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Respite Care for Children with Emotional / Behavioral Disorders in a Foster Care Setting

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MASTERS IN SOCIAL WORK THESIS

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Program Evaluation

Marcia L. Bolte

20 April 1994

MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
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CERTIFICATE OF APPROVAL

This is to certify that the Master's thesis of:

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has been approved by the Examining Committee for the thesis requirements for the Master of Social Work Degree.

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Abstract

Respite care for children with emotional/behavioral disorders in a foster care setting

Program Evaluation

Marcia Bolte

20 April 1994

The Time Apart respite program provides short-term, temporary care, outside the home of the primary caregiver. In the evaluation process, questionnaires were given to social workers and case managers whose clients have used the program and to licensed, specially trained, foster parents who provided respite services. The study was designed to answer the following seven questions: 1) What are the characteristics of the consumers of this program?; 2) Does the respite provider training address the needs of respite providers in serving the children in their care?; 3) Does the child information packet given to providers supply the information they need to provide care for a child on a 24-hour basis?; 4) Do respite providers feel supported by the coordinator and county staff with whom they are in contact?; 5) Are staff being served by the coordinator and respite providers in a satisfactory manner?; 6) What parts of the program need improvement?; and 7) Does teaming of parents and staff work? Findings indicate overall satisfaction from providers and increased need for communication between the program coordinator and Anoka County staff.

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CHAPTER I

Introduction

The purpose of this research study is the evaluation of a county-run program of respite care for families of children with emotional/behavioral disorders. This program is located in Anoka County, Minnesota and is funded through federal grant monies combined with county funds. At this point in time it is the only respite program in the state of Minnesota designed solely to provide respite care for children with emotional/behavioral disorders.

Statement of the problem

Families of children with emotional/behavioral disorders face a multitude of problems. They are often stressed financially by the added expenses of medical, psychiatric and other treatment interventions needed to aid their child. If the parental unit is intact, the marriage is stressed because of the added responsibilities challenging children bring to the relationship. Frequently, a family member, usually the mother, experience the stress of missed opportunities. For example, a mother may want to continue her education and must forego her schooling or quit school because she is unable to locate adequate child care for her child or, indeed, is unable to find anyone willing to care for her child.

In addition to the stresses placed on parents and other family members it is important to understand the difficulties the child with challenging behaviors experiences. Many of these children are bright, creative people whose behaviors and/or emotional disorders are obstacles which prevent them from experiencing successful peer relationships and keep them from achieving feelings of self-worth. Other children may avoid them and actions of adults in their lives can give these children the message that they are bad. For example, a child who experiences frequent moves from one daycare setting to another, due to his/her behavior, can interpret those moves as failure and confirmations that he/she is no good and unwanted. With each negative message the child's self-esteem suffers. The child, as well as the parent, needs reassurance and acceptance; an opportunity to experience success in his/her life.

When the family attempts to access services for its child, it often discovers the services available are fragmented and offer little or no continuity. The family may access a case manager responsible for developing a plan of service, but the case manager is unable to link it with services such as respite care to aid family coping.

The information the family gets is confusing and contradictory as well. Frequently these children, after visiting a number of professionals, will receive multiple diagnoses which change the complexion of services available because different interventions address different diagnoses. While the child may achieve access to one service because he or she is determined to have a developmental delay in one area, the child may not qualify because another diagnosis has been determined as primary. Thus, services for children with developmental delays are not available. The family is thrown into a catch 22 dilemma. Out of frustration, the family may even jump at the chance to have its child diagnosed and labeled with something in an effort to get any kind of help or recognition.

When, and if, the family accesses services it is confronted with a multitude of professionals whose input in the decision-making for the child may exclude the family. For example, in the development of an individual educational plan (IEP) for the child, the psychiatrist, the teacher, the case manager and others involved with the child may meet as a cast of thousands to decide interventions for the child with little or no input from the parent. Parents are thus forced to become avid advocates for their child while coping daily with the frustrations of rearing a child with a disability.

Now that parents have succeeded in receiving a label for their child and struggled with the myriad of professionals thrown into the arena, they must cope with an additional stress. They and their child may become stigmatized. Unlike the parent of a child with a visible handicap, such as Down Syndrome, the parent of a child with an emotional/behavioral disorder is often subjected to much scrutiny. The parent's ability to parent is in question.

If they parented differently would this child have this problem?

As a result of the stigma, the parent and child may become mired in a sense of hopelessness. The family becomes isolated. On the positive side, parents find out who their friends really are, but may have little or no time to access the comfort these friends may be to them because caring for their child takes so much of their time. The hopelessness these families may experience is compounded by fear for the future of their child. Because professionals, expect so much advocacy from them, they fear no one will be there for their child should something happen to them.

Families of children with emotional/behavioral disorders rarely meet current guidelines for respite eligibility unless the child has other presenting issues such as developmental delays or extreme medical problems. The parents, unable to access respite, are then faced with two alternatives: they can struggle on and continue to search for others willing to help or they must consider out-of-home placement. The first option frequently leads to despair and ultimately can lead to out-of-home placement as the only alternative.

The parent(s) begin to feel trapped which in turn, affects the entire family system. The parent(s) may begin to resent the child, may become overwhelmed with guilt for the resentment, may possibly conclude they are inadequate as parents or other children in the family may resent the amount of time the parents must expend caring for the difficult sibling. All of these factors combined with the inability to meet the needs of other family members create a situation rife with possibilities for abuse or neglect as well as parental health and social collapse. These families can be caught in a downward spiral of guilt, resentment and fear. This situation is additionally compounded by a judgmental society which often blames the parents for their child's behaviors; for example, Johnny would not be this way if his parents, particularly his mother, were better parents. The cost is both financial and personal.

At the county level, out-of-home placement is also a difficult and costly venture. Out-of-home placement of a child with moderate to severe behaviors can mean therapeutic foster care at a minimum cost of one thousand dollars per month; residential treatment center fees can be as much as one hundred dollars per day. These treatment fees do not include the additional cost of case management, medication management, psychiatric services and the like. If the family is able to access and receive respite services, the expense to the family and county agencies is minimal compared to out-of-home placement costs. According to Access to Respite Care and Help (ARCH) national resource center the average savings achieved through provision of respite care services versus institutionalized care, per child, is $49,000 per year (ARCH, 1994).

History of Children's Mental Health Services

Prior to the 1980's, coordinated efforts to address children's mental health issues were few and far between. In 1984 the federal Child and Adolescent Service System Program (CASSP) was established to assist states and communities in efforts to develop comprehensive services to meet the needs of families of children with serious emotional disturbances (SED).

In the late 1980's the Minnesota Comprehensive Adult and Children's Mental Health Act (MCACMHA) came into existence. Expansion of clinical services to serve seriously emotionally disturbed children and their families and development of new services was needed. Full implementation of all stipulations of the Act was set for January 1994. In 1992, the Child Mental Health Services Initiative (CMHSI), authorized by Section 565(f) of the Public Health Service Act was established to fund treatment services where states currently have an infrastructure to support community services.

More monies at the federal level have been appropriated for 1994. The appropriation for Children's Mental Health Services Program (Public Law 102-321) will be $35 million, a $30 million increase over 1993. The increase is intended to fund collaborative efforts of child advocate groups and agencies serving the special needs of children with SED and their families. To acquire some of these monies, states and communities must establish interagency systems of care with one case manager responsible for all agency services working with a family.

Under the MCACMHA, counties are mandated to expand services and offer case management, community support services and day treatment to all eligible children. These services must be child centered which means they should be fitted to the unique needs of a particular child and his/her family. They must be family focused; this is a systems approach to address the needs of the child and family within their particular community. They are to be community based, using whatever least restrictive services are available within the child's community appropriate to the child's needs. The services offered must also be offered in a mode which respects the child's cultural and ethnic identity.

On March 1, 1993, Informational Bulletin #92-53A from the Minnesota Department of Human Services (DHS) addressed the "adoption of Rule 79 governing case management for adults with serious and persistent mental illness and children with severe emotional disturbances...". One of the provisions, under this rule, is the development of an individual family community support plan (IFSP).

The services provided in the IFSP could include any of the following, dependent upon the needs of the child:

1) Acute care hospital inpatient treatment
2) Day treatment programs (a structured program of treatment and care in an outpatient hospital, community mental health center which provides group therapy and other therapeutic services).
3) Early identification and intervention services.
4) Emergency services (a 24 hour, 365 day, on-call response service to meet mental health crises)

5) Residential treatment services
6) Functional assessment
    a. mental health needs
    b. drug or alcohol use
    c. vocational or educational functioning
    d. social functioning
    e. self-care skills
    f. medical and dental needs
    g. financial need
    h. housing or transportation needs
    i. other
7) Consideration of local resources
8) Medical Assistance eligibility
9) TEFRA eligibility
10) Outpatient services (could be individual, group or family therapy, medication management, additional psychological testing)
11) Diagnostic assessment
12) Home-based family treatment (intensive mental health services provided in the home environment, includes child and family)
13) Respite or child care services
14) Special mental health consultant (to address cultural or ethnic uniquenesses)
15) Therapeutic foster care

This list is a summary of MCACMHA (1989, 245.462. Subd. 11a).

History and description of Anoka County Time Apart Respite Program

In October, 1991, Anoka County Social Services submitted a grant application to the state of Minnesota. The grant monies pursued were funded under Title II of Public Law 99-401, 42 U.S.C. 5117, et seq., the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act of 1986.

Funds derived from this grant were intended to develop and implement respite care services for children with emotional disturbances, respite care which would be provided in foster care settings. At the time of grant application, few respite care homes were available in Anoka County for children with emotional disorders. The goal of the proposed program was to develop and retain respite care homes in Anoka County for children who have emotional disorders.

<u>The components of the proposed project included:</u>

1. Hiring of a 30 hour a week respite care coordinator to:
    a. coordinate recruitment, training and matching of providers with clients
    b. recruit and identify respite care homes
    c. license respite care homes
    d. coordinate marketing of respite program
    e. report program process and progress to funding agency
2. Specialized training for respite providers
    a. twelve hours of specialized training in:
        1. child development, developmental disorders in children
        2. child first aid and medication management
        3. non-violent restraint and de-escalation techniques of behavior management
        4. provider self-care

    A series of trainings to be offered on a quarterly basis throughout the year.
3. Group support for respite care providers which would combine support and an on-going educational component.

The need for respite care was identified as a preventative intervention to avoid the need for out-of-home placement of children with emotional/behavioral disorders. Family Service supervisors and families indicated a great need for this service. At the time of proposal submission, approximately 30 children on open caseloads were identified by Anoka County Children's Mental Health unit as in need of respite care. The Anoka County family intake supervisor reported at least two families a week could benefit from respite care. At that time also, the new Anoka County Crisis Nursery, three months in existence, indicated at least six families of children with emotional/behavioral disorders had contacted them and could benefit from respite care services.

Although the exact number of children in Anoka County with an emotional/behavioral disorder was unknown, statistics from the Minnesota Department of Human Services, Mental Health Division, indicated approximately 1 child in 8 (11.8%) on a National level has an emotional/behavioral problem limits his/her capacity to function.

