FAMILY CARE FIRST

INVESTING IN INNOVATION

TRANSFORMATION OF THE DOMINANT CARE MODEL

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Department of Social Work

FAMILY CARE FIRST

Emerging Practice of Alternative Care for Children in Cambodia Research Findings

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FAMILY CARE FIRST

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ABBREVIATIONS AND ACRONYMS

CCWC	Commune Committee for Women and Children
CRC	Community Rehabilitation Center
CSO	Civil Society Organization
FAST	Families are Stronger Together
FCF	Family Care First
FP	Family Preservation
FR	Family Reunification
KC	Kinship Care
LTFC	Long-Term Foster Care
NGO	Non-government organization
RCI	Residential Care Institution
RGC	Royal Government of Cambodia
RUPP	Royal University of Phnom Penh
STFC	Short-Term Foster Care
TSG	Thematic Sub-Group
USAID	United States Agency for International Development

FAMILY CARE FIRST

INTRODUCTION

Family Care First (FCF) is a United States Agency for International Development (USAID) supported project with the goal of making lasting improvements in the well-being of Cambodia's children. FCF assists children outside of family care or those at risk of losing family care. It seeks to prevent unnecessary separation of children from their families and enable children to be placed in appropriate family care. FCF is led by Save the Children with multiple implementers. Initially FCF has focusing on developing and testing projects in four thematic subgroups (TSG):

- TSG1 Government system strengthening
- TSG2 Direct response to children and families through improved social service workforce
- TSG3 Prevention of unnecessary family-child separation
- TSG4 Transformation of the dominant care model

Each of the TSGs have Actions that address the overall goal of FAST. The documentation and standardization process described in this report is targeted to *TSG4 Transformation of the Dominant Care Model, Action 3 Investing in Innovation.*

TSG4 Action 3 Investing in Innovation

Despite a large body of evidence demonstrating the harmful effects of institutional care on children, and extensive government policies, legislation, and frameworks favoring family and community-based care, Residential Care Institutions (RCIs) continue to proliferate in Cambodia.[1] Several interventions have attempted to address the issue, yet community perceptions, lack of resources, non-government organization (NGO) behaviors, and the capacity of government to implement the Alternative Care Policy continue to be major barriers to systemic change.[2]

One recent study conducted by researchers from the Columbia University found over 11,000 children in residential care in just five provinces. Based on this figure, the researchers also extrapolated the data and calculated that approximately 49,000 children in Cambodia live in residential care centers. The research also suggested that approximately 75 percent of the children in residential care are placed there by family members because of either poverty or lack of access to education. This research concluded that approximately 1 in every 100 children in Cambodia live in an institution.

[1] Summary Thematic Mapping Report, FCFC – Save the Children, February 2016.
[2] Ibid.

Further research conducted for the Mapping of Residential Care Facilities in the Capital and 24 Provinces in the Kingdom of Cambodia identified 639 residential care facilities operating in Cambodia serving 28,187 children. This research identified there are slightly more boys than girls and the majority of the children are school age. Additionally, most are run by Cambodians and there are more faith based than non-faith based residential care institutions (MoSVY 2017).

Clearly, there are large numbers of children in residential care in Cambodia.

Major Steps Forward

As several major donors, multi-laterals, and local government agencies align, there is great potential to see major changes take place in the child protection sector in Cambodia. To that end, the Ministry of Social Affairs, Veterans and Youth Rehabilitation's (MoSVY) has set an aggressive target to reduce the number of children within institutions by 30 percent in just 3 years. In addition, the FCF program is working with MoSVY to initiate collective impact in the area of child protection and deinstitutionalization.

The Gap

As the MoSVY plans move forward, an estimated 3,500 children will require reintegration and alternative family care services in the coming years. Of that figure, approximately one in seven children will need kinship and foster care services. However, major stakeholders (USAID, MoSVY, etc.) have expressed concern over the lack of alternative care options in the country to accommodate the children leaving RCIs.

Additionally, the sector is in need of better and more thorough documentation of the child protection space in Cambodia. Reintegration services[3] to family, kinship care, or adoption are not adequately documented. As a result, the factors of success and the challenges of placements from the point of view of children, families, community, and service providers are rarely identified. Consequently, there is no clear data recorded to describe successful models and approaches to reintegration of children from residential care in Cambodia.

Priorities for Investing in Innovation

Action 3: Investing in Innovation has supported the study and documentation of existing reintegration and alternative family care services in Cambodia, which are provided by civil society organizations (CSOs) throughout Cambodia. These services include: reintegration services to family, kinship care; long and short-term foster care; and semi-independent supported living situations. This action was designed to build the capacity of existing service providers to take emerging good practice to scale as an increased number of RCIs transition.

A major focus of this action included the documentation and standardization of good practice across these different interventions. Therefore, there were two streams of work for the action, the services delivered by the agencies for placements and then the overarching research

[3] This includes assessment, case management, positive parenting, individual and family counselling, economic empowerment, legal support, safety planning, follow-up and others

piece across the services to ensure learning is captured. Holt International and its research partner, the Department of Social Work at Royal University of Phnom Penh (RUPP), have worked closely with service providers to document services to effectively identify various variables of success and challenges of placing children in family-based care. The documentation process has relied on accepted indicators and on gathering input from children, their families, and the communities on their perceptions of the children's placements.

DOCUMENTATION AND STANDARDIZATION RESEARCH

Objectives

The objectives of the documentation and standardization research are designed to:

1. Enhance understanding of best approaches to reintegrating and placing children in alternative care programs and how to effectively scale and strengthen them in the future
2. Establish and enhance the understanding of scalable standard operating procedures to reintegrating and placing children in alternative care programs

Implementing Partners

The partners included in the documentation and standardization research are partners in TSG4 Action 3 Investing in Innovation providing alternative care and reintegration services. These are Cambodia Children's Trust, Children in Families, First Step, Friends International, Hagar, M'lup Russey and M'lop Tapang. Initially, Community Care First Organization was a partner, but they dropped out before the research was completed. Service providers are not identified by name in the research. All findings are aggregated and summarized.

Research Partners

The research partners were Holt International and the RUPP Department of Social Work. Holt International served as the lead research organization with technical support in research design, data collection and analysis from RUPP Department of Social Work.

Methodology

Technical Approach

The technical approach for carrying out the documentation process was systematic and collaborative in nature. The documentation process was designed and coordinated by Holt

International in collaboration with Save the Children FCF Initiative TSG4, and with technical input from RUPP Department of Social Work.

The research design employed a mixed methodology approach using both qualitative and quantitative measures. This methodology included a desk review of existing resources and evaluative input from key informants. The quantitative data was used to illustrate the demographic information of respondents and to document the current services provided by CSO partners as well as to measure the situations and impacts of the current practice model on children and care providers. Qualitative methods examined in depth the experiences, perspectives, challenges, and lesson learn of service providers, care providers and children (who were the key informants) on the current practice model of child care. These quantitative and qualitative parts were used to complement each other to more deeply under the situation.

Research Questions

The documentation and standardization process was designed to answer the following research questions:

- What international good practice models are identified as successful in permanency for children?
- What/how are current laws/regulations support or are barriers to successful permanency planning (examples and recommendations)?
- What are the approaches and models currently being implemented (in this project) for permanency for children in Cambodia?
  - For example: What type of care -temporary foster care, long-term foster care, kinship care, residential care etc.; what types of services are children and families receiving -training of providers, type of service, quality and quality of services, etc.
- How are these approaches and models contributing to permanency for children? what are the challenges? how can the challenges be addressed?
  - For example, in foster care, domestic adoption, foster to adopt, i.e. issues of recruiting, training and retaining, foster parents etc. Ways challenges are being addressed successfully?
- What are the specific indicators of success for reintegration from residential care?
- What is the point of view of the child, family, service provider, and community in the success of the placement?
- What is the recommended model and approach for a pathway to permanency for children that can be effective and efficient at a larger scale, the extent to which model practices can be further streamlined or modified for use at scale considering the situation in Cambodia and international good practice standards?

Sampling

The FCF project in Action 3 projected to fund services to support 150 placements of children.

The initial target was to examine the cases of 50 children receiving services. Due to one partner closing out after the sample was selected, finally there were 45 children included in the research.

To select the cases a stratified random sampling method was used in order to reduce researcher's bias and get a representative sample with a balanced proportion from each identified subgroup. Factors or subgroups considered were the types of care, gender, age group, disability. Geographical location was originally considered, however, as the service providers were in three provinces and Phnom Penh, along with children served residing in additional provinces, geographical location was not considered as the sample was already separated by location. The sample was selected after a significant number of cases were participating in the project, but not the full 150 cases in the initial cohort.

The selected sample included:

CHILDREN	
TYPE OF CARE	
Emergency or Short-Term Foster Care	7
Long-Term Foster Care	10
Kinship Care	13
Family Preservation	8
Family Reunification	4
Community Rehabilitation	3
GENDER OF CHILD	
Male	19
Female	26
AGE GROUP	
Under 8	13
8-12	16
13-16	16
DISABILITY	
Children living with disability	5

Data Collection

Desk Review of Secondary Sources

Secondary data sources were reviewed on international good practices in reintegration, evaluations of program models, and other research or documentation of practices in Cambodia or other contexts, current alternative care policies and other relevant literature. This review was conducted to inform the design of the documentation process and identify the gaps in information and knowledge.

Collection of Primary Data

Program Design Profile: Interviews were conducted with project staff and case workers to understand and document the project design of each implementing partner. This was to try to identify the 'model' for each type of care provided (kinship care, foster care, independent living arrangements, adoption or other) including success factors. Areas documented were the specific target groups (age, gender, situation, etc.), project goals, approaches or theoretical frameworks, specific services/trainings/provided, and service delivery systems or

mechanisms, timeframes and other factors. Processes such as the case management systems were also document. A total of seven organizations completed the interview process.

