the house to go to the party.

She did not speak to anyone in the house the rest of the day.

My husband and my two sons were home and witnessed all of the events of the day with Cindy.

RMG 6/4/16
Self-Concept Builders

Praise

- Verbal

- Nonverbal

- Physical

Rewards / Privileges

Establishing a successful environment

Sharing positive feelings

Asking advice or opinion of the child

Asking for help from the child
Building a Positive Self-Concept

Self-concept can be defined as the view one has of oneself and one’s abilities. A child’s self-concept begins to develop at birth. It begins with how adults respond to the child. Parents and caregivers create a positive emotional bond with an infant through warm and caring interactions with a lot of eye contact and touch. This positive emotional bond with parents and caregivers promotes a child’s healthy self-concept. It is the basis of a relationship in which the child feels the parents’ and caregivers’ love, acceptance, and respect.

As the child grows, their ability to interact successfully with their environment promotes a healthy self-concept. This is critically important in early childhood. The development of a positive self-concept at an early age empowers the child to feel competent, try new things, and strive for success. As parents, we have the opportunity (and responsibility) to help build a positive self-concept in our children.

So, how can you tell if your child has a positive or negative self-concept? Children with a positive self-concept have a "can do" attitude. They believe in their ability to complete tasks without help, or with minimal help. They do not exhibit problematic behaviors as doing so would be against their positive self-concept.

Children with a negative self-concept have a "can't do" attitude. They become frustrated easily and give up on difficult tasks. These children may exhibit behavior problems if "naughty" or "bad" is a part of their self-concept.

What can parents do to help their children develop a positive self-concept?

1. Be mindful of the language you use to describe your children. Do not label them with words such as “lazy,” “naughty,” “aggressive,” or “stupid.” Instead, look for and point out your child's strengths.

2. Provide them with opportunities for success. Give your child age-appropriate tasks they can complete on their own. Having done so will give the child a sense of pride and help build a "can do" mentality and positive self-concept.
Building a Positive Self-Concept, Continued

3. Show your children that you have faith in their goodness and in their abilities. This is a matter of language choice. For example, if your toddler, out of frustration, hits another child, you might say, "You naughty girl! How can you be so mean? I can't believe you hit him! You're in big trouble!" Or, you could say, "You got frustrated and hit him. It's not ok to hit. I know you didn't mean to hurt him. How can you express your frustration in different ways? Would you like a stress ball to squeeze?" Which do you think leads to a positive self-concept?

Alternatively, let's use the example that your child is working on a puzzle and is having trouble getting it to fit together properly. If you see frustration building, you might say, "Looks like you can't do that puzzle. Why don't you forget about that one and try something easier?" Or you can offer encouragement and help. "You've gotten several pieces in the right place. If you keep working on it, I'm sure you'll get it. Would you like me to help you with a couple pieces?" The second leads to success while the first leads to failure.

4. Give your child the opportunity to explore their environment, ask questions without feeling like a nuisance, and engage in make-believe play activities.

Failure is also a learning tool for children, and we don't want to shield them from all failures. In fact, children with positive self-concepts who experience failure can accept mistakes or weaknesses because they know they are competent overall.

Competence = Confidence

Parents sometimes think they must point out mistakes and often correct the child in order to make the child competent. This is dangerously false. Constant criticism erodes self-confidence as you're always pointing out their failures and weaknesses. When you emphasize what your children do right, however, children will feel good about themselves and continue to strive to meet that positive self-concept.

Giving your child opportunities to do things for themselves will help them to develop that “can-do” attitude. Allowing them to dress themselves (no matter how mismatched or odd the choices are); putting things within their reach, such as their plates and utensils in a low drawer, handy snack packs on a low shelf in the refrigerator, clothes hanging on a low rack so that he may choose for himself, and step stools so he may reach the sink himself; will all help aid in
Building a Positive Self-Concept, Continued

making the child feel competent, and therefore, confident.

Allowing them the freedom to try to climb a tree or ride a bike without training wheels will also help them discover their abilities. Hovering parents inhibit competence in young children. Have faith in their abilities while remaining close by to offer assistance if they ask.

The Effects of Behavior

Misbehavior is the usual outcome of discouragement and a poor self-concept.

*It is so much more satisfying to behave properly that most children would if they had confidence in their ability to succeed.*

Encouragement is not the same as praise. Encouragement recognizes his capabilities and expresses faith in your child as he or she is. Use words that encourage, not discourage your children.

Words that Encourage

- You can do it!
- I have faith in you.
- You're doing well.
- I see you put a lot of effort into that.

Words that Discourage

- Be careful. You usually color outside the lines.
- That's probably too hard for you.
- You can do better that that!
- Most of the room is clean, but you left your socks out.

Be careful with your parental power. While it is important to establish and enforce limits, when parents try to dominate their children, it strips them of self-respect and erodes their self-esteem. When self-respect is lost (or not developed), the potential for violence and deviant behavior is fostered. Children who feel powerless often behave destructively towards themselves and/or others. This acting out is an undesirable attempt at gaining some control over their environment. As a parent, use your power wisely while demonstrating respect and appreciation for your child's growing need for self-determination and a strong self-concept.
Building a Positive Self-Concept, Continued

A healthy self-concept is the foundation for the positive development and over-all well-being of a child. When a child has a healthy self-concept, they see themselves as being loved, loving, and valuable. A child with a healthy self-concept is also better able to reach their full potential. They do better in school. They are better able to set goals for themselves and make decisions. They are more willing to learn new things and try new activities. With a healthy self-concept, a child has better relationships with family members and friends. They can control their behavior and get along with others.

References

- http://www.highreach.com/highreach_cms/LinkClick.aspx?fileticket=eEoXBIdCNXk%3D&tabid=106
Choices

Brea – 5 years old
Very dirty and smelly, and resistant to taking a bath

Cassia – 3 years old
Does not want to go to sleep

Danny – 13 years old
His room is a complete disaster.

Ali – 8 years old
You have asked him to turn off the video games and he has not followed through.

Briston – 6 years old
At a family gathering, he suddenly drops his pants and starts masturbating.
Name It to Tame It

What would your response be?

Ali – 8 years old
His pet rat has died. He is storming around the house telling everyone that he hates them.

Brea – 5 years old
In a rage, Brea tears up the photo of her and her mom. She comes to you mad and says, “It’s all your fault and I do not want to live here anymore.”

Cassia – 3 years old
She asks for a cookie and you say no. She starts sobbing.

Danny – 13 years old
He comes home from school slamming doors and saying his teacher is a jerk.

Marcus – 15 years old
Marcus comes home from school and starts to pack his bags. He is cursing under his breath and keeps saying, “I am done. I am out of here.”
The Brain in the Palm of Your Hand
From Parenting from the Inside Out, by Daniel Seigel and Mary Hartzell

**Your Wrist and Palm:** Brain Stem. Responsible for survival instincts (flight, freeze or fight); autonomic ("automatic") functions

**Your Thumb:** Mid-brain. Freeze, flight or fight response; emotions, where we store and integrate memories, and hold fears.

**Your Fingers over Your Thumb:** Cortex. Perception, motor action, speech, higher processing and what we normally call "thinking."

**Your Fingernails:** (This is approximately behind your eyes in your head) Orbitofrontal cortex/prefrontal cortex – a primary integration center for the brain, almost like a switchboard that makes sure messages get where they need to go. Documented functions of the prefrontal cortex are: regulation of body through autonomic nervous system, emotional regulation, regulation of interpersonal relationships, response flexibility, intuition, mindsight, self-awareness, letting go of fears, morality.

What happens when you are stressed, overwhelmed, or trying to deal with traumatic or painful memories? The prefrontal cortex shuts down; it no longer functions. (This is temporary, thank goodness!) You have flipped your lid. You can’t use most of those 9 functions above. And you can’t learn without them. To engage, to learn, you need to calm down and bring the orbitofrontal cortex back into functioning.

**Mirror Neurons:** The “monkey see, monkey do” neurons that play a key role in social interaction, connection and learning. Go to: [http://www.pbs.org/wgbh/nova/sciencenow/3204/01.html](http://www.pbs.org/wgbh/nova/sciencenow/3204/01.html) to see an excellent 14-minute Nova episode on mirror neurons.
The Brain in the Palm of Your Hand, Continued
From *Parenting from the Inside Out*, by Daniel Seigel and Mary Hartzell

Your brain, when the prefrontal cortex is working:

**Integrative Functioning (The High Road)**

Integrative functioning is “A form of processing information that involves the higher, rational, reflective thought process of the mind. High-road processing allows for mindfulness, flexibility in our responses and an integrating sense of self awareness. The high road involves the prefrontal cortex in its processes.”

**Non-Integrated Function (Flipping Your Lid, The Low Road)**

“Low road functioning involves the shutting down of the higher processes of the mind and leaves the individual in a state of intense emotions, impulsive reactions, rigid and repetitive responses and lacking in self-reflection and the consideration of another’s point of view. Involvement of the prefrontal cortex is shut off when one is on the low road.”

*Drawings adapted from Siegel and Hartzell, Parenting from the Inside Out, P. 157*

An Effective Crisis Plan
A crisis plan must:

1. **Be user-friendly**
   Caregivers must be able to initiate the plan, or else it is worthless.

2. **Have clear directions**
   It must be understood by all, including the child.

3. **Be individualized**
   A crisis plan is not a one-size-fits-all plan.
   It must be specific to the child’s:
   i. Age and size
   ii. Development
   iii. History (including trauma triggers)

4. **Be preventive**
   Expect and plan for difficult situations.
   Know trauma triggers and try to avoid them.

5. **Plan for real-life situations**

6. **Be developed collaboratively**
   Work with the team – including the child – in forming a Crisis Plan.
   Involve the social worker, the therapist, etc.

7. **Change as the child changes**
   Adjustments will need to be made as the child’s behavior changes.

*Child Welfare Training Institute at the University of Southern Maine, 2006.*
Crisis Planning with Youth

1. When I am feeling good, I am __________________________________________
   ____________________________________________________________________.

2. When I begin to feel ________________, it feels like ______________________
   and it looks like _____________________________________________________.

3. When I am feeling _____________________, I want _______________________
   ____________________________________________________________________ from other people.

4. When I am feeling _____________________, I do not want _________________
   ________________________________ from other people.

5. When I am feeling _________________, I want to talk to ________________.

6. When I see my caregiver ____________________________________________, I will
   recognize this as a sign to ____________________________________________.

Child Welfare Training Institute at the University of Southern Maine, 2006.
Connection before Correction
De-escalation Tips for When the Mid-Brain Takes Over

We refer to this as “having a flipped lid” or “flood ing.”