According to the 1990 census, Anoka County had 74,369 children between the ages of 0-17. Extrapolating from the national average of 11.8%, Anoka County could expect 8,776 children had emotional disorders. In response to the perceived needs, Anoka County, in its continuing efforts to offer quality services to children and to prevent institutionalization whenever possible, sought to develop respite care services.

In February, 1992, 3 year-funding for the Anoka County Time Apart respite care program was granted. Program development began and in October 1992, the program began to accept referrals for respite care services.

CHAPTER II

Description of the Time Apart Respite Program

Time Apart is a planned respite care service. The service is offered to families of children with emotional/ behavioral disorders ages 0 - 18. Respite care is provided in licensed, specially trained foster homes. Families are allowed 30 days respite care per calendar year. Respite care generally occurs on a weekend; weekends generally begin Friday evening and end Sunday afternoon. This Friday to Sunday time is considered to constitute 2 days of respite, therefore families are allowed 15 weekends per calendar year respite care, or approximately once every 3 to 4 weeks. If a family has more than one child with an emotional/behavioral disorder, each child's respite is determined as separate from his/her sibling; thus each child is allowed the maximum number of days of respite per calendar year.

Although respite is primarily on a planned basis, upon agreement from respite providers, unplanned emergency respite may occur.

PROGRAM STAFF

The Time Apart program currently has 12 licensed foster homes which provide respite care services to the families of children with emotional/behavioral disorders.

The program coordinator is contact/support person for the respite providers. The coordinator is responsible for licensing foster homes, contracting services for marketing, advertising, and contracting with private agencies in Anoka County for support services, as well as recruiting providers. Currently, the Time Apart program holds a contract with Central Center for Family Resources to provide a trained counselor to facilitate an educational support group for its respite providers. In addition, the coordinator serves as the referral contact person, maintains the waiting list and is responsible for matching client families with respite providers.

The current coordinator and author of this thesis, Marcia Bolte, is a licensed social worker with paid experience as a foster parent, a social worker for special needs clients and a crisis family counselor.

Training of respite providers

Respite providers receive 12 hours of specialized training, in 3 hour segments, on 4 consecutive Wednesdays. Training sequences are offered 4 times a year on a quarterly basis. Individual presenters are contracted by Wilder Child Guidance, Northwest Branch. Anoka County contracts with Wilder for this service. Terms of the contract include contracting with presenters, scheduling rooms and provision of child care.

The topics featured in the training include:

Week 1: Child development and case study of children with emotional/behavioral disorders.

Week 2: Child First Aid and Medication management. (Many of the children in the program receive some type of medication to treat their disorders.)

Week 3: Behavior Management, non-violent restraint and de-escalation techniques, and basic physical blocking (trains participants to deflect blows, disengage bites or dislodge hands from hair pulling).

Week 4: Provider Self-Care. Understanding support systems, information about provider support group which meets 1 time a month, relaxation techniques and issues of client confidentiality and the provider's role as a mandated child abuse reporter.

In addition the the specialized trainings provided by the Time Apart program, providers have the opportunity to attend trainings offered to the general foster parent population. These trainings include topics such as: child abuse, the first placement experience, cultural diversity and the like.

Payment for respite

The cost of respite to families is determined on a sliding fee scale (see appendix, pp. 91-92). Families receiving Aid to Families with Dependent Children (AFDC) are exempt from payment. These payments are offset by county and grant funds.

Referral process

Referral to respite services is received through current case managers or through child intake services. Families entering through child intake, requesting respite alone, are given case management services for respite only.

Respite criteria

Criteria for consideration of child's eligibility for respite care are as follows:

- Anoka County resident
- Children ages 0 - 18 who are emotionally disturbed and may exhibit behaviors such as: being abusive to self or others, being disruptive at home or school, being excessively shy or withdrawn, being depressed, being anxious or having other behaviors which create excessive stress. A child may exhibit just one of these types of behaviors or some combination of them.

Placement process

Upon referral to the respite program, the coordinator meets the child and family and identifies the individual needs of the family. The respite coordinator then matches the child and family to the most appropriate respite care provider and a pre-placement visit is arranged. The respite program coordinator and the child's social worker or case manager accompany the family on this visit. During the pre-placement visit, the family and provider become acquainted and, together, decide if respite in that home is satisfactory to all parties. Once a match is made between the client family and the provider family, the child, barring any unforeseen incidents, will receive respite from that family on a consistent basis. From this time forward, families and respite care providers work together to develop a respite plan for the child. It is believed this partnership of parent and provider is a more user friendly, respectful process. The respite coordinator and case manager are available to provide on-going support to parents and providers.

Required paperwork

Families using the Time Apart program are required to contact the county collections department to be assessed for determination of their portion, if any, of respite payment. They must also sign a voluntary placement contract and are required to provide information in a child informational packet (see appendix, pp. 75-90), which a provider uses while the child is in respite placement. For example, parents are required to supply emergency information which includes: Child's physician's name, address and phone number, psychiatrist's name, address and phone number, dentist's name, address and phone number, social worker's name and phone number, child's blood type, child's weight, preferred hospital, insurance company and policy number, and name, phone number and relationship of a person or persons to be contacted if parent is unavailable. In addition, parents must designate a person or persons authorized to pick up the child and must include the designated person's relationship to the child. The parents are also asked to sign a release of consent for medical treatment. The emergency information form can be found in the appendix, page 79.

CHAPTER III

Literature Review

The key components of the Time Apart respite program are families of children with emotional/behavioral disorders, licensed foster care parents, training of licensed foster parents, out-of-home respite, teaming staff and families to work toward helping the child and family, and supporting foster providers whose homes are used for respite care.

An issue of concern is the stress which leads families to seek respite care. Family theorists indicate a number of factors such as the family's resources for handling hardships, the family's perception of the hardships, the family's lack of social contacts and relationships, and negative attitudes toward the child who is disabled and the family among the issues which impact the stress levels of families with children who are handicapped (Summers, Turnbull & Brotheson, 1985).

The literature search for materials uncovered very little written about respite programs specifically designed for children and adolescents with emotional disorders. Much of the literature addresses issues, principles, programs and research about respite care developed for other populations. However, much of this information appears to be relevant to families of children with emotional disorders.

Common themes found in the literature are discussed below.

History of blaming the family for the child's problems

Historically, families have been blamed for the mental illnesses of family members. During the Jacksonian Era, the cause of mental illness was viewed as the faulty organization of the community and the family (Rothman, 1971). Prior to the civil war era, the family was seen as the last bastion of hope to protect children from the negative influences of the greater society (Rothman, 1971, p. 121).

In the 1930's and 1940's the family was still seen as the garden in which the seeds of mental illness were sown but a new twist was added. Families became the target for change along with their family member (McCrea 1910). In addition, with the dawn of the psychodynamic view of mental illness the mental health community began to identify specific causes of an individual's disturbance. For example, under the influence of Freudian psychology, the schizophrenogenic mother was said to be the cause of her child's schizophrenia (Fromm-Reichman, 1948, Stehno, 1986). In the 1950's and 1960's, general family therapy theory saw family transactions as leading to the development of mental illness (Woesner, 1983).

A study of clinical mental health journals, published from 1970 - 1982 indicated, of the

> "125 articles in the study, mothers were held responsible for 72 different kinds of psychological

> disorders in their children, ranging from agoraphobia to arson, hyperactivity to schizophrenia, premature mourning to homicidal transsexualism. In the articles, not a single mother was described as emotionally healthy although some fathers were" (Caplan, 1986, p. 70).

Blaming parents for their child's psychological problems has a long-respected history, particularly in the mental health community (Breckinridge, 1924, Bremner, 1971, Kantner, 1985, Caplan, 1986, Pelton, 1992).

Parents vs. Professionals

Attitudes of professionals are changing but historically, parents were not included in the treatment program for their child. They were excluded from involvement by mental health professionals at every turn (Knitzer, 1975). When parents were finally included in the treatment process in the 1920's, the only parent generally seen was the mother (Grotberg, 1976).

Later, mid-twentieth century, parents were allowed their perceptions of the ills of their child, but if they disagreed with professionals they were disregarded. In addition, their disagreement was seen as proof of their inability to see clearly and affirmed the professional's view of them as dysfunctional (Knitzer, 1975, Grotberg, 1976 & Terkelsen, 1983).

Current scientific research has begun to supplant the view of parental responsibility in children's disorders to an understanding that some, if not many, of these disorders have a physiological genesis (Beels, 1985). Though some reluctance to recognize the competency of parents still exists, attitudes of professionals are changing due to pharmacological, neurophysiological, and genetic research. It is not so easy to blame parents for problems that may be biologically based (Beels, 1985).

Recent legislation has also aided in the struggle between parents and professionals. Passage of P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, set the stage for case planning with parent involvement (Stehno, 1986).

In addition to opening the door for parent involvement in case planning for his/her child, P.L. 96-272 also supported the permanency planning movement. "Permanency planning is the systematic process of carrying out, with a brief time-limited period, a set of goal-directed activities designed to help children live in families that offer continuity of relationships with nurturing parents or caretakers and the opportunity to establish life-long relationships" (Pecora, Whittaker, Maluccio with Barth & Plotnick, 1992, p. 318). According to Fein and Maluccio (1982), permanency planning should begin before a child is removed from the home (p. 338). The goal of the system must be caring for the child in the least restrictive environment which is best suited to meet his or her needs (Stehno, 1990).

Although professional attitudes and legislation are moving away from blaming parents, the problem still exists. As parents are given, and accept, blame for their child's problems, the family may become isolated from the larger society.

Isolation of the family & family relationships

As families accept the blame given them for their child's disorders their sense of guilt and the reactions of the general public cause them to withdraw from society. As social contacts lessen, the family moves farther from the center of society to the position of an outsider looking in. They may even view themselves and their families as pariahs to their own communities. (Bernheim & Lehman, 1985).

Problems arise within the family as well as outside the family. The child(ren) with emotional/behavioral disorders may come to be seen as proof of parental failure because the child(ren) cannot meet societal expectations (NASW, 1987).

Family Stress

Parents may become so trapped in their caretaking roles that they have time for few, if any, social interactions (Bernheim & Lehman, 1985). Families often feel that holding onto a social support system is more trouble than it is worth. When families lack this outside support, caring for their child can become a draining focus in their lives (Bernheim & Lerwine, Beale, 1982, 151). This draining can negatively impact family members' ability to cope without a break from caretaking, they must still meet the needs of their disabled child while adjusting to the changing life styles and development of their other family members (Berhneim & Lehman, 1985).

The family is not allowed a homeostasis because each of its members, as they develop, bring new issues to be explored and new adjustments to be made within the family. As with most families, they are in a continuous mode of flux. Unlike many families, they may not have the social supports to see them through (Bernheim & Lehman, 1985). In addition to lack of social supports the family must acclimate to the child's disability.

Adjusting and learning to accept their child's disability involves many of the same elements as the grieving process except each new event in the family's development may recycle the grief reaction of family members (Summers, 1985).