Case Worker Profile: Data was collected on service providers to better understand the 'who' of service delivery. This included the collection of demographics and descriptors including educational background, years of experience, type of trainings received, availability and use of supervision, case load, and other variables. A total of 18 service provider profiles were collected.

Case Worker Interview on Specific Child: Service providers were asked to provide their perceptions of different success factors and challenges in the reintegration of children from residential care. Eighteen case workers were interviewed about 45 children.

Children: On-going data was collected on children being provided services through the program reporting. In addition, data was collected on children through interviews with their case workers, care providers and from children themselves. No names were collected of children, and only children over eight years of age were interviewed.

Data that was collected on children included the demographics of the child, placement history, school attendance. The case assessment and planning process, services and intervention provided, and follow-up received was documented. Services included child counseling, parent or caregiver counseling, home visits, education support, parent education, vocational training, income generation health care and other services.

Data was also collected from children to understand their perceptions of their current well-being, acceptance in school, placement settings, and the community. A total of 27 children were interviewed. Two children were assessed by their case worker to not be in an appropriate stage in their recovery to be interviewed and one child had run way. Other children were below eight so were not interviewed.

Care Providers: Data was collected from care providers to understand their basic demographics, motivation, training, perceptions of success and challenges, and satisfaction with services. A total of 42 care providers were interviewed. The total did not equal the sample because some care providers provided care to multiple children (siblings). In one case the care provider was not available.

Data Collection Methods and Tools: Qualitative data was gathered through an in-depth interview using a structured interview guide and observation as data collection tools. There were various of tools for both quantitative and qualitative data collection Each different data collection tools was used for each different selected respondents/key informant. These tools were Program Staff Interview, Case Worker Interview on Program, Case Worker Interview on Specific Child, Care Provider Interview, Child Interview, and Child Status Index.

Validation Workshop: After all data was collected preliminary findings were presented in a workshop on 10 April 2018. Participants in the workshop were TSG4 Action 3 case workers and other organization members. Comments from the workshop were integrated into this report.

Ethical Considerations

As part of this study, children were interviewed through individual interviews This direct communication with children required a review of ethical considerations. International standards stipulate the prime importance to consider is that the participation is fully informed, permission is gained, and the data collection does not cause the participant harm.

To ensure compliance a consent procedure was developed. Consent was received from the service provider, the case worker and the care provider (for themselves and the child). The consent procedure included a description of the project, its purpose, the use of the information, confidentiality procedures and an opportunity to ask questions. If consent was not obtained the interview did not continue.

An assent procedure was applied with children. It included the same information and was administered after the consent was obtained from the caseworker and/or care provider.

Limitations

The data is necessarily limited by the type of data collected. The data cannot be independently verified, and responses must be taken at face value. To mitigate this challenge, similar questions were asked from a variety of informants to triangulate findings.

During data collection it was identified that children were not in the types of care reported. For example, a child would be reported to be in foster care but was reintegrated by the time of interview. As a result, this impacts the overall sampling as types of care changed. In fact, an overall finding is that types of care are not clearly identified.

The sample is a large sample of the population of children receiving services, but the data cannot be generalized to children in Cambodia receiving services.

FINDINGS

International Good Practices in Reintegration

Children and Residential Care Institutions

Research has widely demonstrated that children grow up better in safe, healthy and nurturing families. However, children are too often separated from their families due to poverty, migration, parents having poor physical or mental health, family violence, limited services or education opportunities in the family's village, drug or alcohol problems, child maltreatment or other challenges.[4]

When children are separated, despite significant evidence that family-based care is the best place for children to thrive, the numbers of children living in RCIs continues to grow. An estimated two to eight million children are in institutional care worldwide and of that it is estimated 90 percent have at least one parent (Faith to Action Initative 2016). This trend is on the rise even in situations where family-based care is an option. Throughout the world, many of the children entering residential care are not orphans and usually have one or more parents living (OHCHR 2013).

Currently, there are an estimated 48,755 children living in RCIs across Cambodia (MoSVY 2016). A recent mapping conducted by MoSVY in 5 provinces in Cambodia revealed there are 257 RCIs, 20 transitional/emergency homes, and 57 group homes (MoSVY 2016). Most of the children in living in these RCIs are also not orphans. Only twenty three percent of children in residential care had no parents alive in 2009 study (UNICEF 2013).

Clearly, there is a direct connection between poverty and high levels of residential care. Residential care in Cambodia is reported to be seen as a way to give children a better life when their own family faces poverty and lack of resources (OHCHR 2013) (MoSVY 2016).

Research shows children in residential care face many more challenges and issues than children who are living in family care (Bick, et al. 2015) (UNICEF 2011). These include negative effects such as slower development rates, higher rates of abuse, difficulties of reintegration back into society, and poor developmental conditions for the child, especially among younger children under the age of three (UNICEF 2011) (Williamson and Gross 2012).

Some children who live long term in residential care also become accustomed to this way of life and find the transition out of care into adult very difficult, even finding it hard to leave care (Walakira, Duma-Nyanzi and Bukenya 2015). Although residential care is very prevalent worldwide it is not the best method of care for children and does not lead to permanency for children.

Permanency for children means creating family connections and placement options for a child to provide a continuity of care through their lifetime, while establishing a sense

[4] FAST Proposal

of belonging and legal and social status that goes beyond temporary care (Faith to Action Initative 2016) (Williamson and Gross 2012) (Williamson and Greenberg 2010) (Inter-agency group on Children's Reintegration 2016).

In recognition that residential care should be a last resort for children, in 2009, the United Nations General Assembly Adopted the Guidelines on Alternative Care of Children in which a call to end or use residential care as a last resort was made for international practices with out of the home care for children.

At this point the Royal Government of Cambodia (RGC) had already established the Policy on Alternative Care (2006) and Minimum Standards on Alternative Care for Children (2008), both which prioritized moving away from RCIs for alternative care. In fact, the RGC has set a significant goal to reduce children in RCIs by one third in the next few years. This strategy, of course, makes it imperative that an increased understanding of good practices in reintegration are identified and documented.

Principles of Good Practice for Reintegration into Community Based Care

With wide recognition, that children should not grow up in RCIs, the RGC has prioritized the reintegration of children into family-based care. While significant efforts are (and have been) underway to return children to family care, little formal research has been conducted in Cambodia on what makes a successful reintegration of a child into a family. In this section, a review of the current research on principles for good practice in reintegration are reviewed.

Reintegration describes the process of returning and reintegrating a child to family-based care or kinship care from a RCI. Reintegration describes the process of reunification, follow-up, community mainstreaming, and full case closure.

A successful reintegration requires understanding of success indicators, and the interventions that work. Clearly, any model must be tailored to the needs of the individual child and based on their best interest.

Two foundational principles identified in the Guidelines for Alternative Care (UN 2010) are the necessity and suitability principles. The necessity principle means examining conditions and situations which lead to alternative care and ways in which to prevent the need for alternative care. Suitability principle means coordinating care to matching the individual care needs of a child (Cantwell, et al. 2012). This means there must be a robust gatekeeping mechanism in place to first determine if care is appropriate and then find the most suitable care for each individual child.

A number of studies and guidance documents have *identified key factors for successful reintegration.* This means measures to determine if the *process* and *result* of the reunification has resulted in a successful reintegration of the child back into a family and community.

A recent study in Cambodia identified a range of criteria for successful reintegration. In this study, it was noted that positively reintegrated children have sufficient food; attend school or are safety employed; access adequate shelter and stability; are safe from harm; are positively embedded in their communities; and maintain strong, positive relationships with family members (Jordanwood and Monyka 2014).

An ongoing study that is currently being implemented in Uganda, by 4Children has identified domains of success for reintegration. These include psychological health of child and caregiver; child-parent relationship and attachment; social and community acceptance; education access, quality, and achievement; children and health development; and child protection and safety. Basing reintegration in multiple domains creates a holistic approach on creating permanency for children. In addition to the success domains, the project focuses on a comprehensive package of services using high quality case management, reunification cash grants, and a parenting program. This project results are expected to be promising (4Children 2016).

These two key areas focus on key factors for successful reintegration. While the domain categories are, similar and overlapping, a critical factor is how to measure success in each of the domains.

Other research has focused on the *types of services that might be required for a successful reintegration*. The Core Assets Group, a group of international private care providers, formulated a *Framework of Excellence for International Policy and Practice for Positive Outcomes for Children in Care*. This framework, in line with the United National Convention on the Rights of the Child focus on seven standards of service delivery are promoting children's safety; promoting health and wellbeing; promoting growth and development; promoting belonging and kinship; promoting culture; promoting skills for life; and promoting participation. This framework addresses service in a holistic way focusing on key areas of development, safety, and belonging for children in care (Key Assests 2016). This framework is meant to inform service, assessment, evaluation, and support of children and care.

A recent report by the *Interagency Group on Reintegration* focused on learnings on family reintegration among low and lower-middle income countries produced principles of promising practice: respecting an individual's journey; rights-based and inclusive programming; gendered perspective; child perspective; holistic view of the child; standard operations guidelines and procedures; monitoring, reporting, and evaluation; coordination and collaboration; and long-term investment (Wedge 2012). .

This report also provided recommendations on addressing some of the key challenges of successful family reintegration by: creating more dialogue across settings and service providers, working collectively to strengthen and evaluate the reintegration process, undertake key joint research pieces, and develop a toolkit of practices and tools to inform and strengthen global practices of reintegration (Wedge 2012).

