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SUPPORTING VERMONT'S FOSTER PARENTS THROUGH INNOVATIVE SYSTEMS OF SUPPORT

Presented to the House Committee on Human Services

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TABLE OF CONTENTS

EXECUTIVE SUMMARY **1**

1. INTRODUCTION **1**

1.1 GENERAL DIFFICULTIES ASSOCATED WITH FOSTER CARE ARRANGEMENTS 1
1.2 TRAINING AND SUPPORT FOR FOSTER PARENTS 2
1.3 BACKGROUND ON FOSTER CARE IN VERMONT 3
1.3.1 Vermont's Opioid Crisis 3
1.3.2 Vermont's Federal Funding Streams 3

2. METHODOLOGY **4**

3. OVERVIEW OF APPROACHES IN COMPARISON STATES **6**

3.1 COMPARISON STATES TO VERMONT 6
3.1.1 Financial Dimensions 6
3.1.2 Training Requirements and Availability 6
3.1.3 Involvement of Non-Profits 7

4. INNOVATIVE POLICY OPTIONS **8**

4.1 PREVENTATIVE APPROACHES PAIRING SUBSTANCE ABUSE COUNSELORS AND CHILD PROTECTIVE SERVICES 8
4.2 PREVENTATIVE APPROACHES INVOLVING THE CO-LOCATION OF SUBSTANCE ABUSE TREATMENT AND PARENTING EDUCATION 11
4.3 PREVENTATIVE APPROACHES USING EARLY INTERVENTION DRUG COURTS 13
4.4 REACTIVE AND SUPPORTIVE APPROACHES 14
4.4.1 Family Treatment Drug Courts 14
4.4.2 Kinship Programs 15
4.5 INTERNATIONAL APPROACHES 17

5. ADDITIONAL FUNDING OPPORTUNITIES **18**

5.1 REGIONAL PARTNERSHIP GRANT 18
5.1.1 Vermont Lund Family Center 18
5.2 FEDERAL DISCRETIONARY GRANT 19

6. CONCLUSION **20**

REFERENCES **22**

The Nelson A. Rockefeller Center at Dartmouth College

The Center for Public Policy and the Social Sciences

EXECUTIVE SUMMARY

Not only are many current foster parents unsatisfied with the supports offered to them, but inadequate supports may also deter people from becoming foster parents in the first place.[1] To aid Vermont foster parents and the policymakers and organizations that support them, this project explores innovative and potentially-underutilized approaches to supporting foster parents. Vermont currently offers foster parents financial reimbursement, support groups, training, and the assistance of support coordinators, and parents can also qualify for food and medical benefits.[2] Representative Anne Pugh, Chair of the Vermont Committee on Human Services and Joint Legislative Child Protection Oversight Committee, tasked us with determining if other innovative approaches to supporting foster parents exist and whether they might be applicable in Vermont. This report examines various models for support currently implemented outside of Vermont while taking into account their feasibility for Vermont. The report examines alternative methods of supporting foster parents through three approaches: a) comparative case studies of programs in other state and countries, b) studies of state nonprofits, and c) expert interviews with administrators and stakeholders involved in innovative foster care system programs. Programs are grouped into two categories: preventative programs that reduced the need for children to be placed into foster care, and innovative reactive programs that support foster parents and their families. Based on these analyses, the report identifies options Vermont might pursue in supporting foster parents, describes information about program cost, implementation, and utilization, and discusses potential feasibility and potential outcomes if pursued in Vermont.

1. INTRODUCTION

In 2014, over 415,000 children were in foster care in the United States, and about 260,000 children entered foster care for the first time. Roughly half of these children were white, while roughly half were either black or Hispanic.[3] Of these children, 29 percent were living in relatives' homes and 46 percent were in nonrelative foster family homes. Close to half of the children who left foster care in 2014 were in care for less than one year. With respect to outcomes, 51 percent of those who left foster care were reunited with parents or primary caretakers, 21 percent were adopted, and the rest were placed out-of-home or lived with a guardian.[4] Foster children are on average nine years old, and spend approximately two years in foster care.[5]

1.1. General Difficulties Associated with Foster Care Arrangements

General difficulties associated with foster care arrangements include challenges involved in caring for children with disabilities, child abuse, and the twin issues of the high rate of psychiatric disorders in foster children–nearly 60 percent suffer from at least one psychiatric disorder–and overmedication.[6] Foster parents of children with disabilities struggle with navigating the education system for their child, as well as with finding medical assistance, and managing behavior both at home and in public. Further, many

report quitting their jobs because they were unable to balance work and children's medical appointments. Foster parents also report feelings of isolation due to the social stigma of having a child with disabilities.[7]

Outside of the parent-child relationship, foster parents also report difficulties associated with the institutional features of foster care, like training, medical care, and the legal system. Foster parents report feeling overwhelmed and unprepared despite going to training sessions, noting that they were rushed to get the material right in the training sessions without actually internalizing it. Foster parents also report feeling misunderstood and dealt with disrespectfully by medical professionals, and uncertain about their about their legal rights relative to the biological parents of the children.[8] Cases where foster parents face allegations of child abuse, which affect roughly 33 percent of foster parents nationwide, also often involve substantial trauma and confusion about information, legal rights, duties, processes, and supports, for all parties, exacerbating an already difficult situation.[9] Likewise, cases where foster children are prescribed psychotropic medications, which occur in the majority of cases, raise a range of issues, including in Vermont, where American Academy of Child and Adolescent Psychiatry (AACP) evaluation standards exist, but there is no system to oversee the execution of such evaluations.[10] Older foster parents also report needing additional support and financial services, including respite services for their own medical needs.[11]