The multiplicity of needs the child with special needs presents to families tends to increase the stressors in families. Unless given a break from caregiving and the reduction of stress accompanying this intervention, the quality of care the child receives can be decreased and the child can become at risk for neglect or abuse (ARCH 32 Jan. 1994).

Effects of Stress

Family stress differs from other forms of stress because, from a systems perspective, stress on one member of the family affects all members of the family (Curran, 1985). In systems theory, the family's interactions with social networks, business, government, communities, nations and the biosystem all impact the coping abilities of families (Flach, 1988).

As stress increases, with little or no relief, caregivers, family and child can experience somatic complaints such as stress-related illnesses. As the stress and strain continue, various signs of breakdown or illness of a physical or mental nature can manifest (U.S. Dept. of Health & Human Services, 1981). In addition to the stress are emotional and behavioral difficulties in other family members, child or spousal abuse, dissolution of marriages, physical and verbal aggression, anger, loss of patience and a morbid sense of helplessness (Zastrow & Krist-Ashman, 1987).

To address the family's stress, two types of coping modes in families. The first mode is "transformational" coping in which the family has the ability to recognize incidents of stress as not as bad as they seem. The second mode of coping is "avoidance" which becomes a continuous cycle of denial (U.S. Dept. of Health and Human Services, 1981).

The family's ability to cope with future stress can be compared with previous coping experiences from the family's past; the more success experienced the more likely the family will withstand the current stresses. However, the family's ability to successfully cope can be undermined if the family becomes absorbed in comparing its successes or failures to those of other families. If the family sees itself as inferior to others it can become trapped in a cycle of self-fulfilling prophesy in which one failure leads to another (U.S. Dept. of Health and Human Services, 1981).

The family system

In addressing the needs of families of children with disabilities, it is important to understand that the whole family, not individual members, is affected positively and/or negatively by the disability of one or more members. Linear causality, in the traditional perspective, would see a sequencing of effects from the disability. Systems approach, on the other hand, looks at the "circular reflexive effects"; as each family member's actions and reactions create change for other family members. This action/reaction process can be defined as a positive feedback loop when the actions of one member increase the probability of other members repeating or escalating their own behaviors (Sprey, 1980).

The family caught in a feedback loop which is unhealthy for the family, may need to turn to professionals to assist them.

Family Process

To understand the needs of the families of children with emotional/behavioral disorders it is important to look at the process the family goes through in adjusting to its child's disability. The adjustment process involves 1) crisis, 2) information/education, 3) social skills development, 4) emotional support, 5) task oriented activities. (Olson, 1988). By the time a child's problems become serious enough to arouse the attention of professionals, the problem has likely reached crisis level. Stabilizing the family must occur at this point through the use of interventions which meet the immediate needs of the family. Other, more far reaching interventions may not be helpful at this point (Olson, 1988).

There are many conceptions of family therapy, but no matter which type of family intervention is used, as long as it ignores the family's stated needs, the same predictable outcome is apt to occur. The parent's level of guilt, anxiety and frustration is increased and the level of coping ability decreases (Johnson, 1986, Bernheim & Lehman, 1985).

Service Needs

Professionals frequently look at long term goals in working with these families. Professionals tend to plan for the family's future rather than focus on current issues within the family. The focus of intervention with families of children with disabilities must be turned from the professional's perceived needs of the family and redirected to interventions more suited to crisis situations. As in Maslow's hierarchy, the basic needs of the families must be met before going on to address the larger picture (Zastrow & Krist-Ashman, 1987). Prevention programs must also be cognizant of the needs of low-income families, issues of race and culture, gender, single parenting, etc. The services provided need not be complex. Help in day to day needs will go far to start the family on the road to better things for all members. In one study, both parents and children alike named these types of concrete services as the most helpful they could receive (Nelson & Deutelbaum, 1990, p. 7). Family therapy will not be seen as a solution to a family who has difficulty meeting the everyday demands of living (Pelton, 1992).

If children are to remain in the home, one of the concrete services to assist that goal is respite care. In Anoka County, respite care is provided by licensed foster parents, specially trained to serve the needs of children with emotional/behavioral disorders. This type of family-centered service brings a holistic focus to service delivery. This focus includes social workers, their supervisors, and the community as players in meeting the child's needs and those of his/her parents (Nelson, 1985).

Parental Needs

Parents need to become educated, or receive education from professionals, regarding their child's emotional/behavioral disorders. They need help accessing and getting through the system. They need training and help in developing skills to cope with their child's unique needs and they need service providers who are compassionate to their issues who will support their efforts in their journey to adjustment (Knitzer, 1982).

Family Support

Family support needs to begin with a goal of prevention. Families must be supported in their efforts to achieve a higher level of functioning while remaining intact. Human service policies and fiscal interests continue to look to sources outside the family to address family needs. Placing children outside the home has been a recurring objective in meeting that goal (Pelton, 1992, Stehno, 1986 & 1990).

Current legislation has begun to address prevention services which help to maintain the child within the home while seeking to reduce the safety risks of children in the home (Omnibus Budget Reconciliation Act, 1993).

Along with services which seek to ensure that the family remains intact, the services must also give families a sense of self-determination (Syracuse University, 1987). In addition, further consideration must be given to current definitions of the word family. The definition of family differs from culture to culture and includes not only biological parents but also all primary caregivers for a child or children. One type of family to be considered is the foster family.

Foster Parents as recipients of respite care

Historically, foster parents have been excluded from using formal respite care services. This can lead to burn-out and result in the need for continual recruiting and training of new providers. If foster parents can be allowed use of formal respite, the stresses they experience in caring for challenging children can be lessened and increase the probability they will continue to be foster parents. Human service agencies are beginning to see they can reduce expenditures in recruitment, training, and licensing if they provide respite services to foster homes as well as biological and adoptive homes (Federal Family Preservation and Support Services, 1993 & ARCH 32 Jan. 1994).

In the Time Apart respite program, foster parents are not excluded from using respite care; although not many have accessed the program for their own needs. Not unlike biological or adoptive parents, foster parents need a break from time to time. Until recently, respite care was not funded for foster parents. They have been expected to pay for their respite care from personal funds. This lack of sensitivity to the needs of foster parents, in maintaining a home for their foster child, has compounded the difficulty of recruiting and retaining foster homes in a time when they are sorely needed.

Currently, human service agencies recognize respite as a cost-effective way to help ensure the quality of care in foster homes, to reduce multiple placements of children and to lower the resultant costs of recruiting, training and licensing new foster homes. The new federal Family Preservation Support Services legislation passed in August, 1993, specifically targets foster and adoptive parents as eligible for respite care and should provide additional funding in this area (ARCH 32 Jan. 1994).

Times are changing. The number of families available to provide foster care is being reduced by societal pressures and economic realities which preclude the ability of mothers to stay at home. An additional element is introduced when one understands the increasingly difficult role of foster parents which requires specialized training. Finding families willing to make the sacrifices needed to provide quality care for children outside of their own family is becoming increasingly problematic (Stehno, 1990, p. 555).

As the difficulty of recruitment increases it becomes more important to look at how an agency can retain foster parents. According to ARCH 32 Jan. 1994, high provider retention serves a number of positive purposes for the respite program:

- Low turnover saves hiring and training many different providers.

- Families want consistency in providers to build trust and confidence.
- Providers increase their skills and experience the longer they work for the program. (p. 2)

The skills of foster parents can be enhanced by providing specialized training to address the needs of challenging children.

Training Foster Parents

Foster parents who receive specialized training are more likely to be prepared to meet the unique needs of the children in their care. Training must include what to do as well as what to avoid. Information about children's rights must be a component in this training. With good training and support, the possibility of burnout is lessened and foster parents can continue their competent care of children (Daly, 1992).

Definition of Respite Care and its benefits

Respite care is the provision of short-term, temporary care with the primary purpose of offering relief to the families of persons with disabilities. Respite care, in this context, is frequently an element in a continuum of care intended to provide the least restrictive, least intrusive type of service necessary to help the family maintain the child in his/her own home. Respite care is one service that enhances this possibility According to an evaluation conducted by Access to Respite Care and Help (ARCH) national resource center for Crisis Nurseries and Respite Care Services:

> "A majority of families serviced reported a high level of satisfaction with the services provided. The positive outcomes reported included: receiving a needed break from caregiving, being able to spend more time with other family members, an increase in the child's independence, stress reduction, improved quality of life, and prevention of out-of-home placement" (ARCH 31 Jan., 1994, p. 2).

The tide toward out-of-home placement is abating, as evidenced in the federal Family Preservation and Support Services part of the Omnibus Budget Reconciliation Act of 1993, a new subpart of the title IV-B, the Child and Family Services program of the Social Security Act. Prevention services for families are typically services designed to help families alleviate crises that might lead to out-of-home placement of children; to maintain the safety of the child in their home. "All children, regardless of disability, belong with families and need enduring relationships with adults. Families should receive the supports necessary to maintain their children at home. Family supports should maximize the family's control over the services and supports they receive" (Syracuse University, 1987, p. 2). If these supports are to be made available to families, monies must be found to fund these services.

Respite funding

The majority of the monies alloted to children's mental health are budgeted to residential or hospital treatment as opposed to in-home services (Pelton 1992). Considerable savings are to be realized in focusing on respite services as opposed to institutional care for children with disabilities (ARCH 31 Jan., 1994). Professionals and parents must combine efforts to increase awareness among legislators regarding the cost-effectiveness of respite over out-of-home placement.

Teaming parents and professionals

Teaming parents with providers and other professionals can be seen as a type of partnership. This type of union would be comprised of respect, caring, honesty and equal responsibility (VanDenBurg & Donner, 1986). If such a union is formed, with parents seen as the experts on their particular child, a common goal can be decided upon and acted on by all (Bernheim & Lehman, 1985, & Kantner, 1985).

Social Work Values

To operationalize social work values we see both parents and children need to gain from the service that is provided. Social work seeks to aid clients in attaining their full potential and achieve their own sense of self-determination (Carroll, 1977). Advocacy and brokering are two skills social workers can implement to help families of children with disabilities achieve a higher level of functioning.

Chapter IV

Research Questions

1) What are the demographic characteristics of the consumers of this program?
2) Does the respite provider training address the needs of respite providers in serving the children in their care?
3) Does the child information packet (See appendix D, pp. 75-90), given to respite providers, supply the information they need to provide care for a child on a 24-hour basis?
4) Do respite providers feel supported by the coordinator and county staff with whom they are in contact?
5) Are staff being served by the coordinator and respite providers in a satisfactory manner?
6) What parts of the program need improvement?
7) Does teaming of parents and staff work?

Definition of Terms

Respite care services means "temporary services provided to a person due to the absence or need for relief of the person's family member or legal representative who is the primary caregiver and principally responsible for the care and supervision of the person. Respite care services are those that provide the level of supervision and care that is necessary to ensure the health and safety of the person" (Sec. 8, Subd. 15, Minnesota Statutes 1990, section 245A.02).

