Child Welfare Visitation Services

Meheret Sellassie

EXECUTIVE SUMMARY

This case study focuses on San Francisco County's Human Services Agency's visitation model. During SF-HSA's monthly workgroup meeting, chaired by the department's representative, I was able to observe the different partners involved in their visitation model. The coordination between two county agencies and several different community-based organizations (CBOs) is a complex matter, and it is a work in progress. As such, the level of commitment among those involved is impressive. Contrary to what research is showing to be beneficial, in practice, child welfare social workers prefer to host visitations in a more controlled environment. The preferred locations for providing visits to the families and children involved in the child welfare system are visiting houses or visiting rooms.

As part of my BASSC internship, I observed monthly visitation work groups; additionally, I attended meetings at First 5 regarding contract coordination and at CBHS with the therapeutic visitation providers. Participants at the meetings included private panel attorneys, Bay Area Academy (BAA) representatives, Community Mental Health (CMH) staff, a social worker from the agency, and the various CBO partners. In this weekly meeting, the workgroup discussed the current and future openings they had for visitation, as well as their successes and challenges.

Parents who are receiving Family Reunification services are separated from their children for a variety of reasons, and almost all of them resent having to visit their children in the visitation environments. Consequently, SF-HSA is hopeful that the Family Resource Centers (FRCs) will provide a more family-friendly setting, which might help mitigate concerns that parents may have about visits.

When used properly, visits may be used to enhance and strengthen the parent-child bond. Research reveals that children who do not participate in regular visits with their parents stay in care three times longer than those who receive regular visits with their parents. Visits can also be an indicator to parents that the agency respects their parental role; this may help parents to remain and participate in the case plan.

In addition to upholding the existing policies and procedures regarding visitation, I strongly recommend that the agency examine different venues and visitation programs nationwide to gain ideas for improving visitation.

Meheret Sellassie, Social Work Supervisor,
Santa Clara County Social Services Agency

Child Welfare Visitation Services

Meheret Sellassie

Introduction

The Child Abuse Prevention and Treatment Act of 1975 is the federal legislation that provides the minimum standard of care as it pertains to the definition of child abuse and neglect. ASFA requires states to enact laws and adopt procedures that support families receiving services in a timely manner. The main role of child welfare workers is to provide services to children and families who are in need of prevention and intervention services. Most of the time, these services are initiated as a result of child abuse or neglect. While a case of child abuse or neglect is being investigated, children are sometimes placed in alternative placements (e.g., foster homes, relative care). It is reported that child welfare services received about 5,000,000 calls in the year 2006; of these, 3,000,000 were accepted as reports of child abuse (US DHHS, 2007). According to the US Department of Health and Human Services (2007), less than 1,000,000 of these children were found to be victims of abuse or neglect. Among the children who are found to be victims of abuse or neglect, some are unable to remain in their family home until their parents successfully complete their case plan. As part of their case plan, parents are almost always provided with visits with their children.

Background

As a new social worker beginning in 1994, I was troubled by the lack of visitation services provided to the parents receiving Family Reunification services. Visits were dependent on multiple factors: the locations where the visit would be held, determining whether the visit would be supervised or unsupervised, deciding who could supervise the visit, the parent's availability, and transportation, among other considerations. I wanted to give families and their children as many visits as possible, because I thought the most natural thing to do was to maintain the family relationship. I soon realized that my workload and other job responsibilities did not allow me to give families their much-needed and court-ordered supervised visits.

Prior to 1989, Santa Clara County Department of Family and Children Services (DFCS) offered limited visitation services. One can only try to imagine how children felt sitting on the other side of a table trying to have a relationship with their parent. How can a relationship be fostered with a parent sitting on the opposite side of a table from their child in an auditorium setting? Research tells us that those types of visits may not be doing what social workers intend them to do; further, they make it very difficult to have a real sense of the parent-child interaction. The issue of visitation presents challenges to social workers for a variety of reasons, including dealing with situations such as when a parent does not show up or when parents discuss their case during visitation. The situation is particularly challenging for parents, children, and social workers when visits come to an end. Child welfare workers have the responsibility of providing timely and meaningful contacts between parents and their children who are placed in foster care.

In 1989, in an effort to address the need for timely and meaningful visits, DFCS opened the door to Clover House Visitation Center (CH). CH is one the first visitation centers in California. Today, Clover House is contains a social services program that is staffed by two social work supervisors, six social worker and a receptionist. Family participants are able to use a semi-private room where they can interact with their children. During visits, the visiting supervisor remains located outside the door taking notes. Visiting houses and visiting rooms are not a natural environment to the family; therefore, the

quality of the visit will be compromised. Although Clover House is not a perfect environment for visits, it has accommodated many families. According to DFCS, OPP social workers should reassess families every three months to determine if there is still a need for continued supervised visits.

Tables 1–6 describe some of the scheduled visits and length of visits at Clover House during recent years.