Foster parents also face risk and liability issues. If a child is injured, the biological parents can sue. Accordingly, states have adopted four approaches to insure foster parents. They either 1) purchase a liability policy for the parents, 2) provide a trust to indemnify foster parents for losses, 3) offer foster parents immunity unless in the presence of gross misconduct, 4) are treated like state employees.[12] However, there remain statutory gaps that leave foster parents at risk and deter potential foster parents.[13]

1.2 Training and Support for Foster Parents

There is currently little evidence about the efficacy of foster care training, primarily due to the wide variation in training programs across states and localities. Foster parent training is required by the Foster Care Independence Act of 1999, which mandates "adequate preparation" before a child enters the care of a foster parent. This language allows a range of interpretations and approaches to training. Currently 48 states require such training, but training hours vary from four to 30 hours; there are many gaps in documentation, with relative parents receiving the least amount of foster parent training.[14] Foster parents with children from different racial, ethnic, religious, and cultural backgrounds report wanting greater culturally relevant resources available to them.[15] Foster parents also report needing help interacting with the biological families of children. Likewise, foster parents report wanting access to experienced foster parents, CPR training, and the real life scenarios they are likely to encounter.[16]

1.3 Background on Foster Care in Vermont

In 2015, 1,332 children were in foster care in Vermont, with 265 children waiting for adoption. Of the children in foster care, nearly 95 percent are white.[17] In Vermont, 6,836 children currently live in kinship care. Of these, 5,593 live with grandparents and 1,243 live with other relatives.[18]

1.3.1 Vermont's Opioid Crisis

From 2010 to 2015, the number of people treated in the Vermont Substance Abuse Treatment System for opioid usage more than doubled.[19] The number of people treated for heroin dependency in particular almost quintupled in the five-year period.[20] This crisis led to an increase in the number of children involved in the foster care system. From 2014 to 2015, the number of children in state care increased by 75 percent, and opioids were involved in 80 percent of cases in which children under three were placed in state child care. A 2015 Child and Family Services Reviews report (CFSRs) found that Vermont had not yet been able to shift resources to adequately address these challenges, resulting in a limited availability of services.[21] Combined with the increasing difficulty in finding foster parents, the DCF is having difficulties dealing with this increased caseload.[22]

1.3.2 Vermont's Federal Funding Streams

Table 1. Federal Funding Streams in Vermont

Funding Source	Percent of Federal Funding Utilized by VT	What it Funds
Medicaid	44%	Covers health related services for low-income and disabled individuals. In foster care, funds rehabilitative and case management services,[23] treatment and special services for children with developmental issues
Title IV-E	35%	Reimburses states for foster care maintenance expenses, administrative costs, training expenses, and Statewide Automated Child Welfare Information System (SACWIS)
Social Services Block Grant (SSBG)	10%	Utilized by state agencies to provide services that prevent child maltreatment, reduce improper use of institutional care, promote self-sufficiency and dependency

Temporary Assistance for Needy Families (TANF)	6%	Supports low-income families and children in the welfare system, provides funding for emergency assistance services needed for children
Title IV-B	3%	Prevention of maltreatment, family preservation, reunification services, training for welfare professionals, and adoption services

Sources: Child Trends, Center for Health Care Strategies[24]

2. METHODOLOGY

To examine foster care support in Vermont and find innovative approaches from other states, we took a multi-method approach, conducting comparative state case studies, examining the opioid crisis, its effects on foster care, and innovative responses to it, evaluating outside organizations, and conducting expert interviews.

We chose states for comparative case study that are similar to Vermont based on demographics, the foster care population, and the state budget. These states are Maine, Rhode Island, Delaware, New Hampshire, and Wyoming. Below is a comparison of these states in terms of population, state budget, race, and the number of children in foster care. These are also Democratic Party-leaning states, with the exception of Wyoming.

Table 2. Comparison of State Characteristics

	Population	Percent Caucasian	Children in Foster Care	State Budget (billions)	Percent Democrat
DE	945,934	71.1	555	3.9	45.1
NH	1,330,608	94.2	715	5.4	37.6
RI	1,056,298	85.6	2509	8.9	48.3
ME	1,329,328	95.2	2189	7.6	38.8
WY	586,107	92.7	1278	8.8	27.8
Average	979,053	89	1374.33	6.65	41.58
VT	626,042	95.2	1332	5.3	51.9

Source: U.S Census Data, Ballotpedia, and Gallup Polls.[25]

In addition to these comparison states, we also examined Texas, California, Pennsylvania, and New York, states that have large populations, budgets, and foster populations, to see if they had more extensive or innovative foster care systems with dimensions that might be relevant to Vermont.[26] However, we found that because the scopes of many of the programs in these larger states are so expansive, they are unlikely

to be replicable in Vermont, and so are not discussed in detail in this report. We did, however, include locally-based innovative programs found within these larger states, and discuss them in Sections 3 and 4.

To find information about the financial and social characteristics of specific innovative foster care and related programs and identify innovative approaches to further research, we examined state government and non-profit websites, local media reports, academic journal articles, and research reports conducted by private organizations. With the exception of state websites, we conducted our searches primarily using ProQuest and Google Scholar. We also conducted interviews with experts in other states who have experience working for foster care agencies, private foster care organizations, or research organizations.

In addition, we identified innovative programs to research through looking at Title IV-E waiver demonstration projects. More than half the states in the U.S. have implemented such projects. The waiver allocates funds designated to the state through Title IV-E of the Social Security Act more flexibly and directs them toward projects to promote safety, well being, and permanency in the foster care system.[27] Vermont did not participate in a waiver demonstration project because the majority of federal funding for foster care in Vermont is provided not through Title IV-E but through Medicaid.[28] Nonetheless, we still examined the twenty projects that have been completed and the twenty-nine projects that are currently ongoing in the country and focused on four projects–three completed and one ongoing–in states similar to Vermont that could potentially address some of the issues faced in Vermont. We chose these four projects based on what population they targeted and their scale. Many of the demonstration projects targeted minority populations and were implemented in states that were much larger and received much more funding than Vermont. The four title IV-E waiver demonstration projects we focused on are Project First Step (NH), Co-location Demonstration Project (DE), Family Services Support Team Program (MD), and Enhanced Parenting Project (ME).