Emotional disturbance is defined as follows:

A condition exhibiting one or more of the following characteristics over a long period of time to a marked degree, which adversely affects educational performance:

a) An inability to learn which cannot be explained by intellectual, sensory, or health factors.

b) An inability to build or maintain satisfactory interpersonal relationships with peers or teachers.

c) Inappropriate types of behavior or feelings under normal circumstances.

d) A general pervasive mood of unhappiness or depression.

e) A tendency to develop symptoms or fears associated with personal or school problems.

(Federal Education for All Handicapped Children Act [Public Law 94-142], 1975).

CHAPTER V

Methodology

Research Design

The evaluation of the Time Apart program involved the collection of qualitative as well as quantitative data. The evaluator was interested in discovering which elements of the program were working well and which were in need of improvement. Review of current literature indicated specific areas of family and provider needs, such as support and education. Therefore quantitative information was explored through the use of ordinal scales.

The evaluator of the program was the respite care coordinator. Anoka County social services sanctioned the evaluation of this program. The evaluation was implemented to meet two specific needs. Foremost, the evaluation was conducted to meet federal funding requirements and secondly to meet Masters program requirements for Augsburg college.

The units of analysis were Anoka County social services staff who had referred clients to respite service and whose clients had received respite care in the Time Apart program. The other subjects involved were licensed, specially trained, respite care providers who have provided respite for the Time Apart program.

The questionnaires, given each respondent groups, were designed to address issues specific to the consumer or provider status of the respondent.

Sampling

The selection of subjects was criteria based. The county staff surveyed were social workers and case managers who have referred clients to the Time Apart program and whose clients have used the service. The respite providers surveyed were only those respite providers who have provided respite through Time Apart. Surveys were given to 10 county staff persons, 3 of whom responded. Surveys were given to 12 respite providers, 8 of whom responded.

The number of staff responses was quite small thus the responses may not be indicative of the results of a fuller participant response. The respite provider responses, because the high response rate are likely to be representative of the entire provider population of the Time Apart respite program. However, the evaluator does not know what the responses of the other 4 respite providers who did not return questionnaires would have been.

At the inception of this evaluation the decision was made, by the evaluator, for puposes of this thesis, to survey the client families at a later date. It was determined the evaluation would be too lengthy. Thus two of the possible three survey populations were studied.

Instrument design

Two ordinal scales were used in the questionnaires distributed to elicit quantitative information. The scales were designed on a 1 to 5 scoring, 1 indicating the subject strongly disagreed with the statement and 5 indicating the subject strongly agreed with the statement.

The qualitative portion of the questionnaires used open-ended questions requesting subject suggestions and impressions of various components of the respite program. Questionnaires are located in the appendixes, pp. 71-73.

Data Collection

The study was conducted in March, 1994. Questionnaires were sent to the county staff who have referred clients throughout the existence of the program, and to all respite providers who have provided care since the beginning of the program. A self-addressed, postage paid, envelope was included for survey returns. Respondents were given 2 weeks to complete and return surveys to the evaluator.

In addition to information received from the questionnaires, the coordinator reviewed program records for information on characteristics of the families who have received respite through the Time Apart program. This information included demographics such as age of child, sex of child, race of child, number of days of service the family received, number of persons in the household of the child, number of adults in the child's home, family income and payment mode used by the family. In addition, the coordinator was interested in discovering the dominant clinical diagnoses of child participants. Although criteria for respite care use is not dependent upon a diagnosis, many of the children served have at least one presenting diagnosis.

Ethical protection

A letter of explanation of the study accompanied each survey sent. Respondents were not required to respond and questionnaires offered no indicators to trace respondents to their responses (see appendix, p. 74).

Analysis

Conclusions to be derived from the study came from a combination of descriptive statistics and exploratory data analysis. The descriptive statistics were used to define the service population and the exploratory study was implemented to elicit additional information from respondents which the evaluator may not have entertained prior to receiving findings in this study. Tables were used to portray various socio-demographic characteristics of the children and parents in the client population.

The questionnaires were processed and screened by the coordinator for common themes and patterns in responses. Some of the information received in the qualitative portion of the questionnaire was found to be useful information which was not pointedly addressed in the questionnaire.

Chapter VI

Findings

Quantitative findings

Characteristics of the client population

During the period October 1, 1992 to March 1, 1994, 45 children from 41 families received respite care through the Time Apart respite program. A socio-demographic study of the clients served produced the following information: The average age of the children served, at time of referral, was 9.75 years old (Table 1.1); 19 females and 26 males (Table 1.2).

Racial/ethnic distribution of the client population was: Caucasian 91%, Native American 7% and Bi-racial 2% (Table 1.1). These ratios are consistent with the general population distribution of Anoka County.

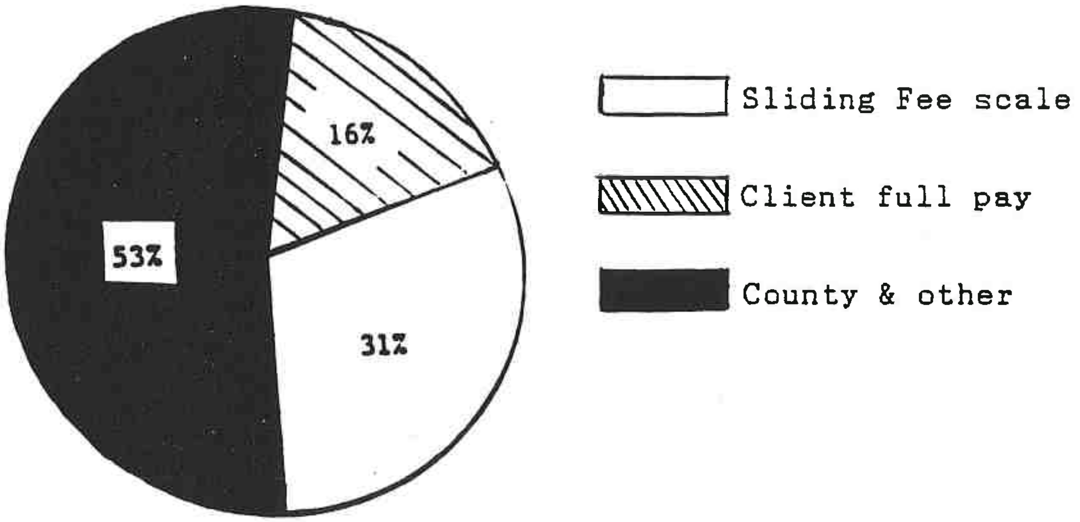
The median number of respite days used, throughout the program's existence, per child, was 11.5, the least number of days used was 1 and the most number of days used used was 23. The average size of the family whose child received respite was 3.4 (Table 1.1). Thirteen single parent families and twenty-eight two parent families were served (Table 1.3).

Family income range of the client population was less than $10,000 to greater than $80,000 per year (Table 1.4). The payment methods of families receiving services are divided into three categories, sliding fee scale, client full pay, county funds (includes adoption subsidies, Aid to Families with Dependent Children (AFDC) and Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)(Table 1.5, a plotting of methods of payment and number of families using each method and figure 1, graphic of the distribution, by percentage of payments for respite care).

Adoption subsidies are funds available to adoptive parents of handicapped children and Tefra is an array of services to handicapped children paid by Medical Assistance (M.A.) regardless of the parent's income.

Distribution, by percentage, of payments for respite care Time Apart Respite program, October 1, 1994 to March 1, 1994.

Figure 1



The diagnoses and gender distribution of diagnoses can be seen in Table 2. Of the males who received respite care, 77% (N=45) had the diagnosis of Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder, 42% (N=45) of the females had that diagnosis. A greater number

Table 1.1
Socio-demographics of children and families who used the Time Apart respite program: October 1, 1994 to March 1, 1994

Age	Gender	Race	Service Days	#in Family	Adults in home
3	M	C	4	2	1
3	F	C	1	2	1
4	F	C	11	4	1
5	F	C	3	4	1
5	M	C	1	2	1
6	F	C	10	2	1
6	M	C	5	3	1
6	F	C	3	3	1
6	M	C	2	3	1
7	M	C	23	4	1
7	F	C	6	4	2
7	M	C	5	4	2
7	M	C	1	2	1
7	M	C	3	2	1
8	M	NA	4	4	1
8	F	C	1	3	1
9	F	C	2	3	1
9	M	C	3	4	1
9	M	C	7	3	1
9	M	C	7	4	1
9	F	C	6	2	1
9	F	C	2	2	1
10	M	C	1	2	1
10	M	C	1	4	2
10	M	C	3	3	1
10	M	NA	4	4	1
10	M	C	2	5	2
11	F	C	3	3	1
11	F	BI	2	2	1
12	M	C	4	5	2
12	M	C	8	6	2
12	M	C	4	4	2
12	M	C	2	3	1
13	M	C	17	2	1
13	M	C	5	4	2
13	M	C	14	3	2
14	F	C	16	4	2
14	M	C	13	3	1
14	F	C	4	4	2
14	F	C	2	4	2
14	F	NA	4	4	1
14	F	C	16	5	2
15	F	C	6	3	2
15	F	C	1	6	2
17	M	C	4	5	2

C=Caucasian (91%) NA=Native American (7%) BI=Bi-racial (2%)

Average referral age = 9.75 Median # of days respited = 11.5
Average family size = 3.4
See Tables 1.2 & 1.3 for Male/female & Adult #s

Table 1.2
Age and gender distribution of children respite through the Time Apart respite program October 1, 1992 to March 1, 1994.

Age	Female	Male
0 - 2	0	0
3 - 5	2	2
6 - 8	5	7
9 - 11	5	8
12 - 14	5	8
15 - 18	2	1
	19	26

Table 1.3
One adult and two adult households of children using respite through the Time Apart respite program October 1, 1992 to March 1, 1994.

One Adult	Two Adults
13	28

Table 1.4
Income of families using the Time Apart respite program October 1, 1992 to March 1, 1994.

Level of Income	Number of Families
Less than $10,000	12
$10,001 - $20,000	11
$20,001 - $30,000	6
$30,001 - $40,000	6
$40,001 - $50,000	5
$50,001 - $60,000	0
$60,001 - $70,000	0
$70,001 - $80,000	0
Greater than $80,001	1

Table 1.5
Method of payment of families using Time Apart respite program October 1, 1992 to March 1, 1994

Method of payment	Number of families
County Pay & Tefra	23
Sliding Scale	11
Client Pay	7

Table 2

Diagnoses and gender of children who received respite care through the Time Apart respite program October 1, 1992 to March 1, 1994. (n=45)

Diagnosis	Males	Females	Total
*ADD/ADHD	20	8	28
High functioning Autistic	2	0	1
Borderline Personality	0	1	1
Cyclothymic	2	0	2
Depression	0	3	3
Oppositional Defiant	2	3	5
**Post-Traumatic Stress	1	4	5
Tourette's Syndrome	3	0	3
No Diagnosis	3	3	6
***Totals	32	22	54

*Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder

**Post-Traumatic Stress Disorder in all of these children is the result of sexual abuse.

***Note that the totals are not consistent with the 45 children who received respite because some of these children have multiple diagnoses.

of males than females suffered from Tourettes Syndrome and a greater number of females than males suffered from depression and/or post-traumatic stress disorder.

