Well Being:

Court Performance Measures for Children

DRAFT ISSUE BRIEF

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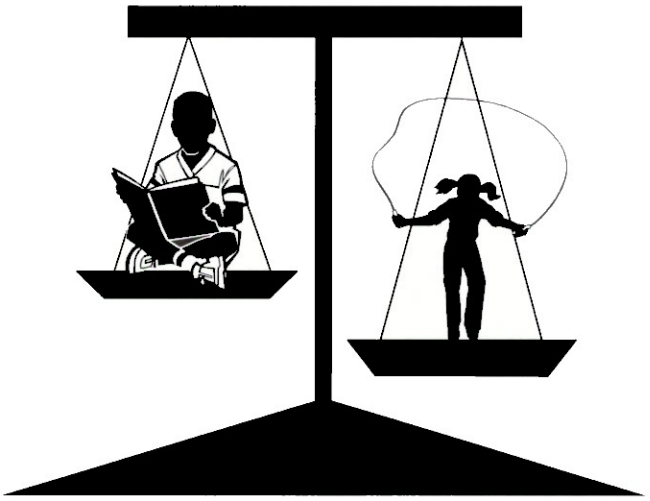

National Child Welfare Resource Center on Legal and Judicial Issues

Focus Group on Well-Being Performance Measures

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I. Introduction

Along with safety and permanency, well-being is one of the three major goals named in the Adoption and Safe Families Act of 1997 designed to improve outcomes for children. Consequently, well-being measures have been an integral part of the performance measures used by child welfare agencies to measure their own performance and the standard used by the federal government to assess state performance during the Child and Family Services Review (CFSR) process. Until now, there have been no equivalent well-being outcome measures directed at court responsibilities for ensuring well-being of children. Courts have the responsibility to make sure the state is providing proper care to children in its custody, and so must inquire whether those children over whom they have jurisdiction are receiving a quality education and are physically and emotionally healthy.

Courts are responsible for making and approving decisions affecting children in foster care. To do so effectively, judges and court managers need information about individual children, as well as information about how the court is functioning as a whole with regard to the overall outcomes. For child abuse and neglect cases, it is not only important to measure and evaluate the timeliness of case processing as well as the quality of court processes, but most important to determine how these process measures result in improved outcomes for children and families. Court performance data can also assist judges and court staff make process improvements and decide upon the best allocation of resources. Additionally, performance measurement permits courts to establish a baseline against which to measure the success of their improvement efforts and resulting progress in achieving better outcomes for children.

Given the need to measure joint progress toward achieving the ASFA goals, a collaborative effort between the American Bar Association (ABA), the National Center for State Courts (NCSC), and the National Council of Juvenile and Family Court Judges (NCJFCJ) with support from the David and Lucille Packard Foundation, initially proposed a set of court performance measures in the 2004 publication, *Building a Better Court: Measuring and Improving Court Performance and Judicial Workload in Child Abuse and Neglect Cases*. That publication focused on the common direct areas of interest shared by courts and child welfare agencies-- safety and permanency as well as the importance of measuring court-specific performance domains-- due process and timeliness of court proceedings. The measures were field tested and revised and published as the "Toolkit".[1] All thirty Toolkit court performance measures are listed in Appendix A.

[1] *Toolkit for Court Performance Measurement in Child Abuse and Neglect Cases*. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (2009).

The *Toolkit* measures have been well disseminated and technical assistance made available to states. In a survey of Court Improvement Program Directors in 2010, the National Resource Center on Legal and Judicial Issues found that the nine Key Toolkit measures were being used statewide in Connecticut, New York, and Pennsylvania. Idaho, Kentucky, New Jersey, South Carolina, Utah, and West Virginia are using eight of the nine measures statewide, and many other states are using the measures in selected jurisdictions. Now that these "Toolkit" measures are in the process of being implemented, the time is right to complete the process by proposing a set of well-being outcome measures for courts. In a survey of CIP Directors conducted in 2010 by the National Center for State Courts as partner in the National Resource Center on Legal and Judicial Issues, many respondents indicated the desire for assistance in the development of well-being measures.[2]

II. Well-Being: Completing the Set of Court Outcome Measures

Under ASFA, children's well-being refers to factors other than safety and permanency that relate to a child's current and future welfare—most notably, the child's physical and mental health as well as educational achievement. CFSR well-being outcome goals are:

1. Families have enhanced capacity to provide for their children's needs;
2. Children receive appropriate services to meet their educational needs; and
3. Children receive adequate services to meet their physical and mental health needs.

In a discussion of the development of well-being indicators in child welfare, *Child Trends* listed several "take home" messages, one being that well-being indicators can "change the discussion surrounding child abuse and neglect, and can help emphasize normal development and desired outcomes." [3]

Given that courts have the responsibility to ensure the state is providing proper care to children in its custody, courts need to consider whether those children over whom they have jurisdiction are receiving a quality education and are physically and emotionally healthy. At the time the *Toolkit* court performance measures were being developed in the domains of safety, permanency, due process, and timeliness, staff of the then child-welfare collaborative of the ABA,

[2] The National Resource Center on Legal and Judicial Issues , *Current Use of Dependency Court Performance Measures*. Unpublished document, (Sept. 2010).

[3] Rosemary Chalk, Kristin Anderson Moore, and Alison Gibbons, *The Development and Use of Child Well-being Indicators in the Prevention of Child Abuse and Neglect,"* Final Report to the Doris Duke Charitable Foundation, *Child Trends* (December 2003), p. 2.

NCSC, and NCJFCJ, now partners in the National Resource Center on Legal and Judicial Issues, decided to postpone working on court well-being measures.

One reason for the delay was the uncertainty with which outcome measures in general would be received by courts. So, the decision was made to focus first on safety and permanency—areas which the courts were perceived as having more direct responsibility. Moreover, the reception given to well-being measures in the child welfare area was tentative in the sense that some child welfare professionals believed that determination of child well-being would require them in effect to perform medical or mental health diagnoses, which they did not feel qualified to do. The same belief may have permeated the court community, even though judges have typically exercised a more limited role in inquiring about the health and well being of children—monitoring whether the child welfare agencies have seen that children under their care have been to a doctor or a dentist or have had a mental health screening.

Another reason for the hesitation in creating well-being performance measures is the increased collaboration involved, which, as a practical matter, involves greatly increased technology requirements. It was noted above that court well-being measures typically require an exchange of data between the courts and child welfare agencies. While the process of exchanging data with child welfare agencies has been a significant barrier in the past, advances in technology and the development of protocols for exchange, such as the National Information Exchange Model,[4] have made progress possible. Even so, adding well-being outcome measures means that the number of collaborative partners must be expanded from bilateral exchanges between child welfare agencies and courts to multilateral exchanges involving courts, child welfare agencies, hospitals, medical professionals, and schools. Even if all parties are not part of a single exchange, for example if the child welfare agency exchanges information with medical professionals and then shares that information with courts rather than all three institutions participating in one exchange, the technological issues increase.

Moreover, adding collaborative partners increases dramatically concerns over privacy and confidentiality, even though recent developments in both policy and technology have ameliorated some privacy and confidentiality concerns.[5]

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[4] (See www.niem.gov).

[5] For information on privacy and confidentiality issues, see *Solving the Data Puzzle*. Legal Center for Foster Care and Education (2008), available at http://www.casey.org/Resources/Publications/pdf/SolvingDataPuzzle.pdf ; and see also AOC Briefing: Sharing Education Information for Children in Foster Care. Administrative Office of the Courts, Center for Families, Children & the Courts (2010), available at http://www.chhs.ca.gov/Documents/AOCFosterCareEd.pdf.

A. Educational Well-Being

Because of the heightened interest in educational well-being outcomes for children in foster care, which also led to its inclusion into the *Fostering Connections Act,* and because of the vagaries of project funding, the NCSC began work on educational well being outcome measures first. Indeed, the successful work on the measures of educational well-being provided the encouragement to tackle the measures of physical and emotional well-being.

1. Focus Group

In October 2010, the National Center for State Courts, in partnership with Casey Family Programs, convened a Focus Group for the purpose of developing dependency court performance measures specific to education as one of the components of well-being for children and youth. The Focus Group was comprised of distinguished representatives from child welfare agencies, educational and research institutions, the advocacy community, and the courts.[6] Its mission was threefold: to identify education performance measures; the data elements needed to produce the measures; and strategies to overcome obstacles to sharing data among courts, child welfare agencies, and education. The result of the meeting was a proposed set of key education performance measures designed to improve the educational outcomes for children involved in the foster care system.

2. The Issues

For many of the almost 800,000 children and youth housed in foster care each year in the United States, "…the educational outcomes are dismal."[7] The long-term outcomes for those with poor educational experiences include difficulty in the transition to adulthood, poverty, homelessness, and incarceration. Children in the dependency system are subjected to a variety of risk factors including their history of abuse and neglect, poverty, emotional disorders, learning disabilities and developmental delays, poor physical health, exposure to antisocial peers, and poor family relationships.[8] Furthermore, children in the dependency system, particularly those children in foster care, face many educational challenges including problems with enrollment; difficult transfer of credits and school records; frequent mobility between school placements; disciplinary

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[6] Focus Group Members were: Ms. Kate Burdick, Zubrow Fellow, Juvenile Law Center, Philadelphia, PA; Dr. Gretchen Cusick, Chapin Hall; Hon. Robert R. Hofmann, Associate Judge, Child Protection Court of the Hill Country, Mason County, Texas; Dr. Michelle L. Lustig, MSW, Ed.D., Coordinator, San Diego County Office of Education, Student Services & Programs, Student Support Services, Foster Youth Services; Ms. Kathleen McNaught, Assistant Director, ABA Center on Children and the Law; Mr. Ronald M. Ozga, Governor's Office of Information Technology, Agency IT Director for CDHS, HCPF, CBMS, Colorado Department of Human Services; Ms. Regina Schaefer, Director, Education Unit, New York City Children's Service, and their invaluable contribution to this effort is gratefully acknowledged.

[7] "Fact Sheet: Educational Outcomes for Children and Youth in Foster and Out-of-Home Care." National Working Group on Foster Care and Education (Dec. 2008).

[8] Peter Leone, and Lois Weinberg. "Addressing the Unmet Needs of Children and Youth in the Juvenile Justice and Child Welfare Systems." Georgetown University, Center for Juvenile Justice Reform (2009).

problems; lack of necessary early education and special education services; and inability to participate in extracurricular activities. As a result of such challenges, these children are more likely to suffer academically, less likely to finish high school, less likely to attend college, less likely to make lasting friendships among peers, and more likely to be ill-prepared for adulthood.