We categorized the innovative programs found across states into two categories: A) preventative programs that supported parents and reduced the need for children to be placed in foster care, and B) reactive and supportive programs that took innovative approaches to supporting foster parents, kids, and families. We looked at programs that succeeded and failed to not only see what worked in states, but to see what challenges were faced in program implementation, since both successes and difficulties in other states may be relevant to Vermont.

3. OVERVIEW OF APPROACHES IN COMPARISON STATES

3.1 Comparison States to Vermont

3.1.1 Financial Dimensions

Table 3. Financial Comparison of Similar States to Vermont in 2014

	State Spending on Foster Care (Millions) [29]	Federal Spending on Foster Care (Millions) [30]	Percent of Foster Care Funded by State (%)	Daily Parental Reimbursement Rate Ranges[31]
ME	$75,631,907	$42,154,564	64	$16.50 - $65.62
RI	$128,455,673	$61,284,545	68	$14.39 - $15.79
DE	$53,319,900	$14,154,577	79	$13.04 - $55.00
NH	$31,678,333	$26,531,592	55	$15.80 - $27.20
WY	$18,463,675	$19,662,321	48	$13.33 - $26.66
Avg	$61,509,897	$32,757,519	63	$14.61 - $38.05
VT	$19,338,344	$51,804,232	27	$17.83 - $25.43

Vermont was similar to the comparison states in its range for daily reimbursement for foster parents; however, Vermont uses far less state-level funding for foster care. Nearly 73 percent of Vermont foster care funding comes from federal sources; whereas in the other comparison states, federal funding is not the primary funding source.[32] One possible reason for this difference is that primary federal funding in Vermont is through Medicaid, where most states are supported by Title IV-E funding as their primary funding source.[33] Title IV-E reimburses states for administrative, maintenance and training costs, whereas Medicaid covers medical and health-related issues for low income children. The amount of spending at the state level on child welfare services is determined by matching federal funds or to meet a required maintenance of effort for a federal program. Therefore, this might cause the states to allocate their state funds in different ways, attributing to the differences in proportions of state spending.[34]

3.1.2 Training Requirements and Availability

Since the process of becoming a foster parent is outlined by state governments, there is variation in the training requirements for prospective foster parents across the country. Of the selected comparison states, Wyoming and Maine require the least amount of foster parent training, just 18 hours each.[35] The Wyoming Pre-Service Foster and Adoptive Parent Training (PRIDE) plan features a highly standardized curriculum that outlines general family development goals and available resources, while foster parent certification in Maine may address the specific needs of a certain foster child, allowing prospective parents to select from a list of approved training options.[36]

On the opposite end of the spectrum, Delaware and Rhode Island require at least 29 and 30 hours of training, respectively, among of the largest time commitments in the country.[37] These two programs also feature a standardized curriculum. New Hampshire and Vermont fall in the middle of this range, each requiring a minimum of 24 hours of training for new foster parents, and New Hampshire offers general training as well as relative caregiver training.

3.1.3 Involvement of Non-Profits

Non-profit organizations play a significant role in providing financial and educational resources for foster parents and families in each of these comparison states. However, many of these organizations operate on a local level, so the availability of services greatly varies. In Wyoming, the state relies heavily on religious organizations like the Wyoming Adoption and Foster Care Alliance for additional support and toy and clothing donations. It is a religious organization that offers "Godly resources" for families, featuring family social events, support groups and an annual conference.[38]

Some states have more formal contractual relationships with nonprofit organizations. For instance, the Maine department of Health and Human Services delivers support by contracting out to Adoptive and Foster Families of Maine, which provides resources like support groups, donations, and tailored resources for kinship parents. Other leading nonprofits in Maine include Families and Children Together, with programs for treatment foster care and for kinship parents, under the program Maine Kids-Kin. Services include a clothing exchange, support groups, and a lending library.[39]

The leading nonprofit in New Hampshire is the Foster and Adoptive Parent Association, which provides support groups, monthly newsletters, and information about other resources. Kinship caregivers receive additional help with legal needs and online or community support networks. The organization oversees 12 support groups that meet with their Division of Children, Youth, and Families (DCYF) District Office. Rhode Island partly funds the nonprofit Foster Forward, which works to educate and support foster families. Foster Forward operates a variety of programs such as the Foster Parent Mentor Program, which pairs new foster parents with longtime foster parents. Foster Forward also provides trainings and a foster parent hotline.

Much of the community and social supports come from nonprofit foster care and therapeutic foster care agencies, which are generally funded through donations and state funds. These agencies appear to be internally directed, operating where they see possible, rather than directed or organized by the state.[40]

4. INNOVATIVE POLICY OPTIONS

In this section we look at the innovative policy options other states have implemented to combat the effect of the opioid crisis on foster care. The section is divided into two parts, preventative approaches and reactive and supportive approaches. The preventative measures that were used include co-location of substance abuse treatment and parenting education, and early intervention drug courts. In terms of reactive and supportive measures, states utilized family drug courts, kinship programs, and specialized foster care training. The bulk of this section deals with preventative measures that are designed to support parents and families such that they might avoid the foster care system in the first place, thereby reducing the foster care burden on the state and existing and potential foster families.