Respite provider responses

Respite provider overall satisfaction with the amount of support received from the program coordinator indicated 12.5 percent (N=8) agreed and 87.5 percent strongly agreed with the statement, the coordinator was supportive. Regarding supportiveness of the training staff, 100 percent (N=7) of those responding strongly agreed, one person did not respond. When asked if interaction with other providers was helpful, 66 percent (N=6) of those responding were neutral, 16.6 percent agreed and 16.6 percent strongly agreed.

Table 3
Statement: The coordinator was supportive.
(n=8)

	1 Strongly disagree	2	3	4	5 Strongly agree
Number				1	7
Percentage				12.5	87.5

Table 4
Statement: The training staff were supportive.
(n=7)

	1 Strongly disagree	2	3	4	5 Strongly agree
Number					7
Percentage					100

Table 5

Statement: Interaction with other providers was helpful. (n=6)

	Strongly disagree 1	2	3	4	Strongly agree 5
Number			4	1	1
Percentage			66	16.6	16.6

33.3 percent (N=6) of the providers were neutral on the trainings, 33.3 percent agreed they were useful and 33.3 percent of those responding strongly agreed with the usefulness of the trainings. When asked if providers were prepared before their respite placement, 12.5 percent (N=8) were neutral, 25 percent agreed and 62.5 percent strongly agreed. 25 percent (N=8) of respondents were neutral on the statement that social worker was helpful, 50 percent agreed and 25 percent strongly agreed. Tables 6, 7 & 8.

Table 6

Statement: Trainings offered were useful. (n=6)

	Strongly disagree 1	2	3	4	Strongly agree 5
Number			2	2	2
Percentage			33.3	33.3	33.3

Table 7

Statement: I was well prepared before my respite placement. (n=8)

	Strongly disagree 1	2	3	4	Strongly agree 5
Number			1	2	5
Percentage			12.5	25	62.5

Table 8

Statement: The child's social worker was helpful.
(n=8)

	Strongly disagree				Strongly agree
	1	2	3	4	5
Number			2	4	2
Percentage			25	50	25

Asked if they were prepared for working with the child and the parents, 12.5 percent (N=8) of respondents were neutral, 37.5 percent agreed and 37.5 percent strongly agreed. The statement, informational packet was useful, received neutral responses from 12.5 percent of respondents and 87.5 percent strongly agreed. See Tables 9 and 10.

Table 9

Statement: I was well prepared for working with the child and the parents.
(n=8)

	Strongly disagree				Strongly agree
	1	2	3	4	5
Number			2	3	3
Percentage			12.5	37.5	37.5

Table 10

Statement: The information packet was useful.
(n=8)

	Strongly disagree				Strongly agree
	1	2	3	4	5
Number			2		6
Percentage			12.5		87.5

<u>Staff responses</u>

When asked to evaluate the ease of the referral to the program, 100 percent (N=3) of the staff were neutral. 33.3 percent of the staff disagreed that the coordinator was available to them and 66.6 percent were neutral. Next, when assessing the helpfulness of the coordinator, 66 percent (N=3) were neutral and 33.3 percent agreed. Tables 11, 12 and 13 provide these results.

Table 11
Statement: The referral process is easy.
(n=3)

	Strongly disagree 1	2	3	4	Strongly agree 5
Number			3		
Percentage			100		

Table 12
Statement: The coordinator is available to staff.
(n=3)

	Strongly disagree 1	2	3	4	Strongly agree 5
Number		1	2		
Percentage		33.3	66.6		

Table 13
Statement: The coordinator is helpful.
(n=3)

	Strongly disagree 1	2	3	4	Strongly agree 5
Number			2	1	
Percentage			66.6	33.3	

When asked if the program was user-friendly, 66.6 percent of the staff were neutral and 33.3 percent agreed. All staff responding agreed providers were competent. When asked to assess the value of provider/

child match, 66.6 percent agreed providers and children were well matched and 33.3 strongly agreed. See Tables 14, 15 and 16 for these findings.

Table 14
Statement: The program is user friendly.
(n=3)

	Strongly disagree				Strongly agree
	1	2	3	4	5
Number			2	1	
Percentage			66.6	33.3	

Table 15
Statement: The respite providers are competent.
(n=3)

	Strongly disagree				Strongly agree
	1	2	3	4	5
Number				3	
Percentage				100	

Table 16
Statement: The provider and respite child are well matched. (n=3)

	Strongly disagree				Strongly agree
	1	2	3	4	5
Number				2	1
Percentage				66.6	33.3

Qualitative Information

Respite Provider responses

Child informational packet

Three providers saw the packet as helpful and did not indicate a need for change. Two providers requested that more daily logs be included in the packet. One person requested specific information on a child's diagnosis, for example, if the child has Tourettes Syndrome the provider would like written materials regarding this disorder. One person indicated a need for more information about the child's background and family to understand the child more fully.

Respite provider's positive reactions to working with child's parent(s)

Five respite providers said working with parents gave them an appreciation for what parents were "up against." For example, one respondent said, "It helps to get to know the child and how the parents react and respond to difficult behaviors." Another person said, "I like being able to talk with parents to know in a situation where a child needs discipline for bad behavior, what works best for that child instead of what our own or other children are used to, so the child does not get more aggravated or upset or what a child likes for rewards for good behavior." Another respondent said "I am able to better understand the child when I get to know the parents." Three persons said it was good to know they were needed.

Respite provider's negative reactions to working with the child's parent(s)

Not all respondents were pleased with their experiences with parents. One person said, "I find nothing positive. Parents I have met seem to feel or give the feeling that we are 'paid' for this and should be grateful. Also that parenting is just difficult for them---easy for everyone else. I think the parents we have seen are using the program! They want the system to help them. They really are not interested in helping or improving themselves---they just want a break!"

Another provider said, "I feel I need to be careful with my daily loggings. Parents don't always want to hear 'straight talk'." One provider said, "parent(s) could rely too heavily on foster parents." Yet another person said, "In some cases, the parents are so negative about the child, it makes me feel like a traitor when I tell them their child is a great kid. They don't want to hear that, it seems." Still another person said "sometimes I feel taken advantage of when parents are late dropping off children or picking them up, it's irritating." A final person said, [respite care] "gets more personal than I was used to as a regular foster parent."

Issues Respite providers, working with parents, would like addressed in future trainings.

One person said, "tell providers to find out more information on the child's home life, the child's responsibilities, abilities, dispensing medications, bringing spending money, being on time delivering and picking up children and bring properly packed weekend bag."

Another respondent would like providers to know "that parents have no training to work with their own children. We are required to take classes and be prepared for all situations yet the actual parents just want to get away. Why are they not required to take some classes to learn how to cope with their own children and learn the whys and what nots to certain behaviors ?"

One person requested "refresher classes" for providers who have been doing respite for a long time.

One provider said future trainings should include more information on the "background of homes these children are coming from. Physically abusive, sexually abusive, parents sleeping with many partners, parent in prison, welfare fraud etc.. These children already know how to use the system." Another person wanted new providers to know "how children manipulate through their 'illness', or from other reasons."

Availability of child(ren)'s social worker to respite providers

Seven of the eight respondents said social workers were available when they needed them or they knew how to reach them if they needed to reach them. One person said social workers were not available, "in my opinion, they view us respite providers as inadequate. They are real sympathetic towards the parents but view respite providers as able to handle anything but receive little credit. We are not the 'parent'."

Openness of child's social worker

Five of the eight respondents saw social workers as open, however three had differing opinions. One person said, "I would like more information on the child (and parents) before we meet." Another respondent said, "no, not all of them---they don't share all of the information they have and one time I called a worker and the worker promised to help and never came through." A final subject said," No! It would probably appear two faced if they were [open]. I realize they are to support the parents but I think they are not helping the parents or child by being sympathetic. In meeting the respite provider they seem to expect the respite provider to get everything under control in two days. Then the child or children go back to the home which is usually in utter chaos. Can't the social worker point out how the parent can make the best use of this break? For the parent to attend some classes, read some material and try to analyze their situation and make some plans on regrouping and trying alternative parenting?"

Most difficult or frustrating parts of the respite program

Several respondents had issues to speak to regarding the difficult or frustrating parts of the respite program. One person said, "The children's parents confiding in you and their life style and how they are committing a crime or fraud. Using their respite care for a weekend getaway with the father of the child or children. How they are working on the side but collecting welfare." Another person said it is "difficult relaying to parents their child's good behavior or getting them to deal effectively with bad behaviors." Two providers wanted children on a regular monthly basis instead of children who go in and out of the program. One provider would like to be paid for no shows and two providers want parents to know how important the information folder is and that they must bring it each time the child comes to the provider's home.

Parts of the program that are working well

When asked what parts of the program were working well, one person said, "not very many. Of the children we've had, and have, 1 in 10 children want this and want to learn differently and none of the parents are even interested in a different technique. It's just a vacation to them."

One respondent said, "trainings, classes available. Also great open communication the coordinator keeps with me." Another respondent said "all of it, the training and the pre-placement visits." Another said, "the idea of giving parents a break." Yet another said, "positive approach in allowing parents some free-time and parents being open to flexible scheduling to avoid conflicts with foster parent's own family plans." A final person said, "giving the parents a break and if the child fits in, he/she also is happy and it's not hard on them, they don't feel punished or abandoned, they know they'll return home and also get to come again".

What administrators could do to make the respite provider's job easier.

When asked what administrators could do to make the respite provider's job easier, one individual said, "maybe a phone contact every couple of months to evaluate the placement and express any concerns." Another respondent said, "I'd like a reminder sheet included in the blue folder {information packet}---children are coming with improper clothing etc.
Parents need to be reminded of their responsibilities."
A final subject said, "require all parents to participate in the same classes as required of respite providers.
Parents to learn more about their child's specific problem. Parents to belong to a support group regularly!"

Additional comments

Respite providers had a great deal to say, common themes are enumerated below.

Parents need training

These parents need training along with the children.
Respite just puts a bandaid on a large wound.
Parents should be required training or not be able to participate.

Parents misuse their time away

Instead of using the time away to improve their parenting skills, parents use the time to go away with their boyfriend or take care of other people's children.

Difficulty working with parents

No provider indicated extreme difficulty with the children but providers had much to say about their negative experiences working with the parents.

Providers are pleased with the respite program.

When asked if they were pleased with the respite program, one person said, "for a new program it has done well." Another said, "we view this as a valuable program that needs to be continued." Still another said," my respite care coordinator has done a very good job with giving me information about a possible respite child and also takes good consideration with placing a child for respite as how the child would fit with my family. So far I am happy with the program."

Staff Input

Parts of the program that make getting respite difficult.

When asked what parts of the program made getting respite difficult, all three staff persons who responded, saw need for more providers as an issue, especially homes willing to take adolescent boys. One person saw the length of time between referral and respite placement as too long. One person requested "communication by team on placement".

Least helpful parts of the program

Staff found the waiting list and communication with the coordinator as issues which needed to be addressed. Two persons said the waiting list was not helpful and one person "would like more consistent feedback from coordinator on how the kids are doing at the respite home."

Most helpful parts of the program

When asked what the most helpful parts of the program were, two persons said the "flexibility of respite providers." One person liked having providers who live near the child's family. One person thought "good matches were made with good providers." Finally, one person said "it helps the child and family receive respite."