Tips for when YOU have flipped your lid:

- **Recognize what it feels like physically:** Fast heart beats, pounding head, a sense of urgency etc. Learn your own body’s warning signs.
- **Recognize what it feels like mentally:** A sense of urgency, thoughts that keep repeating or going in circles, an inability to think calmly and clearly (or do mental math). Learn your own body’s warning signs.
- **Take a time out from the situation to calm down.** Recognize that continued engagement isn’t going to help.
- **Focus on your breathing.** Do belly breathing.
- **Use large muscles:** Walk, do isometrics, do windmills with your arms.
- **Try to engage your cortex.** Do mental math, spell things backwards, list facts...and slow the pace.
- **Notice why you are in survival brain.** “This situation makes me feel vulnerable because (I’m not being heard, I may not be able to prevent injury, I’m not being respected).” Work to not take it personally.

Tips for when the OTHER person has flipped his/her lid (child or adult):

- **Watch for signs in the other person:** Irrational action, flushed face, intense emotion, disjointed sentences.
- **Notice your own body.** Remember that mirror neurons work quickly. Don’t let the other person’s flipped lid “catch you.”
- **Remember safety.** People who are using their mid-brain and not their cortex do not act rationally and can be physically dangerous. Stay calm, move slowly and be aware.
- **Use your mirror neurons.** The more you stay calm and connected, the easier it is for them to calm down.
- **Acknowledge feelings.** Use few words and a calm, empathetic tone.
- **Don’t talk at them.** Don’t touch them, and don’t make fast movements. If they want to leave (and it is safe), let them.
- **Don’t crowd them.** Don’t demand from them, and don’t give complicated directions (they cannot process them).
- **Invite them to take a time-out (non-punitive) or “cool down time” (CDT).** This works best if it is an option, not a command.
- **Simple tasks may engage their cortex.** You might ask them to remind you how their name is spelled, to count to ten, etc.
Connection before Correction, Continued
De-escalation Tips for When the Mid-Brain Takes Over

- **Ask for their help.** When they have begun to de-escalate, change the subject by asking for their help. “I can tell you aren’t ready to engage in work yet, but are you calm enough to help me by...?” “I can tell you aren’t quite ready to play again, but would you be willing to help me by...?”

*Partly adapted from Conflict Unraveled: Fixing Problems at Work and in Families by Andra Medea*
De-escalation Strategies and Skills

Preventative:

- Know that change causes stress for children. During times of change, build structure into the child’s routine. Plan on spending extra one-on-one time with the child.
- Identify triggers for the child, such as time of day, or specific situations that cause stress. Try to avoid triggers when you can; plan for them when you can’t avoid them. Prepare the child.
- Be alert to signs that behavior is escalating. Try to intervene quickly.
- Create a calm and soothing space in times of stress. Play soothing music, read to the child, lower the lights, and speak in a calm voice.

De-escalating the crisis:

- Avoid a battle. Now is not the time to prove who’s in charge. This is not a question of authority; it is a situation where a child is rapidly losing control of his/her behavior and/or emotions.
- If the child is yelling, do not yell over the child.
- Appear calm and in control. If a child senses that you are out of control, this may increase their anxiety, and speed up the escalation of their behavior or emotions.
- Listen to the child. Use reflective listening to acknowledge their feelings of anger, hurt, or embarrassment...whatever that feeling is.
- Allow the child some personal space. Do not crowd the child; do not move quickly and do not touch the child.
- Set limits calmly and firmly with an expectation that the child will comply.
- Ask the child what s/he needs to feel better.
- Do not demand that the child make eye contact. Use problem-solving to help the child find a solution.
Caregiver Core Training – Participant Manual

Session 8: Getting Ready and the Effects on the Caregiving Family

Last session we talked about the legal requirements around caregiving. Then we focused on more of the techniques you can use with youth in your care, especially in crisis moments. Finally we heard from youth who were formerly in care.

In this session, we will talk about your family; how adding to it will impact everyone involved, from the child in care to the members of your family at home now; and how to get ready for this transition. As part of this session, we will hear from a panel of current and previous caregivers. Much of what we touch on in this session will reference content from previous sessions. We will be reviewing and tying together all we’ve learned.
Session 8: Getting Ready and the Effects on the Caregiving Family

Topics covered in Session 8

- Effect on the Caregiving Family
- Understanding Placement
- Planning for Transitions
- Caregiver Panel
- First Placement

Competencies covered in Session 8

CCW103-01  Awareness of the benefits and limitations of different permanency outcomes.

CFAM135-01  Awareness of how foster or kinship caregiving can affect caregiving families.

CFAM138-01  Awareness of how adoption may affect the caregiving family: aware of the differences between caregiving and adoptive parenting, transition issues, and common emotional reactions in adoptive families.

CSELF181-01  Awareness of the importance of receiving all relevant placement information.

CSELF181-03  Awareness of the impact of caregiving on the self, marriage, other adult relationships, permanent children and the family as a whole.

CSELF181-04  Awareness of the ongoing stresses related to caregiving.

CSELF182-01  Awareness of how to access formal support groups and resources (foster and kinship care support groups, parenting resources, Kinship navigators etc.) as needed.

CSELF182-02  Aware of the importance of developing and managing supportive relationships and support systems.

CSELF183-01  Awareness of caregiver’s own emotional cues.

CSELF183-02  Awareness that caregiver’s own history of trauma, grief and loss may trigger strong emotions in caregivers.

Begin Session 8
### Behavioral/Social Concerns for Placement

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Eco-Map

Extended Family

Education

Friends

Work

Recreation

Other

Family / Household
### Weekly Calendar

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Eco-Map and Weekly Calendar Activity Scenarios

Zia, 3 weeks old
Zia tested positive for drug exposure at birth. She was premature and very small. She has just been released from the hospital and is still quite frail. She has to be fed every 2 hours and monitored closely 24 hours a day. Zia has to see a medical professional to be weighed, measured and evaluated 2 to 3 times weekly. She also visits her father 5 times a week (Monday through Friday) from 8 to 9 am at the local DSHS office. An outside agency provides transportation, but they have to pick her up and drop her off at your home.

Josiah, age 16
Josiah is placed separately from his 5-year-old half-sister, Emily.

Josiah is currently attending the local high school. In addition, he is attending a tutoring program to help him catch up in math and science. He meets with his tutor twice per week from 5 to 7 pm on Tuesday and Thursday. Josiah is in the school band and band practice takes place daily after school from 2:45 to 4:15. There are band concerts, competitions and activities most Saturdays from 11 am to 3 pm.

Josiah visits with his parents from 8 am to 8 pm on Sundays in their home. There is no bus service to his parents’ home and the parents do not currently have a vehicle. The family lives 22 miles from you, so it is not possible for Josiah to ride his bike. You have agreed to transport him.

Josiah attends individual counseling weekly from 5 to 6 pm on Mondays. He needs assistance getting to and from therapy.

Josiah and his sibling visit twice per month. You have been asked to coordinate this visit with the sister’s relative placement to keep the two connected.

Josiah is also participating in Independent Living Skills classes from 8 to 9:30 am on Saturdays.
Kimberly, age 5; Calvin and Zane, twin boys age 2

Kimberly is currently attending a developmental preschool through ECEAP. She attends Monday to Friday from 9 am to 1 pm. Kimberly receives services at the preschool.

Kimberly had significant dental issues upon placement and is in the process of having multiple dental visits to determine whether she will need to have a sedated dental procedure (with court approval obtained) to resolve her dental issues.

The children are visiting their parents 3 times per week from 4 to 6 pm on Monday, Wednesday and Friday at the local DSHS office. An outside agency provides transportation, but the agency has to pick them up and drop them off at your home.

Calvin and Zane have developmental delays and are receiving occupational and physical therapy once a week. Occupational therapy is Tuesdays from 4 to 5 pm and physical therapy is Thursdays from 10 to 11 am. The boys have at least one medical appointment per week between the two of them, as they were born premature and both have frequent colds and respiratory issues.

Valeriya, age 11

Valeriya is of Russian descent. Her parents attend their local church and would like to keep Valeriya connected to her church community. Their services are at 10 am on Sunday mornings. They are ok with her also attending services with your family if you wish.

Valeriya visits with her parents twice per week from 3:30 to 6:30 pm at a local visitation center. You are able to provide input on what days may work for your family.

Valeriya is being assessed through the school to determine whether she has any delays. While the process is underway, there are Individual Education Plan (IEP) meetings once per month on Thursday afternoons from 3 to 4 pm.

Valeriya sees a counselor once per week on Wednesdays from 4 to 5 pm.

She is also interested in participating in a gymnastics class that meets Tuesdays from 6 to 7 pm.

Valeriya requires extra homework assistance due to language delays. Her parents primarily spoke in their native language, with limited English skills.
Foster Home Inspection List

Please see the Appendix for this material.
Getting the Household Ready

- Talk with your extended families.
- Hold a family meeting.
- Talk to schools and child care facilities in your neighborhood.
- Talk to a doctor and a dentist about seeing the child as necessary.

In addition to what is required for licensing, make sure you have the following:

**Babies and Toddlers**

- Crib
- Formula
- Bottles
- Pacifiers
- Clothes
- Diapers
- High chair
- Baby food
- Multi-cultural and multi-racial toys
- Toothbrush
- Age appropriate toothpaste
- Car seat

**School Age**

- School supplies
- Puzzles
- Games
- Stuffed animals
- Multi-cultural and multi-racial books and DVDs
- Clothes
- Kid-friendly foods (mac and cheese, chicken nuggets, frozen pizza)
- Toothbrush/Hairbrush

**Teens**

- Toiletries: shampoo, conditioner, toothbrush, hairbrush
- Perhaps sample sizes until you can take the teen shopping to buy what they prefer
- Multi-cultural hair and hygiene products
- School supplies
- Clothes
- Appropriate DVDs
- Teen friendly foods: pizza
How to Support Children during Transitions

When a child enters your home:

- Talk with the child about his or her past experiences.
- Encourage the child to talk about their birth family or previous caregivers (or draw pictures of memorable past experiences).
- Maintain and encourage the child’s attachment to their biological or former family.
- Develop your own attachment to the child.
- Encourage the child to talk about their previous community, sports, friends or school.
- Help the child understand transitions and changes with clear language.
- Relay your approval to the child.
- Take pictures and record the child’s life events with your family.
- Try to obtain pictures from the child's past.
- Value any mementos that the child has from the past.
- Validate the child’s feelings.