One of the primary themes in these principles is the emphasis on *coordination and collaboration* among different actors and service providers. Also, an important standard is *evaluation, documentation*, and building replicable modes of practice. Working together to address community-based care and reintegration while maintaining good practices of monitoring, documentation, and evaluation are core standards in providing permanency for children (Wedge 2012).

Some Promising Practices – International Models

Shifting from residential care to family-based care is in some cases a new way of thinking or 'doing business.' Fears of costs, losing jobs or lack of knowledge or skills can limit effective programming.

Initially shifting out of residential care to family and community-based care can be cost heavy in the beginning, but the long-term cost is less than maintaining residential care for children (Williamson and Greenberg 2010). Using the funds and manpower directed at maintaining a residential care facility can be redirected to the community to better facilitate reintegration and community-based care options.

One model, proven effective by evaluations, academic studies, and recognition as a best practice from the National Implementation Service in the UK and the California Evidence Based Clearing House for Children Welfare is the KEEP model (Chamberlain, et al. 2008). This model originated from Treatment Foster Care Oregon, USA and has since been implemented in parts of New York City, San Francisco, and the United Kingdom. The model focuses on foster placement among children 5-12 years old and to promote child welfare and prevent placement breakdown (Chamberlain, et al. 2008) (Price, Roesch and Escobar Walsh 2012). This evidence-based model primarily targets foster parents and engages participants in an intensive training course and peer support group on practical parenting skills over the course of 16 weeks. A unique aspect of this model is the use of group facilitators who are trained to tailor each session to specific needs and gaps presented by the participating foster parents and been found to be highly effective in maintaining placement and permanency for children (Price, Roesch and Escobar Walsh 2012).

The use of short term foster care was found very useful in the Czech Republic as a step in positive reintegration to permanent homes for children. The survey of short term foster carers looked to better understand the demographics of short terms carers, which children receive foster care, and where children go after short term care. This survey reflected children were in foster care with trained foster parents for around 6-7 months and during this time, ninety-seven percent of these children were placed in permanent homes after temporary foster care, demonstrating short term foster care can be a positive step in the process of permanency for children (Lumos 2015). The survey reflected most carers interviewed were reported to engage in this type of care because they saw this as meaningful and important, most were employed, and about a third took care of children with special needs. This study shows if public awareness is addressed positively and the means are available, people are willing to be foster parents, which can provide a stable home for children while awaiting permanent placement.

The Christian Alliance for Orphans documented replicable models for transition to family-based care internationally among five different case studies. The major themes in all of these case studies is the focus on building of alliances and networks existing in the current communities to focus on family strengthening programs and child protection services (Christian Alliance for Orphans 2015). Another key component in all five case studies was the use of a variety of assessments of family and children before, during, and after reintegration and monitoring the reintegration process starting with supervised family visits and then

working up to full reintegration with biological or foster families, and then even longer-term monitoring after reunification occurs.

Assessments used ranged from initial intake assessments of the children in care, screenings of placement family related to emotional well-being, financial situation, physical health, talks with community, background checks, and references. In addition, home visits were done periodically in many of the models, first to assess parenting skills, current home situation, then, home visit occurred during and after placement to check in and observe the child and family. Assessments used primarily focused on the mental, physical, and emotional wellbeing of the child through placement, in addition to needs being met by the family and the placement. The other focus was assessing the family and their ability to care for the child as well as the progress of the placement.

One case study in Myanmar, documented the transition of an RCI into a family health clinic and community resource center. At the facility, economic and family strengthening services, vocational training, medical care, and tutoring were provided (Christian Alliance for Orphans 2015). What made this case model unique is its focus on family strengthening through economic empowerment. Many of the families undergoing reunification received services to help find employment or start small businesses. All of the children in this residential care center were reunified with family members (Christian Alliance for Orphans 2015).

Another example of working with alterative care practices is Retrak, an international NGO with the mission of keeping children off the streets, which developed standards of practice (SOP) in Ethiopia and Uganda specifically targeted on family reintegration (Corcoran and Wakia 2016) (UNICEF, USAID 2012). Retrak takes a special approach using multidimensional well-being assessments with children through the entire process of reintegration, focusing on addressing poverty and marginalization among children and families, and sees reintegration as a long process (Corcoran and Wakia 2016).

Retrak used parts of this tool as way to steer decision making among different children and families by service providers and also as an ongoing monitoring tool. What is also unique about this approach is the ability to be flexible and address each child's and families' needs on an individual basis. Family and community acceptance was reported to be key to successful reintegration.

In Cambodia, significant work has occurred on reintegration, however, no overall documentation of practices has occurred. While many of the projects funded under FCF are or likely implementing good practices, these are not included in this desk review and will be covered in a separate documentation process. However, following are some key points on good practices from various researches in Cambodia.

Recent work with local NGOs in Cambodia which target providing family strengthening services and educating local duty bearers on the harmful effects of residential care have begun to shift more children out of RCIs and expanding community based care at the sub-national level in Cambodia (USAID 2015) (Jordanwood and Monyka 2014). One key aspect reported in successful reintegration with family in both of these studies is economic support and empowerment among families (Jordanwood and Monyka 2014).

A 2011 MoSVY study on attitudes regarding residential care, revealed about ninety-two percent of those interviewed saw residential care as a good option for poor families who cannot afford to send children to school, making this choice is viewed as a pathway out of poverty (MoSVY 2011). School fees usually take up about twenty five percent of a poor families' household income (World Bank 2005). So addressing economic needs, especially as it relates to school fees and education is essential for positive reintegration in Cambodia.

One step in finding alternative care approaches in Cambodia is the use of mapping of vulnerable children by the Commune Council for Women and Children (CCWC). A recent initiative funded by USAID, reflected mapping worked well in one commune to not only address child protection but also to provide alternative responses to care for children besides residential care (Williamson and Gross 2012). Also, included in this initiative is the emphasis on translating documents on the negative effects of care in Khmer to distribute among local authority at the sub-national level (Williamson and Gross 2012).

Other success in Cambodia include working on adoption and innovative approaches to care, like working through Buddhist leaders, cash transfers, family-based care and practices, family strengthening programs, and the formation of day care and community-based centers to support family preservation and the use the of residential care as a first step (UNICEF 2013).

Transitioning Out of Residential Care

Residential care should only be used as a last resort and only in RCIs with staff trained and certified in child development and child protection (UN 2009)(Walakira, Duma-Nyanzi and Bukenya 2015).

If possible, a best practice is transitioning a RCI or other institutionalized care into another form of support for children and families, like a daycare, community center, or some other type of family service or family strengthening entity (Faith to Action Initative 2016). This could also mean closing down RCIs all together and focus energy and support on family strengthening and child projection mechanisms already present in the community.

Transition from residential care takes time and the transition process will vary depending on the context. process.. The key elements of a transition include:

- Understanding the primary causes of separation for the children in care;
- Assessing the national policies and community contexts;
- Raising awareness about family care with key stakeholders to reduce stigma, encourage family support, and identify those interested in serving as foster or adoptive families;
- Developing a clear vision and plan for a model of family care;
- Developing a business plan to sustain the transition with adequate resources;
- Identifying and cultivating partnerships with individuals and organisations;
- Developing individualized plans for each child and preparing to join families;
- Tracing children's families to determine if reintegration into biological families is possible;

- Recruiting and preparing families along the continuum of care (e.g. kindship care, foster care, adoption)
- Transiting each child into an appropriate placement option; and
- Monitoring children and families to ensure that their needs are being met (Faith to Action Initative 2016)

Common Elements in Good Practices for Reintegration

Based on a review of international models the following common elements have been identified as good practice in reintegration.

Permanency for children is in family-based care is the best avenue for children because they have deeper sense of belonging, more independent, and transition into adult much easier (Walakira, Duma-Nyanzi and Bukenya 2015).

Regular contact between the child and their family. Elements included in alternative care models is regular contact between children and their families, with reunification as the goal if it is in the best interest of the child (UNICEF 2011). Effective alternative care models and family support programs offer a mix of targeted service options and view parent support as a universal concept (Daro 2016).

Gatekeeping is an approach which ensures alternative care only occurs when needed and offers support on an individualized basis (Better Care Network & UNICEF 2015). Gatekeeping places the primary focus on the needs of the child and family to better inform decisions regarding care. These practices are usually formulated based on national standards and develop protocols to keep children out of unnecessary care (Williamson and Greenberg 2010).

Tracing is a practice used to ensure all possible kin has been found and contacted for permanency and care placement. Family connection mean keeping an established connection to family members even if the child is place in care outside of the home.

A **case management approach** provides services based on individualized needs and offers a variety of assistance. This management approach is typically rooted in greater child protection framework backed up by policy and law.

Monitoring, evaluation, and assessment is also a fundamental successful practice of permanency. All of the principles and models emphasize using documentation, assessment, monitoring, and other evaluations throughout the process of reintegration and after reintegration occurs as a tool in sustainable permanency.

Understanding the national context national context as it related to child protection and the mechanisms in place to safeguard children (Inter-agency group on Children's Reintegration 2016). Understanding alternative care as it relates to the context of each's nation current capacity and context establishes the what best care practices will be needed. This is particularly important as it relates to informal aspects of child protection within a government formal system, as most formal government child protection systems do provide space for flexibility in alternative care practice (Williamson and Gross 2012).

Best alternative care for children is usually family care and kinship. A family-based model of children's care centers on placing children with biological, foster, or adoptive families, while simultaneously strengthening families through educational, economic, material, and psychological support services to prevent separation. (Faith to Action Initative 2016). Family care and kinship care are rooted in community response and services to ensure safety and wellbeing of the child while supporting the family. This is especially true of economic support and keeping children in school.