4.1 Preventative Approaches Pairing Substance Abuse Counselors and Child Protective Services

New Hampshire, Project First Step

This project was implemented in New Hampshire from 1999 to 2005 to identify parental substance abuse problems that would put children at-risk of or result in placement into foster care and reduce substance abuse risk behaviors in caregivers. In Project First Step, Licensed Alcohol and Drug Abuse Counselors (LADCs) worked with Child Protection Services (CPS) in two districts to advise and support families with substance abuse issues.[41] The LADCs worked alongside CPS to provide training, assessment, treatment, case management services, and initial drug and alcohol assessments for parents. Additionally, the LADCs could provide outpatient treatment or help treatment access for participating parents.[42]

Parents were enrolled in Project First Step after an initial CPS maltreatment report. Caregivers placed in an Enhanced group received the services provided by the LADCs and CPS and were given a formal substance abuse assessment. Those placed in a Standard group received the usual services provided by NH Department of Children Youth and Families.[43]

This project faced challenges in program enrollment and participation in the substance abuse treatment services. Families were enrolled in Project First Step at the beginning of a maltreatment investigation, before any substantial findings of abuse or neglect were found.[44] Claims of maltreatment made circumstances difficult from a case management perspective and social workers wanted to place children in the best environment possible.[45] Additionally, challenge of the voluntary participation in the program made it hard to garner interest of caregivers into the program.[46] Defensiveness of the caregivers was a concern of the project, and many involved in the program were concerned that the caregivers would not be ready or willing to acknowledge substance abuse problems or participate in treatment. Throughout the project, however, it was found that caregivers

who were willing to open up about their substance abuse issues and ready to change were significantly more likely to receive the services given through Project First Step and to be involved with an LADC.[47]

Upon evaluation, the project succeeded in uniting two areas – child protective services and substance abuse treatment – and in providing for the needs of vulnerable families. Children from the Enhanced group had fewer placements and greater stability than children from the Standard group and the strongest positive effects were seen in the district site that consistently had an LADC available and promoted consistency in the staffing of the office.[48] In terms of parent well-being, Enhanced group parents were more likely than those in the Standard group to have received help with their abuse issues at follow-up and more found full time employment after the project was completed.[49]

Delaware, Co-location Demonstration Project

The Delaware Demonstration Project ran 1996 to 2002 and consisted of treatment teams composed of a substance abuse counselor located with Child Protective Services in a CPS unit in each county of the state.[50] The counselors attended initial home visits with Child Protective Services where they both evaluated the substance abuse problem and its effect on the caregiver's parenting ability. The counselors then made referrals for treatment and remained in contact with the family throughout the treatment process. The state assigned a substance abuse counselor to work with one CPS unit in each of its three counties.[51]

Early problems in project implementation were found with referrals for substance abuse treatment, but improved when a supervisory review was put in place to identify cases with substance abuse.[52] Delaware also found that substance abuse counselors worked with each family much longer than the three months they initially intended.[53] While all of the families that were identified with substance abuse problems were offered a referral for treatment or services, few caregivers actually followed through with entering the treatment process because the state lacked appropriate treatment programs and resources.[54] Because of this, rather than referring caregivers to treatment programs, substance abuse counselors spent more time than expected with each caregiver resulting in a back-up of casework and lack of availability of counselors.[55]

Final evaluation of the Delaware demonstration project showed positive results for the well-being of children affected by substance abuse families.[56] The average time of foster care decreased by one-third in children who were a part of the experimental group seen by the joint CPS and substance abuse counselor partnership. Additionally, the proportion of children entering into foster care was lower in the experimental group than the control group.[57]

Since the project ended in 2002, Delaware has continued to implement a system in which a substance abuse liaison (SAL) is co-located with a Department of Family Services staff member in four regional locations.[58] In 2014, the SALs worked with 789 families with

substance abuse issues, and of those families 15 percent had children placed in foster care.[59] Additionally, the SALs provide substance abuse training for staff members of the Department of Family Services. The program no longer receives federal funding, but outside organizations continue to fund the program.[60]

Maryland, Family Services Support Team Program

In Maryland the substance abuse demonstration project began in September 1999 but was terminated early after three years. Maryland found that its program faced many barriers in program implementation, participation, and worker caseload.[61]

The demonstration project targeted mothers who had a child placed in out-of-home foster care or were at risk of having a child placed in out-of-home care because of substance abuse.[62] The project planned to develop Family Support Services Teams (FSST) made up of Chemical Addiction Counselors, treatment providers, local child welfare agency staff, parent aides, and parents in recovery to serve as mentors.[63] The FSSTs were tasked with providing services to eligible families through three treatment options: inpatient treatment for parents and their children, intermediate care, or intensive outpatient care. The local child welfare agencies were responsible for coordinating the FSSTs and the other members would coordinate in their particular areas.[64] The treatment providers offered care management and supportive services that included housing, employment, child care, and individual/group/family therapy. The parent aides and mentors were resources for the families in transition to treatment.[65]

A year into the project, evaluators conducted focus groups with staff on the teams and identified various challenges to the project. The intake workers found it hard to identify mothers in order to recruit them, especially after their child was placed in foster care, and many were uncomfortable with identifying and addressing substance abuse issues because they had not been properly trained.[66] To combat this issue for the remainder of the year before the program was terminated, an addiction specialist in one of the sites took up a more active role in training intake workers to identify and confront substance abuse in families they were trying to recruit.[67]

Low enrollment provided the largest barrier in the project. Intake workers were tasked with recruitment of families and found challenges in that many of families with reported substance abuse were ineligible for the demonstration for a variety of reasons. For example, nearly half of the families in substance abuse cases were already participating in a different state pilot project that served mothers with substance abuse issues and could not participate in the new program. Additionally, participants were confused about the difference between this project and other substance abuse initiatives in the state.[68] Lack of communication and a cohesive effort in the state stretched participants too thin and prevented one unified program from finding success.