When a child is leaving your home:

- Gradually shift your role from caregiver to visitor.
- Communicate with and educate the new caregiver about the child’s:
  - every day world
  - developmental world
  - attachment world
- Bridge the gap by displaying to the child your approval of the transition, and empowering the new caregiver in the eyes of the child.
- Transfer attachment to the new caregiver.
- Avoid any competition or loyalty conflict; give the child permission to do well in the new home; and show approval of the relationship between the child and the new caregiver.
How to Support Children during Transitions, Continued

- Develop a trusting relationship with the new caregiver and, when possible, support the new caregiver.
- Maintain connection with the child whenever possible.
- No matter what the physical connection with the child looks like, assure them that they will always live in your heart and hopefully you, in theirs.
- Empower the child.
- Validate the child’s feelings.
7 Trends among Successful Transitions

The 7 trends are listed below, as summarized in The Chronicle of Social Change by author Elizabeth Green. For the full study go to:

http://www.tandfonline.com/doi/pdf/10.1080/15548732.2016.1148092

1. **Settling in:** To help a child settle in, foster parents referenced taking the time to help the child settle into the home. This included doing things like helping the child personalize their room, and taking them to the grocery store to buy their favorite foods. Many enlisted the help of other children in the house to connect with a new foster child and help them feel more comfortable with their relationship with the parents. The interviewees also discussed the ways in which they might be tested by the foster child, to see how far a parent can be pushed and still be there for them. Parents set the new relationship up for success by using language from the beginning that this is “our house,” not “my house,” to emphasize security and belonging for the child.

2. **Claiming language from the foster child:** A common thread in the interviews was the language a child uses, and the ways in which it reveals their comfort level in the placement. For example, one parent noticed when their child switched from using the phrase going to “the house” to “going home” and felt that this represented positive growth of their relationship. Interviewees also believed that it was important to take the child’s lead and not push them to use language that was not their own, such as making them call a foster parent “mom” or “dad” before they’re ready (or at all).

3. **Claiming language by the foster parent:** This is also crucial, with interviewees stressing that it is important to call them your child, and not foster child. One woman shared that she always made sure to have pictures of her foster children fully integrated into her home alongside pictures of her biological family. When visitors would ask which ones were “hers,” she would say that all of them were her children.

4. **Establishing routines:** Routines were identified as a critical component to helping a child adapt to their new environment. This discussion ranged from the need to implement consistent bed times and meal times to expectations such as doing chores around the house.
7 Trends among Successful Transitions, Continued

5. **School and neighborhood adjustment:** Helping a child adjust to a new school and neighborhood environment was one of the bigger challenges many families discussed and they emphasized the need to “actively fight” for the services for a child, like support from school leadership and individual education programs. These foster parents worked to help the child maintain relationships from before they were placed in foster care, including driving them to see old friends and siblings in many cases.

6. **Relationship with the child’s birth family:** Interviewees highlighted how important it was to remember that a child’s relationship with their birth family is very complex, and will bring out equally complex emotions that can include acting out. In light of that, foster parents should try to parent in a way that “honors the birth family,” and also shows the child that it’s okay to love their birth family and their foster family.

7. **Frustration with the child welfare system:** While this wasn’t a practice particular to helping a child adapt, it is something that interviewees discussed the need to be prepared for. Researchers note that “several foster parents were stymied by the unpredictability of the family court system.” Many felt that in the future, the ability to learn information such as prior school details, health or mental health problems that their children have faced in the past before being placed in their care would help them support their foster children adapt into a new environment more easily.
Successfully Transitioning Your Family

There are common areas in which biological children of foster parents may have difficulty in adjusting to their new role as foster siblings. Below are some of the common areas of difficulty, especially around times of initial adjustment, and things that you can do to help.

Decision Making

- Involve all family members in the decision to foster.
- Clearly explain what fostering means – the behaviors that may accompany children; the feelings that this will evoke in your children, etc.
- Involve all family members in the decision to accept (or not) each specific child.
- Have a family generated checklist of what will be an acceptable new placement.
- Try not to use guilt to encourage children to conform to your wishes.
- Allow and encourage your children to talk about their feelings.
- Hold regular family meetings so all children can voice their opinions.

Sharing

- Make sure that your children have some personal items that they are not required to share.
- Always have extra clothes on hand, so that your children do not have to share their clothes.
- If possible, minimize the sharing of bedrooms.
- Provide all children with a special box or footlocker to store their important belongings.
- Allow and encourage your child to talk about their feelings.

Confidentiality and Privacy

- Explain to your children that there are things that you know about them that they don’t want others to know, and that there is no reason for others to know – compare this to the confidentiality/privacy needs of a child in care.
- Clarify secrecy vs. privacy: for example, the family may know when a child is showering, but it is still private. Privacy is allowed and encouraged; secrecy is not.
- Discuss behaviors that they should watch for, and beware of, and tell you about.
- Have rules about knocking before entering rooms with closed doors.
- If possible, minimize the sharing of bedrooms.
Successfully Transitioning Your Family, Continued

Different Expectations

- Explain that all people develop at different rates. Point out areas to your child where they themselves may be advanced or delayed.
- Explain that children of different ages have different rules (a 14-year-old can ride his/her bike to school alone; a 4 year old cannot); children of different developmental levels will also have different rules.
- Acknowledge the added responsibility that your child assumes.
- Do not change your expectations for your own child.
- Allow and encourage your child to talk about their feelings.

Role Displacement

- Whenever possible, maintain the role that your child finds most meaningful.
- It may be easier to displace the youngest child than the oldest child.
- Praise your child in the roles that he/she does well.
- Do not burden your child with a new role of care for the foster child unless your child truly wants this role.
- Allow and encourage your child to talk about their feelings.

Differences in Values

- Ask your child what the most important family traditions to them are, and do not change these. (Note that this may have nothing to do with holidays, but may be something like Friday pizza nights.).
- Regardless of the culture of your foster children, introduce books and toys into the home with a multi-cultural theme.
- Do not erase any of your old traditions when introducing new ones.
- Clearly state your family’s values and expectations to all members of the household.
- Prepare your children for the likelihood of inappropriate language and behaviors.
- Allow and encourage your child to talk about their feelings.

Sharing Parents

- Always set aside time alone with your child.
- At least weekly, have an hour to spend alone with each child in the home (go for a walk; take him/her grocery shopping; etc.).
- Identify potential resources for respite; use respite when needed.
- Allow and encourage your child to talk about their feelings.
Successfully Transitioning Your Family, Continued

- Take a break between placements.

Loss and Grief

- Introduce your children to the five stages of grief.
- Allow and encourage your child to talk about their feelings.
- Seek counseling if a child seems especially saddened.
- Take a break between placements.
- Allow your child to keep a memento, such as a photo, of the child who is leaving.
- Have a good-bye ritual.
- Have times throughout the year when past foster children are remembered.
- Create a memento for everyone (i.e. family photo with the child who is leaving; handprints of all; etc.).
It was raining as my son and I made our way from the parking lot to the movie theater on Friday to see the new Star Wars movie. His Luke Skywalker costume – an oversized karate jacket from a thrift store and a lightsaber tucked into his Cub Scouts belt – attracted smiles and winks, and I got more than a few “thumbs ups” from people who appreciated the sight. After waiting for an hour in line, we filed into the theater, all anticipation and wonder as we tried on our 3D glasses, ate our massive bucket of popcorn, and laughed at the fun we were having.

No one looking at us would have guessed that my son has been my son for less than two years.

As we waited for the movie to start, I couldn’t help but remember what life was like those first few months after a social worker dropped him and his baby sister off at our house. As new foster parents, my husband and I had no parenting experience and minimal training, so on day six of their placement with us, when the “honeymoon period” ended, we were not prepared for what followed: violent outbursts, fits of rage, running away from school, hiding, and non-stop talking. It was mentally, physically, and emotionally exhausting, and it took a toll on everyone in the house.

After one particularly difficult afternoon, my nerves frayed and my faith on edge, I phoned a friend of mine who has worked as a CPS social worker for many years. She gave me what has become some of the best advice I have ever received. “If you can make it past four months, you’ll begin to see a turn. Just stay. Stay with him.”

Just stay. Stay with him.

My husband and I, who had been determined from the start that we would keep this child for as long as the state placed him with us, made a fresh resolve that we would stay, not knowing how – or how long – it would take to get to a healthier, less chaotic home life.

Thankfully, my friend was right. The turn was subtle at first: less hitting, less running. But over time, after four months turned to eight months, then a year, we were amazed to look back and see incredible progress. Slowly, our foster son began improving in school, making friends, and, most importantly, trusting us.

After more than two years in foster care, and after twenty months in our home, we were allowed to adopt our boy and his baby sister. Often, I think about what might have happened if
“Just stay. Stay with him.” Continued

we had decided it was just too hard – if we had given up. We would have lost out on an incredible gift. While our son still experiences some effects of early trauma, and while he will carry with him the unique and often difficult story of how he became our son, he is thriving, and today he is growing to be a remarkable boy whose intelligence, humor, wit, and exuberant enthusiasm for life bring tremendous joy to our home and to everyone who knows him.

Christy Tennant Krispin: https://www.youtube.com/user/afosteredlife
Resources to help Caregivers:

The main source for all relevant caregiver forms is DSHS’s own website. The forms are updated frequently so it’s best to go to the website rather than downloading the forms and copying them.

On the main page for foster parents are links to relevant news, contact information and important links. https://www.dshs.wa.gov/ca/foster-parenting

The link for becoming a foster parent shares up to date information about what to expect including licensing requirements, and financial assistance (including reimbursement rates). https://www.dshs.wa.gov/CA/fos/becoming-a-foster-parent

Another page has most commonly used forms in their most up-to-date version. https://www.dshs.wa.gov/ca/foster-parenting/important-forms-caregivers

In addition, there are resources to help guide you through relevant policies, laws and guidelines. https://www.dshs.wa.gov/ca/foster-parenting/guidelines-laws-rules

Fostering Together has a library of useful forms for caregivers. http://fosteringtogether.org/resources/forms/

Foster Parent Association of Washington State (FPAWS) has some resources on their website as well including a rate assessment tool. http://www.fpaws.org/content/foster-care-rate-assessment-form

The Alliance for Child Welfare Excellence has training on all kinds of subjects that will come in handy as problems arise. http://allianceforchildwelfare.org/caregivers
Caregiver Placement Packet Overview

Please see the Appendix for this material.