The Fostering Connections Act requires states to create education stability plans for all children in foster care. These plans must include assurances that 1) foster care placements take into account the appropriateness of a child's educational setting and proximity to the school in which the child is enrolled at time of placement; 2) children remain in the school they were attending at the time of placement (unless not in their best interest) even if they move away from that school's boundaries; and 3) when it is not in the best interest to remain, that children are immediately enrolled in a new school with all education records to follow.[9] Judges are beginning to recognize their role in ensuring the well-being of children in child protection cases as well, and some courts are becoming interested in tracking well-being indicators. For example, California's 2009 Implementation Guide to Juvenile Dependency Court Performance Measures includes well-being measures.[10] Educational well-being is also one of the indicators of family self sufficiency, an index of family strength developed and used in Oregon. (See Appendix E).

3. The Measures

A list of the proposed measures of educational well-being is provided in Appendix B.

B. Physical Well-Being

1. The Focus Group

In June, 2011, the National Resource Center for Legal and Judicial Issues convened a Well-Being Focus Group to identify outcome measures for the remaining well-being areas, including physical and emotional well-being. The members of the focus group, whose names and affiliations are listed in the front section of this document, are all distinguished experts from child welfare agencies, the courts, and research institutions. The purpose of the focus group was to identify performance measures in the areas of physical and emotional well-being that would, combined with the recently- developed education measures, complete the set of court-related well-being performance measures.

Well-being court performance measures will help to achieve the following desirable outcomes:

- Children and youth under court jurisdiction should immediately receive necessary physical and dental health care evaluations once under court jurisdiction.

[9] *Fostering Connections to Success and Increasing Adoptions Act of 2008* (Pub. L. 110-351),
[10] *Implementation Guide, loc. cit.*

- Children and youth under court jurisdiction should receive all necessary physical and dental health care services, including preventative care and treatment.

- Judicial decision makers, along with child welfare workers and health care providers, should have access to the child's complete health histories in order to make informed decisions.

- Caregivers should understand all the health needs of the children in their care.

2. The Issues

Some estimates say approximately 80 percent of children in foster care have significant health care needs, including chronic health conditions and developmental concerns.[11] Many of these health care needs are a result of maltreatment and a history of inadequate health care. Once these children and youth enter the child welfare system, barriers exist in the coordination and provision of health care services. While courts are responsible for ensuring that children and youth under their jurisdiction receive health services necessary to secure their well-being, Judges often have difficulty making informed decisions regarding these children due to a lack of current and accurate health care information.

Another significant barrier includes problems with eligibility and access to health care coverage. All states have extended Medicaid coverage to children in foster care. However, policies exclude some children from coverage, including noncitizens, children with private health insurance, and children who leave foster care while on trial home visits.[12] Furthermore, youth who are also involved in delinquency system and in detention are often excluded from federal financial participation through Medicaid while in detention.[13] Other barriers include inadequate funding for health care services, poor health care record keeping, and a lack of training for child welfare workers on the array of health care services needed by children in foster care.[14] The review of the 2001-2004 Child and Family Service Reviews by the Administration of Children and Families (ACF) also found that a common challenge 27 states faced with respect to meeting the physical health care needs of children in foster care was that "the number of physicians and dentists in the state willing to accept Medicaid is not sufficient to meet the need."[15]

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[11] Foster Care: State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care. United States Government Accountability Office (Feb. 2009).
[12] Green, et al. Medicaid Spending on Foster Children. The Urban Institute (2005). <http://www.urban.org/publications/311221.html>.
[13] 42 U.S.C. § 1396d (a)(28)(A); 42 C.F.R. § 435.1009(a)(1). See also, Medicaid for Youth Involved in the Juvenile Justice System. Youth Law Center (Feb. 2011). <http://www.ylc.org/pdfs/MedicaidforYouthintheJuvenileJusticeSystem2011.pdf>.
[14] Hartney, et al. Health Care for Our Troubled Youth: Provision of Services in the Foster Care and Juvenile Justice Systems of California (Mar. 15, 2002).
[15] Summary of the Results of the 2001-2004 Child and Family Service Reviews. Administration for Children and Families

Proposed Measures of Physical Well-Being

The measures proposed below are numbered sequentially following the pattern of all of the other court performance measures. Now that the *Toolkit* measures have been extended to cover well-being, it is clear that a better numbering scheme is needed. For this document, however, the format of the old measures will be continued. After all of the measures have been tested, adopted and recommended, perhaps then would be an opportune time to consider a new numbering sequence.

6A: Percentage of children and youth under court jurisdiction that received an initial health screening no later than 72 hours after the first hearing

What is the goal? Physical well-being

The American Academy of Pediatrics (AAP) recommends that all children in foster care receive an initial health screen within 72 hours of entering care.[16] See Appendix C for the AAP recommended components of an initial screening for children and youth in foster care. According to a 2010 study by the Center for Health Care Strategies, 46 states require an initial physical health screening for children and youth removed from their home, and 11 of these states require the screening to occur within 72 hours.[17] To make this measure more relevant to courts, the Focus Group chose to change the point of measurement from placement to time of first hearing.

How is the measure calculated?

- Identify all children who had an initial health screening
- Compute the number of hours between initial health screen and first hearing
- Calculate the percentage of children and youth who received initial health screen no later than 72 hours after the first hearing

What data elements are required to complete the measure?

- Initial health screen = "yes/no"
- Initial health screen date
- First hearing date

Implementation Notes

Courts will need to define what qualifies as an initial health screen. For example, would a child who received a comprehensive health assessment 48 hours before the first hearing require another one? The AAP recommended components of an initial screening for children and youth in foster care are listed in Appendix C.

To calculate this measure precisely (to exactly 72 hours), courts would need to know the time and date of the initial health screen and the time and date of the first hearing.

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[16] Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics (2005).

[17] Allen, Kamala. Health Screening and Assessment for Children and Youth Entering Foster Care: State Requirements and Opportunities. Center for Health Care Strategies, Inc. (Nov. 2010). http://www.chcs.org/usr_doc/CHCS_CW_Foster_Care_Screening_and_Assessment_Issue_Brief_111910.pdf

Related Measures
Note that this measure applies only to those cases where the child received an initial health screening. The court may also wish to consider a related measure that would show the percentage of children and youth under court jurisdiction who received an initial health screening.

6B: Median number of days from first hearing to initial health screening

What is the goal? Physical Well-Being
The American Academy of Pediatrics (AAP) recommends that all children in foster care receive an initial health screen within 72 hours of entering care.[18] See Appendix C for the AAP recommended components of an initial screening for children and youth in foster care. According to a 2010 study by the Center for Health Care Strategies, 46 states require an initial physical health screening for children and youth removed from their home, and 11 of these states require the screening to occur within 72 hours.[19] To make this measure more relevant to courts, the Focus Group changed the point of measurement from placement to time of first hearing.

How is the measure calculated?

- Identify all children and youth who had an initial health screening
- Compute the number of days between initial health screen and first hearing
- Calculate the number of days from initial health screen to first hearing

What data elements are required to complete the measure?

- Initial health screen? = "yes/no"
- Initial health screen date
- First hearing date

Implementation Notes
Courts will need to define what qualifies as an initial health screen.

Related Measures
This measure applies only to those cases where the child received an initial health screening.

[18] Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics (2005).
[19] Allen, Kamala. Health Screening and Assessment for Children and Youth Entering Foster Care: State Requirements and Opportunities. Center for Health Care Strategies, Inc. (Nov. 2010).
http://www.chcs.org/usr_doc/CHCS_CW_Foster_Care_Screening_and_Assessment_Issue_Brief_111910.pdf

6C: Percentage of children and youth under court jurisdiction who received a comprehensive health assessment within 30 days of first hearing[20]

What is the goal? Physical Well-Being
Because children under court jurisdiction are at risk for medical, mental health, and developmental conditions, comprehensive health assessments can detect such conditions and learn about risks for ongoing health problems.[21] The American Academy of Pediatrics recommends that all children undergo a comprehensive health assessment within 30 days of placement in care.[22] See Appendix C for the AAP recommended components of a comprehensive health assessment for children and youth in foster care. According to a 2010 study by the Center for Health Care Strategies, 24 states require an in-depth health assessment for children removed from their home. Fifteen states require that the assessment be completed within 30 days of removal. To make this measure more relevant to courts, the Focus Group changed the point of measurement from placement to time of first hearing.

How is the measure calculated?

- Identify all children and youth under court jurisdiction who had a comprehensive health assessment
- Compute the number of days between first hearing and comprehensive health assessment
- Calculate the percentage who received a comprehensive health assessment within 30 days of first hearing

What data elements are required to complete the measure?

- Comprehensive health assessment? = "yes/no"
- Comprehensive health assessment date
- First hearing date

Implementation Notes
Note that courts will need to define what qualifies as a comprehensive health assessment. See Appendix C for the AAP recommended components of a comprehensive health assessment for children and youth in foster care.

Related Measures
Also note that this measure applies only to those cases where the child received a comprehensive health assessment.The court may also wish to consider a related measure that would show the percentage of children and youth under court jurisdiction who received a comprehensive health assessment.

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[20] The American Academy of Pediatrics recommends that all children in foster care receive comprehensive health screen within 30 days of entering care. See Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics (2005).
[21] Klein, Eva, et al. *Healthy Beginnings, Healthy Futures: A Judge's Guide*. ABA Center on Children and the Law, Council of Juvenile and Family Court Judges, and Zero to Three (2009), 21. http://www.americanbar.org/groups/child_law/pages/healthybeginnings.html
[22] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2nd ed. American Academy of Pediatrics, Task Force on Health Care for Children in Foster Care. Elk Grove Village, IL: American Academy of Pediatrics (2005). http://www.aap.org/fostercare/PDFs/FosteringHealth/FosteringHealthBook.pdf

6D: The percentage of ASFA hearings where the child's preventative health care was addressed

What is the goal? Physical Well-Being
A child's preventative health care should be thoroughly addressed at every ASFA hearing in order to ensure physical well-being for children and youth under court jurisdiction. According to the American Academy of Pediatrics, the purpose of preventative health care for children and youth in foster care includes:

- To promote overall wellness by fostering healthy growth and development;
- To identify significant medical, behavioral, emotional, developmental, and school problems; through periodic history, physical examination, and screenings;
- To regularly assess for success of foster care placement;
- To regularly monitor for signs or symptoms of abuse or neglect; and
- To provide age-appropriate anticipatory guidance on a regular basis to children and adolescents in foster care and foster and birth parents.[23]

Children and youth in foster care are eligible for Medicaid and states are required to offer periodic comprehensive health assessments and treatment services to children and youth up to age 21 who are enrolled in Medicaid. These Medicaid screenings, called Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT), must include, at minimum:

- Comprehensive health and developmental history;
- Comprehensive unclothed physical examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Appropriate laboratory tests; and
- Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.[24]

State Medicaid agencies establish the standards for the timing and frequency of these services, but Federal regulations require that EPSDT services comply with reasonable standards of medical and dental practice determined by the state after consultation with recognized medical and dental organizations involved in child health care.[25]

How is the measure calculated?