4.2 Preventative Approaches Involving the Co-location of Substance Abuse Treatment and Parenting Education

Texas, Bexar County Mommies Program

The Mommies Program was launched in 2007 to address the opioid addiction problem in Bexar County, Texas. The program aims to co-locate substance abuse and parental education in a centralized location so as to streamline the care that parents, in particular mothers with substance abuse problems, receive. All pregnant women who use CHCS services with any type of diagnosed substance abuse disorder are eligible for the program.[69]

All the programs offered are housed centrally in the Center for Health Care Services (CHCS), a Department of State Health Services (DSHS) funded Medication Assisted Treatment (MAT) program and substance use disorders treatment provider. Patients receive free transportation to and from the center. CHCS houses a methadone clinic, which is free of charge to mothers; educational classes provided by University Health System's hospital staff members; opioid addiction treatment services outpatient clinic; residential and ambulatory detoxification services; substance abuse public sobering unit; crisis care center; and primary healthcare services. It also offers free on-site childcare.[70]
In addition, mothers have access to benefits coordinators, who assist women with enrollment in healthcare and other benefits, referrals for prenatal care, and scheduling appointments; and a patient navigator, who advocates for the enrollees as they interface with other services (by means such as communicating client history, sending out an overview of client progress to all essential staff, and coordinating educational sessions). Each participant receives counseling and an individualized plan of care that is developed by a professional, reviewed by the client herself, and periodically updated. The mother is subject to weekly urine analyses, which are used to monitor her progress in the program.[71]

Mommies provides services to roughly 160-175 women and their children each year. The program costs $175,000-$400,000 total per year, depending on available resources; in recent years due to funding cuts the program had to cut its outreach specialist (who did home visits for participants who had dropped out) and case manager (who orchestrated staffing and resources between agencies). The program reported that the infants whose mothers participated in the program and have neonatal abstinence syndrome (NAS) spend 33 percent less time in the NICU compared to infants who do not. In 2014, 1,132 infants in Texas were born with NAS, of which 865 required hospitalization in the NICU, indicating a 76 percent chance of an infant with NAS staying in the NICU. Assuming that this holds true for the participants in Mommies, approximately 133 of the 175 infants will require a stay in NICU. Given that the average cost to Medicaid for NAS related hospital expenses is $1,246 per infant per day, and that the average stay for NAS is around three or four weeks, roughly calculating for a three-week average stay the program can be estimated to save around $3.5 million per year for Bexar County. The program was

initially funded by a Substance Abuse and Mental Health Services Administration grant of $2.5 million over five years, and once the grant ran out, University Health System and the Center for Health Care Services took over, in conjunction with Medicaid reimbursement for services, and the Department of State Health Services as a payer of last resort.[72]

New York, Broome County Bridge Residential Pilot Program

Bridge was launched in May 2016 in order to help addicted mothers stay with their children while they work to get clean. It is aimed at filling a gap in the current treatment infrastructure for opioid addiction that discourages pregnant women with an addiction from seeking treatment out of fear of losing their child to foster care right out of a hospital, or avoiding entering drug treatment because they have no infant child care.[73]

Women who participate in the program are be placed in 24-hour-a-day staff supervised housing during their time in the program, which is provided by the YWCA of Binghamton. They will additionally have access to other wraparound services (defined as a collaborative system of care that involves the individuals most relevant to a participant's well-being), including child care, intensive case management, daily group meetings and access to programs with local licensed addiction treatment providers. Once their stay is over, Bridge will provide further assistance in securing housing in the community. [74]

Women with a baby born with opioid addiction are eligible for the program, as well as up to one other child. Eight women can participate in the program at a time, and each woman can stay for a minimum of seven months to a maximum of eighteen months. The program cost $263,000 to implement, with two-thirds of the funds coming from New York's child welfare stream, and one-third coming from local county funds. It was presented as part of Broome County Mental Health and Broome County Department of Social Services' 2016 budget.[75] It was designed to be cost-effective for tax payers; expenses related to treating an opioid addict average $100,000 per year, not including the additional costs of placing an infant in foster care, and Bridge would provide higher-quality services for one-quarter of that total per participant. The program is funded for one year, with the possibility of being renewed for another two years.[76]

Maine, Enhanced Parenting Project

Maine's Enhanced Parenting Project (MEPP) began in April of 2016 and is funded through a Title IV-E waiver. The focus of Maine's Enhanced Parenting Project is to stabilize and reunify children and families, increase family recovery, and reduce or avoid the out-of-home placement of children. The Project targets children through age five that are involved in the child welfare system, with either an open in-home case or who are in out-of-home care.[77] Maine joined two existing interventions to increase parental education and provide outpatient substance abuse services. Eligible families are referred

from child services to partake in the Matrix Model Outpatient Program and the Positive Parenting Program (Triple P), both implemented throughout the country and around the world.[78] One parent must meet the substance abuse assessment criteria for the Matrix Model Intensive Outpatient Program, a 16-week substance abuse treatment program offered through the project. Families also participate in Triple P, an 8-week parent education intervention program.[79] The Triple P has been has been utilized in 25 countries worldwide and has been found to work in families with children who have moderate to severe behavioral or emotional difficulties.[80] The project set out to eventually serve 250 families in the state. Maine plans to have an evaluation report after two years of implementation.[81]

4.3 Preventative Approaches Using Early Intervention Drug Courts

Early intervention drug courts, and drug courts more generally, are policy options that have become increasingly attractive to public officials attempting to address the broad and costly consequences of addiction.