The documents referenced in the Caregiver Placement Packet Overview can be found here: https://www.dshs.wa.gov/ca/foster-parenting/important-forms-caregivers
Caregiver Core Training – Participant Manual

Appendix

Session 1
• Dependency Timeline and Schedule of Case Staffings
  Licensing RoadMap

Session 2
• Notice of Hearings to Caregivers
• Caregiver Guidelines for Foster Childhood Activities

Session 3
• Family Visitation in Child Welfare

Session 5
• FAS Diagnostic and Prevention Network

Session 7
• FACT Sheet – Frequently Asked Questions – Foster Home Specific
  Caregiver Reporting Matrix

Session 8
• Foster Home Inspection Checklist
• Caregiver Placement Packet Overview
### Children's Administration Dependency Timeline and Schedule of Case Staffings

#### Dependency Process Timeline • Permanency Planning Throughout the Entire Life of the Case

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPS Referral</td>
<td>72 hours max</td>
</tr>
<tr>
<td>Child placed into protective custody</td>
<td>30 days</td>
</tr>
<tr>
<td>(by law enforcement or by court order)</td>
<td>90 days</td>
</tr>
<tr>
<td>Shelter Care Hearing</td>
<td></td>
</tr>
<tr>
<td>Fact Finding Hearing</td>
<td>6 months</td>
</tr>
<tr>
<td>(within 75 days of filing a Petition)</td>
<td></td>
</tr>
<tr>
<td>Disposition Hearing (Dependence Established)</td>
<td>12 months</td>
</tr>
<tr>
<td>First Dependency Review Hearing</td>
<td>18 months</td>
</tr>
<tr>
<td>Permanency Planning Hearing</td>
<td>Every 6 months</td>
</tr>
<tr>
<td>Dependency Review Hearing</td>
<td></td>
</tr>
<tr>
<td>Ongoing Reviews</td>
<td></td>
</tr>
</tbody>
</table>

### Shared Planning Case Staffings

- **Family Team Decision Making (FTDM)**
  - 72 hours of placement and as needed for placement moves.

- **Case Conference**
  - After Shelter Care hearing and 30 days before fact finding hearing.

- **CA Permanency Planning Staffings (Until permanency plan is achieved)**
  - 6 months
  - 9-11 months
  - Every 12 months
  - Termination of parental rights (only in some cases)

### Child, Family and/or Situation-Specific Shared Planning Case Staffings

- **Child Protection Team (CPT)** • Children under the age of 6
- **Tribal Staffing** • To support compliance with state and federal Indian Child Welfare Acts and Children's Administration ICW policies
- **Local Indian Child Welfare Advisory Committee (LICWAC)** • As required prior to permanency planning reviews for children from tribes who have not responded or at tribe's request
- **Behavioral Rehabilitation Services (BRS) Staffing** • Only for youth in BRS
- **17.5 year-old staffing** • Only for 17-year-olds
- **Foster Care Assessment (FCAP)** • Only after an FCAP assessment

7/26/2012

Marianne.Ojimun@dhs.wa.gov

Dependency timeline/staffings
Get help throughout the process. Contact your liaison at:
Eastern Washington • 1-877-620-5748
Western Washington • 1-866-958-KIDS

1. Primary caregiver completes orientation in person or online. You will receive application materials at this time.

2. Caregivers complete Caregiver Core Training. This is required for the primary caregiver.

3. Submit application packet documents. A minimum of completed application form and background check forms are needed to start the process.

4. A licensor will be assigned and you will receive confirmation of your application being received within seven (7) days.

5. Complete all remaining documents and submit to your licensor. Follow along on your Licensing Application checklist.

6. Approved families will receive license and other information in the mail. Thank you for serving our community’s kids!

7. Caregivers finish up any other requirements outstanding for you or your home.

8. Licensor will complete home visits, write family home study and submit to supervisor for review.

9. Your licensor will contact you to schedule interview and home visits.
June 9, 2016

TO: Area Administrators and CFWS Supervisors

FROM: Connie Lambert-Eckel, Director of Field Operations  
Children's Administration

SUBJECT: Notice of Hearings to Caregivers

The 2016 legislature required Children’s Administration (CA) staff to provide “timely and adequate notice” of all hearings to caregivers effective **6/9/2016**. Policy will be updated in October, 2016 to clarify the requirements of this legislation.

The law includes the following responsibilities for CA staff:

- Staff must provide notice of hearings to foster parents, pre-adoptive parents or other caregivers at the same time that parties to a case receive notice. (Foster parents, pre-adoptive parents and other caregivers are not parties to the case.)
- For emergency hearings, staff must give notice as soon as possible.
- For six-month review and annual permanency hearings, staff must give notice upon placement or as soon as possible.
- Notice may be given in writing, by email, or by telephone. Caregivers may be told in person.
- Staff will continue to provide caregivers with the “Caregivers Report to the Court” form (DSHS 15-313). The caregiver’s report cannot include information about the child’s parent that is not directly related to the child’s well-being.
- Staff must be prepared to report to the court the date they provided notice of the hearing to the caregiver.

Responsibilities of the court included in this law:

- The court must establish in the court record:
  - Whether CA provided timely and adequate notice to the caregiver. Standard court orders are being updated to document this information.
  - Whether the caregiver’s report was received by the court.
  - Whether the court provided the caregiver an opportunity to be heard in court.
  - The Administrative Office of the Courts must include in their annual report data on timely notification to caregivers and caregiver reports submitted to the court.

Questions regarding Notice of Hearings policy may be directed to Nelly Mbajah, Supervisor of Permanency and Placement, Division of Program and Policy at nelly.mbajah@dshs.wa.gov or 360-902-8003.
RCW 74.13.710 authorizes caregivers to provide or withhold permission without prior approval of the CA worker or department to allow a child in their care to participate in normal childhood activities based on a reasonable and prudent standard. This standard is characterized by careful and thoughtful parental decisions intended to maintain a child’s health, safety, and best interest which encourage the child’s emotional growth and development.

A “normal childhood activity” includes age or developmentally appropriate “extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for period of over twenty-four hours and up to seventy-two hours. “Normal childhood activities within the described time frames, including being babysat do not require background checks or prior department approval. Licensed foster parents must still follow the minimum licensing requirements for child foster homes in WAC 388-148.

A youth in Extended Foster Care is a ”child” for the purposes of the dependency and must comply with responsibilities in WAC 388-25-0546; otherwise the youth has the legal status and legal rights of an adult and is responsible for their actions.

<table>
<thead>
<tr>
<th>Child Activity Category</th>
<th>Green – Examples of normal Childhood Activities caregivers can approve independently*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA worker approval or a new court order is needed any time an activity is in conflict with any court order or supervision/safety plan. Prior CA worker approval is required if there are costs or fees associated with the child's participation in the activity if the department is expected to pay the participation costs.</td>
<td></td>
</tr>
</tbody>
</table>
| Family Recreation (Children should be closely supervised and use appropriate safety equipment for water activities.) | **Movies**  
**Community events**  
**Family events (less than 72 hours)**  
**Camping (less than 72 hours)**  
**Hiking**  
**Boating wearing a lifejacket**  
**Swimming**  
**Biking using a helmet**  
**Other sporting activities using appropriate protective gear**  
**River tubing**  
**River rafting** |
| Red- Examples of childhood activities CA must approve* or obtain a court order |
| | **Any events or activities over 72 hours** |

*Neither the department or the caregiver will be held liable for injuries to the child that occur as a result of authority granted unless the action or inaction of the department resulting in injury constitutes willful or wanton misconduct.

DSHS 22-533 (Rev. 7/16)
<table>
<thead>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
| Social/Extra-curricular Activities | Less than 72 hours  
- Camps  
- Field trips  
- School related activities  
- Church activities  
- Youth Organization activities  
- Sports activities  
- Community activities  
- Social activities with peers  
- Spending the night away from the caregiver’s home. | More than 72 hours  
- Camps  
- Field Trips  
- School Related Activities  
- Church Activities  
- Youth Organization Activities  
- Sports Activities  
- Community Activities  
- Social Activities with Peers  
- Spending the night away from the caregiver’s home. |
| Motorized Activities  
Children and caregivers must comply with all laws and use appropriate protective/safety gear. | **Children** riding in a motorized vehicle with an adult may include, but not limited to:  
- Snowmobile  
- All-terrain vehicle  
- Jet ski  
- Tractor  
**Youth at least** 14 years operating motorized equipment or vehicle may include, but not limited to:  
- Lawn mower  
- Snowmobile  
- All-terrain vehicle  
- Jet ski  
- Tractor | **Children under** 14 years old are not permitted to operate motorized equipment or vehicles (e.g. lawn mower, motorcycle) |

*Neither the department or the caregiver will be held liable for injuries to the child that occur as a result of authority granted unless the action or inaction of the department resulting in injury constitutes willful or wanton misconduct.*
**Caregiver Guidelines**  
For Foster Childhood Activities  
To Assist In Caregiver Decision Making

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</tbody>
</table>

**Driving**  
- Caregiver acts as the “parent/guardian” for the purposes of the Intermediate Driver's License Law.  
- Caregiver must provide and pay for insurance for the child driving and agree to maintain and pay for insurance until child reaches 18 or until another responsible adult assumes financial liability risks for the child.  
  - Driver’s education classes  
  - Driver’s training  
  - Driver’s test  
  - Issuance of a personal driver’s license  
- CA worker must complete and submit the Request for Washington State Instruction Permit or Personal Driver License (DSHS 02-363) form to DOL before a youth can obtain the permit or license.  
- Youth must have an Identicard form (DSHS 16-029) on file with DOL prior to seeking a driver’s permit or license. (This can be submitted with DSHS 02-363.)

**Travel**  
- All travel within the United States less than 72 hours  
- All travel more than 72 hours.  
- All out-of-country travel  

Travel to the British Columbia (BC) territories of BC Rockies, Thompson/Okanogan and Vancouver Coast and Mountains are considered ‘border counties’ to Washington State and do not require out of country approval if less than 72 hours. All territories beyond are considered out of country travel.

**Employment/ Babysitting**  
Youth 14 years old or older and following WAC 296-125  
- Interview for employment  
- Continuation of current employment  
- Does not interfere with school  

Reminder:  
- Foster children may not babysit other foster children.  
- Sexually aggressive and physically assaultive youth may not babysit other children.