- Determine the number of ASFA hearings[26] completed
- Select and count the number of ASFA hearings in which the child's preventative health care was addressed
- Calculate the percentage

What data elements are required to complete the measure?

- ASFA hearing dates
- Preventative health care questions asked = "yes/no"
- The date court jurisdiction ends or the petition is closed

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[23] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2nd ed. American Academy of Pediatrics, Task Force on Health Care for Children in Foster Care. Elk Grove Village, IL: American Academy of Pediatrics (2005). http://www.aap.org/fostercare/PDFs/FosteringHealth/FosteringHealthBook.pdf

[24] 42 C.F.R. § 441.50 et seq.

25 Id.

26 The Focus Group wanted to limit this measure to substantive hearings such as the protective custody, adjudication, disposition, 6 month review, permanency, and TPR hearings. "ASFA Hearings" is a term designed to refer to these hearings, but exclude hearings that are strictly periodic and administrative in nature.

Implementation Notes
In order to implement this measure, it will be necessary to determine what qualifies as a preventative health care question. This determination is critical for this measure to be valuable in measuring the court's performance in ensuring the physical well-being of children under its jurisdiction. For example, it is not sufficient to ask only, "Is the child healthy?"-- more probing questions should be encouraged.

6E: The percentage of children and youth under court jurisdiction who have current immunizations at exit

What is the goal? Physical Well-Being
Courts are responsible for ensuring that children and youth under its jurisdiction receive necessary health services to ensure their well-being. Because immunizations protect against disease, courts should ensure that all children and youth under its jurisdiction have been properly immunized.[27]

Besides the obvious health benefits, current vaccinations are important for school enrollment. Missing vaccinations can delay school enrollment and or jeopardize enrollment. Vaccination laws and school enrollment laws change and it is critical for vaccinations to stay current.

How is the measure calculated?

- Select and count all cases in which the child had current immunizations at exit
- Calculate the percentage

What data elements are required to complete the measure?

- Immunizations current at exit? = "yes/no"
- The date court jurisdiction ends or the petition is closed

Implementation Notes
Courts could consider as related measures, status of immunizations at entry into care and at intermediate(s) points in care. The Focus Group explicitly chose to measure status of immunization at exit because it is outcome-oriented and best reflects the effectiveness of the court oversight role.

[27] For the most recent nationally recommended immunization guidelines published jointly by the Center for Disease Control, the Advisory Committee on Immunization Practices (ACIP), and the AAP, visit http://www.cdc.gov/vaccines/.

C. Emotional Well-Being

Emotional well-being includes issues of mental health surely, but as the Focus Group began to delve more deeply into the issues, they decided to separate emotional well-being into four categories reported here: mental health, maintaining permanent relationships, transition to adulthood and enhanced family capacity.

1. Desired Outcomes

a. Mental Health

- Children and youth under court jurisdiction receive necessary mental health evaluations
- Children and youth under court jurisdiction receive the necessary mental health treatment services to include regular treatment progress reports
- Judicial decision makers, along with child welfare workers and mental health care providers, have access to the child's complete mental health histories in order to make informed decisions
- Caregivers understand all the mental health needs of the children in their care

b. Maintaining Permanent Relationships

- Family relationships and connections for children and youth under court jurisdiction are preserved

c. Transition to Adulthood

- Youth under court jurisdiction are well prepared for adulthood

d. Enhanced Family Capacity

- Families have enhanced capacity to provide for their children's needs

2. Emotional Well-Being Issues

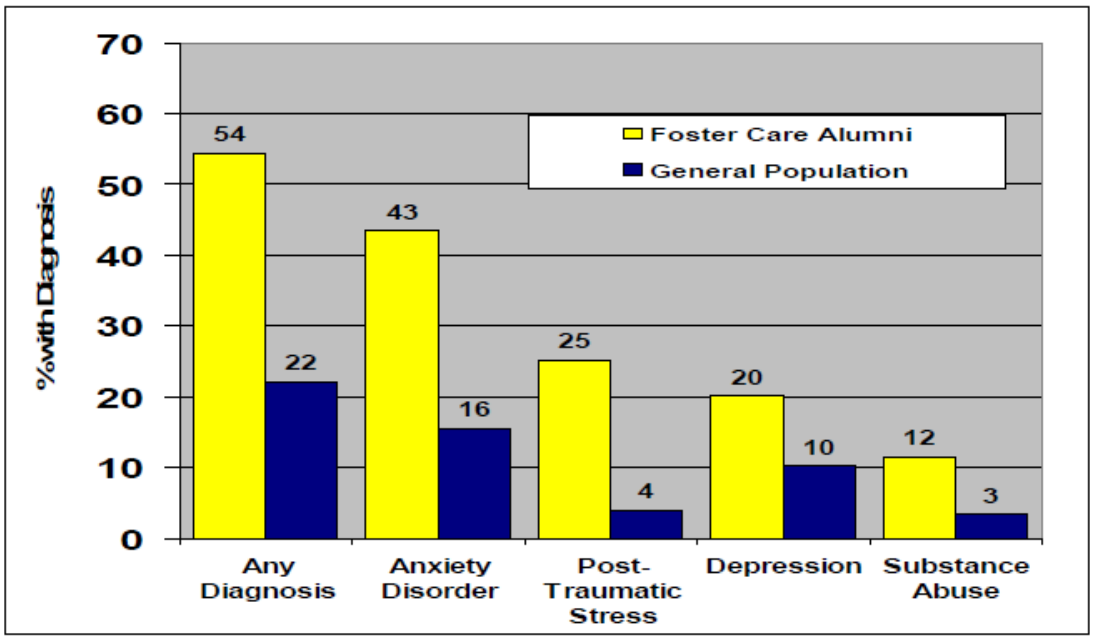
a. Mental Health.

Children and youth in the child welfare system typically have significant mental health needs. They have experienced abuse and/or neglect and are often exposed to family violence, parental substance abuse and mental illness, homeless, or chronic poverty.[28] If the mental health needs of these children and youth are inadequately met, the symptoms persist into adulthood. Further, children with emotional and behavioral problems have a reduced likelihood of reunification or adoption.[29]

[28] Osofsky, J.D. et al. "Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System." *Technical Assistance Brief.* Reno, NV: National Council of Juvenile and Family Court Judges (2002), 5.
[29] Id.

The Northwest Foster Care Alumni Study reviewed the mental health diagnoses of foster care alumni and found they were significantly more likely than the general population to experience mental illness. (See Figure 1) The study also found that foster care alumni were six times more likely to suffer post-traumatic stress disorder, four times more likely to turn to substance abuse, twice as likely to experience depression, and more than two-and-a-half times more likely to be diagnosed with an anxiety disorder.[30]

Figure 1. The Proportion of Adult Alumni from Foster Care with Psychiatric Problems, Compared to Other Young Adults in the General Population[31]



Concerns exist regarding the identification of mental health problems for children and youth in foster care. A study of practices for mental health screening and assessment for children in foster care found that more than half of the child welfare agencies surveyed did not require systematic mental or developmental health evaluations for children entering foster care.[32] The review of the 2001-2004 Child and Family Service Reviews by ACF found no evidence of policies requiring an

[30] Pecora, P.J. et al., *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study.* Casey Family Programs (2005). <http://www.casey.org/resources/publications/ImprovingFamilyFosterCare.htm>.
[31] Pecora, P.J. et al., Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study. Casey Family Programs (2005). <http://www.casey.org/resources/publications/ImprovingFamilyFosterCare.htm>.
[32] Levitt, Jessica M. Identification of Mental Health Service Need among Youth in Child Welfare. *Child Welfare*, Vol. 88 No. 1 (2009), 32, citing Leslie, et al. "Comprehensive Assessments for Children Entering Foster Care: A National Perspective." *Pediatrics*, 112, 134-142.

assessment of foster children's mental health in most states, and one state noted that children in care did not receive a mental health assessment unless there were problems observed.[33]

b. Maintaining Permanent Relationships

When children are removed from parents, siblings, and a familiar environment and placed with strangers in a strange environment, this separation can create negative outcomes ranging from attachment disorders in young children, to significant acting out behaviors, to clinical depression. Therefore, it is critically important to minimize familial separation whenever possible.

Courts have a key role in ensuring that consistent contact with parents and siblings is maintained during out-of-home placement, unless visitation is not in the child's best interest.[34] The Fostering Connections to Success and Increasing Adoptions Act of 2008 ("Fostering Connections") encourages maintaining family connections. For example, Fostering Connections requires states to make reasonable efforts to place siblings in the same foster, kinship, or adoption home, unless such a placement is contrary to the safety or well-being of the siblings.[35]

c. Transition to Adulthood.

Youth who age out of the child welfare system are often "woefully unprepared for independent adult life: only one-third have a driver's license, fewer than four in 10 have at least $250 in cash, and fewer than one-quarter have the basic tools to set up a household, let alone the skills to know what to do with those tools. With generally no more than a garbage bag of belongings, our foster youth commonly emancipate from foster care with no significant connection to a responsible adult, no one to provide them with desperately needed guidance, and no place to turn when they falter."[36]

d. Enhanced Family Capacity

One of the three CFSR outcomes related to the ASFA well-being goal is that families have enhanced capacity to provide for their children's needs. While most of the well-being measures

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[33] Foster Care: State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care. United States Government Accountability Office Report to the Chairman, Subcommittee on Income Security and Family Support, Committee on Ways and Means, House of Representatives (Feb. 2009). <http://www.gao.gov/new.items/d0926.pdf>.

[34] This Issue Brief uses the term "visitation" to refer to the time children spend with their parents, guardians and/ or siblings when they have been placed in out-of-home care. The term "visitation" is widely use, accepted in courts and in statutory language as well as understood by the general public. There is a trend away from using the word "visitation" because it can be perceived to diminish the role of parents/guardians and inaccurately represent the purpose of the time spent together—which is to build stronger familial bonds through regular face-to face interactions. Alternative phrases include "family time," "family contact," "family access", and "parenting time."