Child participation in in care decisions: Also, some more focused aspects of care highlighted in a report not mentioned above on how to implement the Guidelines for Alternative Care (UN 2010) are the importance of the participation of children and young people in care decisions and care settings, placement of children aged 0-3 in family care settings, and support for aftercare or "ageing out" of care (Cantwell, et al. 2012).

Current Laws or Regulations that Support or Are Barriers to Successful Permanency Planning

The Alternative Care Policy (2006) and the Prakas on Procedures to Implement the Policy on Alternative Care for Children (2011) were identified as having a positive impact in promoting permanency planning for children. In this study, managers, case workers and other key informants repeatedly identified these policy documents as a factor in moving away from residential care, and as tools that informed and guided their work. All organizations reported they use the Alternative Care Forms approved by the MoSVY as part of their case management process. Clearly, the setting of policy has had a positive impact in the priorities for family-based care for the organizations participating in this research in this research.

The Explanatory Note for Domestic Adoption (2017) and the Law on Intercountry Adoption (2009) were both identified as policies that promote permanency for children. However, challenges were identified with implementation. Key informants reported that the process for domestic adoption is still unclear and a barrier to formalizing long-term foster care into adoption. Case workers and care providers described the process for domestic adoption as too complicated. It is important to note that other barriers to domestic adoption were also identified in this study including the cultural preference not to disclose the child is adopted. Legal procedures make this practice difficult. Currently, there are efforts to standardize domestic adoption and make it accessible as an option for permanency.

The Intercountry Adoption Law (2009) was also identified as an important policy. This law was promulgated to improve intercountry adoption practice to be in line with The Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption signed by Cambodia in 2007. An Inter-Country Adoption Administration has been established with significant support from UNICEF, The Hague Permanent Bureau and others to standardize procedures and practices. However, there have not yet been any intercountry adoption placements under the new law. A key challenge in promoting ethical intercountry adoptions is

the lack of an adequate permanency planning process/system that provides substantive efforts to preserve or reunify families, and an accessible domestic adoption process.

Emerging practice in the development of practice guidelines was identified as promising to have a positive on permanency planning processes/systems. The development of guidelines in key areas of practice will promote improved permanency planning. Guidelines are currently being developed to standardize and guide reintegration, foster care, and supervision.

Another promising step is the development of Social Work Standards for Generalist Practice and Specialized Levels. These will help guide and improve social work practice which is critical to improved permanency for children.

Another positive effort is the promotion of communities of practice and coordination of services through FCF.

Current Approaches and Models for Permanency for Children in Cambodia

Approaches to Care Models

The seven service providers participating in this research provide a range of care and supportive services to children and families. The service providers were selected to participate in this research based on their involvement in TSG4 Action 3. Each of the organizations is a civil society organization registered to work in Cambodia. The organizations have developed independently based on their organizational history, mission, organizational and donor priorities. However, all have similar priorities to ensure that children grow up in families.

Their services and organizational priorities are focused on:

- Strengthening birth families' capacity to care for their child to prevent placement;
- Addressing protection issues such as violence, abuse, neglect, or addiction;
- Providing alternative family-based care including kinship care and foster care, and emergency care, and independent living arrangements; and
- Supporting successful reintegration of children in their birth families from alternative care placements (i.e. residential care, kinship care, foster care or other living arrangements)

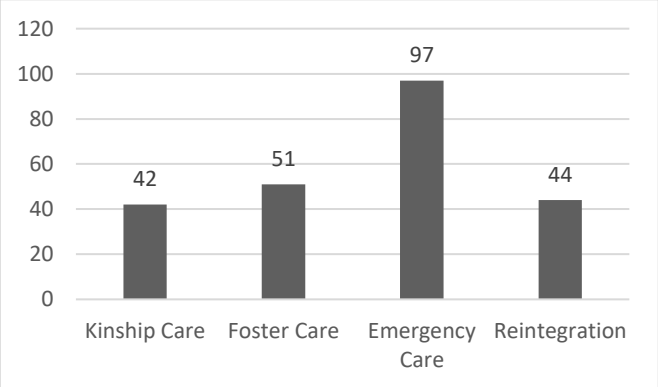

FIGURE 1: TOTAL NUMBER OF CARE PLACEMENTS REPORTED BY TYPE N=234 (SOURCE: PROJECT REPORTS, FEB 2018)

Based on reporting from the seven projects reports there have been a total of 42 children placed in kinship care, 51 in foster care, 97 in emergency care, and 44 reintegrated (see Figure 1). These placement options are discussed in the following section.

Family Preservation

The Prakas on Procedures to Implement the Policy on Alternative Care for Children describes Family Preservation Services as *"services that shall be provided based on the assessment of the risks and the family's own resources to cope with the risks. The services aim to stabilize and empower the family, so the child can be cared for by the caregiver both for the short and long term*" (MoSVY 2011).

This research did not explore family preservation in depth as it is not a type of alternative care. However, in the sample eight children were identified that were family preservation cases. All organizations in the study contributed to or provided family preservation services. Family preservation was prioritized based on their own organizations knowledge and priority for care

in the birth family. All service providers also reported being guided by the priorities of the Prakas on Procedures to Implement the Policy on Alternative Care.

The families receiving family preservation services had sought help because of a family of origin crisis, sexual abuse or other issue (see Figure 2). Families and children were referred from other service providers, from the local authorities or were identified by the agency or sought help on their own.

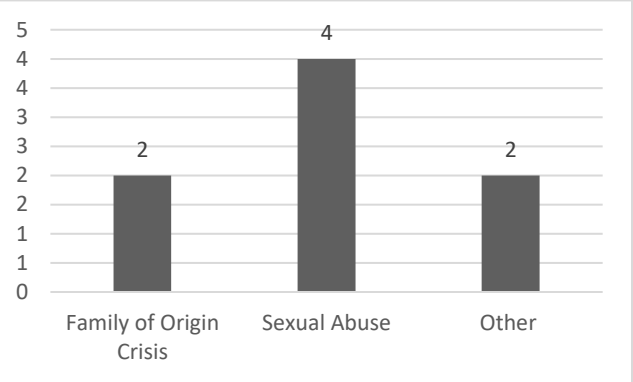

FIGURE 2: FAMILY PRESERVATION: REASON FOR SEEKING HELP N=8 (SOURCE: CARE PROVIDER INTERVIEW)

Services to prevent placement were based on assessment of the families need and an intervention plan to meet the needs based on the services provided by the service provider.

Originally some of the children receiving family preservation services were classified as kinship care, but during the interviews with care providers it was learned that the children had not been placed in an alternative care setting and had received services to prevent placement, so these cases were considered family preservation. If the child had been placed in alternative care of any type, then returned home, the case was classified as reunification.

Services and Support

Services included material support (food, improved shelter), educational support, income generation, individual and group counseling, legal support, health care and parent education (See Figure 3).

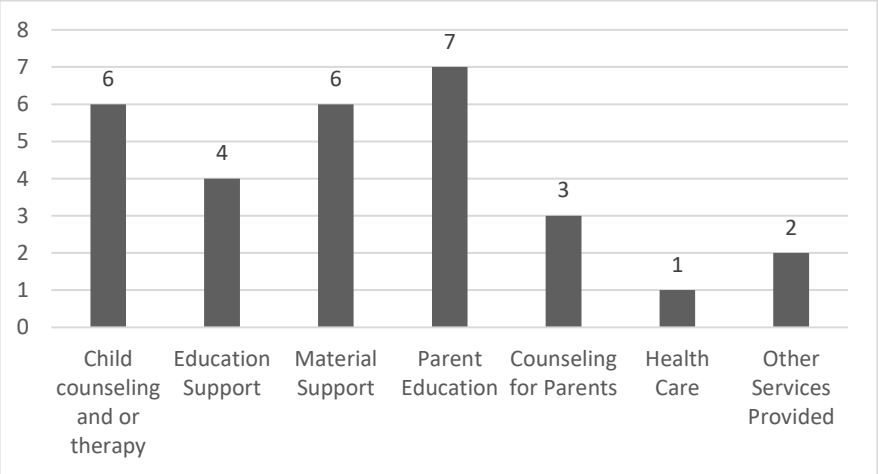

FIGURE 3: FAMILY PRESERVATION: SERVICES PROVIDED TO CHILD AND FAMILY N=8 MULTIPLE RESPONSE PERMITTED (SOURCE CASE WORKER INTERVIEW)

Care providers were also asked to rate their satisfaction with services. The first three categories of service were communication, home visits, and guidance/support for caring for the child). The majority of the families were dissatisfied with all three services (See Figure 4).