**Religious Participation**  
- Attend a religious service of the child’s choice.

**Resource**  
www.TeenWorkers.Lni.wa.gov

Youth is 13 years old or younger

*Neither the department or the caregiver will be held liable for injuries to the child that occur as a result of authority granted unless the action or inaction of the department resulting in injury constitutes willful or wanton misconduct.
Introduction

Family visits may be valuable opportunities for children to heal and cope with the trauma of being separated from their families while in foster care. In fact, regular visitation can help children maintain continuity in family relationships, create a more positive parent-child relationship, and help families prepare to reunite (Weintraub, 2008). Given this, the quality of contact between children in care and their parents over the last 20 years has received much more attention (Triseliotis, 2010). This focus, however, has not resulted in much evidence-based information on guidelines or standardized tests on what to look for during visits nor criteria for evaluating what happens during visits (Triseliotis, 2010). Given the primary goal of reunification with birth parents, visitation becomes the main vehicle for observing parental behaviors and therefore merits attention. The needs of the child must be at the forefront, while ensuring their safety. Visits between parents and their children can:

- Provide parents with an opportunity to learn new parenting skills, practice new skills and/or demonstrate safe parenting skills.
- Increase the mutual enjoyment for parents and children during their interactions.
- Give the case worker an opportunity to observe and assess families and their progress.
- Support/satisfy reasonable efforts requirements (Adoption and Safe Families Act, 1997).
- Promote child welfare system goals of safety, child well being and permanency.

Research shows (Weintraub, 2008) that children who have regular, frequent contact with their family while in foster care experience:

- A greater likelihood of reunification
- Shorter stays in out-of-home care
- Overall improved emotional well-being and positive adjustment to placement

In order to make the most of visits, families need to be prepared for the purpose of visits, what is expected during visits and how visits may change over time in length and frequency. This brief will look at best practices around visitation while children are in foster care. It will look at factors that support visitation as well as challenges. Additionally, ways that the juvenile court system can support parental visitation will be highlighted.
This brief was written for Children’s Administration and Washington State courts to provide a framework for best practice and opportunities to support and improve practice around visitation.

**Timely First Visits**

When possible, for cases in which visits are advised, the first visit would ideally occur within 48 hours of the initial removal of the child. Early visits after removal can help the child to adjust to their placement. Siblings should be included in as many visits as possible (Wentz, 2008). The first visit after a child has been taken into care should be given special attention and planning so that the visit is successful for both the child and parent and future visitation is encouraged (Wright, 2001). A parent’s right to visit with his/her child should be based on the parental behavior at the visit, not as a reward or punishment for compliance or lack thereof with other services (Wentz, 2008).

**Visitation Plans**

Visitation should be part of a larger case plan and strategy for working with a family. It should mesh with the other services that are part of the case plan, such as counseling for the child and/or parents, parenting classes or substance abuse treatment. Services ordered should center around parent-child visits, which provide the opportunity to test the effectiveness of these services and parents can demonstrate an increased ability and willingness to parent (Wright, 2001).

Guiding principles to develop child visitation plans:

1. Child development and parenting skill acquisition are kept in mind and supported.
2. Family culture should be respected and encouraged.
3. Type of abuse will dictate level of supervision needed.
4. Inclusion of siblings as often as possible.
5. Time in care: visits supervision, frequency and length should change as the family makes progress.
6. Other factors to consider: parental mental illness and/or substance abuse, incarceration, domestic violence history.

**Levels of Supervision**

All cases require that the level of supervision needed during visits be addressed. It should be thought of as a continuum that ensures safety while allowing the most normal family interactions possible (Wentz, 2008).

Factors to consider when determining the level of supervision required:

- Age of child
- Type of abuse the child experienced
- Parent’s history of family violence
- Potential for abduction of child
- Emotional reaction of the child
- Where the visit will occur
- Who will be present at the visit
- Progress parent is making to improve parenting skills
- Parental issues such as addiction and mental illness

**Progressive Family Visitation**

Visits usually start as supervised with many restrictions on location, activities and frequency. When parents and child are interacting successfully during visits, the plan should change one element of the visit at a time, such as increasing the length of the visit or changing the location (Wentz, 2008). The goal is to slowly increase the parent’s responsibility and move towards unsupervised visits in the parent’s home while safely assessing the parent’s ability.

If there is a failure or repeated problems, go back to the last successful visit plan and determine what will make the visit more successful. Again, change only one element at a time even when there has not been a problem (Wentz, 2008).

**Stages of Family Visitation**

Family visitation can be thought of as occurring in three stages: preparation and planning, the visit itself, and follow-up (Holcomb, 2004). Each stage of visitation is important to supporting successful visits.

**Preparation and Planning**

The preparation and planning stage of visitation is when the logistics of the visit are decided and agreed upon. This stage is not only critical to the success of the first visit, it’s critical to the success of future stages (Holcomb, 2004). Case worker observation of family visitation should occur at least monthly.

Good preparation and planning cover the following and should incorporate case goals (Hess, 2003):

- Visitation schedule: dates, times and location of visits
- Who will arrange visit place and time?
• Who will be present?
• What can be expected?
• Arrangements for monitoring, visit coaching, or supervision, if any
• Plan for handling emergency situations
• Procedures for handling problems with visitation
• Visit frequency
• Visit length
• Visit activities
• Transportation arrangements
• Visit do’s and don’ts

The Visit

This is the actual time that the parent and child will spend together. It can either be formal or informal. Visits that are either supervised or semi-supervised can provide necessary guidance to help support a positive interaction between parent and child (Holcomb, 2004). The visit supervisor can assist by modeling appropriate interaction while empowering the parent to guide the visit.

Things to keep in mind for the visit:
• Homelike settings work best.
• Psychologically preparing the parents for the visit has been shown to predict a positive experience (Holcomb, 2004).
• Visits should increase and lengthen as a family approaches reunification.
• Parents should be clear on the goal of the visit as it relates to their case plan.
• Help the family create rituals around visits, such as a “hello” and “goodbye” ritual to reduce stress at transition times.

After the Visit

Each visit should be documented by the visit supervisor and reviewed by the case worker. Input should be sought from all parties involved, focusing on successes and challenges of the visit and desires and goals for future visits (Holcomb, 2004). This process can help the worker to refine the visitation plan to reflect obstacles, changes, and parental progress (Wright, 2001). If all is going well, visitation restrictions may be removed and visits lengthened.

Documentation of visits should include the following (Children’s Services Practice Notes, 2000):
• Who participated and in what activities.
• The time the parent arrived and the length of the visit.
• Interactions between participants (level of affection).
• Extent to which parent exercised role (setting limits, disciplining child, engagement with child).
• Whether the visit supervisor or case worker needed to intervene.
• How parent and child separated.
• What happened after the visit – both the parent and child’s reactions.

Assessing reactions to visitation by participants is important to help them understand and handle their own reactions to visits appropriately (Wright, 2001). All participants – including the parent, child, foster parent and others present – need to be educated about visitation and its emotional impact (Wright, 2001). If the feelings experienced by family members such as anger, sadness and helplessness that are common to reunion and separation cannot be expressed, this will often create behavioral difficulties for the child (Hess & Proch, 1993). It is important for foster parents to understand that behavioral reactions after visits may be expected and do not necessarily signify that visitation should be stopped (Wright, 2001). By carefully evaluating participants’ verbal and non-verbal reactions to visits, the case worker can determine whether (and what) changes should be made to the visitation plan (Hess & Proch, 1993).

Visitation Oversight

Ideally, visitation services would be provided by the same agency staff members as those who are providing the reunification services. However, in order to maximize visitation resources, it is likely that others will be involved in the supporting visitation such as foster parents, relatives and volunteers. The case worker therefore may not be present before, during or after many of the visits. In these cases, it is very important that the family’s primary case worker maintain responsibility for creating and evaluating the visitation plan (Hess & Proch, 1993). If responsibility for the visitation plan and its implementation becomes diffused, it can lead to missed visits, missed opportunities and delays in reunification (Hess & Proch, 1993).
Factors that Support Visitation

The following have been found to increase the likelihood of visitation by parents (Children’s Services Practice Notes, 2000):

- Case worker is committed to visitation.
- Case worker has empathy for parents.
- Foster parents/kin are committed to visitation.
- Agency requires written plans for frequent visits.
- Agency has resources that promote visitation, such as a visitation room with comfortable furniture, age appropriate toys and/or activities for families.

How Social Workers Can Address Challenges to Parents’ Participation in Visits

Understanding the common challenges that prevent or discourage parental visitation should be investigated prior to drawing any conclusions about parents’ feelings toward their children (Patterns & Outcomes in Child Placement, 1991). When investigating potential barriers to visitation:

1. Build an accurate picture of current levels of visitation across a series of cases: How often have the child and parents actually made contact during the past two months? Has the court set any limitations on contact? Have parents attempted to visit with their children? How did the visits go?

2. Assess agency policy and practice around choice of placement for children: How close are the children placed to their parents’ home? Are siblings able to be placed together? What are the standards around the number of children, especially children with special needs who are allowed to be placed in home? Do case workers have manageable caseloads to allow for time to assist with visitation?

3. Understand and investigate financial challenges: Parents involved with the child welfare system are largely those living in poverty. What kind of support do families need to attend visits? Gas vouchers/bus tickets? Child care money for other children? Money for gifts, food, and entertainment during visits?

4. Engage the foster parents: How supportive are they of visitation? Are they a resource to the birth parent? How prepared are they to deal with the emotions of the child once a visit is over? Do they know what to expect?

Problem-solving the barriers with parents can be a valuable way to engage them and to decrease the likelihood that they will get in the way of visitation.

How the Courts Can Support Parents’ Participation in Visits

According to Edwards (2003), the juvenile court can also play an important role in supporting family visitation:

- Attorneys representing birth parents should make visitation a major focus of their advocacy efforts.
- The role of the judge is to oversee the delivery and adequacy of reunification services offered to a family, including visitation.

Also according to Edwards (2003), judges have the ability to impact visitation policy by doing the following:

- Meeting with Children’s Administration leaders and reminding them of their responsibility to provide meaningful visitation.
- Creating clear, enforceable, and written visitation orders to help set the courts tone around the value of visitation.
- Developing local visitation rules that emphasize the importance of visitation and how visitation will be covered in each hearing.
- Ensuring frequency and duration of visitation meet the needs of the child and parent.
- Providing training on visitation for participants in the juvenile dependency court.
- Using the “no reasonable efforts” finding when the Children’s Administration has not complied with reasonable efforts visitation.
- Assisting the Department in being creative with resource allocation that would support visitation.