As illustrated in these tables, 74% of the visits conducted at Clover House in 2010 were two hours in length, compared with 65.8% of visits in 2009 and 55% of visits in 2008. This increase may be an indication that DFCS social workers are valuing the power of visitation.

As seen in the Table 7, very few family get frequent visits: only 17 families per year saw each other three times per week, compared with 404 families who had visits two times a week. The frequency of visits has been found to be a key variable in predicting the likelihood of successful reunification (Wars & Pine 2000).

DFCS also provides intensive therapeutic visitation services in collaboration with children and family Mental Health Day Break FFA and Catholic Charities. This visitation service takes place at Kindred Souls (KS). Case-carrying social workers can refer parents and children to this service as they see fit. To be eligible for the program, they must have Medi-Cal. The visits are at KS are observed by therapists; unlike at CH, the therapists at KS will provide hands-on parenting support. They also provide written observations for the referring social worker, who in turn uses the information to best assess families' needs and progress. At both CH and KS, there are separate entrances for parents and care providers. Additionally, the two visitations houses maintain the same rules.

The San Francisco County Department of Family and Children Services Visitation Services

Over the course of my interagency project at SFHSA-FCS, I was able to meet the following learning objectives:

- Understand the roles of various professionals' and the partnerships between them.
- Understand the coordination between providers and needed services that promotes the efforts of these model visitation programs in achieving their federal outcomes. Providers included Mental Health representatives, risk and safety partners, and SF-HSA FCS.

SF-HSA chose to focus on the following areas:

- Improve Differential Response
- Standardize assessments
- Improve its family-to-family component
- Enhance linkages to coordinated case plans and after-care plans
- Enhance community partnerships

Their self-improvement plan consisted of three levels of review and analysis of the agency's current practices, as well as a commitment to implement new evidence-based practices.

Of their focus areas, I was particularly interested in enhanced community partnership. As a result, I was given me the opportunity to attend and observe the monthly innovative visitation work groups and meetings with the Department of Mental Health. The Department of Mental Health is in charge of the therapeutic mental health contracts (known as Community Behavioral Health Services (CBHS)) that are established with therapeutic visitation providers. SF-HSA work orders the match to CBHS.

A Better Way, Inc. and Alternative Family Services provide strength-based family services. Their services promote safety, well-being and permanency for children and their families, in order to improve the negative impacts due to involuntary separation, to address any mental health issues that may prevent parents from benefiting from services, to reduce family conflict and improve family connection, and to increase the potential of reunification for families. At any given time, they provide services to 70 clients. The average treatment lasts between 6 to 9 months.

According to the SF-HSA court order, the first visit between a parent and child should occur within five days of the initial removal. To achieve that goal, SF-HSA partners with Seneca's First Stop Visit Cen-

TABLE 1
Number of Scheduled Visits at Clover House for April–May 2008

Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Total
504	553	627	636	652	609	612	514	537	**5,244**

Average Monthly Number of Scheduled Visits at Clover House: **582.667**

TABLE 2
Number of Scheduled Visits at Clover House for 2009

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
536	486	546	559	520	581	509	496	516	558	466	498	**6,261**

Average Monthly Number of Scheduled Visits at Clover House: **521.75**

TABLE 3
Number of Scheduled Visits at Clover House for January–March, 2010

Jan	Feb	Mar	Total
444	419	407	**1,270**

Average Monthly Number of Scheduled Visits at Clover House: **423.33**

TABLE 4
Length of Time of the Scheduled Visitations at Clover House for April–December, 2008

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Total
1 hour	217	223	264	271	275	296	252	188	210	**2,196**
1½ hours	12	12	15	32	25	23	22	10	14	**165**
2 hours	275	318	348	333	352	290	338	316	313	**2,883**

TABLE 5
Length of Time of the Scheduled Visitations at Clover House for 2009

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
1 hour	181	188	231	225	192	166	120	98	123	188	144	143	**1,989**
1½ hours	9	7	21	15	9	14	13	12	3	4	9	31	**147**
2 hours	346	291	294	319	319	401	376	386	390	366	313	324	**6,261**

42% of the visits at Clover House are 1 hour in length, 3% of the visits are 1.5 hours in length, and 55% of the visits are 2 hours in length.

TABLE 6
Length of Time of the Scheduled Visitations at Clover House for January–March, 2010

	Jan	Feb	Mar	Total
1 hour	96	106	86	**288**
1½ hours	22	8	7	**37**
2 hours	326	305	314	**945**

TABLE 7

	2008		2009									
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Jan	Total
1× a week	97	35	35	49	45	45	27	38	37	40	35	**368**
2× a week	105	61	61	37	45	43	34	47	42	35	61	**404**
3× a week	6	2	2	1	3	1	0	2	2	3	2	**17**

ter, which is supported by wraparound reinvestment funds. Seneca is located in the heart of the Mission District in a family-friendly building. The center is decorated in a family-friendly manner and has different visitation rooms to fit the needs of the families who use its services. The visitation counselors who monitor visits are trained to remain neutral in their observations. They will not discuss cases, nor will they encourage or discourage relationships between parents and their children; however, staff do help facilitate good visitation experiences for families. From this service, it is expected that visitation counselors will gather unbiased information about families and will provide the information they observe to the social workers. Social workers will then use that information to assess families' needs and progress. This is in contrast to San Francisco's former visitation practice where visits were mainly conducted in visitation rooms with the capacity for 120 families.