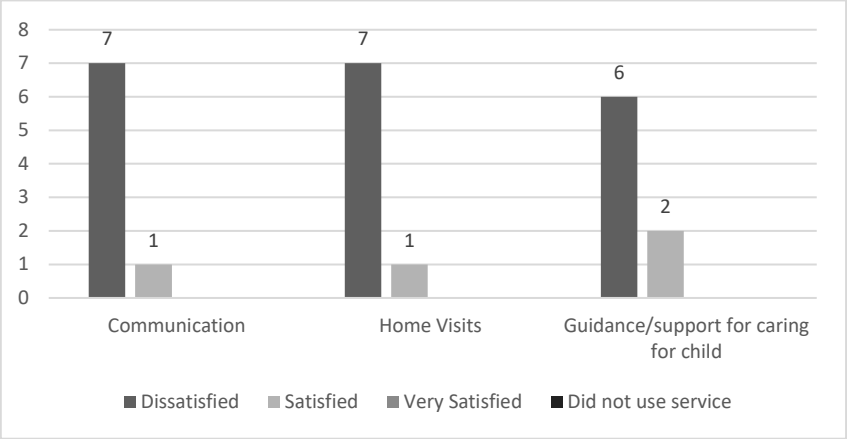

FIGURE 4: FAMILY PRESERVATION: SATISFACTION WITH SERVICES N=8 (SOURCE CARE PROVIDER INTERVIEW)

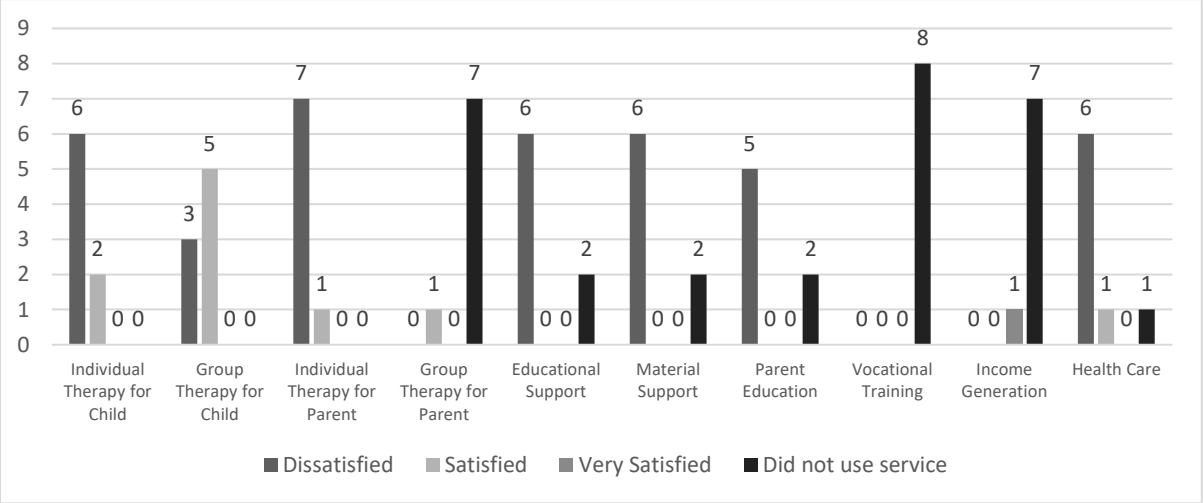

FIGURE 5: FAMILY PRESERVATION: SATISFACTION WITH SERVICES N=8 (SOURCE: CARE PROVIDER INTERVIEW)

Families (care providers) were asked about their satisfaction with other services. For individual therapy for the child, material support, parent education, health care and educational support the majority of families reported being dissatisfied with the services if they used it. For vocational training and income generation most families had not used the service (See Figure 5).

While the families receiving services reported a high rate of dissatisfaction, the primary concern raised was that the services were 'not enough'. Families reported worry about their ability to provide for the child, send him/her to school, and provide health care and meet other needs.

Kinship Care

The Prakas on Procedures to Implement the Policy on Alternative Care for Children describes Kinship Care as a "*situation in which extended families take an orphaned or other child in. Carers can be grandparents, aunts or other relatives of the child. This common practice is*

deeply rooted in Cambodian culture. This type of care, may however be based on a written agreement between parents, extended family, local or central authorities and an organization" (MoSVY 2011).

The UN Guidelines for the Alternative Care of Children (2009) define kinship care as *'family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature'.* (UN 2009).

In this study, five of the seven organisations participating in the research supported kinship care services and all prioritized kinship care based on their organizations knowledge and policy promoting family-based care and all mentioned the Policy on Alternative Care as guiding this practice.

The organizations participating in the research did not have a consistent definition of kinship care across organizations. Some cases that were classified as kinship care were actually birth parents and the case had to be reclassified as family reunification or preservation after the interview.

Based on project reports, by February 2018, the service providers in the research had made a total of 42 kinship care placements, 51 care plans for kinship care, 31 children referred for permanency. With these cases there 573 home visits were conducted. Fifty cases were conducted in cooperation with relevant authorities to ensure legal framework and 10 included the Department of Social Affairs Veterans and Youth Rehabilitation (MoSVY) in the process of service delivery (See Figure 6)

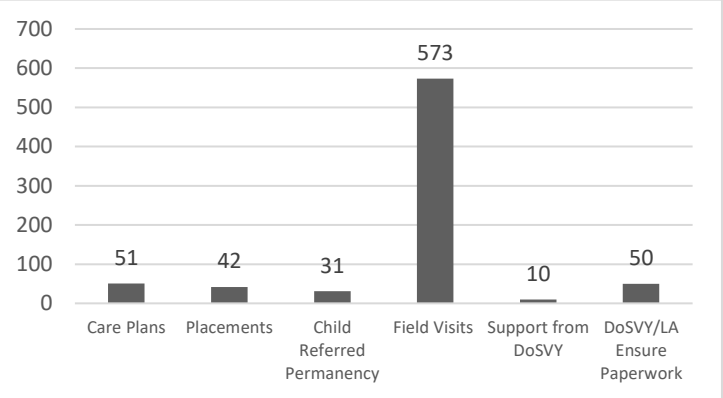

FIGURE 6: KINSHIP CARE CASES (SOURCE: PROJECT REPORT FEBRUARY 2018)

Locating Kinship Care Providers

All organizations participating in the research reported their organization carried out family tracing in cases of kinship care when required. Types of family tracing methods reported were using genograms or other mapping tools to identify family members, seeking information from local authorities, or using knowledge the organization already had about the family.

In the cases explored in this sample most of kinship care cases did not require tracing (only three used family tracing). Some of the children were already living with extended family members when they sought help and others had known family members.

Criteria and Training for Kinship Carers

Case workers and organization staff were asked about the criteria to be a kinship care provider. The criteria were described as the ability of a relative to provide safe and adequate care, be financially stable, and have no drug or alcohol abuse or other child protection issues in the family.

Kinship carers are provided some training to be care providers, but it is not mandatory or universal between service providers. Case workers reported an orientation process, parenting training, first aid and other training related to child rights or other topics.

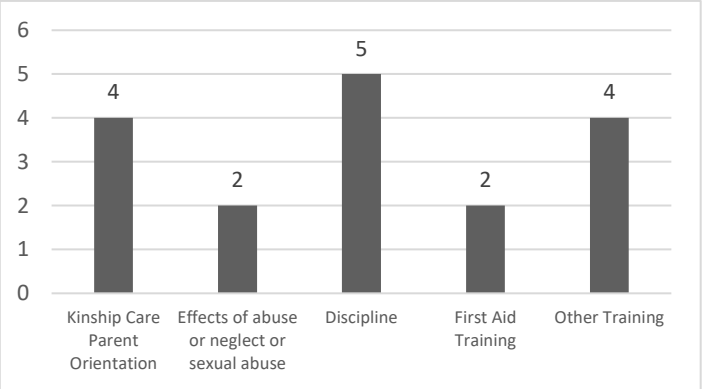

FIGURE 7: KINSHIP CARE: TYPES OF TRAINING RECEIVED N=11 MULTIPLE RESPONSES PERMITTED (SOURCE: KINSHIP CARE PROVIDER INTERVIEW)

Kinship care providers described receiving a variety of training including orientation, effects of abuse and neglect, discipline, first aid and other training (child rights also) (see Figure 7).

There were no unique characteristics of children that were eligible for being placed in kinship care.

Motivation of Kinship Care Providers

Kinship care providers were most commonly motivated to care for the child because of family problems and a resulting perceived obligation to care for the child. Carers described various crisis such as divorce, death, illness, and others combined with the responsibility they felt to care for the child. A few reported the desire to help a child or being asked (See Figure 8).

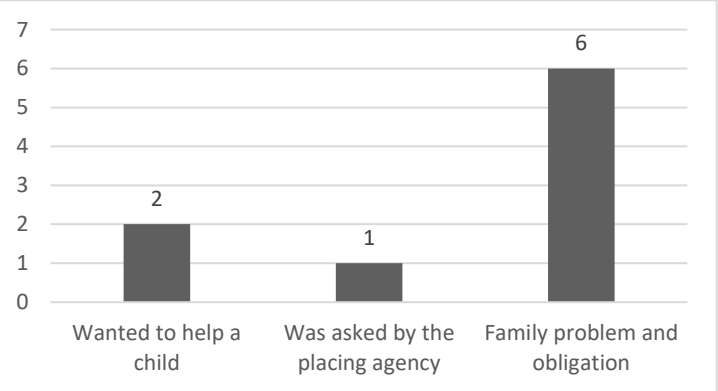

FIGURE 8: KINSHIP CARE: MOTIVATION OF CARERS N=11 (SOURCE KINSHIP CARE PROVIDER INTERVIEW)

Care providers interviewed were most often older (grandparents) and caring for multiple children. In a few cases the carer was an aunt or other relative.

Kinship care providers described the rewards and challenges in providing care. They described being happy/proud they were able to care for their relative and see the child's life improve either in health or behavior. Some challenges were not having enough money to adequately care for the child or provide adequate health care. Others described being older and having challenges providing care or having concerns for the child when they are no longer able to care for the child.

Support and Services for Kinship Care Providers

Kinship carers were provided a range of support by the various service providers. Commonly potential (or existing) kinship care providers were assessed to determine their needs to be able to care for the child. As a result of the assessment, carers were provided support based on the need identified if the service provider had that services.