Conclusion

The primary goals of visitation are to meet the developmental needs of the child and to mitigate the trauma of placement. Additionally, visitation supports familial relationships as well as provides a means for case workers to assess parents’ progress toward correcting deficiencies. Given the critical role of visitation in family reunification efforts, more attention should be directed to this important service both by social workers and researchers alike. Additionally, more information on what constitutes quality visitation is needed as well as standardized
ways to evaluate visits and their impact on children. Thoughtful planning should go into visitation plans and should be changed over time as the parents demonstrate change. Birth parents should also be given more support in problem-solving the challenges – both emotional and physical – to participating in visitation. The juvenile court can also play an important role in ensuring that visitation services remain a supported priority in reunification efforts. The importance of connection to family is too important to children to not be a priority, whether the child is able to return home or not.

Sources


We’d like to thank the Children’s Administration’s Everett office for their time and participation in this collaborative effort.

For more information, please contact:
info@partnersforourchildren.org.
The 4 Diagnoses under the FASD Umbrella

**Fetal Alcohol Spectrum Disorders (FASD)** is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. An individual would not receive a diagnosis of FASD.

Four diagnoses fall under the umbrella of FASD: FAS, Partial FAS, Static Encephalopathy/Alcohol Exposed (SE/AE) and Neurobehavioral Disorder/Alcohol Exposed (ND/AE). Each year, as many as 40,000 babies are born with FASD, at a cost of over $4 billion dollars nationwide.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Growth</th>
<th>FAS Face</th>
<th>Brain</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. FAS</td>
<td>growth</td>
<td>face</td>
<td>severe</td>
<td>alc</td>
</tr>
<tr>
<td>2. PFAS</td>
<td>face</td>
<td>severe</td>
<td>alc</td>
<td></td>
</tr>
<tr>
<td>3. SE/AE*</td>
<td></td>
<td>severe</td>
<td>alc</td>
<td></td>
</tr>
<tr>
<td>4. ND/AE</td>
<td></td>
<td></td>
<td>moderate</td>
<td>alc</td>
</tr>
</tbody>
</table>

* Also referred to as:
  - Alcohol Related Neurodevelopmental Disorder (ARND) or
  - Neurodevelopmental Disorder Prenatal Alcohol Exposed (ND-PAE)

**Fetal Alcohol Syndrome (FAS)** is a birth defect syndrome caused by maternal alcohol consumption during pregnancy. FAS is characterized by:

- growth deficiency (height or weight \( \leq \) 10th percentile).
- a unique cluster of minor facial anomalies (small eyes, smooth philtrum, thin upper lip).
- severe CNS abnormalities (structural, neurological, and/or functional abnormalities).
- prenatal alcohol exposure (confirmed or unknown).

The prevalence of FAS is estimated to be 1 to 3 per 1,000 live births. This is roughly equivalent to the prevalence of down syndrome. FAS is the leading known cause of intellectual disabilities and is entirely preventable.

**Partial FAS** is a diagnostic classification for patients who present with:

- most, but not all, of the growth deficiency and/or facial features of FAS.
- severe CNS abnormalities (structural, neurological, and/or functional abnormalities).
- prenatal alcohol exposure (confirmed).

**Alcohol Related Neurodevelopmental Disorders (ARND)** is a diagnostic term that is being phased out for reasons described below for FAE. It was coined by the Institute of Medicine in 1996 for patients who presented with:

- central nervous system damage (structural, neurological, and/or functional impairment).
- prenatal alcohol exposure confirmed.

**Fetal Alcohol Effects (FAE)** was a term, introduced in 1978, that was used to describe abnormalities seen in individuals that were compatible with those caused by prenatal alcohol exposure, but the pattern was not sufficiently complete to render a diagnosis of FAS. FAE was rapidly adopted as a medical diagnostic term. In 1995, Aase et. al, published a paper expressing concern about the clinical validity of the term FAE. The term implied a causal association between prenatal alcohol exposure and abnormalities observed in an individual patient that could not be confirmed. With the likely exception of the full FAS facial phenotype, no other physical anomalies or cognitive/behavioral disabilities observed in an individual with prenatal alcohol exposure are necessarily specific to (caused only by) their prenatal alcohol exposure. Features such as microcephaly, neurological abnormalities, attention deficit, mental retardation, and growth...
What is FASD?

Deficiency frequently occur in individuals with prenatal alcohol exposure, and frequently occur in individuals with no prenatal alcohol exposure. Aase et al (1995) wrote "We propose abandoning the clinical use of the term FAE with its implications of causation, and urge simple recording of the verifiable conclusions concerning the individual patient."

The FASD 4-Digit Diagnostic Code does not use the terms ARND and FAE because, as clearly expressed by Aase et al., (1995), they imply alcohol exposure caused the neurodevelopmental disorder or effect. The 4-Digit Code avoids this problem by using diagnostic terms that report the patient was exposed to prenatal alcohol rather than reporting the patient's outcomes are alcohol effects or alcohol-related outcomes. As recommended by Aase et al., (1995) "If prenatal alcohol exposure has taken place, but FAS cannot be substantiated, the exposure still should be indicated, and any nonspecific abnormalities or problems noted." The 4-Digit Diagnostic Code uses the following two terms in lieu of ARND or FAE.

**Static encephalopathy/Alcohol Exposed (SE/AE).** The term "encephalopathy" refers to "any significant abnormal condition of the structure or function of brain tissues" (Anderson, 2002). The term "static" means that the abnormality in the brain is unchanging; neither progressing nor regressing. This diagnostic classification is for patients who present with:

- severe CNS abnormalities (structural, neurological, and/or severe functional abnormalities).
- prenatal alcohol exposure (confirmed).

**Neurobehavioral Disorder/Alcohol Exposed (ND/AE)** is a diagnostic outcome classification for patients who present with:

- moderate CNS dysfunction.
- prenatal alcohol exposure (confirmed).

**Neurobehavioral Disorder-Prenatal Alcohol Exposed (ND-PAE)** is a diagnostic outcome classification recently introduced by the DSM-5. It essentially replaces the term ARND and adopts the "outcome-exposure" approach to nomenclature. Confirmed prenatal alcohol exposure is required.

The prevalence of SE/AE and ND/AE are 5 to 10 fold higher than the prevalence of FAS/PFAS. The severity of brain dysfunction increases as one advances from ND/AE to SE/AE to FAS/PFAS.
**Frequently Asked Questions Foster Home Specific**

**Q** What is a Division of Licensed Resources (DLR) Child Protective Services (CPS) Investigation?

**A** When Children’s Administration (CA) gets a report alleging that a child has been abused or neglected in foster care, the report is investigated by a DLR/CPS Investigator. These reports are investigated to determine whether abuse or neglect occurred and to assess the safety of children in the foster home.

**Q** What is DLR/CPS investigating when they investigate Child Abuse/Neglect?

**A** Child abuse or neglect means the injury, sexual abuse, or sexual exploitation of a child by any person where circumstances indicate that the child’s health, welfare, or safety is harmed. This includes negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. (RCW 26.44.020)

**Q** What are examples of things investigated by DLR/CPS?

**A** Examples of things investigated by DLR/CPS include, but are not limited to: disciplinary practices that result in injuries, inappropriate restraints, lapses in supervision that place a child in danger, inappropriate administration of medications, sexual contact or physical altercations between children, and engaging in sexual touching of a child. (WAC 388-15-009)

**Q** How will I be contacted during a DLR/CPS investigation?

**A** You will be interviewed about the events and you should expect to have a home visit by the investigator handling your case. The children in your care will also be interviewed at an appropriate time and place. If additional information is needed, you can also expect the investigator to follow up with witnesses or other professionals that can provide relevant information. If it is alleged that a crime has occurred, you can expect that law enforcement will be notified. If law enforcement is involved, DLR/CPS will work collaboratively with the law enforcement agency. Your licensor will be informed of the allegations and the progress of your investigation. If you feel you need support you can call FIRST.

**Q** How will DLR/CPS contact me about an investigation?

**A** An investigator will notify you at the earliest point in the investigation that does not jeopardize child safety. They may contact you by phone or in person at your home. A DLR/CPS investigator may come to your home unannounced, DLR/CPS will work with law enforcement and follow their lead. You may as the investigator for estimated time frames for a face to face meeting.

**Q** What will I be told about the investigation?

**A** Initially you will be informed about the nature of the allegations such as Negligent Treatment/Maltreatment, Physical Abuse, Sexual Abuse, or Sexual Exploitation. Often times the investigator will not provide additional details about the investigation until they are able to meet with you in person. The investigator will provide for you in person as much information as possible without jeopardizing the integrity of the investigation.

**Q** Can I tell the Investigator what happened from my point of view?

**A** The investigator will contact you either in person or by phone for an interview. In most cases the DLR/CPS investigator will interview the children in your care first. You may send in a written explanation of what happened (even if you think the referral will be determined to be unfounded). Your interview and any written documents you provide will be considered in the investigation and placed in the DLR/CPS file.

**Q** How long will the investigation take?

**A** The Division of Licensed Resources aims to complete your investigation within 45 days. However some investigations may take longer. Unless law enforcement or a prosecuting attorney is involved, state law requires DLR/CPS to complete the investigation within 90 days (RCW 26.44.030). If law enforcement is involved in the investigation, DLR/CPS defers to local law enforcement protocols.
Q: Are there consequences for my biological children?
A: A Children's Administration social services specialist or investigator must report an allegation of abuse or neglect of any child. If an investigator believes that your children's safety is at risk, we will provide services to help keep your children safe. The DLR/CPS investigator wants to hear from everyone with relevant information about what happened regarding an allegation of abuse or neglect, and may interview your child in an investigation. State law allows CA to interview alleged victims and foster children without their parents’ permission. The investigator may ask for your permission to interview your child, if your child witnessed the incident. A neutral third party adult can be present during the child interview if you or your child requests one.

Q: Are my foster children going to be removed?
A: Sometimes foster children are removed during an investigation. However, often they are not. These decisions are made early in the case with limited information and with the goal of protecting the safety of foster children. The DLR/CPS investigator looks at an allegation and assesses the risk to foster children in the home. If the Division of Licensed Resources does not have enough information to ensure the safety of foster children in your home, they will recommend the foster children be removed. Children’s Administration is the legal guardian of foster care and has the responsibility to move foster children when it is necessary to address their safety, well-being and permanence.

Q: Will Children's Administration place more foster children with me during an investigation?
A: Your licensor will address this with you on a case-by-case basis. If there are concerns about the safety of children in your home, your licensor may put a stop placement on your home. Placing you on a stop placement list with Children’s Administration does no result in a negative action against your license. This informs the department that no more children may be placed with you until the risk is assessed and reduced. Also, you may choose not to have children placed with you during the investigation, if you feel like it would be too stressful for you or your family.