Sacramento County, California

The Sacramento Early Intervention Family Drug Court EIFDC is a voluntary program that coordinates Child Protective Services interventions with families.[82] The EIFDC constitutes a new model for family court and substance abuse treatment, protecting the welfare of children while allowing parents to provide for their families and stay sober. The EIFDC aims to intervene at the earliest point possible, in cases where moms or babies test positive for drugs at birth or when parental substance abuse begins to impact the health and safety of children up to age 5. The court also serves fathers of substance-exposed infants and toddlers.[83]

The goals of the program are to: increase the number of children who can safely remain in their parents' care without court dependency, decrease the recurrence of maltreatment, increase the capacity of service providers to offer timely substance abuse treatment, develop sustained support plans through partnerships with Family Resource Centers or other community organizations, and provide a 16-week skill-building parenting program that incorporates addiction and recovery tools.[84]

A program evaluation confirmed that the program was able to reduce trauma in children and reduce the foster care case load, resulting in social and financial savings. In its first five years, the EIFDC served 892 adults (729 families). Only 7.9 percent of children in the program ended up being removed from their homes prior to case closure, compared to 30.5 percent of children in comparison families who did not participate in the program.[85] The recurrence rate of families ending up in court was lower as well, 9.6 percent at 24 months vs. 16.4 percent. In 2012 the EIFDC recorded a 78 percent compliance rate since its inception in 2008, which is high for a program of this kind. Overall it is estimated that the program results in around $7 million in savings for the state.[86]

The Court was started through a Regional Partnership Grant, but was discontinued by the county once the grant ran out. Funds accessed at this point included the State General Fund's allocation for Perinatal, Supportive and Therapeutic Options Program (STOP), and Drug Court Realignment.[87]

4.4 Reactive and Supportive Approaches

Many other programs seek to innovatively respond to circumstances in which children have been placed into foster care, primarily by supporting foster parents in their efforts.

4.4.1 Family Treatment Drug Courts

Family Treatment Drug Courts (FTDCs) are coordinated through a state's judicial branch and implemented at the district court level. Supports are provided for families with parents who are found to have substance abuse issues and the children are at risk of being taken out of the home or have been taken out of the home due to abuse or maltreatment. In more than 300 programs that are operated in the U.S., FTDCs vary in their process and structure. The overall FTDC model includes regular court hearings, monitoring by a judge, provision of timely substance abuse treatment, and other services that include frequent drug testing and rewards and sanctions based on the participant's progress. The goal of these programs is to provide support for parents facing substance abuse issues and to provide reunification, permanency, and stability for their children.[88]

Maine, Family Treatment Drug Court

The Maine Family Treatment Drug Courts provide supports for families with parents who are found to have substance abuse issues. This program is funded by the Office of Substance Abuse and Mental Health Services of the DHHS and is a coordinated effort between the Department of Health and Human Services and the Judicial branch of Maine, which provides judges.[89]

The program focuses on establishing permanency for the child in a timely fashion; providing comprehensive and intensive substance abuse treatment and wraparound services for the parents; and enabling parents to function better in their families and communities, thereby becoming less likely to have future involvement with the courts and the child welfare system.[90] Adults age 18 years or older with a child with an open child protective case at the local Department of Health and Human Services office, and who have a serious substance abuse disorder (some may have other mental health issues), are eligible to participate. No criminal charges are required, and participation is voluntary but encouraged by a referral from the DHHS.[91] The program lasts around 8-12 months, although it may last longer depending on the participant's progress.[92]

During the program, the judge meets with a team comprised of the case manager, a Department of Health and Human Services caseworker and casework supervisor, and local treatment providers. This team meets every other week with the participant to discuss the program and update the participant's service plan, which includes a substance abuse and mental health treatment plan.[93] Participants are required to meet with the FTDC case manager weekly and have random drug and alcohol tests no less than twice per week; attend all treatment services recommended by their counselor; and are expected to work on the reunification plan developed by them and the Department of Health and Human Services. Participants may either graduate the program, choose to withdraw, or be terminated.[94]

Maine has family treatment drug court in Augusta, Lewiston, and Bangor. The courts in Augusta and Lewiston are currently near capacity with thirty participants each, and Bangor is lower with seven participants. Several barriers have been found to implementation of the courts, the main barrier being accessibility of treatment services. The courts are only implemented in cities because services in rural areas are scarce and many of the parents do not have access to transportation or any way to get to treatment or court appointments. Another challenge that this program faces is that it is voluntary. Many participants have the perception that the Department of Health and Human Services is out to get them and will use the court system against them because of the random drug testing.[95]

4.4.2 Kinship Programs

Kinship support is offered to relative caregivers who have taken custody of a child if the parent is found to be no longer capable of raising the child. In Vermont, the number of kinship caregivers has increased due to the opioid crisis, and the majority of kin caregivers are the grandparents of the child who is at risk of being placed into foster care. Navigating the custody process and the welfare system in general is difficult for kin caregivers, as many of the families are going through difficult circumstances and are not as aware of or able to make time to take advantage of the supports that are offered to them. Support programs are in place to help both the children and their kin caregivers navigate the system to ensure the well-being of the child.[96]

Kinship Navigator programs provide information, referral, and follow-up services to grandparents or relatives raising children, to link them to the benefits and supports they or their children need. Several states, including Washington, Maryland, Michigan, New York, California, and Maine have Kinship Navigator Programs funded at the federal level through the Children's Bureau Family Connections Grant in 2012.[97]

Vermont does not have a nationally funded Kinship Navigator program, however, it has several organizations that have stepped into a similar role as these nationally funded programs including KIN-KAN Vermont and Vermont Kin As Parents.