Rating of program

When asked to rate the program, two staff persons rated the program as good and one rated it as fair.

Additions or changes to improve the program

Staff were asked for suggestions to change or improve the program and two staff persons stated the need to recruit more foster homes.

One person said shorter waiting periods for placement. One person said, "more support for foster parents - monthly contact by coordinator" and would also like "statistics on a bi-monthly basis on open/closed homes".

Number of referrals made and number who received respite.

When asked how many of the clients they referred to the respite program received respite care, all three respondents indicated approximately 50% of the children they referred received respite.

Chapter VII

Discussion and Implications

Comparison of findings to literature review

Some respite providers, consistent with the information in the readings, blame the parents for their child's behavior. The indications from provider responses place blame for the child's situation firmly at the doorstep of the parents.

Providers noted histories of abuse and dysfunction, of various sorts, in the the child's home life. This also is consistent with the readings which indicate as the parent's level of stress increases, coping ability decreases, placing the child at risk.

One of the providers spoke to concerns regarding the parent's apparent opinion that others were more capable of parenting than they. As the readings show, parents who have had little success dealing with their child's disorder can begin to compare their abilities to those of others, and thus find themselves lacking.

Many of the providers requested more information regarding the child's background in order to better understand the child. The readings suggest, from a system's perspective, the child must be viewed in context to its family environment to more fully understand the dynamics at work in the family and thus how the child's behavior impacts the family and the family impacts the child.

Several of the providers expressed concern regarding the parents' seeming inability to look at respite care as a way to improve family functioning and a time to improve its skills. As the crisis process reveals, many of these families are at a point of stress where they are not capable of looking beyond their immediate needs. As the family continues to use respite perhaps the family can stabilize to a point where they can begin to look more to the future.

An additional area of interest is one of lack of understanding due to socio-economic bias on the part of providers. Most of the providers are middle class individuals with limited experience working with low income families. They therefore have difficulty generalizing the client family's environment to their own. They have become accustomed to a way of life which bears little similarity to that of the majority of families with whom they are in contact through respite provision. They are coming from a place where meeting basic needs is an accepted way of life. It is quite difficult, from that perspective, to walk in the client's shoes.

One provider was greatly disturbed by the perception that parents and children were skilled in working the system. As the literature evidences, by the time families access respite care, they have become quite familiar with the system. They know the system's workings and may have acquired an admirable ability to verbalize the jargon of the system. For example, the coordinator met with a new child, in the preliminary stages of matching the child with a provider, and the first question the child (age 12) asked was, "Is this an assessment interview?"

Using the system is not necessarily a bad thing for families seeking respite care. Indeed, their knowledge of the system makes it possible for them to be players in the process. Thus the holistic focus the Time Apart program introduces to the families empowers them to use the system in a positive fashion.

Certainly the literature shows providers are not wrong in their conclusions that parents need education and skills training to work with their child. In addition, one provider suggested support groups for families as a requirement. The Time Apart program currently contracts with Central Center for Family Resources to provide an educational support group for respite providers. Central Center also provides support groups for parents, both respite users and members of the general public, with children who have emotional/ behavioral disorders.

Training and support are important to parents and foster parents alike in meeting the unique needs of children with emotional/behavioral disorders. According to the literature, training and support are key elements in retaining foster homes.

As the literature indicates, support is an important component to families seeking to achieve a higher functioning level. Providers said provision of that support, or the sense they were needed, was a motivating factor for them.

Supporting families means supporting primary caregivers for a child, be they biological parents, adoptive parents or foster parents. One provider was discouraged that no foster parents had used his/her services.

An element of supporting families is the consistent, unflagging involvement of respite providers in the child's life. If an enduring relationship can be made with the child, the child is more likely to see respite care as a positive intervention in his/her life. For example, during the process of writing an individual family service plan (IFSP) for a family in the program, the family requested the respite provider attend the meeting. The provider's input was seen as invaluable by the members of the team developing the plan. This type of personal investment has a solidifying effect on the parent/provider/child relationship. It is instrumental in creating an environment of mutual respect between parents and team members.

Finding's relevance to research questions

The findings studies described the client population served by the Time Apart respite program.

The qualitative and quantitative studies of provider response to training issues and concerns produced information which will be helpful in future trainings of providers. Providers indicated the need for more information about the families being served. Future trainings can be constructed in a way which includes this information. At the inception of the program, the developer had little knowledge of the client family needs and thus was unable to adequately prepare providers for the families they would be serving. Learning the specific concerns of respite providers regarding the child's family of origin will provide a framework for future trainings.

Providers indicated both qualitatively and quantitatively the positive value of the information packet. It is unclear, at this point, how much more information can be included about the child's background without negatively impacting the client/provider relationship. Perhaps, at the pre-placement visit, the social worker can be asked to explain more about the family's internal dynamics. This must be carefully thought through because the parent and child have a right to confidentiality. This questioning must be approached delicately and respectfully. Perhaps a more thorough meeting of the coordinator and the social worker, prior to the pre-placement can defray some of the need for this exploratory process. Discussion of the family's perceived issues could be invasive and detrimental to the parent/provider relationship and ultimately drive families away from using the service.

Comments and quantitative information suggest respite providers feel supported by the coordinator and county staff with whom they are in contact. The county staff, however, do not rate their relationship with the coordinator as highly as providers did. Part of this may be explained by understanding an historical issue between the placing side of child services and the licensing side. Placement is concerned with expeditious service results while licensing is concerned with matching and accommodating both parties. Each side frequently expects the other to do more, thus the conflict.

Availability of the coordinator to staff scored below average ranking. Part of this can be explained by the fact that while placement staff are 40 hour staff persons, the coordinator is a 30 hour staff person. Placement staff is available 5 days a week, coordinator is available 4 days a week. Much of the work the coordinator does, interviewing, licensing, observing children, and attending pre-placement visits, occurs outside of the office. Thus it is true the coordinator's time in-office is at a minimum. The coordinator is working to help and accommodate many staff persons. The staff person is working with one coordinator. The coordinator also serves on a number of interagency committees and subcommittees which influence provision of child mental health services throughout the county. Increasing the number of coordinator hours to match the 40 hours staff are available would help increase the availability of the coordinator to the staff.

Unlike their relationship to the coordinator, the staff appears to be satisfied, overall, with the performance of respite providers.

Areas in need of improvement in the program are seen as: increasing the number of respite homes available to families, shortening the length of time between referral and preplacement visits and increasing team involvement in after-placement communications. The first two issues can be combined as increasing the number of respite homes would serve to shorten the amount of time between referral and preplacement. Seventy-five percent of the respite homes currently restrict placement by age and other characteristics of the child. For example, only one home is willing to take adolescent boys at this time. Two of the homes will only take girls ages 13 and up. Some of the homes only want children under the age of 10 and so forth. These provider imposed limitations greatly impact the speed with which children can be matched to a home. The program has experienced the loss of three respite homes, since its inception because providers became overwhelmed by the number of children requiring respite. If a home has too many placements, the program is at risk for losing that home. Therefore a new child may have to wait an indefinite amount of time before a home can become available that can meet his/her needs.

Increased marketing and advertising of the program must be done to recruit more qualified homes and thus increase the pool of available respite homes.

As the number of homes increases, communication between staff and coordinator must occur. If staff know how many homes are available, this will impact their understanding of the availability when they speak with future clients. The coordinator must be increasingly made aware of the importance of this communication within the team.

Teaming of staff and respite providers appears to be working but it appears respite providers are having some difficulty accepting that parents are to be made a part of that teaming. Increased effort on the part of the coordinator and the child's social worker to develop a positive relationship between respite provider and family is needed.

Limitations of the study

In a full evaluation of the effectiveness of the Time Apart respite program, it will be important to survey recipients of respite services. This will mean surveying parents to determine their impressions of the strengths and deficits of the program.

The low response rate from county staff makes self-selective staff responses difficult to measure as it cannot be assumed from this small number of responses that the information received can be generalized to all staff using the program.

In addition, as the primary purpose of this program is the prevention of out-of-home placement, it would be important to conduct further study. This study would need to involve a series of surveys, over time, to determine whether or not the program is effective in reducing the need for out-of-home placement.

Reduction of out-of-home placement, in this program, is seen as a cost-effective measure. A series of questionnaires, distributed over time, would help to determine if the program is meeting that goal. Do the benefits of the program outweigh the costs of the program?

Of final consideration is the concern that having the coordinator as the evaluator of this program may have resulted in a social desirability bias, a type of systematic error in measurement in which a positive response set of answers is the result of the study. Were provider responses skewed because they knew the coordinator was the person receiving the data? Also, because the provider pool was small, and the coordinator's investment in the program is extensive, it is not unlikely the coordinator could identify some of the responses as coming from a specific provider; therefore providers may have been selective in their responses.

Recommendations

In future, a time series evaluation of the program will be needed to assess the ability of the program to decrease the need for out-of-home placement.

It would be helpful to have the program evaluated by an outside evaluator with no personal investment in the program.

Future evaluations should survey parents and children who participate in respite care. As previously stated, this population has a history of being excluded.

As the findings indicate, another way to include parents in the team would be to include parents in the trainings given providers.

Increased interaction between team members must be a focus of future program planning. Future trainings must include the relative importance of viewing parents as participating members of the team. In addition, trainers must spend some time helping providers understand the socio-economic biases inherent in their relationship with prospective respite families.

Implication for social work practice

Time Apart and other respite services are an important component in the continuum of service needs of families of children with emotional/behavioral disorders. Many of the families seen by the Time Apart respite program operate in a crisis mode, meaning their inspiration for seeking services arises from a crisis situation.

In Anoka County few services exist to accommodate these crisis needs. Currently, families of a child with an emotional/behavioral disorder have three options if their child is in crisis. They can call the Crisis Nursery which serves ages 1 through 12 and hope a provider is available and willing to take their child into care. They can call Mercy Crisis Intervention and hope their child meets criteria for in-patient placement or they can call 911 and hope the police officer dispatched views the situation as serious enough to place the child in temporary foster care.

Mercy Crisis Intervention will only accept children in full-blown crisis which means if the parents are able to calm the child enough to get them to Mercy it is unlikely the staff there will see a need for admitting a child. In addition, Mercy will only take adolescents. A family with a 5 year old in crisis has no where to turn but 911. If the family calls 911, and the child is taken into temporary foster care, they face the likelihood of losing their child for an extended amount of time and are likely to have to struggle with the system to keep their child.

While it is true some of the Time Apart providers are willing to take children on a moment's notice they are very few. More attention must be paid to addressing the crisis needs of children with emotional/behavioral disorders. Social workers can be enlightened to this need and advocate within their community, county and state to assure families in crisis will have a place to turn when the need arises.

At the legislative level, social workers can lobby for funds which address continuation of pilot programs such as Time Apart. Currently, the trend is to offer hundreds of thousands of dollars to fund start up programs but little commitment exists to provide continuation funding once a program is in place. Many pilot programs have been forced to close their doors because they are unable to acquire continuation funding.