Q: Will a foster child who is removed from my home be returned?
A: The child’s social services specialist will decide the best placement for the child. It is helpful for them to know whether you would like to be a placement option for the child who was removed. However, the child’s worker and supervisor will consider the child’s permanent plan and whether a secure and positive relationship has been formed between the child and the new caregivers. Moving the child back to your home may not be in the child’s best interest.

Q: What are the possible outcomes, or “findings,” of a DLR/CPS investigation?
A: Investigations are either “founded” or “unfounded.” Findings are defined by state law (RCW 26.44.020 and WAC 388-15). The majority of DLR/CPS investigations result in unfounded findings.  
**Founded:** More likely than not abuse or neglect occurred.  
**Unfounded:** More likely than not abuse or neglect did not occur or there is not enough information to determine whether abuse or neglect occurred.

Law Enforcement has a different burden of proof than CPS. This means that one can have a founded finding for abuse even if law enforcement does not file criminal charges.

Q: How will this affect my employment?
A: In most circumstances, unfounded findings will not affect your employment. However, if you have a founded finding and you are employed by an agency that works with children or vulnerable adults, it may affect your employment.

Q: How will I be notified of the outcome of the investigation?
A: The investigating supervisor will send you a letter with the finding when the investigation is complete. If the finding is “founded,” the appeal process is outlined in the letter. After the investigation is completed, you may request a copy of the investigative assessment and your DLR/CPS file.

Q: Can I make a written statement explaining what happened?
A: You may send the investigator a written statement at any time during the investigation. It will be placed in the DLR/CPS file. If the investigator gets your statement before the investigation is complete, it will be considered in the investigation findings.

Foster Intervention/Retention Support Team (FIRST) is a resource that is available to foster parents to provide you with assistance during a DLR/CPS investigation. They also provide referrals to community resources. Contact FIRST at (253) 219-6782.

As a licensed Foster Parent, where can I get more information?  
www.dshs.wa.gov/ca/fosterparents
## Reporting Responsibilities for Foster Parents

The following tables are intended as a guide to foster parents. The text below is condensed, full text can be found in WAC 388-148-1420 through 388-148-1430.

### Report to CA intake and child’s worker or CPA case manager or tribal case manager

<table>
<thead>
<tr>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of child in care.</td>
</tr>
<tr>
<td>Illness, injury, or psychiatric care that is serious in nature, requiring medical treatment or hospitalization. Serious means potential loss of life or limb if left untreated.</td>
</tr>
<tr>
<td>Suspected, or disclosure of, physical or sexual abuse, neglect or exploitation of a child.</td>
</tr>
<tr>
<td>Child’s suicide attempt <strong>requiring</strong> medical treatment or hospitalization.</td>
</tr>
<tr>
<td>Sexual contact between children not considered typical preschool play.</td>
</tr>
<tr>
<td>Physical restraint alleged to be improper or excessive.</td>
</tr>
<tr>
<td>Physical assault between children <strong>resulting</strong> in off-site medical attention or hospitalization.</td>
</tr>
<tr>
<td>Physical assault of foster parent, employee, volunteer or others, by a child in care <strong>resulting</strong> in off-site medical attention or hospitalization.</td>
</tr>
<tr>
<td>Any medication given or consumed incorrectly, <strong>resulting</strong> in off-site medical attention.</td>
</tr>
<tr>
<td>Property damage that is a safety hazard and not corrected immediately or which may affect children’s health and safety.</td>
</tr>
</tbody>
</table>

### Report to child’s worker or CPA case manager or tribal case manager

<table>
<thead>
<tr>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment by a medical professional for emergency medical or emergency psychiatric care, or; Unexpected health problems outside the usual range of reactions caused by medication that <strong>do not require</strong> professional medical attention.</td>
</tr>
<tr>
<td>Suicidal or homicidal thoughts, gestures or attempts that <strong>do not require</strong> medical treatment or hospitalization.</td>
</tr>
<tr>
<td>Any inappropriate sexual behavior by or toward a foster child.</td>
</tr>
<tr>
<td>Use of prohibited physical restraint for behavior management.</td>
</tr>
<tr>
<td>Physical assault between children resulting in injury, but <strong>not requiring</strong> professional medical treatment.</td>
</tr>
<tr>
<td>Physical assault of foster parent, employee, volunteer or others, by a child in care <strong>not requiring</strong> professional medical treatment.</td>
</tr>
<tr>
<td>Medication incorrectly administered or consumed.</td>
</tr>
</tbody>
</table>

### Child missing from care reports

- Notify child’s worker right away, or CA intake if after hours or worker is not available.
- Contact law enforcement within six hours. Ask for the missing person report number and provide to child’s worker. You must contact law enforcement immediately if:
  - Child is believed to be taken, lured from placement or has left placement and you believe child is at risk of physical or sexual assault or exploitation
  - Child is under age 13
  - Child has physical, mental or emotional conditions that if not treated will place child at severe risk
  - Child is parenting or pregnant
  - Child has an intellectual and developmental disability that impairs child’s ability to care for self
  - Child has a serious alcohol or substance abuse problem
  - Child is at risk due to other circumstances.
- After contacting law enforcement, contact the National Center for Missing and Exploited Children at 1-800-843-5678.
- If you learn of child’s whereabouts or child returns to your home, report to child’s worker.

### Report to licensor

- Address or phone number change.
- Damage or changes to structure.
- Changes from original application.
- Foster parent moving to a new location. Moves must be completed within 30 days of the foster parent residing in their new home to maintain a valid license.
- Any significant change to home or people living in home including changes in marital status, separation from partner, arrest of anyone in home or having access to children, death of family member, people moving in or out, physical incapacity, mental incapacity or medication changes that may interfere with care, change in employment or significant decrease in income, or adoption of a child.
## Foster Home Inspection Checklist

<table>
<thead>
<tr>
<th>HEALTH AND SAFETY</th>
<th>COMMENTS / NOTES / CORRECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1440</strong> Facility is clean, sanitary, and free of hazards including window blind cords.</td>
<td></td>
</tr>
<tr>
<td>1440-1 Home has adequate ventilation.</td>
<td></td>
</tr>
<tr>
<td>1440-2 Light fixtures provide children good visibility and comfort.</td>
<td></td>
</tr>
<tr>
<td>1440-3 Room temperatures at reasonable levels.</td>
<td></td>
</tr>
<tr>
<td>1440-4 Premises are free from pests.</td>
<td></td>
</tr>
<tr>
<td>1440-5 Toxic materials are out of reach of children and separated from food items</td>
<td></td>
</tr>
<tr>
<td>1440-6 Home has adequate laundry and drying facilities or makes other arrangements on a regular basis.</td>
<td></td>
</tr>
<tr>
<td>1440-7 Easy access to the outside in case of an emergency.</td>
<td></td>
</tr>
<tr>
<td>1440-8 All doors open easily from the inside and outside.</td>
<td></td>
</tr>
<tr>
<td>1440-9 Supervision plan is in place if hazardous conditions exist.</td>
<td></td>
</tr>
<tr>
<td><strong>1445</strong> Sewage is discharged into a public or functioning system or into a DOH and/or tribal approved alternate system.</td>
<td></td>
</tr>
<tr>
<td>1445-1 Water is from public system or approved private supply.</td>
<td></td>
</tr>
<tr>
<td>1445-2 Water temperature does not exceed 120 degrees.</td>
<td></td>
</tr>
<tr>
<td><strong>1450</strong> Disinfect diaper-changing areas and toilet-training equipment between each use or use disposable covering.</td>
<td></td>
</tr>
<tr>
<td>1450-1 Electrical outlets are tamper-proof if needed.</td>
<td></td>
</tr>
<tr>
<td>1450-2 Access to working telephone at all times when children are present in the home.</td>
<td></td>
</tr>
<tr>
<td>1450-3 Address is clearly visible and location is accessible.</td>
<td></td>
</tr>
<tr>
<td>1450-4 Poison control number is posted on or near telephone.</td>
<td></td>
</tr>
<tr>
<td>1450-5 Wheeled baby walkers will not be used.</td>
<td></td>
</tr>
<tr>
<td><strong>1455</strong> Pools or other bodies of water are fenced with locking gate or other DLR approved safety device.</td>
<td></td>
</tr>
<tr>
<td>1455-1 Hot tubs locked when not in use.</td>
<td></td>
</tr>
<tr>
<td>1455-2 A supervision plan is in place when the home has a pool or bodies of water.</td>
<td></td>
</tr>
<tr>
<td><strong>1460</strong> Family conducts at least quarterly fire drills with children.</td>
<td></td>
</tr>
<tr>
<td>1460-1 Family has emergency supplies of food, water, medication, and other necessary supplies.</td>
<td></td>
</tr>
<tr>
<td>1460-2 Family has a written evacuation plan for the home.</td>
<td></td>
</tr>
<tr>
<td><strong>1480</strong> Pets and animals are safe and cared for in a sanitary manner.</td>
<td></td>
</tr>
<tr>
<td>1480-1 Complies with local, state, or federal regulations regarding: animal safety, vaccinations, and standard veterinary care.</td>
<td></td>
</tr>
<tr>
<td><strong>1485</strong> Alcoholic beverages and marijuana are inaccessible.</td>
<td></td>
</tr>
</tbody>
</table>
# Foster Home Inspection Checklist

<table>
<thead>
<tr>
<th>APPLICANT / PROVIDER NAME</th>
<th>TELEPHONE NUMBER</th>
<th>INSPECTION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1495</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1510</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1520</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1540 (2)(3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Fire Safety

<table>
<thead>
<tr>
<th>1465</th>
<th>Comments / Notes / Corrections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-level homes must have escape from upper floor.</td>
<td></td>
</tr>
<tr>
<td>Bedroom windows for children in care are large enough for emergency rescue, unless approved by the local fire marshal or building official.</td>
<td></td>
</tr>
<tr>
<td>Easy access to all rooms in case of emergency.</td>
<td></td>
</tr>
<tr>
<td>Smoke detectors are in good working condition inside and outside of all sleeping areas. Smoke detectors must also be on each story of the home, in all play areas and the basement.</td>
<td></td>
</tr>
<tr>
<td>Home has at least one working 2A10BC-rated 5lb. or larger ABC fire extinguisher.</td>
<td></td>
</tr>
<tr>
<td>Fireplaces, wood stoves, heating systems have barriers for under age six (6).</td>
<td></td>
</tr>
</tbody>
</table>