35 Judicial Guide to Implementing the Fostering Connections to Success and increasing Adoptions Act of 2008 (PL 110-351). Grandfamilies State Law and Policy Resource Center (2011). http://www.grandfamilies.org/images/pdf/Judicial%20Guide%20to%20Fostering%20Connections.pdf

36 Charting a Better Future for Transitioning Youth: Report from a National Summit on the Fostering Connections to Success Act. American Bar Association Commission on Youth at Risk (2010). http://www.americanbar.org/content/dam/aba/publications/center_on_children_and_the_law/youth_at_risk/transitioning_foster_youth_report.authcheckdam.pdf

relate to children, the Focus Group believes it is important to have some measures related to the well-being goal of enhanced family capacity.

3. Proposed Measures of Emotional Well-Being

6F: Percentage of children and youth under court jurisdiction that received a mental health screening within 30 days of first hearing

What is the goal? Mental Health
The AAP recommends children and youth in foster care should have a mental health evaluation within 30 days of entering care. This measure allows the court to see the percentage of cases that met this recommended benchmark.

How is the measure calculated?

- Identify all children and youth under court jurisdiction who received a mental health screening
- Compute the number of days between first hearing and mental health screening
- Calculate the percentage who received a mental health screening within 30 days of first hearing

What data elements are required to complete the measure?

- Mental health screening? = “yes/no”
- Mental health screening date
- First hearing date

Implementation Notes
While the AAP recommendation is tied to when children and youth enter care, the Focus Group decided that this measure should be applied to all children and youth under court jurisdiction, regardless of placement type. Therefore, the measure is tied to the date of the first hearing.

Related Measures
This measure applies only to those cases in which the child received a mental health screening within 30 days of the first hearing. The court may also wish to consider a related measure that would show the percentage of children and youth under court jurisdiction who received a mental health screening.

6G: Percentage of court-ordered child or youth mental health assessments that occur within 60 days of order

What is the goal? Mental health
This measure will provide the court with a measure of the timeliness of mental health assessments.

How is the measure calculated?

- Identify all children and youth under court jurisdiction who received a mental health assessment
- Compute the number of days between order and mental health assessment
- Calculate the percentage who received a mental health assessment within 60 days of order

What data elements are required to complete the measure?

- Mental health screening date
- Child mental health assessment order date

Implementation Notes
While the AAP recommendation is tied to when children and youth enter care, the Focus Group decided that this measure should be applied to all children and youth under court jurisdiction, regardless of placement type. Therefore, the measure is tied to the date of the order.

6H: The percentage of ASFA hearings during which the child's mental health needs were addressed

What is the goal? Mental health
A child's emotional and mental health should be addressed at every ASFA hearing in order to ensure emotional well-being for children and youth under court jurisdiction. Further, when the judge asks questions about the child's mental health from the bench, it sets expectations and standards for practice that will hopefully lead to a changed culture that includes a focus on the well-being of children and youth under court jurisdiction. This measure provides the court with an indicator of how often the child's mental health is addressed at ASFA hearings.

How is the measure calculated?

- Determine the number of ASFA hearings completed
- Select and count the number of ASFA hearings in which the child's mental health needs were addressed
- Calculate the percentage

What data elements are required to complete the measure?

- ASFA hearing dates
- Mental health questions asked = "yes/no"
- The date court jurisdiction ends or the petition is closed

Implementation Notes
It will be necessary to determine what qualifies as a mental health question. More importantly, it is not obvious or easy to identify who will record data on whether or not mental health questions were addressed and how that data will be put into court information systems. Courts that have clerks in the courtroom entering other key information may find it easier to include this data element as well.

6I: When psychotropic medications are prescribed, the percentage of ASFA hearings during which the child's psychotropic prescriptions are reviewed

What is the goal? Mental health
The prevalence of psychotropic medications among youth in foster care is estimated to be between 26% and 43%.The rate of psychotropic medication use among the general youth population is 4%.[37] National organizations such as the AAP, the American Academy of Child and Adolescent Psychiatry, and the Child Welfare League of America have called for experts to be involved in managing children's medications and asking states to implement oversight practices. Congress has passed legislation requiring states to explain to the federal government how they are monitoring prescription medications for youth in foster care.[38]

The court plays a role in the oversight of this process, and in a few states, the court must actually consent to the psychotropic prescription for children and youth in foster care. In California, for example, consent rests with the judge, and only with the judge. The judge may delegate the authority back to the parents when that decision will not pose a danger to the youth. When a California child in foster care is prescribed a psychotropic medication, the agency must request court authorization and within seven days of receiving the request, the court must approve or deny the request or set a hearing date.[39] This measure provides courts with an indicator of ASFA hearings where the child's psychotropic prescriptions are reviewed.

How is the measure calculated?

- Identify all children and youth under court jurisdiction who were prescribed psychotropic medications
- Determine the number of ASFA hearings completed for the children and youth prescribed psychotropic medications
- Select and count the number of ASFA hearings during which the child's psychotropic medications are reviewed

What data elements are required to complete the measure?

- Psychotropic medications prescribed = "yes/no"
- ASFA hearing dates
- Psychotropic medications reviewed at hearing = "yes/no"

Implementation Notes
It is not obvious or easy to identify who will record data on whether or not mental health questions were addressed and how that data will be put into court information systems. Courts that have clerks in the courtroom entering other key information may find it easier to include this data element as well.

[37] Karen Worthington. *Psychotropic Meds for Georgia Youth in Foster Care: Who Decides?* Georgia Supreme Court Committee on Justice for Children (Jan. 2011), 3. http://w2.georgiacourts.org/cj4c/files/Psych_meds_paper%20(2).pdf
[38] *Fostering Connections to Success and Increasing Adoptions Act of 2008* (Pub. L. 110-351),
[39] Id. at 29.

6J: Percentage of children placed with all siblings who are also under court jurisdiction

What is the goal? Maintaining Permanent Relationships
Fostering Connections requires states to make reasonable efforts to place siblings in the same foster, kinship, or adoption home, unless such a placement is contrary to the safety or well-being of the siblings. This measure would provide the court with an indicator of how often all siblings are placed together.

How is the measure calculated?

- Identify all siblings under court jurisdiction in out-of-home placement
- Select and count the cases where all siblings are placed together
- Calculate the percentage of children placed with all siblings who are also under court jurisdiction

What data elements are required to complete the measure?

- Siblings under court jurisdiction = “yes/no”
- Placement type = “in-home/out-of-home”
- Placed with siblings under court jurisdiction = “all/some/none”

Implementation Notes
Courts may wish to analyze the instances where siblings were not placed together. For example, was there a documented reason why siblings were not placed together? Were reasonable efforts made to provide frequent visitation between siblings? Courts may also wish to consider applying this measure only to children removed at the same time. For example, the court may decide not include in this measure older children placed many years earlier.

6K: Percentage of children placed with at least one but not all siblings who are also under court jurisdiction

What is the goal? Maintaining Permanent Relationships
Fostering Connections Act requires that states make reasonable efforts to place siblings in the same foster, kinship, or adoption home, unless such a placement is contrary to the safety or well-being of the siblings. This measure would provide the court with an indicator of how often siblings are placed together.

How is the measure calculated?

- Identify all siblings under court jurisdiction in out-of-home placement
- Select and count the cases where some but not all siblings are placed together
- Calculate the percentage of children placed with some but not all siblings who are also under court jurisdiction

What data elements are required to complete the measure?

- Siblings under court jurisdiction = “yes/no”
- Placement type = “in-home/out-of-home”
- Placed with siblings under court jurisdiction = “all/some/none”

Implementation Notes
Courts may wish to also analyze the instances where all siblings were not placed together. Was there a documented reason why siblings were not placed together? Were reasonable efforts made to provide frequent visitation between siblings?

6L: The percentage of ASFA hearings where sibling placement or visitation was addressed

What is the goal? Maintaining Permanent Relationships
This measure would provide the court with an indicator of how often sibling placement and visitation is addressed at ASFA hearings. Visitation is particularly important in situations where siblings are not placed together.

How is the measure calculated?
Identify all children and youth under court jurisdiction who have siblings also under court jurisdiction

- Determine the number of ASFA hearings completed for the children and youth with siblings under court jurisdiction
- Select and count the number of ASFA hearings where the sibling placement or visitation was addressed

What data elements are required to complete the measure?

- Sibling(s) also under court jurisdiction = “yes/no”
- ASFA hearing dates
- Sibling placement or sibling visitation addressed during hearing = “yes/no”

Implementation Notes
The court must define what constitutes a sibling placement or visitation question, not to mention what constitutes a reasonable visitation schedule.

6M: Percentage of youth parents placed with all their children

What is the goal? Maintaining Permanent Relationships
Research suggests that female foster youth are at a high risk of becoming pregnant.[40] This distinct subgroup of the foster youth population, foster youth who are pregnant or parenting, require special services and programs, including placement with their children. This measure provides the court an indicator of the percentage of youth parents who have custody of children that are placed together.

Federal regulations indicate that a child placed with youth parent in the same home will receive a foster care maintenance payment sufficient to meet the child's needs without the state taking custody of the child. 45 C.F.R 1356.21(j); based on 42 U.S.C.A. § 675(4)(B). Still many appellate cases, two class actions and anecdotal accounts suggest that children are removed legally or physically from minor parents in care with less evidence of abuse or neglect than would be otherwise required.

How is the measure calculated?

- Select all youth under court jurisdiction who have custody of their children
- Select and count youth who are placed with all their children
- Calculate the percent of youth parents who are placed with all their children

What data elements are required to complete the measure?

- Is youth a parent with custody = "yes/no"
- Placement type = "in-home/out-of-home"
- Placed with all children = "yes/no"

[40] Dworsky, Amy, and Jan DeCoursey. Pregnant and Parenting Foster Youth: Their Needs, Their Experiences. Chapin Hall (2009). http://www.chapinhall.org/sites/default/files/Pregnant_Foster_Youth_final_081109.pdf

6N: Percentage of children in out-of-home care placed in relative placement

What is the goal? Maintaining Permanent Relationships
When a child is removed from home, every effort should be made to place the child in the least restrictive, most family-like setting, and efforts should be made to place the child in a relative or kinship placement. Relative placements tend to be less traumatic and disruptive for the child compared with other out-of-home placements. Relative placements also tend to be more stable placements than traditional foster care placements.[41] The Fostering Connections Act requires state agencies to exercise due diligence to identify and provide notice to all grandparents and other adult relatives of a child (including any other adult relatives suggested by the parents) within 30 days after the child is removed from his or her parents' custody. This measure provides the court an indicator of the frequency that children and youth under court jurisdiction, who are in out-of-home placement, are in a relative placement.

How is the measure calculated?