KIN-KAN Vermont is a coalition of trained kinship navigators who provide peer support for relative families. KIN stands for Kinship Information and Navigation, where parents in each county have access to a network of Kinship Navigators who have training and experience and will guide them toward opportunities for assistance. The KAN stands for the Kinship Advocacy Network that advocates for the emerging area of kinship care in welfare policy decisions.

KIN-KAN provides direct services for families in the form of personal case management assistance, classes, and help with navigating DCF as a kin caregiver.[98] KIN-KAN is an entirely volunteer based organization and is not a 501(c)(3) organization, therefore it is very limited in its funding. Any donations it receives go directly to supporting families who need extra support.[99] It has chosen not to be a 501(c)(3) even though it would receive more funding because it does not want nor have the resources to have a full time, paid executive director and full time grant writer.[100] The current executive director, Sani Yandow, has served in a volunteer position and says that she would rather be focused on the mission than having to continuously search for funding. Moving forward, she would hope to see a more robust support system for kinship families at the state level, especially since their organization currently has limited funding.[101]

Vermont Kin as Parents (VKAP) is a non-profit in Vermont that advocates for relative caregivers and their children. The foundation provides a resource for kinship caregivers and social service providers. VKAP works directly with families throughout Vermont and advocates for kinship families in committees and in the legislature.[102] VKAP places Kinship Navigators in local DCF offices to point kinship caregivers to supports or to make referrals to other agencies. In addition to the kinship navigators, VKAP offers warmline support, a communication line provided by peers who have previously served as kinship caregivers, points kinship caregivers in the directions that they need in connecting families with support groups, and organizes an annual picnic and conference for kinship caregivers and their families.[103] The organization would like to see expansion of Kinship Navigators to every district in the state, but currently its limited funding and personnel do not allow it to place navigators in every district.[104]

Both the executive director KIN KAN Vermont and chair of VKAP pointed out several challenges that kin caregivers face. First, kin caregivers are given less support both financially and programmatically than non-relative foster parent caregivers. Also, kin caregivers have the difficult task of trying to retain a relationship with the child's parent, usually their own son or daughter, as most kin caregivers are grandparents. Conflicts arise between the social workers, the parents, and the kinship caregivers who all want what is best for the child, but all have different ideas about the involvement of the parent. Additional problems arise when the birth parent is restricted by visitation hours.[105]

The director of KIN KAN and the chair of VKAP both also noted the need to establish a Kinship Mentor in addition to the Kinship Navigators that serve in DCF offices. The Kinship Mentor is someone who previously served as a kinship caregiver that would assist and support kinship caregivers to guide them from their own experience. The Kinship Navigator would serve as the informational point-person, but the Mentor would provide more emotional support and guidance to the family from a kin caregiver perspective.[106]

4.5 International Approaches

Care for foster children is a prominent issue in countries across the world. In developing nations, there is generally less of a reliance on formal systems of foster care, as children are provided for by members of their extended family or kinship group in times of need. While this system may create issues with accountability for children who are mistreated, developed nations have also attempted to emulate these stable and self-supporting family systems. In Sweden, for example, in response to a decline in traditional two-parent families, the country developed provisions for community support, increased parental leave benefits, youth clubs and child safety initiatives. [xxxvi]

Social network care can be applied in a variety of socioeconomic and cultural contexts, and is relatively detached from financial capital relative to other interventions. Countries like Sweden, with sophisticated civil organizations, have improved their foster care systems by forging formal alliances between the government and private foster care organizations as well as empowering parents and children with child-centric policies. [xxxvii] Compared to the United States, which has not explicitly incorporated the "impact of family breakdown" into foster care policies, Sweden has been able to make strides in reducing child poverty, abuse, delinquency and drug addiction among children in foster care. These outcomes have been attributed partially to policies that develop social network-based foster care systems. [xxxviii]

New Zealand has also implemented an innovate program that aims to improve access to foster care services. Local foster care agencies were becoming increasingly unable to provide appropriate care for children with complex needs, like those with behavioral and medical issues. [xxxix] In response, the ministries of Health, Education, Social Development and the Department of Child Youth and Family Services joined forces to develop the High and Complex Needs (HCN) Strategy. This program provides funding and coordinates services with other agencies across the country. The key to the program's success is the interagency collaboration. An interagency team works with the representatives of these special needs children in cases where the needs of the child are more extensive than what their local foster care agencies can provide. This unit also works to provide funding through the national HCN fund.

5. ADDITIONAL FUNDING OPPORTUNITIES

5.1 Regional Partnership Grant

The Regional Partnership Grant (RPG) is awarded by the Children's Bureau of the Administration on Children, Youth, and Families of DHHS. The grants provide funding for five-year programs designed to improve outcomes for children and families. These programs involve a partnership between a child welfare department, usually at the state or county level, a substance abuse treatment agency at the county or community level, and other partners that provide services. These other partners have included services to support affected children, mental health agencies, and family treatment drug courts.[107] The first cycle of Regional Partnership Grants began ran from 2007 to 2012, when 53 grants were awarded to programs across the country, 45 of which continued to be funded. In the second cycle of the RPG, seventeen grants were awarded in the cycle beginning in 2012 and ending in 2017. The RPG is now on its third cycle, and four programs were awarded grants in the cycle beginning in 2014 and concluding in 2019.[108] According to the Department of Health and Human Services Grant Forecast, RPG will continue to fund programs in its third cycle until 2019, and applications are due June 6, 2017 for programs that improve outcomes for children affected by substance abuse.[109]

Grantees have pursued a range of programs, including the creation or expansion of family treatment drug courts, improvement of system-wide collaboration, expanded access to comprehensive family-centered treatment, and use of evidence-based practice approaches such as motivational enhancement therapy, parent advocates, and recovery management approaches to drug treatment monitoring. [110]