## Bedrooms

<table>
<thead>
<tr>
<th>1470</th>
<th>Comments / Notes / Corrections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room has adequate privacy and floor space for safety and comfort.</td>
<td></td>
</tr>
<tr>
<td>Bedrooms must have unrestricted direct access to outdoors as well as direct access to common areas.</td>
<td></td>
</tr>
<tr>
<td>Each child has an appropriately sized separate bed with clean bedding, and a mattress in good condition.</td>
<td></td>
</tr>
<tr>
<td>Provide waterproof mattress covers or moisture-resistant mattresses, if needed. Each child's pillow must be covered with waterproof material or be washable.</td>
<td></td>
</tr>
<tr>
<td>Crib must have no more than 2 3/8 inches between slats.</td>
<td></td>
</tr>
<tr>
<td>Cribs or infant beds used for sleeping have waterproof mattress materials.</td>
<td></td>
</tr>
</tbody>
</table>
## Foster Home Inspection Checklist

<table>
<thead>
<tr>
<th>APPLICANT / PROVIDER NAME</th>
<th>TELEPHONE NUMBER</th>
<th>INSPECTION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Loose blankets, crib bumpers, stuffed toys, pillows not placed in cribs with infants.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infants are placed on their backs for sleeping.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Swaddled infants must use one lightweight blanket upon advice from a licensed health care professional (LHCP). Swaddling may be used on infants under two months, unless directed otherwise by LHCP. Swaddled infants must have the blanket loose around the hips and legs, and in a manner that does not allow them to overheat.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wedges and positioners are not used with a sleeping infant, unless advised differently by a LHC.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Weighted blankets cannot be used with children under the age of 3 years or that have mobility limitations. The weighted blanket cannot exceed 10% of the child’s body weight, use metal beads or other choking hazards, be used above the middle of the child’s chest, hinder a child’s movement, or be used as a restraint.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Upper bunks not used by anyone who might be endangered.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children six (6) years and older do not share bedroom with opposite gender.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>80 square feet if parent and his / her infant share bedroom.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Only one parent and infant(s) per bedroom.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No more than four (4) children per bedroom.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child one (1) year and older does not share bedroom with an adult that is not the child’s parent unless MD recommends.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Extended foster care youth may share a bedroom with a younger child of the same gender. If the younger child is unrelated, the youth must be at least 10 years of age; exceptions can be made if in the best interest of the child.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Immunizations / Medical Care / Medications

<table>
<thead>
<tr>
<th><strong>Comments / Notes / Corrections</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Foster parents must show proof of their own children’s current immunizations. These documents are to be viewed by the licensor and returned to the foster parent, not placed in the file.</strong></td>
</tr>
<tr>
<td><strong>If an exemption is being used for a child the DSHS 15-455 must be placed in the file.</strong></td>
</tr>
<tr>
<td><strong>Pertussis immunizations for all household members if taking placements of children under age two.</strong></td>
</tr>
<tr>
<td><strong>Influenza immunizations for all household members if taking placements of children under age two. If a household member meets the criteria for an exemption the DSHS 10-565 must be in the file.</strong></td>
</tr>
<tr>
<td><strong>First aid supplies are on hand.</strong></td>
</tr>
<tr>
<td><strong>All medications are in locked storage with pet medications separate from human medications and external medications separate from internal.</strong></td>
</tr>
<tr>
<td><strong>Prescription medications given to foster children recorded.</strong></td>
</tr>
<tr>
<td><strong>Medications are given only according to prescription labels.</strong></td>
</tr>
</tbody>
</table>
**Food / Diet**

<table>
<thead>
<tr>
<th></th>
<th>Comments / Notes / Corrections</th>
</tr>
</thead>
<tbody>
<tr>
<td>1440</td>
<td>Home must meet acceptable health standards for the storage and preparation of food.</td>
</tr>
<tr>
<td>1520</td>
<td>Food served to children and infants meets needs of the children.</td>
</tr>
</tbody>
</table>

**Qualifications / Training**

<table>
<thead>
<tr>
<th></th>
<th>Comments / Notes / Corrections</th>
</tr>
</thead>
<tbody>
<tr>
<td>1320</td>
<td>TB test completed for all caregivers / licensees and other adults in the home over age 18 including foster parent’s own teens turning 18.</td>
</tr>
<tr>
<td>1365</td>
<td>Applicants are at least 21 years of age.</td>
</tr>
<tr>
<td>1375</td>
<td>All caregivers have First Aid/CPR: training expires</td>
</tr>
<tr>
<td></td>
<td>CPR training is appropriate to the age range of children on the license: training for ages</td>
</tr>
<tr>
<td></td>
<td>All caregivers have HIV / AIDS training.</td>
</tr>
</tbody>
</table>

**Signatures**

<table>
<thead>
<tr>
<th>Applicant’s Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensor’s Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Additional items to discuss with the Foster Parent:**

- Adequate handrails and ramps
- Operating emergency lighting available.
- Toilet and bathing facilities allow privacy for child five (5) years and older.
- Toddlers have potty chairs and toilet training equipment.
- Bathing facilities have grab bars or non-skid pads.
Caregiver Placement Packet Overview

Thank you for your commitment in providing safe, quality, and loving care for the child placed in your home. Children’s Administration (CA) designed the Caregiver Placement Packet to ensure you receive accurate and timely information about the child placed in your home. We understand new information can sometimes be overwhelming; please take a few minutes to review the material about the child placed with you.

In this packet you will find:

1. **Child Information Placement Referral** - **required to be given to all caregivers and signed by the caregiver.** Provides specific information about the child to assist you in safely caring for the child and meeting their needs. Contains information on: siblings, contact information, reason for placement, visit plan, medical info, health concerns, medications, emotional/behavioral concerns. *Only limited information may be known about a child at the time of initial placement. CA will provide updated information as it becomes available. This completed form must be printed twice so both the caregiver and worker have signed copies.*

2. **Placement Agreement** - provides necessary and important information for caregivers to ensure the safety and well-being of the child placed in your home by CA. It establishes the agreement between CA and the Caregivers and will assist you in understanding your role in helping meet the needs of the child, working with CA, the assigned social worker and the Court.

3. **Caregiver Authorization** - Provides verification of the child's placement in your home, and allows the caregiver to engage in specific medical/dental, treatment, education, decisions for the child and identifies information about out of state travel requirements.

4. **Foster Care Initial Health Screen** – form to be completed by Dr. for the child’s first scheduled medical appointment. This appointment is called the Initial Health Screen and is required within five (5) days of placement. Please obtain copies of the form once completed by the doctor for the assigned CA worker and for your records.

5. **Voucher for Interim Pharmacy Services** – document to use for medical services, **if you have not received the child’s ProviderOne Medical card.** Authorizes medical/dental/pharmacy services and is to be provided to each provider for when service is received.
   - *A Spanish cover memo instructs Spanish speaking caregivers to take this form to all medical providers until the child’s ProviderOne Card arrives.*

6. **Caregiver Monthly Mileage Form** – child specific mileage can be reimbursed for caregivers. This form helps you know what travel can be reimbursed and guides you through submitting the completed form to the child’s assigned CA worker.

7. **School Notification Form** - The School Notification Form is a tool for social workers to inform schools when a child or youth has been: newly placed in foster care, changed placement, or returned home. The form provides details to schools "at a glance" that is essential for them to know about children and youth placed with CA.
8. **CA Worker Health & Safety Visits Caregiver Checklist** Suggestions to help guide the worker’s observations and conversations with the caregiver during the child’s monthly health and safety visit. Included to help caregivers be prepared for questions asked by the worker.

*FORMS SPECIFIC TO RELATIVE CAREGIVERS - Receiving Placement of a Child through Children’s Administration:*

1. **Unlicensed Caregiver Placement Checklist** – lists requirements the assigned worker must complete within 72 hours of placing the child in your home. Contains your emergency contact information. Lists basic safety household items the worker must identify. Please assist the worker in completing these requirements –Please share your e-mail address with the worker. *(RELATIVES ONLY)*

2. **Household Safety Inspection** - Unlicensed Relatives / Suitable Others – the form ensures specific health and safety factors in your home are addressed by the social worker before placement. *(RELATIVES ONLY)*

3. **Application for Temporary Assistance for Needy Families (TANF) Benefits** – you may file this application with your local Community Services Office to assist you in receiving financial support for the child in your care. This application is based on the child’s need and does not consider your income while the child has an open case with CA. *(RELATIVES ONLY)*

4. **Relative and Other Suitable Person Support Services Funds** – information about funds that can be authorized for relatives or suitable persons to help support placement of a child with their relatives. *(RELATIVES ONLY)*

*A separate Caregiver Resource Packet has been developed to provide:*  
- General information,  
- Links to CA’s caregiver website,  
- Caregiver Listserv,  
- Caregiver Connection monthly newsletter,  
- Policy information,  
- CA staff contacts, and  
- Caregiver training information.

*We hope this additional resource will help answer your questions, and help you learn more about working together with us as part of the child’s team.*
# Household Safety Inspection for Unlicensed Placements and Adoption Home Study Updates

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<th>Applicant / Provider’s Name</th>
<th>Telephone Number (include area code)</th>
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## Hygiene
- Clean, sanitary home
- Working toilet / bathing facility
- Working sewage discharge

## General
- Working telephone on site when a child is present (landline or cell)
- Access to exits (no obstruction to any exit)
- All rooms and outbuildings inspected
- Emergency Evacuation Plan completed

## Fire Safety
- A. Applicant has fire ladder for upper story bedrooms(s) OR
  - Fire ladder was recommended (not required) OR
  - No need for fire ladder as access is adequate or no upper story
- B. Applicant has fire extinguisher OR
- C. Working smoke detectors
- D. Conversation with the family must be held to discuss escape routes in case of a fire from all levels and areas of the home

## Hazards
- No electrical or fire hazards
- Poisons, alcohol, marijuana, and medications are inaccessible, exception made for a child that has social worker approval to take his / her own medication
- Site Specific Conditions are addressed in the home study
- Weapons / ammunition are locked
- Discuss safety concerns if caregiver has animals

## Sleeping Arrangements
- Minimum of two accessible exits (e.g. window large enough for rescue personnel and door)
- Individual beds for children in care unless other arrangements have been approved by the supervisor
- Cribs are safe, and safe sleep requirements have been discussed with the family when caring for an infant

## Comments

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**NOTE:** If this form is being used for an adoption home study update on a licensed home, minimum licensing requirements still apply.

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<thead>
<tr>
<th>CA Worker’s Signature</th>
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<th>CA Worker’s Printed Name</th>
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**HOUSEHOLD SAFETY INSPECTION FOR UNLICENSED PLACEMENTS AND ADOPTION HOME STUDY UPDATES**

**DSHS 10-453 (REV. 10/2017)**