- Select all youth under court jurisdiction who are in out-of-home placements
- Select and count youth who are in a relative placement
- Calculate the percent who are in a relative placement

What data elements are required to complete the measure?

- Out-of-home placement = "yes/no"
- Relative placement = "yes/no"

Implementation Notes
Courts will need to define relative placement.

Related Measures
Courts might also wish to measure the percentage of children and youth under court jurisdiction in non-relative kinship placements.

6O: Percentage of youth who have a court-approved transition plan within 90 days prior to aging out of care

What is the goal? Transition to Adulthood

The Fostering Connections Act requires a personal transition plan for youth be in place within 90 days prior to their 18th birthday or whatever later age as the state may elect under section 201 of Fostering Connections. This requirement does not replace the previously required independent living plan "for youth ages 16 and older" under ASFA at 42 U.S.C. § 675 (1)(D) or the case review documentation for youth age 16 and above of "the services needed to assist the child to make the transition from foster care to independent living" at 42 U.S.C. § 675(5).[42] This measure provides the court an indicator of the percentage of youth who have a court-approved transition plan within 90 days prior to aging out of care.

How is the measure calculated?

- Select all youth under court jurisdiction who had a court-approved transition plan
- Select and count youth who had a court-approved transition plan in place within 90 days prior to their 18th birthday or later age established by state law
- Calculate the percent of youth with a court-approved transition plan within 90 days prior to their 18th birthday or later age established by state law

What data elements are required to complete the measure?

- Court-approved transition plan = "yes/no"
- Date of court-approved transition plan
- Date of 18th birthday or later age established by state law

[42] Judicial Guide to Implementing the Fostering Connections to Success and increasing Adoptions Act of 2008 (PL 110-351). Grandfamilies State Law and Policy Resource Center (2011). http://www.grandfamilies.org/images/pdf/Judicial%20Guide%20to%20Fostering%20Connections.pdf

6P: Median number of days from date of each parent's court ordered mental health assessment to date of assessment completion

What is the goal? Enhanced Family Capacity
Families in which there is parental mental illness face many barriers to reunification, including inadequate access to the proper mental health services. Further, a 2008 study of state statutes revealed that five states and the territory of Puerto Rico listed parental mental illness among possible "aggravated circumstances," as potential grounds for not making reasonable efforts to reunify a family.[43] This measure would provide the court an indicator of the timeliness of court-ordered parent mental health assessments.

How is the measure calculated?

- Identify all parents with a court ordered mental health assessment
- Compute the number of days between order and mental health assessment
- Calculate the median number of days from date of each parent's court ordered mental health assessment to date of assessment completion

What data elements are required to complete the measure?

- Court-ordered parental mental health assessment = "yes/no"
- Date of court-ordered parental mental health assessment
- Assessment date

[43] Friesen, B. J., et al. Parents with a Mental Illness and Implementation of ASFA, in Intentions and Results: A Look Back at the Adoption and Safe Families Act. Urban Institute (2009)., citing Scott J. (2008). *Reunification Statute Table:* UPenn Collaborative on Community Integration. Philadelphia: University of Pennsylvania. http://www.urban.org/uploadedpdf/1001351_safe_families_act.pdf

6Q: Percentage of ASFA hearings during which parent visitation was addressed

What is the goal? Enhanced Family Capacity
A large body of research suggests that children who have regular visitation "make better adjustments to care, are more likely to be reunified, and when reunification is not possible, are more likely to be adopted by their foster parents."[44] Courts can establish visitation orders and are in the position to emphasize the importance of parental visitation and improve current practice. Because courts have the responsibility of determining whether the agency has provided reasonable efforts to parents attempting to reunify with a child, courts arguably play a role in the oversight of parental visitation.[45] This measure provides the court with information on the percentage of ASFA hearings during which parental visitation was addressed.

How is the measure calculated?

- Identify all children and youth under court jurisdiction in out-of-home placements
- Determine the number of ASFA hearings completed for the children and youth in out-of-home placements
- Select and count the number of ASFA hearings during which parental visitation was addressed

What data elements are required to complete the measure?

- Out-of-home placement = "yes/no"
- ASFA hearing dates
- Parental visitation addressed during hearing = "yes/no"

Implementation Notes
Courts will need to define what qualifies as a parental visitation question. For example, it is not sufficient to ask only, "Have there been parental visits?" Instead, more probing questions should be encouraged, such as questions regarding the quality and quantity of the visits, reasons for failed scheduled visits, etc.

[44] Edwards, Judge Leonard P. (ret.) Judicial Oversight of Parental Visitation in Family Reunification Cases. Juvenile and Family Court Journal (Summer 2003), 3. http://www.f2f.ca.gov/res/pdf/LenEdwards.pdf
[45] Id. at 10.

6R: Median time from date of order for supervised visitation to date of first order for unsupervised visitation

What is the goal? Enhanced Family Capacity
Because of the challenges that measuring improvement in the outcome of parent's enhanced capacity to provide for children's needs, this measure was proposed as a proxy. The rationale is that when visitation transitions from supervised to unsupervised there has been an improvement in a parent's capacity to provide for their children's needs. This measure would provide the court with an indication of the improvement in the parent's capacity to provide for their children's needs.

How is the measure calculated?

- Identify all cases with supervised visitation orders
- Select and count the number of cases where supervised visitation transitioned to unsupervised visitation
- Count the number of days between order for supervised visitation and order for unsupervised visitation
- Calculate the median number of days

What data elements are required to complete the measure?

- Order for supervised visitation? = "yes/no"
- Order for unsupervised visitation? = "yes/no"
- Date of order for supervised visitation
- Date of order for unsupervised visitation

Implementation Notes
Some thought may be given to cases that begin with unsupervised visitation.

III. Setting Priorities

The Focus Group recognized not only the importance of the measures listed above, but many others as well, but consciously sought to find a balance between obtaining all of the measures that would be desirable to obtain a clear picture of the physical and mental health status of children in foster care and the cost in terms of personnel time and money required to collect all of the data that would assist decision making. Creating too many measures may discourage some courts and agencies from even attempting to obtain measures of well-being. With that in mind, the Focus Group was asked to select a smaller number of measures, akin to the nine "key" *Toolkit* performance measures chosen from the longer list of 30. Priority setting was done to prevent some courts from arguing that because they could not provide all of these measures, they would not do any. Our response is that it is important to measure outcomes in all areas, but they can be sequenced and it is better to have some outcome measures to provide an indication of how successful we are in achieving goals than no indication at all. With that consideration in mind, the Focus Group was asked to select a small number of well-being measures that would provide courts with the most important outcome measures.

The five key priority performance measures selected by the Focus Group are:

1. **6C: Percentage of children and youth under court jurisdiction who received a comprehensive health assessment within 30 days of first hearing**
2. **6G: Percentage of court ordered child or youth mental health assessments that occur within 60 days of order**
3. **6J: Percentage of children placed with all siblings who are also under court jurisdiction**
4. **6O: Percentage of youth who have a court-approved transition plan within 90 days of aging out of care**
5. **6R: Median time from date of order for supervised visitation to date of first order for unsupervised visitation**

It may not be easy to even produce these five priority measures of well-being, but it is here that the process should begin. In addition to the data elements listed under each of the measures, this measurement scheme assumes that basic information about children in foster care is available. For example, a unique child identifier, as well as basic information about age, gender, and race of the children is assumed so that disparities in various performance domains can be calculated.

The work of the Well-Being Focus Group has provided an excellent foundation for the mission of developing court-related outcome measures for children in foster care. The next step in

this project has been to vet these measures to a larger audience. Other experts and stakeholders are reviewing and evaluating these measures for practicality and usefulness and to provide recommendations on how best to improve collaboration as well as how best to facilitate the exchange of data required to produce these measures. What data, for example, do courts require and can they get that information from child welfare agencies? Does obtaining this information require an exchange of data between health care providers and child welfare agencies? Currently, the well being measures are being pilot tested to determine how they work in practice and what obstacles arise when a way to measure well-being is instituted.

Focus on child well-being is not the exclusive responsibility of child welfare agencies - courts, schools, physicians and mental health professionals also have an important role to play, and all are needed to improve the well-being of children in care.

Resources

Well-Being: Physical Health

Chalk, Rosemary, et al. The Development and Use of Child Well-Being Indicators in the Prevention of Child Abuse and Neglect. ChildTrends (Dec. 2003).
http://www.childtrends.org/Files/childabuseexecsummintro.pdf.pdf

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Well-Being: Emotional Health

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http://www.americanbar.org/groups/child_law/pages/healthybeginnings.html

Assessing the Effects of Foster Care: Mental Health Outcomes from the Casey National Alumni Study. Casey Family Programs.
http://www.casey.org/Resources/Publications/pdf/CaseyNationalAlumniStudy_MentalHealth.pdf

Well-Being: Enhancing Family Capacity

Edwards, Judge Leonard P. (ret.) Judicial Oversight of Parental Visitation in Family Reunification Cases. Juvenile and Family Court Journal (Summer 2003).
http://www.f2f.ca.gov/res/pdf/LenEdwards.pdf

Friesen, B. J., et al. Parents with a Mental Illness and Implementation of ASFA, in Intentions and Results: A Look Back at the Adoption and Safe Families Act. Urban Institute (2009).
http://www.urban.org/uploadedpdf/1001351_safe_families_act.pdf

Well-Being: Education

Addressing the Education Needs of Children in Foster Care: A Guide for Judges, Advocates, and Child Welfare Professionals. New York State Permanent Judicial Commission on Justice for Children.
http://www.abanet.org/child/education/needs.pdf

Asking the Right Questions II: A Judicial Checklists to Meet the Educational Needs of Children and Youth in Foster Care. Reno, NV: National Council of Juvenile and Family Court Judges, Permanency Planning Department (Dec. 2008).
http://www.ncjfcj.org/images/stories/dept/ppcd/pdf/EducationalOutcomes/education%20checklist%202009.pdf

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http://www.abanet.org/child/education/publications/blueprint.html

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"Fact Sheet: Educational Outcomes for Children and Youth in Foster and Out-of-Home Care." National Working Group on Foster Care and Education (Dec. 2008).
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Measuring Court Performance in Child Abuse and Neglect Cases

Building a Better Court: Measuring and Improving Court Performance and Judicial Workload in Child Abuse and Neglect Cases. Williamsburg, VA: American Bar Association, National Center for State Courts, and National Council of Juvenile and Family Court Judges (2004). http://www.ncjfcj.org/content/view/603/427/

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Measuring Progress in Improving Court Pr

Flango, Victor E. "Issue Brief: Can Data Exchange between Courts and Child Welfare Agencies Improve Outcomes for Children?" Williamsburg, VA: National Center for State Courts (2009).