If families had the capacity and resources the only service was providing supportive services to monitor the placement. This was in the form of home visits. Families that lacked capacity or resources could receive additional resources. Some service providers provide monthly stipends, some provide parent education, other training or other support and services (see Figure 9).

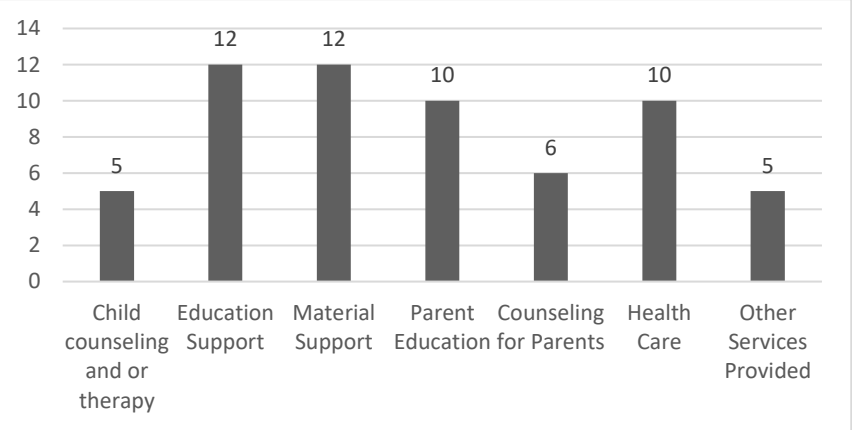

FIGURE 9: KINSHIP CARE: SERVICES PROVIDED N=14 MULTIPLE RESPONSES (SOURCE CASE WORKER INTERVIEW)

Kinship care case workers were asked to report on the services provided in the cases that were reviewed. Commonly each child and family receive multiple services (see Figure 10).

The most common service received was education support, and material support (food, clothing, etc.), followed by parent education, and health care. Other services were counseling for the child and counseling for the parent (carer). Most commonly counseling was described as supportive counseling or guidance. Some organizations held kinship care meetings bringing together kinship carers for training or support.

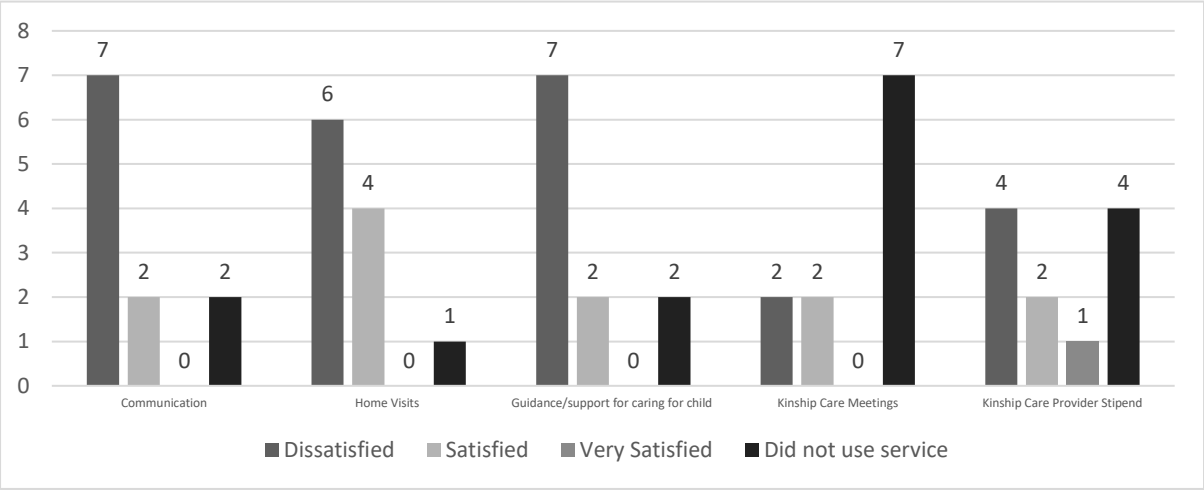

FIGURE 10: KINSHIP CARE SATISFACTION CARER WITH SERVICES N=11 (SOURCE KINSHIP CARE PROVIDER INTERVIEW)

Kinship carers were asked to respond to their satisfaction with services received (see Figure 10). The first set of statements were about satisfaction with communication, home visits, guidance/support for the child, kinship care meetings, and kinship care stipend. The majority of kinship carers were not satisfied with the communication, home visits, and guidance and support for the child. Most had not participated in kinship care meetings. Of the ones that received as stipend the majority were dissatisfied. In discussion with kinship care providers the reason for dissatisfaction was commonly because they wanted 'more' of whatever service it was. Some noted the helpful case workers providing information and support. They raised their fears and concerns about their ability to care for the child into the future most commonly because of the lack of resources in the family.

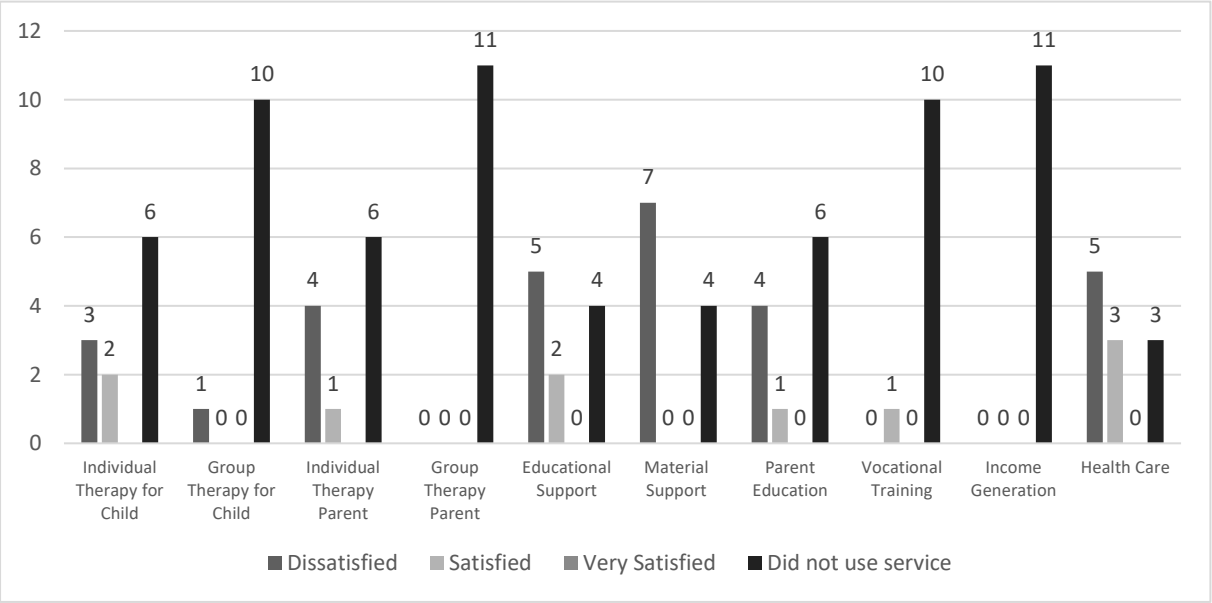

FIGURE 11: KINSHIP CARE: SATISFACTION OF CARER WITH SERVICES N=11 (SOURCE KINSHIP CARE PROVIDER INTERVIEW)

When exploring further the satisfaction with services received by the child or carer, the most common services received were educational support and health care (most commonly for the child). Of those receiving these services almost half of carers reported they were not satisfied with the services. Generally, with all services received most carers were not satisfied with the service (see Figure 11).

As was noted earlier in family preservation services, the reason stated was that they wanted more from the service. For example, kinship carers commonly mentioned concern about educational support. Some stated they feared they would not be able to send the child to school if the support ended. Others were concerned for higher education costs for the child. Material support was another service where kinship care providers were not satisfied. This was again because the support they received was not perceived as enough to meet the need or burden of caring for the child. In a few cases where the child had disability the carer raised concerns about who would care for the child when they were not longer able to do so.

Foster Care

The Prakas on Procedures to Implement the Policy on Alternative Care for Children describes foster care as *"a form of temporary care in which a family agrees to take an unrelated child in. It is usually for a short-term duration and does not involve the permanent transfer of parental rights and responsibilities. Its main aim is the eventual reunification of the child with the birth family or the child's adoption into a permanent family. This practice is deeply rooted in Cambodian society and generally does not involve any legal agreement. It may however be based on a written agreement between parents, extended family, local or central authorities and an organisation*" (MoSVY 2011).

The draft Reintegration Guidelines developed with support of FCF propose a broader definition defining foster care "*using the as care arrangement administered by a competent authority, whether on an emergency, short-term or long-term basis, whereby a child is placed in the domestic environment of a family who have been selected, prepared and authorised to provide such care, and are supervised and may be financially and/or non-financially supported in doing so*."[5] This definition recognizes the importance of formalizing the foster care relationship by a competent authority.

The service providers in this study were identified as providing two types of foster care – short-term or emergency foster care and longer-term foster care.

Emergency or Short-Term Foster Care

Emergency or short-term foster care is being implemented by service providers as a family-based care option for a child while case workers investigate longer-term options. As described in the Family Care First Project Proposal in emergency or temporary foster care "children will receive care in an alternative family in a safe and loving environment while case workers seek a permanent solution for the children. Permanent soluti ons include: reintegration, kinship care, long-term foster or adoption".

Three projects are providing emergency or temporary foster care. The projects vary in the way they operate. However, commonly projects had manuals or organizational procedures and tools that guided their implementation of foster care.