We have all seen what strong advocacy has done to further the service needs of senior citizens and people with developmental disabilities. It is time families of children with emotional/behavioral disorders were given equal voice.

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APPENDIX

SURVEY OF STAFF WHO HAVE USED THE TIME APART PROGRAM TO SERVE THEIR CLIENTS

Please rate the following on a scale of 1 to 5.

	Strongly Disagree				Strongly Agree
___ The referral process is easy	1	2	3	4	5
___ The coordinator is available to staff	1	2	3	4	5
___ The coordinator is helpful	1	2	3	4	5
___ The program is user-friendly	1	2	3	4	5
___ The respite providers are competent	1	2	3	4	5
___ The provider and respite child are well matched	1	2	3	4	5

1. What parts of the program make getting respite services difficult?

2. What parts of the program are least helpful?

3. What parts of the program are most helpful?

4. In general, how would you rate this program? Please circle one:

poor fair good exceeds expectations excellent

5. What additions or changes would you make to improve the program?

6. Additional Comments:

7. How many times have you referred to this program?________________

8. How many of your clients received service?________________

Thank you for your time and participation. Please return to Marcy Bolte by Monday, March 28, 1994.

LICENSE\MISC\STAF-SUR.TA\dt

RESPITE PROVIDER SURVEY

We would like to have your impressions of the Time Apart respite program. As a provider, we value your feedback. Please answer the following questions, keeping in mind that the information will be kept strictly confidential. The purpose of this survey is to improve training and support to respite care providers.

Please rate the following on a scale of 1 to 5.

	Please circle a rating for each question:	Strongly Disagree				Strongly Agree
___	The coordinator was supportive.	1	2	3	4	5
___	The training staff were supportive.	1	2	3	4	5
___	Interaction with other providers was nelpful.	1	2	3	4	5
___	Trainings offered were useful.	1	2	3	4	5
___	I was well prepared before my respite placement.	1	2	3	4	5
___	The child's social worker was helpful.	1	2	3	4	5
___	I was prepared for working with the child and the parents.	1	2	3	4	5
___	The information packet was useful.	1	2	3	4	5

Feedback

1. We have tried to be comprehensive in providing information on the children you are caring for in your homes. However, we would like to know if you would like any other information included in the packet. Please offer suggestions below.

____
____
____

2. In this program you have a great deal of contact with the parents. Please describe the positive sides of that experience:

____
____
____

Please describe the negative sides of that experience:

____
____
____

3. Are there issues in working with the parents of the children you respite you would like addressed in training of future respite providers?

____
____
____

4. Can you think of anything not covered in the training you would like to see presented to future providers?

5. Are the children's social workers available to you?

Are the children's social workers open with you?

6. What parts of the program do you find most difficult or frustrating?

7. What parts of the program do you think are working well?

8. What could the program administrators do to make your job easier?

Additional Comments:

Thank you for your participation in this survey.

Please return your survey response in the enclosed, self-addressed, postage paid envelope by Thursday, March 31, 1994.

LICENSE\MISC\PROV-SUR.TA\dt

EVALUATION OF TIME APART RESPITE CARE FOR CHILDREN WITH EMOTIONAL/BEHAVIORAL DISORDERS

You are invited to take part in a study of the Time Apart respite care program of Anoka County. We hope to learn how the program is working and how it meets the needs of staff using this program and those of the foster homes providing respite care. Survey questionnaires will be given to social workers and respite care providers who have used respite care services through the Time Apart program.

This study is being conducted by: Marcia Bolte, respite care coordinator, as part of her graduate work at Augsburg College, Masters in Social Work program. The study will also fulfill requirements from the program funding source.

Your participation in this study is completely voluntary. If you decide to participate or not to participate, it will not affect your relationship with Anoka County or Augsburg College.

If you decide to participate, we would ask you to do the following things. Please fill out the questionnaire, you may skip any questions which you are not comfortable answering. Include any comments you have, both negative and positive, about your experience with this program.

Information collected in this study will be used to improve and make additions or changes in the program. The study will also produce information regarding characteristics and demographics of the consumers of this program. Study information will be available to Anoka County staff, and the Caregiver Support unit of the Minnesota Department of Human Services.

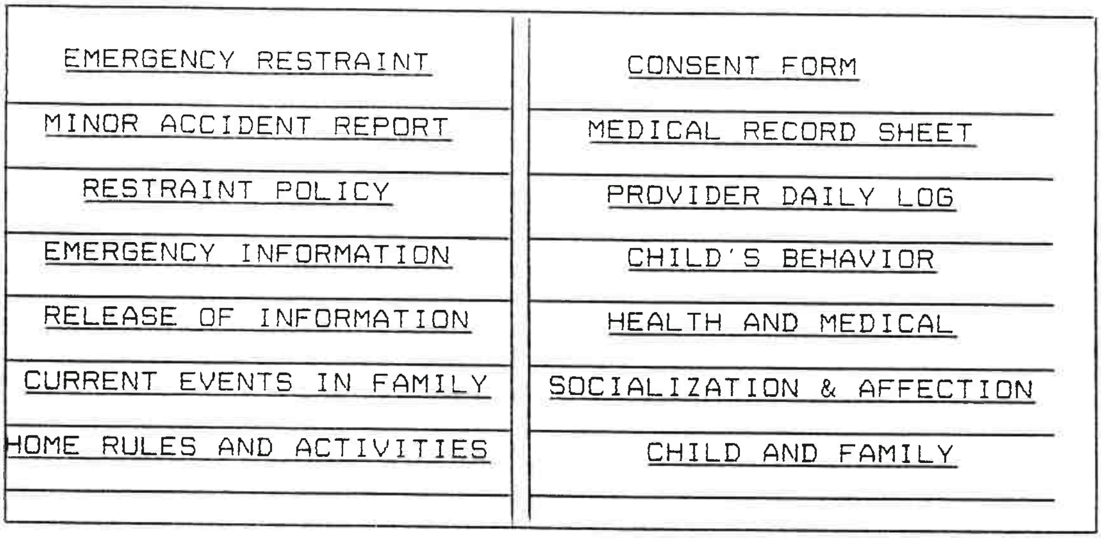
If you have any questions about the study, you may call Marcia Bolte, phone: (612) 422-6911 or her student advisor at Augsburg College, Dr. Sharon Patten, phone: (612) 330-1723.

The enclosed survey questionnaire is designed for the specific service area or consumer status of the respondent.

The survey should take 20 to 30 minutes to complete. The evaluators appreciate your time and consideration in completing and returning this survey. All information will be confidential. Group, not individual, responses will be used in the study.

LICENSE\MISC\EVAL.TA\dt

Child informational packet - Time Apart Respite Program



The informational packet is a pocket folder containing individual colored sheets of paper, of graduated sizes, with specialized headings.

See appendix for examples of each of these informational sheets.

EMERGENCY RESTRAINT

Child's Name____

Child's Date of Birth____________________________________

Child's Caseworker (if any)________________________________

Respite Provider______________________________________

Date restraint was used__________________________________

Time restraint was used__________________________________

Person(s) involved in the restraint procedure:

____

____

Procedure used:____

____

____

Situation which required restraint:

____

____

____

____

Results of restraint:

____

____

____

____

Did injury to the child or provider occur as a result of this procedure? Yes___ No___ If yes, please describe:

____

____

______________________________ ____________________

Signature of Provider Date

mb/du/sav/emrgrest

MINOR ACCIDENT REPORT

NAME OF CHILD____ AGE______

Description of Accident:____

____

____

____

Action Taken:____

____

____

____

Date:________________________ Time:________________________

Respite Provider's Signature:____

MB/dt/sav/m-accrpt/8/31/92

RESTRAINT POLICY

In most cases, verbal de-escalation is sufficient to diffuse a potentially volatile situation. However, should the respite provider determine the respite child is at risk of harming himself/ herself or endangering the safety of another person, physical restraint may become necessary. If the respite provider perceives the situation will require an emergency restraint procedure, call 911. Physical restraint of the child may be necessary during the wait for 911 to respond.

Restraint may be used as a means of intervention only if the child's caseworker has a written behavior intervention which includes physical restraint as a step in that intervention. If the child's caseworker has included a restraint in his/her behavior management program a restraint permission will be signed by the child's parent(s) or guardian.

**Any time a physical restraint is used, the respite care provider will document the situation that precipitated the use of restraint, what restraint was used, date and time of the incident. person(s) involved int he intervention, and the results of the intervention. This information will be given to the parents and the Respite Care Coordinator.

mb/dt/sav/restpol

EMERGENCY INFORMATION

Physician's Name______________________________ Office Phone________________

Office Address______________________________ After Hours________________

Psychiatrist's Name______________________________ Office Phone________________

Office Address______________________________ After Hours________________

Dentist's Name______________________________ Office Phone________________

Office Address______________________________ After Hours________________

Social Worker's Name__________________________ Phone________________

Child's Blood Type__________ Child's Weight____________________

Preferred Hospital____

Ambulance____

Insurance Company___________________________ Policy #________________

Other____

Person(s) who can be called if parents can not be reached:

Name______________________________ **Home Phone**________________

Relationship______________________________ **Work Phone**________________

Name______________________________ **Home Phone**________________

Relationship______________________________ **Work Phone**________________

Person(s) authorized to pick up child other than parent:

Name__________________________ Phone________________

Relationship____________________

Name__________________________ Phone________________

Relationship____________________

Medical Release:

I hereby give consent to ______________________________ to seek medical treatment for my child(ren).

______________________________ ____________________

Parent or Guardian Signature Date

RELEASE OF INFORMATION

I HEREBY AUTHORIZE ANOKA COUNTY RESPITE CARE PROGRAM TO OBTAIN INFORMATION FROM, AND TO SHARE INFORMATION WITH THE FOLLOWING AGENCIES:

Person to Contact	Name of Agency	Phone
Person to Contact	Name of Agency	Phone
Person to Contact	Name of Agency	Phone

I UNDERSTAND THAT THE INFORMATION AND AUTHORIZATIONS INDICATED ON THIS FORM WILL APPLY TO ANY AND ALL SUBSEQUENT SERVICES TO THE ANOKA COUNTY RESPITE CARE PROGRAM UNLESS OTHERWISE NOTED.

Signature

Date

MB/dt/saf/relinfo/8/31/92

CURRENT EVENTS/ISSUES IN CHILD'S LIFE

HOME RULES AND ACTIVITIES

1. Do you allow smoking in your home? Yes_____ No_____

If you have established rules regarding the following, please briefly explain the rule(s).

Pets______________________________

T.V.______________________________

Eating______________________________

Showering______________________________

Bathing______________________________

Homework______________________________

Phone______________________________

Transporting______________________________

Shopping______________________________

Bedtime______________________________

Bedtime Routine______________________________

____

2. **Daily Routine:**

Mealtimes: **Breakfast**_______ **Lunch**_______ **Supper**_______
Snacks:______________________________

3. Bathing: Prefers Tub_______ Shower_______

Specify usual frequency and time for baths and shampoo:______________________________

____

Child's Favorite Activities______________________________

____

4. Are there any rooms and/or areas in your home which are off limits? Yes____ No____
If so, where?______________________________

____

5. Are there items in your home that are off limits for touching and/or handling?
Yes____ No____ If so, explain:______________________________

____

RESPITE CARE CONSENT FORM

MEDICAL RELEASE: I hereby give my consent for my child(ren) to receive emergency medical treatment and to give the emergency treatment provider adequate information to care for my child(ren) properly.