5.1.1 Vermont Lund Family Center

The Lund Family Center in Vermont was awarded a Regional Partnership Grant in Round 1 (2007- 2012). Lund created a regional partnership with Burlington DCF and the Department of Health Division of Alcohol and Drug Abuse Problems. The funding contributed to the continuation of Lund services in providing a residential treatment program for mothers with substance abuse and their families.[111] The RPG created a program that provided a screening, assessment, and treatment component to address and treat substance abuse issues in parents. Trained Substance Abuse Screeners were co-located at the DCF Burlington district office to screen for parental substance abuse and assess the proper treatment plan.[112] Lund then provided substance abuse and mental health treatment services, in addition to early childhood services including a Play Lab involving supervised visitation for the family.[113]

This project produced positive outcomes including increased and earlier identification of substance abusers and families engaged in treatment, fewer children in foster care in the

city of Burlington, increased number of families receiving Lund's community based services, and improved timeliness of DCF services.[114]

Due to the success of this project in the first year, Lund created the Regional Partnership Program in 2007 to implement a similar project in additional Vermont districts.[115] Through RPG funding, the program has expanded to implement the same screening and assessment process in five additional towns including Barre, Hartford, Rutland, Springfield, and St. Albans. Regional Partnership Grant funding ended in 2012, however, the Regional Partnership Program will be funded for an additional five years by ADAP (Alcohol and Drug Abuse Programs of the Vermont Department of Health), CIS (Children's Integrated Services of DCF), and KidSafe Collaborative.[116] In 2015, 425 caregivers were referred to the Regional Partnership Program across the district and participants have completed the program at roughly a 75 percent success rate in each district.[117]

5.2 Federal Discretionary Grant

The Children's Bureau of the Administration of Children and Families of the DHHS offers funding for a variety of competitive grant programs that serve children and families across the country. These discretionary grants award funds to nonprofit, for-profit, and government institutions that establish programs that promote the wellbeing of families, individuals, children, and communities.[118]

Federal discretionary grants are awarded in several different areas: Adoption Opportunities, Child Welfare Training, Child Abuse Prevention and Treatment Act Discretionary Funds Program, and the Promoting Safe and Stable Families Program (PSSF).

In the Adoption Opportunities area, funding is available for programs that help eliminate barriers to adoption and find permanent families for foster children, especially children who have special needs. In child welfare training, funds are dedicated to programs that train child welfare workers and increase training services for foster parents. For example, most recently in 2016, a $750,000 three-year grant was rewarded to the Michigan Spaulding for Children for a foster/adoptive parent preparation, training, and development initiative.[119] This grant was given to develop a foster and adoptive parent training program and for the research of foster and adoptive families to determine characteristics of successful relationships in well-being and stability.[120]

In the Child Abuse Prevention and Treatment Act Discretionary Funds Program, funding is available for programs that work to prevent child maltreatment. These programs include both research on the causes, prevention, and identification of child abuse and the development of evidence-based training programs. Lastly, in the PSSF program funding

is available for programs that prevent child abuse and neglect, promote permanency for children within their own families, kinship, or adoptive families.[121]

A discretionary grant was awarded to Vermont in 2012 to create the VT-FUTRES program, a collaboration between the University of Vermont College of Education and Social Services, Vermont Department of Education, Vermont Department of Children and Families, the Justice Children's Task Force of the Vermont Supreme Court, and children and families involved in the child welfare system. This developed an intervention program to improve stability for middle school and high school students in foster care. [122]

A discretionary grant was also awarded to Vermont in 2013 to create the VT-FACTS (Vermont Functional Assessment, Case Planning, and Treatment Services) initiative to increase training of child welfare workers in order to improve placement stability and permanency children in custody or receiving post permanence services and to increase training for foster/adoptive caregivers.[123] The VT-FACTS Initiative is a collaboration between the University of Vermont, the Vermont State Department of Children and Families, Vermont State Department of Mental Health, Vermont Agency of Human Services' Integrated Family Services, Chadwick Center for Children and Families, The Butler Institute for Children and Families, UnaMesa, and The Center for Adoption Support and Education.[124] VT-FACTs implemented universal screening, functional assessment, improved referral, and collaborative case planning for children in the welfare system. The project also implemented a system to train and educate service providers in evidence-based treatments and services that support foster, kin and adoptive families through the Child Welfare Training Partnership.[125]

6. CONCLUSION

While we initially set out to find programs that supported foster parents, we found that, in response to the opioid crisis, many states and programs are focused on preventing the need for foster care in the first place, or supporting reunification or treatment services for parents that have lost custody of a child. We looked for programs in two areas: preventative programs that try to decrease the need for a child to be placed out of the home, and innovative, supportive programs that helped foster parents beyond the financial support and training that all states offer.

Preventative programs are especially necessary given the current opioid crisis that is drastically increasing the number of children needing to be placed out of home due to maltreatment or abuse. States have experimented with a number of co-location programs involving either substance abuse treatment and parenting education, or collaboration between child protective services, state child welfare agents, and a substance abuse drug counselor, to provide treatment and support for families that risk losing a child. In addition, they have tried implementing early intervention drug courts which provide

parents with resources that foster sobriety and reduce the foster care case load by reducing the number of children who end up being removed from their homes. [126]

Supportive programs include family treatment drug courts are being implemented through states judicial branches to provide treatment and reunification services for parents with substance abuse issues. Support programs are also provided for kin caregivers that are related to the children who are at risk of entering foster care.

We additionally found several funding opportunities at the national level, in the form of grants that the Children's Bureau of the Administration of Children and Families provides. Organizations in Vermont have previously taken advantage of these two programs to create unique programs that involve a collaborative effort between multiple organizations including the Vermont Department of Children and Families, non-profits, and other supportive services.

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