Based on project reports, by February 2018, the service providers providing emergency or short-term foster care participating in this research had made a total of 108 care plans, 97 placements, 14 children referred for permanency and 841 field visits. In 43 cases support from DoSVY was provided in service delivery and in 34 cases the service provider cooperated with local authorities and or DoSVY to ensure paperwork was in line with appropriate procedures (See Figure 12).

[5] Draft Reintegration Guidelines. Original source definition: Interagency Working Group on Unaccompanied and Separated Children (2013) *Alternative Care in Emergencies Toolkit,* published by Save the Children on behalf of the Interagency Working Group on Unaccompanied and Separated Children.

The time limit for a child to be in emergency or short-term foster care ranges from one month to six months, but these limits are described as flexible.

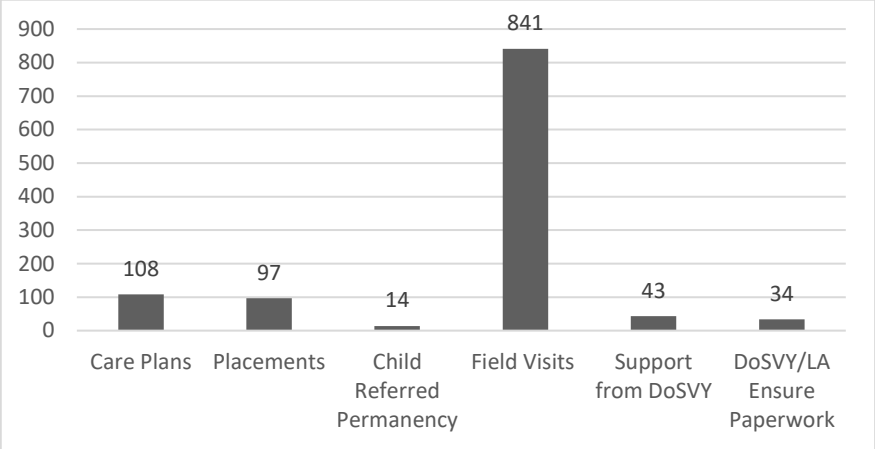

FIGURE 12: EMERGENCY CARE CASES (SOURCE: PROJECT REPORT FEBRUARY 2018)

The age limit for emergency or short-term foster care also varies. One project has an age limit of 0-6 years, another targets younger children only (with no stated age limit), and others target children 5-17 years of age. This has the appearance of showing a wide range of availability of short term or emergency foster care, but, geography and numbers of available families limit the available care.

Long-term Foster Care

As described in the project documents, long-term foster care is implemented when other reintegration and kinship care efforts have proven to be untenable. This is expected to be after 22 weeks, but entry into long-term foster care varies based on the unique situation of the child and family. Some stay longer if there is a possibility of reunification within a short time past the time limit.

Three projects are implementing longer term foster care. One organization transitioned from providing care in an RCI to long-term foster care.

Long-term foster care is most commonly used/viewed as a permanent placement, although some organizations do use longer term foster care as temporary care but just longer than six months.

Based on project reports, by February 2018, the service providers providing foster care participating in this research had made a total of 60 care plans, 51 placements, 24 children referred for permanency and 1471 field visits. In 23 cases support from DoSVY was provided in service delivery and in 37 cases the service provider cooperated with local authorities and or DoSVY to ensure paperwork was in line with appropriate procedures (see Figure 13)

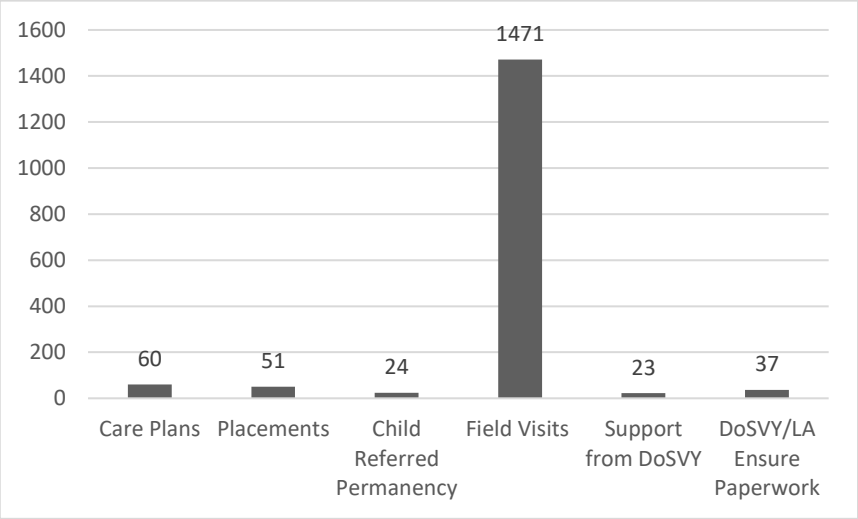

FIGURE 13: FOSTER CARE (SOURCE: PROJECT REPORT FEBRUARY 2018)

While the entry into long-term foster care is expected to be after about six months, the time limit for long-term foster care is not clearly defined. For children where long-term foster care is considered a permanent placement the child is expected to stay until he/she is 18.

The organizations did not report an age limit for long-term foster care.

Because long-term foster care considered by some service providers as a permanent placement even though the status of the child has not been formalized, care providers were asked if they intended to adopt (formalize) the child in their care. Forty percent responded 'yes' they planned to adopt (See Table 1). It is unclear however, if they understand the legal process and commitment of adoption, however this does show a positive intent to care for the child long-term. The concern is for protecting the child's rights in the family if the relationship is not formalized.

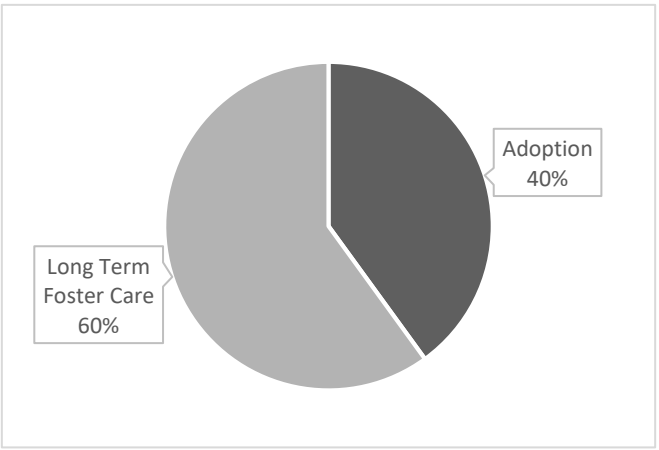

TABLE 1: LONG TERM FOSTER CARE: PLAN TO ADOPT N=10 (CARE PROVIDER INTERVIEW)

Recruitment of Foster Parents

Case workers and service provider staff reported a variety of ways that both short term and long-term foster parents are recruited. The common ways described were announcements for recruitment of foster parents to local authorities, other foster families and project staff. Some

used tools such as radio advertisement and at least one advertised or placed notices through a church.

Criteria and Training for Foster Parents

Case workers and project staff were asked about the criteria to be a short-term or emergency and longer-term foster parent. Every organization had specific criteria for foster parents. A variety of criteria were described that focused on the stability of the family and their capacity and commitment to care for the child.

Criteria described by case workers were that potential foster parent(s) loved children, are financially and emotionally stable, with a good living environment and appropriate housing, have knowledge and experience in caring for children, understands child rights and child protection issues, and can serve as a role model for children. All mentioned that potential families should not participate in gambling, alcohol or drug abuse or domestic violence. Some mentioned families must be willing to participate in training.

The process for becoming a foster family is an application and assessment process (including the background check). This process typically is guided by a formal application. Potential foster parents must pass a background check that includes interviews or reports form the local authorities, police, neighbors and family.

A few service providers have additional specific criteria for foster families such as number of children in home, restrict the child being placed to be younger than then youngest child in care. Others permit multiple foster children in one home.

One important difference in criteria for long-term and short-term or emergency foster families is that long-term must be willing to commit to caring for the child long term.

Training for foster parents was required by all organizations. Generally, an orientation to be a foster parent is provided (short, emergency and long-term), and a variety of trainings are provided. Trainings topics reported by case workers are on parenting skills, first aid and basic health care, hygiene, child rights and child protection, Minimum Standards of Alternative Care, legal issues for children, caring for children with disabilities, trauma, and food preparation.

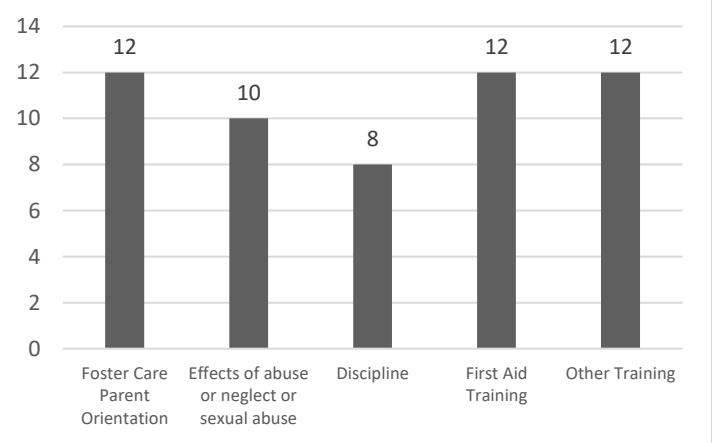

FIGURE 14: FOSTER CARER TRAINING TYPES OF TRAINING RECEIVED N=16 MULTIPLE RESPONSES PERMITTED (SOURCE: FOSTER CARE PROVIDER INTERVIEW)

Foster parents reported receiving orientation, training on effects of abuse, neglect or sexual abuse, discipline, first aid and other training such as child protection, child rights, first aid, hygiene and others. Foster parents reported they were regularly invited to trainings

(See Figure 14). Fifty percent of foster parents requested additional training on discipline and on caring for children with disabilities.