Medical Assistance#: ______________________________

Other Insurance: ______________________________

Family Doctor: ______________________________ Phone: ______________

Clinic Name/Address: ______________________________

Parent or Guardian Signature: ______________________________

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS: I hereby give my consent for ______________ to dispense ______________, a non-prescription drug, or ______________, a prescription drug, to ______________ which I am supplying. I understand that respite providers dispensing these medications will not exceed the manufacturer's guidelines for dosage or frequency without the advice of medical personnel.

Parent or Guardian Signature: ______________________________

TRANSPORTATION & FIELD TRIPS: I give my permission to ______________ to transport my child(ren) by car as necessary for their participation in all activities during the respite time period.

Parent or Guardian Signature: ______________________________

USE OF EMERGENCY RESTRAINT: I give my permission to ______________ to use emergency restraint to protect my child, ______________ from injury to himself/herself or from endangering the safety of another person. If my child has use of restraint documented as part of his/her behavior program, I give permission for restraint to be used as part of that behavior program.

Parent or Guardian Signature: ______________________________

DISCONTINUANCE OF RESPITE SERVICES POLICY

Failure to notify respite homes of a change of plans, on more than 2 occasions, will result in denial of further respite services.

I have read the statement above and agree to these terms.

______________________________ ______________

Parent or Guardian Signature Date

mb/dt/sav/consfrm

MEDICATION RECORD SHEET

Child's Name ______________________________

Medication: ______________________

Dosage: ______________________

Frequency: ______________________

Special Instructions:

____

____

____

Medication: ______________________

Dosage: ______________________

Frequency: ______________________

Special Instructions:

____

____

____

Dispensing of Medication:

Date	Time	Name of Medication	Initials of Person Dispensing Medication

PROVIDER DAILY LOG

DAY

DAY

DAY

mb/dt/sav/respfrms/8/28/92

BEHAVIOR

1. Please indicate if there are any behaviors which may cause his/her respite provider concern. (check any that apply)

_____ very shy
_____ does not like to be hugged
_____ does not like to be touched
_____ aggressive (towards objects, towards persons)
_____ easily frustrated
_____ self abusive (head banging, hand biting, gagging)
_____ acts defiant
_____ hyperactive (unable to sit still for more than a few minutes)
_____ criticizes, belittles, swears, or calls names
_____ appears to be in his/her own private world frequently
_____ argues and must have the last word in verbal exchanges
_____ has nervous ticks (muscle-twitching, eye-blinking, nail biting, hand wringing, etc.)
_____ bed wetting
_____ temper-tantrums. If checked, please describe
____
____
_____ has rapid mood changes
_____ weeps or cries without provocation
_____ engages in inappropriate sexually-related behaviors
_____ physically runs away from people
_____ deliberately makes false statements
_____ must have immediate reward or gratification
_____ makes inappropriate noises

DANGER OR EMERGENCY

_____ does not realize what is dangerous (needs supervision)
_____ is aware of, but does not watch for danger
_____ needs to be reminded to watch for danger
_____ is generally cautious

2. Please explain below specific fears your child may have:____________________
____

3. What rewards do you use for good behavior?____________________
____

4. What methods have worked for you when addressing these misbehaviors?__________
____

HEALTH AND MEDICAL

1. Does the child/adolescent have any allergies? If so, please list ____________________

____

2. Is the child/adolescent on any specific diet? Are there any foods he/she shouldn't eat?

____

____

3. Are there any foods the child/adolescent particularly likes? ____________________

____

____

4. Other ____

____

MEDICAL

1. **Medication**____________________________ **Rx#**________________________

Dosage____________________________ **Time given**________________________

How given____

Side Effects____

____

Purpose____

Prescribing Physician_________________________ **Phone**____________________

2. Medication____________________________ Rx#________________________

Dosage____________________________ Time given________________________

How given____

Side Effects____

____

Purpose____

Prescribing Physician_________________________ Phone____________________

3. Date of last Tetanus Shot____

4. Allergies to medications? Yes_______ No_______

If yes, please identify____

____

5. Does he/she have seizures? Yes_____ No_____ If yes, please describe in detail ___

____

____

If yes, What should be done during seizure?____________________________________

____

How long does the seizure last?____

If he/she is on seizure medication, how long has he/she been taking it?_________ Has he/she reached an effective dosage level? Yes_____ No_____

SOCIALIZATION & AFFECTION

1. Is your child/adolescent manipulative in social interaction? Yes_____ No_____ If so, how?

____

____

2. Does your child engage in inappropriate behavior(s) to get attention? Yes____ No____ If so, how?

____

____

3. Does your child insist on being right? Yes_____ No_____

4. Does he/she share easily? Yes_____ No_____

5. Is your child sensitive to the needs of others? Yes_____ No_____

6. Does your child have close friends? Yes_____ No_____

7. Does your child seek opportunities for closeness? (i.e. sitting close on the couch with other family members) Yes_____ No_____

8. Does your child express or indicate a high degree of:

Check those that apply:

_____ Self Hatred
_____ Feeling inferior
_____ Jealousy
_____ Boredom
_____ Anxiety
_____ Loneliness
_____ Shyness
_____ Stress
_____ Clinging
_____ Possessiveness
_____ Depression
_____ Anger toward others

CHILD AND FAMILY

Child's Name______________________________ Nickname________________

Birthdate_________________________________ Address_________________

Social Security #__________________________ Phone__________________

Hair Color__________________________ Eye Color_________________

Height______________ Weight______________ Blood Type____________

Parent(s)/Guardian's Name(s)______________________________________

____

Other Family Members Living in Household:

Name	Relationship	Age

Parent's Home Phone (F)________________ Work phone________________

(M)________________ Work phone________________

Important Notice About Parental Fees

Your child's Medical Assistance (MA) application was approved without considering your income and assets. Your child with developmental disability, severe emotional disturbance, or physical handicap may also use services paid for through your County. Under State law you may have to pay a fee to the Minnesota Department of Human Services (DHS) or to your County because your child receives MA and/or services paid for through your County.

How Is Your Parental Fee Figured?

- The amount of your fee is based on your income and family size. The total amount you pay each year cannot be higher than the cost of services your child receives each year.
- Your fee will be figured out and collected by either DHS or your County.
- Start with your Adjusted Gross Income from last year's federal tax form. Do not include the income of stepparents.
- A Parental Income Deduction based on your family size is subtracted from your adjusted gross income before we figure your fee. If your child lives with you, we deduct an extra $200.00 per month.
- Family size means parents and dependents under age 21, living in or outside of the home. The child receiving services is also included. Stepparents are not counted in your family size but dependent stepchildren are counted.
- Parents not living with each other may each have to pay a fee. However, we subtract Court ordered child support payments paid by a parent for a child who gets services.
- At least once a year your fee will be reviewed. You must report a gain or loss in income or loss of a family member within 30 days. This may make your fee go up.
- Your fee may go up by another 5%. This happens if you can get health insurance for your child through your employer that costs you less than 5% of your adjusted gross income but you have not taken it. If cost effective, MA may pay your child's share of the premium.
- You can ask to have your fee changed for any of the following reasons:
  - Your family size changes;
  - Your income goes down by more than 10%;
  - Your past cost for services are at least 60% less than your fee;
  - It would be a hardship according to the law for you to pay the fee.
- You must give us the information we need to figure your fee. Legal action can be taken against you if you do not give us the information.
- We will figure your fee after we get your information. You will be mailed a notice of the amount and date that it is due. YOU HAVE A RIGHT TO APPEAL THE DECISION.
- Legal action can be taken against you if you do not pay your fee.
- YOUR CHILD WILL STILL GET SERVICES EVEN IF YOU FAIL OR REFUSE TO PAY YOUR FEE.
- Information we get from you will be used by the Reimbursement Division of DHS, your County Social Service Agency, and other agencies allowed to use it by law.
- If you have questions about this notice or want to ask for a change in your fee call your County Social Service Agency, the Reimbursement Division at 612/296-6530, the DHS Medical Assistance Eligibility Unit at 612/296-8517, or the Family and Children's Services Division at 612/296-7635.

This form has important welfare information. If you do not understand it, get help now.

Información importante de welfare. Hagála traducir inmediatamente.

Lus tseem ceeb txog kev pab (welfare). Yog koj tsis to taub, nriav neeg twm thiab txhais rau koj sai sai.

Tin tốc wuan trọng về chương trình an sinh (welfare). Xin nhờ thông dịch tốc khắc.

[illegible]

ຂໍ້ຄວາມສຳຄັນກ່ຽວກັບ [illegible]
ຖ້າຫາກທ່ານບໍ່ເຂົ້າໃຈ
ຫາຄົນອ່ານແລະແປໃຫ້ຟັງຮີບດ່ວນ.

DHS-2977 (6-93)
PZ-02977-04

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1. Using your last year's Federal Income Tax Form 1040, line 31 or 1040A line 16, enter adjusted gross income .... $____________

2. Enter the Parental Income Deduction for your family size .... $____________
(See Parental Income Deduction chart below)

3. Subtract line 2 from line 1 .... $____________

4. Multiply the amount in line 3 up to $50,000 by 10%* .... $____________

5. Multipy the amount in line 3
   A. Between $50,000 and $60,000 by 12%* .... $____________
   B. Between $60,000 and $75,000 by 14%* .... $____________
   C. AND the remaining amount over $75,000 by 15%* .... $____________

*Add another 5% to the percentage on lines 4 and 5 if you can get health insurance through your employer for your child who receives services that costs you less than 5% of your adjusted gross income, but you have not taken it.

6. Add lines 4, 5A, 5B and 5C .... $____________

7. Divide line 6 by 12 .... $____________

8. Enter $200 if your child who receives MA lives with you.
If your child does not live with you enter $0 .... $____________

9. Subtract line 8 from line 7 .... $____________

10. Enter the monthly amount of court-ordered child support payments you make for your child who gets MA. If none, enter $0............... $____________

11. Subtract line 10 from line 9 .... $____________ **Your Estimated Monthly Parental Fee**

Parental Income Deduction Chart

The Parental Income Deduction for your family EFFECTIVE July 1, 1993 is:

Family of 2 - $18,860	Family of 6 - $38,540
Family of 3 - $23,780	Family of 7 - $43,460
Family of 4 - $28,700	Family of 8 - $48,380
Family of 5 - $33,620	Plus $4,920 for each additional family member

If you feel you are treated differently about the parental fee because of race, color, national origin, political beliefs, marital status, religion, sex, age or because of physical, mental or emotional disability, you may file a complaint with either the Department of Human Services, Office of Civil Rights, 444 Lafayette Road, St. Paul, Minnesota 55155-3833; or the Department of Human Rights, 500 Bremer Tower, 7th Place and Minnesota Street, St. Paul, Minnesota 55105.