Issue Brief 3-23.pdf

Toolkit for Court Performance Measurement in Child Abuse and Neglect Cases. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (Dec. 2008). http://www.ojjdp.ncjrs.gov/publications/courttoolkit.html

Appendix A

Toolkit for Court Performance Measurement in for Child Abuse and Neglect Cases[46]

SAFETY MEASURES
Measure 1A: Child Safety While Under Court Jurisdiction
Measure 1B: Child Safety after Release From Court Jurisdiction

PERMANENCY MEASURES
Measure 2A: Achievement of Child Permanency
Measure 2B: Children Not Reaching Permanency
Measure 2C: Children Moved While Under Court Jurisdiction
Measure 2D: Reentry into Foster Care after Return Home
Measure 2E: Reentry into Foster Care after Adoption or Guardianship

DUE PROCESS MEASURES
Measure 3A: Number of Judges Per Case
Measure 3B: Service of Process to Parties
Measure 3C: Early Appointment of Advocates for Children
Measure 3D: Early Appointment of Counsel for Parents
Measure 3E: Advance Notice of Hearings to Parties
Measure 3F: Advance Written Notice of Hearings to Foster Parents, Pre-adoptive Parents, and Relative Caregivers
Measure 3G: Presence of Advocates during Hearings
Measure 3H: Presence of Parties during Hearings
Measure 3I: Continuity of Advocates for Children
Measure 3J: Continuity of Counsel for Parents

TIMELINESS MEASURES
Measure 4A: Time to Permanent Placement
Measure 4B: Time to Adjudication
Measure 4C: Timeliness of Adjudication
Measure 4D: Timeliness of Disposition Hearing
Measure 4E: Timeliness of Disposition Hearing
Measure 4F: Timeliness of Case Review Hearings
Measure 4G: Time to First Permanency Hearing
Measure 4H: Time to Termination of Parental Rights Petition
Measure 4I: Time to Termination of Parental Rights
Measure 4J: Timeliness of Termination of Parental Rights Proceedings
Measure 4K: Time from Disposition Hearing to Termination of Parental Rights Petition
Measure 4L: Timeliness of Adoption Petition
Measure 4M: Timeliness of Adoption Proceedings

[46] *Toolkit for Court Performance Measurement in Child Abuse and Neglect Cases*. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (Dec. 2008).

Appendix B

Education Performance Measures

1. Outcomes Targeted

These proposed measures derived from, with minor modification, the educational outcomes identified by Casey Family Programs in *A Roadmap for Learning: Improving Educational Outcomes in Foster Care* (2007). The six outcome areas are:

a) School placement stability;
b) Academic performance;
c) Early education;
d) Special education;
e) Social behavior; and
f) Postsecondary entrance rates.[47]

(a) School Placement Stability

According to 2002 AFCARS data, children have an average of one-to-two living placement changes per year while in care.[48] Changes in living placements can often result in a change in school placement. Frequent school moves have an extremely negative impact on the educational outcomes for children and youth with multiple school placements, in part due to enrollment delays and credit transfer problems. Furthermore, children and youth that experience frequent school transfers are unable to make lasting relationships with friends and teachers and experience difficulty participating in extra-curricular activities.

(b) Academic Performance

Overwhelming research has shown that the academic performance and educational outcomes for children and youth in foster care is considerably lower than other demographically similar students. For example, a 2001 Washington State study found that twice as many youth in foster care at both the elementary and secondary levels repeated a grade compared to youth not in care.[49] School attendance is one indicator on the Family Self Sufficiency Scale (Appendix B).

(c) Early Education

Research has established the importance of the early years of a child's life in terms of their social and emotional development and educational success.[50] Over half of children ages 0-3 in foster care "experience developmental delay or have a physical or mental condition with a high

[47] *A Roadmap for Learning: Improving Educational Outcomes in Foster Care.* Casey Family Programs (2007).
[48] Id., citing National AFCARS data, 2002.
[49] *A Roadmap for Learning: Improving Educational Outcomes in Foster Care.* Casey Family Programs (2007).
[50] *Addressing the Education Needs of Children in Foster Care: A Guide for Judges, Advocates, and Child Welfare Professionals*. New York State Permanent Judicial Commission on Justice for Children.

probability of resultant delay."[51] The National Survey of Child and Adolescent Well-Being (NSCAW) data in 2003 showed that "59% of foster children ages two months to two years could be described as being at high risk for a clinical level of impairment." Only 9% of these children were described as at low risk.[52]

(d) Special Education

Many studies indicate that somewhere between one-quarter and one-half (23%-47%) of children and youth in foster care receive special education services. This compares to the national average of about 12% for all school-aged children. A 1990 Oregon study found that children who had multiple foster placements and who needed special education services were less likely to receive those services than children in more stable placements.[53]

(e) Social Behavior

Children and youth in foster care are at risk for behavioral problems in school. "Several studies have found that children and youth in foster care are significantly more likely to have school behavior problems and that they have higher rates of suspensions and expulsions from school."[54]

(f) Postsecondary Entrance Rates

Foster youth should be supported in their preparation, pursuit, and success in post-secondary education. However, according to the Northwest Alumni Study, only 1.8% of foster care alumni included in the study completed a bachelor's degree. This compares to 24% in the general population of individuals the same age.[55] Further, "75% of students in foster care said that they wanted to go to college but few had taken the necessary coursework."[56]

2. Proposed Education Performance Measures

After serious deliberation, discussion, and revision, the focus group settled on the following 14 proposed measures of educational well-being.

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[51] *Addressing the Education Needs of Children in Foster Care: A Guide for Judges, Advocates, and Child Welfare Professionals*. New York State Permanent Judicial Commission on Justice for Children.
[52] "Fact Sheet: Educational Outcomes for Children and Youth in Foster and Out-of-Home Care." National Working Group on Foster Care and Education (Dec. 2008).
[53] Id.
[54] "Fact Sheet: Educational Outcomes for Children and Youth in Foster and Out-of-Home Care." National Working Group on Foster Care and Education (Dec. 2008).
[55] *A Roadmap for Learning: Improving Educational Outcomes in Foster Care.* Casey Family Programs (2007).
[56] *It's My Life: Postsecondary Education and Training*. Casey Family Programs (2006).

MEASURE	SHORT DEFINITION
5A	Percentage of Children under Court Jurisdiction Who Did Not Have a School Change When They Had a Change in Living Placement
5B	Median Number of School Transfers While under Court Jurisdiction
5C	Median Number of School Days Between the Last Day Attended At Old School To First Day Attended At New School
5D	Percentage of ASFA Hearings Where The Child's Education Was Addressed
5E	Percentage of Hearings Where the Child's Education Decision-Maker Was Present
5F	Percentage of School-Aged Children Performing At or Above Grade Level at Case Closure
5G	Percentage of Children Who Drop Out of School While Under Court
5H	Percentage of Children Who Attended at Least 95% of School Days While under Court Jurisdiction
5I	Percentage of Children Ages 0-3 Who Have Been Evaluated For Early Intervention Programs While Under Court Jurisdiction
5J	Percentage of Children Ages 3-5 Who Have Been Enrolled In An Enriched Early Education Childhood Program While Under Court Jurisdiction
5K	Time from Referral for Special Education Services to Assessment
5L	Time from Completion of Special Education Services Assessment to Delivery of Services
5M	Percentage of Children under Court Jurisdiction Who Have Received School Disciplinary Actions
5N	Percentage of High School Graduates/GED Holders under Court Jurisdiction Who Have Been Accepted Into a Post-Secondary Education Program

The work of the education Focus Group has provided an excellent foundation for the mission of developing court-related education measures in child abuse and neglect cases. The next step in this project has been to vet these measures to a larger audience. Other experts and stakeholders are reviewing and evaluating these measures for practicality and usefulness and to provide recommendations on how best to improve collaboration among education, child welfare and the judiciary as well as how best to facilitate the exchange of data required to produce these education measures. For example, should child welfare agencies be exchanging data with the schools and then sharing with the courts or should the courts receive some information directly from schools? This was discussed by the Focus Group, and the consensus was that education and child welfare would most commonly share information, and then child welfare agencies would normally be the agency that shares data with courts.[57]

Currently, the educational measures are being pilot tested to determine how they work in practice and what obstacles arise when educational well-being measurement is instituted.

[57] For example, San Diego County has developed a protocol for the automated exchange of data between education, child welfare, and the courts under Education Code §49076(a) (1).

Appendix C:
Initial and Comprehensive Health Screenings for Children in Foster Care as Recommended by the American Academy of Pediatrics[58]

INTIAL HEALTH SCREENING

Purpose

1. To identify health conditions that require prompt medical attention such as acute illnesses, chronic diseases requiring therapy (eg, asthma, diabetes, seizure disorder), signs of abuse or neglect, signs of infection or communicable diseases (eg, varicella, lice, tinea), hygiene or nutritional problems, pregnancy, and significant developmental or mental health disturbances
2. To identify health conditions that should be considered in making placement decisions

Time Frame

Within 24 hours of removal.

Performed By

Child welfare staff or designated primary care physician. (Ideally, this will be the child's medical home while in foster care.)

Components

1. Review of available medical, developmental, and mental health history
2. Review of systems (standard medical review)
3. Symptom-targeted examination to include
    - Vital signs (with blood pressure measurement if 3 years or older)
    - Height and weight (and head circumference, if younger than 3 years) with percentiles, and calculate body mass index
    - If indicated or available, physical examination by physician or pediatric nurse practitioner (Ideally, this is included at this visit.)
    - External body inspection (unclothed) for signs of acute illness, signs of abuse (unusual bruises, welts, cuts, burns, trauma), and rash suggestive of infestation or contagious illness; range-of motion examination of all joints by health staff
    - External genitalia inspection for signs of trauma, discharge, or obvious abnormality by health staff
    - Assessment of chronic conditions (eg, respiratory status if known to have asthma)
4. Developmental and mental health screen (using standard screening tool) for
    - Significant developmental delay
    - Major depression
    - Suicidal thoughts
    - Violent behavior
5. Actions that may be required after medical screen

    Referral to primary care physician, pediatric ambulatory service, or pediatric emergency department for conditions warranting immediate attention or evidence of abuse warranting further evaluation, documentation, and treatment. For history and/or physical findings suspicious for sexual abuse, referral is recommended to a center with staff that specializes in evaluation, documentation, and treatment of sexual abuse

[58] *Fostering Health: Health Care for Children and Adolescents in Foster Care,* 2nd ed. American Academy of Pediatrics, Task Force on Health Care for Children in Foster Care. Elk Grove Village, IL: American Academy of Pediatrics (2005). http://www.aap.org/fostercare/PDFs/FosteringHealth/FosteringHealthBook.pdf

COMPREHENSIVE HEALTH ASSESSMENT

Purpose

1. To review all available data and medical history about the child or adolescent
2. To identify medical conditions
3. To identify developmental and mental health conditions requiring immediate attention
4. To develop an individualized treatment plan

Time Frame

Within 30 days of foster care placement (preferably as soon as possible following placement).