In an effort to promote evidence-informed visitation practices, SF-HSA had a workgroup evaluate its current practices and need for change. During my visit, I was impressed with the interactions between the Center's staff and the service recipients. As part of their contract with SF-HSA, First Stop connects families with the FRCs, connecting families to a program that can provide ongoing visitation. Prior to the restructuring of the visitation program, therapeutic visits were provided for a fee under the supervision of clinicians. Additionally, in certain cases, SF-HSA paid general fund dollars directly to private agencies to have clinicians supervise visitations. This was due to the type of structure there currently is now in terms of referral review and clinical intervention.

They were able to accommodate about 50 families a month. They had limited access to the Family Resource Centers for visitation and they serviced 30. Caretakers also provide supervised visits.

I am a strong believer that visits need to occur as soon as possible after children are initially removed from their parents. Research tells us that visitation is among the top reasons why family reunification succeeds. Accordingly, SF-HSA hosted trainings called "Train the Trainer" for staff and partners with Rose Wentz, who trains on visitation around the nation, and developed their model with her consultation. BAA staff who attended "Train the Trainer" can now provide training to others on the model. Additional trainings were also held with George Doub and Margi Albers of the BAA.

Visitation was identified as an issue in the PQCR; therefore, budgetary considerations its protocol and policy. Budgetary concerns were an issue as the SF-HSA was using its general fund dollars and was not using matching revenue, such as Early Prevention, Screening, Diagnosis and Treatment (EPSDT). Additionally, the Controller's Office prohibited SF-HSA from providing a fee for service to private providers as they had been doing for a long time, since there was no contract in place to do so. These factors helped push the timeline to restructure visitation. However, it wasn't just the funding that was driving the new model: it was also an effort to improve outcomes, increase successful and more-timely reunifications, and reduce re-entries.

The EPSDT that supports therapeutic visitation is funded with a 5% match that SF-HSA work orders to CBHS. There are also additional dollars in place

to support the effort, including county funds that support clients who cannot access Medi-Cal and that support therapeutic visitation program evaluation, OCAP and other funds supporting visitation at the FRCs, and wraparound reinvestment dollars for First Stop.

CBHS staff assess children as they enter foster care and provide their recommendations to social workers as to what type of visits they deem appropriate. CBHS staff complete the CANS for all kids who enter care. CBHS also has clinicians working directly on visitation to help observe family interactions and to ensure there are appropriate program linkages and supports.

Early Prevention, Screening, Diagnosis and Treatment for the EPSDT FSC provides an EPDST match of $125,397 to CBHS for contracted clinicians and services. To be served under EPSDT, clients must be under the age of 21, must meet medical necessity, including a DSM-IV TR diagnosis, and must be approved by Foster Care Mental Health. Siblings may qualify for the services, as well as other care providers.

$2.5 million leveraged from EPSDT goes toward clinical assessments, intervention and supervised visits for families receiving family reunification services. Cases are discussed as needed in the weekly meetings with the therapeutic visitation providers, CBHS, and FCS.

One area that has been a challenge is determining what type of visitation services cases involving sex trauma will benefit from. CBHS and SFHSA continue to have ongoing conversations as to what visitation is most appropriate that will not harm the children involved.

Although San Francisco was below its federal standards, it improved its performance on all three of the reunification measures during the latest reporting period. The timeliness for reunification (C1.2) has improved for four consecutive quarters and it now exceeds the federal standard.

Santa Clara DFCS is below the federal standards on achieving reunification within 12 months. Santa Clara's SIP indicates that workers will be provided with detailed training for increasing child and family involvement in developing individualized case plans. Training is better when it is provided as part of a department's philosophy.

Recommendation for Santa Clara County

Given that more than half of the children in foster care are left alone once they reach the age of majority and that more than half end up becoming homeless, it is my recommendation that the county implement the following strategies:

- Enforce existing policies and encourage social workers to develop individual written visitation plans. The case plan should indicate where and when contact should happen and whether supervision is required.
- Involve parents in the development of the case planning that includes establishing regular meaningful contacts between children and their family of origin.
- Actively search for other visitation models across the nation.
- Since Santa Clara DFCS provides services to a multi-ethnic community, social workers should take parents' culture into consideration when they are observing visits.

Acknowledgments

I want to thank my Department Director, Lori Medina, and Jaime Lopez, Deputy Director, for presenting me with this opportunity. I would like to thank Liz Crudo from SF-HSA for her time and for all of the information she provided me with. I would also like to thank Frank Motta, Agency Project Manager, for his support. Special thanks as well to my program manager, Wendy Kinnear-Rausch.