Performed By

Pediatric nurse practitioner or physician of child care agency or primary care physician. The health care professional who performs the comprehensive health assessment ideally should continue to follow the child or adolescent throughout his or her stay in foster care, and possibly beyond.

Attended By

Children or adolescents, foster parents, health care manager, caseworkers, and, when possible, birth parents.

Components

1. Elicit or review complete medical, behavioral, developmental, and social history when possible.
2. Review of systems (ie, standard medical review).
3. Complete unclothed physical examination, including genital examination.
4. Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment with appropriate reporting. The use of figure drawings is helpful; photographs may be taken. Any history or physical findings suggestive of sexual abuse must be fully evaluated, documented, and reported. Primary care physicians with limited experience in this area should refer to a specialty center.
5. Family planning and sexual safety counseling services and appropriate examination should be provided for sexually active females as soon as possible. This should be performed by the primary care physician or a specialist in adolescent medicine.
6. Developmental screen with full evaluation to follow.
7. Mental health screen with full evaluation to follow.
8. Adolescent survey (ie, discussion with adolescent) to include at a minimum
    - Family relationships (foster and birth)
    - Adjustment to foster care
    - Peer relationships
    - Alcohol, drug, or tobacco use
    - Sexual orientation
    - Sexual activity
    - Prevention of sexually transmitted diseases (STDs) and birth control
    - Nutrition
    - Physical activity (ie, exercise)
    - School performance
    - Hobbies
    - Educational or career plans

    The use of a written questionnaire should be considered to help gather this information. Counseling about these issues should be initiated with follow-up appointments, with further counseling scheduled as needed.

9. Immunization review

Every effort should be made to locate the immunization record by the comprehensive health assessment. If this is not possible, the record should be located within 30 days so that an immunization update can be done at the follow-up visit. In the absence of an immunization record at 60 days post-entry, immunizations should be commenced using the catch-up schedule from the AAP and Centers for Disease Control and Prevention (CDC).

10. Dental and oral evaluation

Examination of the oral cavity by the primary care physician is an important part of the comprehensive health assessment, as well as of each periodic preventive health care visit. Anticipatory guidance for oral health appropriate for the child's age also should be a part of these health care encounters. The presence of any risk factors or abnormal findings requires referral to a pediatric oral health care professional or general practice dentist, regardless of the child's age.

- The AAP recommends that children be referred for their first dental evaluation by 2 years of age, with earlier referrals as indicated.
- The American Academy of Pediatric Dentistry (AAPD) recommends that initial and periodic oral health examinations by trained pediatric oral health care professionals begin at 1 year of age.

11.Hearing and vision screening with referral

- Subjective from birth to 3 years of age.
- Objective for 3 years and older.

12. Human immunodeficiency virus risk assessment

Health care professionals should assess patients' capacity to consent for HIV testing based on their ages, developmental ages, and abilities to comprehend what testing means and comply with follow-up. Health care professionals should assess each patient for risk of HIV infection based on history and newborn screening where available. *Assessment of capacity to consent for HIV testing and of risk for HIV infection must be in accordance with guidelines set forth by each state for children and adolescents in foster care. Newborn HIV screening results are available in some states for all children and adolescents born in that state. Procedure for obtaining consent for HIV testing and referral for testing as per state regulations.*

13. Laboratory studies (if not well documented in medical records or records not available)

- Hemoglobin or complete blood count (CBC) (all children younger than 6 years and adolescent females)
- Lead level for children 6 months to 6 years of age, or older child if indicated
- Hemoglobin electrophoresis for children at risk for hemoglobinopathies
- Purified protein derivative tuberculin (PPD) (3 months and older)—must be read by health care personnel within 48 to 72 hours
- Hepatitis B surface antigen (HBsAg) strongly recommended for all ages
- Rapid plasma reagin (RPR) test strongly recommended for all ages
- Urinalysis—dipstick (children older than 2 years or if indicated)
- Human immunodeficiency virus testing if positive risk assessment and if appropriate consent has been obtained¶
- Hepatitis C antibody screen for those at risk strongly recommended.

14. Universal precautions

Discuss with foster parents the use of universal precautions.

15. Anticipatory guidance

Education and counseling is a critical component of each preventive health care encounter, especially for children and adolescents in foster care. The primary care physician should conduct a private interview with the older child and adolescent at this visit. General areas to be covered include

- Temperament
- Developmentally appropriate play or activities, including reading
- Physical activity and exercise
- Good parenting practices
- Discipline
- Nutrition
- Dental and oral health
- Injury prevention
- Child care arrangements

Topics for discussion with the older child and adolescent include
- Normal development
- Good health habits
- Dental and oral health
- Physical activity and exercise
- Discipline
- Sexually transmitted disease and pregnancy prevention
- Human immunodeficiency virus prevention
- Sexuality issues, including gender identity and sexual orientation
- Substance abuse issues (eg, drugs, alcohol, tobacco)
- Academic activities, including the importance of reading
- Future plans

Topics specific to foster care that should be discussed with the foster parent and older child and adolescent include
- General adjustment to new home
- Dealing with different expectations in different families
- Grief and loss issues
- Contact with birth parents, including adjustment issues around visits
- Behavioral problems that have surfaced (eg, adjustment reactions, oppositional behavior, depression, anger, attentional or impulse control problems)
- Sleep problems
- Appetite or unusual eating habits
- Enuresis or encopresis
- School placement, changes in school settings, peer relationships
- Behavioral or academic school problems
- Interaction with other children in home

16. Referrals

    For specialty or ancillary services as needed.

A summary of findings and recommendations, including an individual treatment plan, should be prepared for each child and adolescent; shared with the child or adolescent, foster parents, birth parents, social worker, and health care manager; and become part of the health record and child welfare case plan.

PERIODIC PREVENTATIVE HEALTH CARE

Purpose

1. To promote overall wellness by fostering healthy growth and development
2. To identify significant medical, behavioral, emotional, developmental, and school problems through periodic history, physical examination, and screenings
3. To regularly assess for success of foster care placement
4. To regularly monitor for signs or symptoms of abuse or neglect
5. To provide age-appropriate anticipatory guidance on a regular basis to children and adolescents in foster care and foster and birth parents

Time Frame

In general, more frequent preventive pediatric visits are recommended for the child or adolescent in foster care because of the multiple environmental and social issues that can adversely impact their health and development. Follow the most recent AAP "Recommendations for Preventive Pediatric Health Care" schedule with the following modifications:

- Monthly visits up to 6 months of age.
- Semiannual visits beyond 2 years of age through adolescence.
- Given the high incidence of complex medical, developmental, and mental health conditions in this population, primary care physicians will need to schedule additional visits on a case-by case basis.

Performed By

Periodic pediatric preventive health care visits should be conducted by the foster care medical home professional to ensure the continuity of care deemed essential for this population. Alternatively, pediatric nurse practitioners or physicians of child care agencies may conduct these visits.

Attended By

Children or adolescents, foster parents, caseworkers, and, when possible and appropriate, birth parents.

Components

Follow the most recent AAP "Recommendations for Preventive Pediatric Health Care" schedule, with the following modifications:

1. History and physical examination with special attention to
   - Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment, with appropriate reporting.
   - Close monitoring of growth parameters is critical for this population. Poor weight gain often is the first sign of a suboptimal placement.
   - Assessment of capacity to consent for HIV testing and assessment of any risk for HIV infection at every periodic preventive health care visit, as per individual state regulations.
   - Observation of parent-child interaction for goodness of fit.
2. Sensory screening
   - Vision and hearing screening appropriate for the child's age.
   - Refer for specialized audiology evaluation if speech and language delay is suspected or detected.
3. Procedures
   - Immunizations

     The *Recommended Childhood and Adolescent Immunization Schedule*, which is updated yearly by the Advisory Committee on Immunization Practices of the CDC, the AAP, and the American Academy of Family Physicians (AAFP), should be followed (*see* pages 44–45). An accelerated schedule should be

followed in cases of incomplete or missing immunization records. Given the multiple risk factors that children and adolescents in foster care often face, the following are recommended:
– Hepatitis B vaccine for all infants, children, and adolescents.
– For newborns, follow the hepatitis B immunization schedule for mothers who test positive for HBsAg if perinatal history is unknown.
– Pneumococcal conjugate vaccine is recommended for all children up to 6 years of age.
– Meningococcal vaccine is recommended for college-bound adolescents.
– Influenza vaccine for all children 6 months to 2 years of age unless contraindicated or HIV status unknown

- Annual screenings
  – Annual screening with a blood lead test for children 6 months to 6 years of age (for children with documented risk for highdose lead exposure, screening with a blood lead test should be done according to the schedule set forth in the *Physician's Handbook on Childhood Lead Poisoning Prevention*
  – Consider annual hemoglobin or CBC up to and including 6 years of age.
  – Consider annual hemoglobin or CBC for post-menarchal females.

4. Procedures for patients at risk
   - Purified protein derivative tuberculin annually for children in congregate care
   - Purified protein derivative tuberculin every 2 to 3 years for all other children and adolescents per AAP guidelines for populations at high risk
5. Anticipatory guidance

   Education and counseling is a critical component of each preventive health care encounter with children and adolescents in foster care. The practitioner should conduct a private interview with the older child or adolescent at each preventive health visit. General areas to be discussed with foster parents include
   - Temperament
   - Developmentally appropriate play or activities, including reading
   - Visitation with birth parents
   - Ongoing support for the child and adolescent through process of foster care
   - Physical activity and exercise
   - Good parenting practices
   - Discipline
   - Nutrition
   - Dental and oral health
   - Injury prevention
   - Child care arrangements

   Topics for discussion with the older child or adolescent include
   - Normal development
   - Relationships with foster and birth parents
   - Continued adjustment to foster care
   - Good health habits
   - Dental and oral health
   - Physical activity and exercise
   - Discipline
   - Sexually transmitted disease and pregnancy prevention
   - Human immunodeficiency virus prevention
   - Drug, tobacco, and alcohol use
   - Sexuality issues, including gender identity and sexual orientation
   - Academic activities, including the importance of reading
   - Future plans

6. Initial dental referral
    - The AAP recommends that all children be referred for their first dental evaluation by 2 years of age. Earlier dental evaluations may be appropriate for some children. Subsequent examinations should be scheduled as prescribed by the dentist.
    - The AAPD recommends that initial and periodic oral health examinations by trained pediatric oral health care professionals begin by the first birthday. Oral screening by primary care physicians should occur prior to this age, with referral to dentists as deemed medically necessary.

Appendix D

Federal Legislation Related to Well-Being

Adoption and Safe Families Act of 1997 (ASFA)
Act: http://www.acf.hhs.gov/programs/cb/laws_policies/cblaws/public_law/pl105_89/pl105_89.htm

The Adoption and Safe Families Act of 1997 is the foundation for federal child welfare policy and practice. It focuses upon achieving safety, permanency, due process, timeliness and well-being for all children in foster care, including adoption.

Child Abuse and Prevention Act of 1974 (CAPTA)
Act: http://www.acf.hhs.gov/programs/cb/laws_policies/cblaws/capta/

The Child Abuse and Prevention Act provides assistance to states to develop child abuse and neglect identification and prevention programs. In addition to other provisions, the Act created a National Center on Child Abuse and Neglect to administer grant programs, focus research needs, and serve as a clearinghouse for information dissemination, program improvement, and best practices. As part of its efforts to address the increased risk of development delay and disability frequently exhibited by children subject to maltreatment, the Act requires states to refer children under the age of three who are involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act.

Family Educational Rights and Privacy Act
Act: http://epic.org/privacy/education/ferpa.html

Regulations: 34 CFR Part 99: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=6b7e313020dfabb7caa0216830b2a7d8;rgn=div5;view=text;node=34%3A1.1.1.1.34;idno=34;cc=ecfr

The Family Educational Rights and Privacy Act protects the confidentiality of students' education records, requiring confidentiality of records that contain "personally identifiable information." Parents may inspect, review, and to some extent, control disclosure of student records. Records may be released to third parties with written consent of a parent or a judicial order. Students age 18 or older may also access their records.

Fostering Connections to Success Act of 2008
Act: http://new.abanet.org/child/PublicDocuments/fostering_connections_law.pdf

Summary of Provisions:
http://www.clasp.org/admin/site/publications/files/FINAL_FCSIAA_LongSummary.pdf

The Act promotes permanent families for children in foster care by increasing support for placement with relatives for guardianship and adoption, and improves education and health care outcomes. The Act also promotes educational stability by requiring child welfare agencies to coordinate with schools regarding school placement. For example, children must remain in the

same school at the time of placement in foster care, unless changing schools is in the best interests of the child.

Health Insurance Portability and Accountability Act of 1996

Act: http://www.hhs.gov/ocr/privacy/

Special Education for School Age Children with Disabilities: Part B of the Individuals with Disabilities Education Act (IDEA):

Regulations: 34 CFR Parts 300 and 301: http://idea.ed.gov/download/finalregulations.pdf

The Individuals with Disabilities Education Act ensures that children receive a "free appropriate public education" by creating a federal framework for states to identify and evaluate children suspected of having disabilities. The act also provides standards to classify and provide services for eligible children, including procedural safeguards to protect students' due process rights. The Act further requires that schools to designate a team to evaluate children and develop an "individualized education program" (IEP) for eligible children. The child's parent is considered an equal participant in education decision-making.

Early Intervention Program for Infants and Toddlers, Part C of the Individuals with Disabilities Act (IDEA)

Regulations: 34 CFR Part 303: http://www.nectac.org/idea/303regs.asp

Program Information: http://www2.ed.gov/programs/osepeip/index.html

Under Part C of the program, all children from birth through their third birthday who are involved in a substantiated case of abuse or neglect must be referred for services based on an Individualized Family Service Place (IFSP) that is developed with professional and family input. Parents, including adoptive parents, legal guardians, relatives with whom a child resides, and in some cases, a foster caregiver, are permitted to receive services to enhance child development.

Preschool Special Education Grant Program of the Individuals with Disabilities Education Act

Regulations: 34 CFR Parts 300 and 301: http://idea.ed.gov/download/finalregulations.pdf

The Individuals with Disabilities Education Act permits children ages three to five to receive special education and related services under Part B of the Act. The Act also permits states to continue Early Intervention Program eligibility standards in lieu of the eligibility standards established under Part B. States may also prevent premature labeling of children using standards for development delay without a specific diagnosis or classification.

John H. Chafee Foster Care Independence Program of the Foster Care Independence Act of 1999

Act: http://www.ssa.gov/OP_Home/ssact/title04/0477.htm
Program Information:
http://www.acf.hhs.gov/programs/cb/programs_fund/state_tribal/jh_chafee_sum.htm

This Act provides states with more funding and greater flexibility to carry out programs designed to aid children in making the transition from foster care to self-sufficiency. Funding is provided to the states to expand opportunities for independent living programs for youth in foster care ages 16 to 21, focusing upon employment, health, life skills and education, including payment for room and board for former foster youth ages 18 to 21. The law mandates that states involve community partners in developing programs and provides youth a role in tailoring their own programs. It also emphasizes permanency by requiring ongoing efforts to find a permanent placement concurrent with independent living education efforts.

McKinney-Vento Homeless Assistance Act of 1987
Act: http://www.seirtec.org/nche/downloads/mv_full_text.pdf

The Homeless Assistance Act addresses the educational needs of homeless children, including educational stability and continuity. School districts are required to follow procedures regarding school selection, enrollment, and transportation, as well as transfers of records. Additionally, a liaison must be appointed to increase homeless students' access to school and community resources.

No Child Left Behind Act of 2001, Title 1, Part D: Neglected, Delinquent, or At-Risk Youth
Act: http://www.neglected-delinquent.org/nd/resources/legislate/intro.asp

Under the No Child Left Behind Act, school districts are held accountable for student achievement in accordance with state-wide learning standards and assessments. Schools that are identified as having a need for improvement receive mandatory interventions and students attending these schools become eligible for school choice. Supplemental education services are also available for students in poverty beyond the established school day.

Promoting Safe and Stable Families Amendments of 2001
Act: http://www.abanet.org/child/rclji/family.pdf

Provides support programs to mentor children of incarcerated parents and provides educational and training vouchers for youth aging out of foster care.

Section 504 of the Rehabilitation Act of 1973
Act: http://www.dol.gov/oasam/regs/statutes/sec504.htm

Regulations: 34 C.F.R. Part 104: http://www2.ed.gov/policy/rights/reg/ocr/edlite-34cfr104.html

Office of Civil Rights Fact Sheet: http://www.hhs.gov/ocr/civilrights/resources/factsheets/504.pdf

Under Section 504 of the Rehabilitation Act, schools that receive federal funding are prohibited from discriminating against individuals with disabilities and must make reasonable accommodations for qualified individuals. Students are do not qualify under IDEA may be eligible for a Section 504 Accommodation Plan, including programs, services or accommodations necessary to address their disability-needs within the educational setting.

Appendix E

Family Self-Sufficiency Scale

Client Name:_____ Rating: Pre Progress Post Follow-up Date:

Rater (Name/Role):_____

Circle most descriptive rating words in each area. Use N/R to indicate unable to rate. See separate two page rating definitions guide if needed.

Self-Sufficiency Area	Self-Sufficiency Continuum and Ratings				
	0	**1**	**2**	**3**	**4**
Program Participation	Refusing/ Resisting	Minimal/ Passive	Some Involvement	Moderate Involvement	Regular/Active
Child Care	None	Friend/Relative Unstable	Non-Certified Stable	Certified Stable	Stable with Backup
Housing	Homeless	Unstable/Unsafe	Friend/Family Residential Program	Substandard Rental	Adequate Rental/Own Home
Employment	No/Poor Work History or Job Search	Employment Training/Job Search	Subsidized work/ Jobs Plus	Part Time/Seasonal Temp*	Full Time*
Partner Relationship	Current Domestic Violence/Stalking	Recent DV Harassment	Big Conflict/ Issues Recent Sep/Divorce	Adjusting/Single	Healthy Relationship or Self-Sufficient Single
Parent/Child Relationship	Founded Case Abuse/Neglect	Issues of Abuse/Neglect Poor Parent/Child Relationship	Need Parent/Child Relationship Improvement	Adequate Parent/Child Interaction	Healthy Parent/Child Relationship
Parent Education/ Literacy	HS Drop Out/ Low Literacy	Educational/ Literacy Assessment Completed	ABE/GED/ESL Literacy Program-Participating	Finished Basic Ed Functional Literacy	Career Training/ College
Youth Risk/Resiliency	Severe Risk A&D Delinq/Drop Out	High Risk Multiple Problems	Moderate Risk Some Issues	Low Risk Few Issues	Successful Youth Development
School Attendance	Dropped Out Not Enrolled	Frequent Absences (without good cause)	Sporadic Attendance/ Chronic Tardiness	Moderate Absences/ Tardiness	Regular Attendance

Family Health	Emergent Care Only Serious Medical Prob	Neglect of Care No Health Provider	Identified Medical Provider	Periodic Health Care	Regular/Preventative Care
Substance Abuse	Suspected/Denial No Treatment	Admitted/Confirmed No Treatment	Screened/Started TX Little Progress	In Treatment Making Progress	Ongoing Recovery Functional
Mental Health	Severe or Chronic in Crisis - No TX	Assessed Needed TX Refused	Assessed/Started TX	In Treatment Making Progress	Ongoing Recovery Functional
Community Involvement	None/Unhealthy Community Conflicts	Minimal Some Previous	Occasional/Uses Community Resources	Involved in 1+ Community Activities	Regular Volunteer
Level of Public Assistance	Eligible but Not Participating	TANF/ Cash Assistance	FS/OHP/ERDC With Co-Pay Retention	Off Public Assistance	Off Public Assistance 6 Months
Family Income	Unable to Meet Basic Needs	Meet Basic Needs Debt/Unpaid Bills	Able to Meet Basic Needs/ Timely Debt Payment	Able to Meet Basic Needs/ Some Discretionary Income	Able to Pay Bills With Some Discretionary Income/Savings
Criminal Justice	In Jail	Supervised Probation	Unsupervised Probation	Finished Probation	No Recividism for 6 Months
Transportation	No Vehicle and Suspended/No License	Either No Vehicle Or No License	Unreliable Car No Insurance	Vehicle OK Has License	License/Insurance Reliable Vehicle

Pre-Test Date:_____ Put a #1 in scale boxes indicating pre-test score

Post-Test Date:_____ Put a #2 in scale boxes indicating post-test score

Protocol: standard confidentiality procedure

* Write hourly wage in corner of these boxes