Criteria for children to be accepted into foster care

The organizations had specific criteria for children to be placed into foster care. For all foster care the requirements were the child is orphaned, abandoned or vulnerable, referred by government residential care institution. For children to be referred to longer-term foster care as a permanent placement, the criteria were the child has no kin or kin with ability to care for the child, the birth family has child protection issues, child is referred from short-term foster care, or transitioned from a residential care institution.

Some organizations have limitations such as not accepting children with disabilities or drug addicted children.

Motivation of Foster Parents

Foster carers were asked their motivation to help a child. Overwhelming most foster parents reported it was because they want to help a child (see Figure 15). A few reported the income was important, or they were asked by the placing agency. At least one reported feeling lonely or they wanted a child.

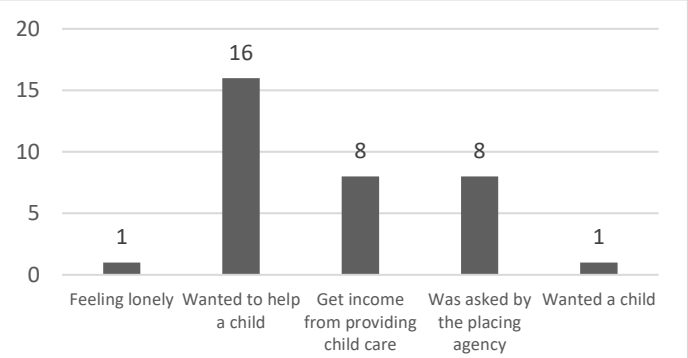

FIGURE 15: MOTIVATION TO BE A FOSTER PARENT N=16 MULTIPLE RESPONSES PERMITTED (SOURCE: FOSTER CARE PROVIDER INTERVIEW)

Support and Services

Foster care providers were provided a range of support by the various service providers. Most receive a monthly stipend for their work to provide care to the child. The stipend ranged from $30 per month to $100 per month. In some cases, the foster parents are staff of the organization resulting in regular pay and some benefits.

In addition, to the stipend or pay, some parents received food support, other household supplies (nappies, shampoo, etc.) school supplies for the children, other household supplies, medical care, sleeping sets, and training.

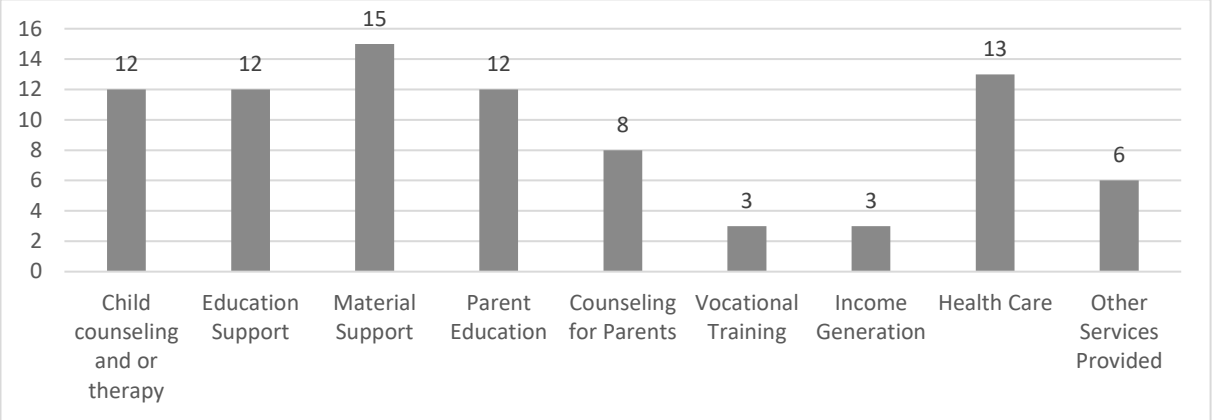

FIGURE 16: FOSTER CARE SERVICES TO CARER AND CHILD (SOURCE FOSTER CARE PROVIDER INTERVIEWS)

Even though a variety of support is provided it is not consistent across agencies. Some report they assess what they family needs and provide based on the assessment. Others provided detailed support for specific items and others provide cash and the foster family provides. Children in foster care, their birth families can access a variety of services (See Figure 16).

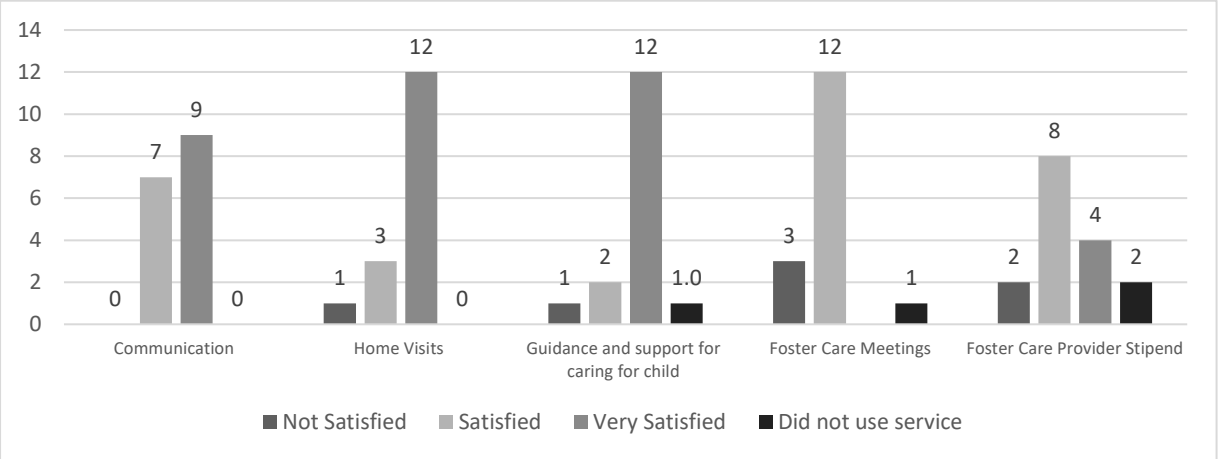

FIGURE 17: FOSTER CARERS SATISFACTION WITH SERVICES N=16 MULTIPLE RESPONSES PERMITTED (SOURCE FOSTER CARER INTERVIEW)

Foster care providers were asked to report on their satisfaction with services and support received from service providers. Generally, foster carers reported satisfaction with services such as communication, home visits, and guidance and support for the child. Only a few were not satisfied with foster care meetings or the stipend (See Figure 17).

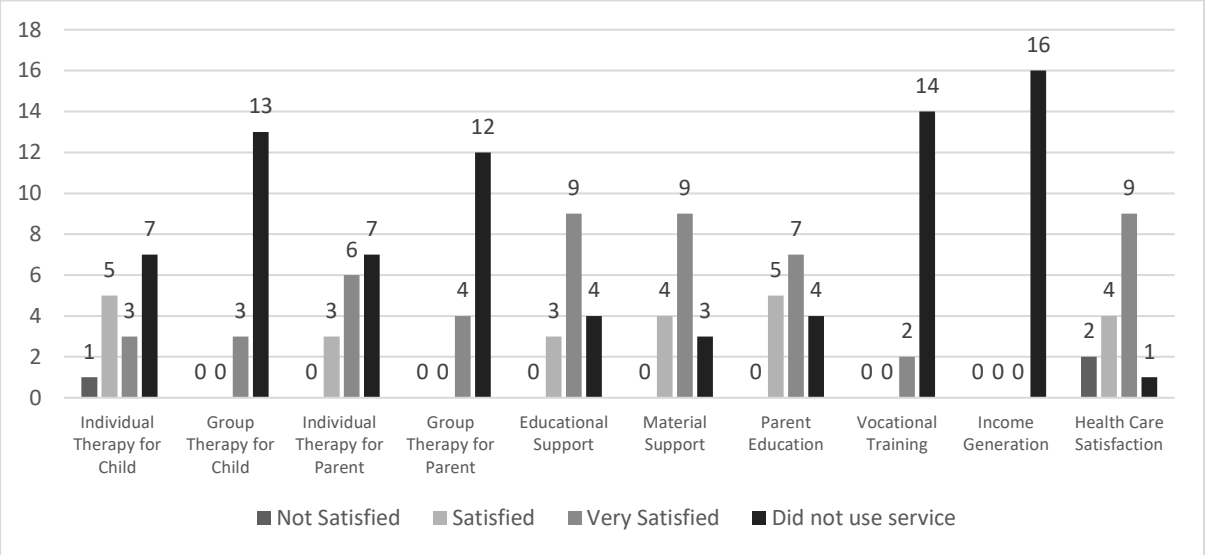

FIGURE 18: FOSTER CARER SATISFACTION WITH SERVICES N=16 MULTIPLE RESPONSES PERMITTED (SOURCE: FOSTER CARE PROVIDER INTERVIEW)

With other services, when a foster care provider used the service, they were most likely satisfied with the services. Only in a few cases did the foster parents note any dissatisfaction. One was with individual therapy for the child. This was a voluntary foster parent, not recruited or supervised by an agency, and this parent reported 'she did not want to mark unsatisfactory because she had such good results with another child'. Other dissatisfaction was with health care (See Figure 18).

Family Reunification and Reintegration

The Prakas on Procedures to Implement the Policy on Alternative Care for Children describes reunification services as "*services to assist children separated from their families due to migration, trafficking, alternative care placement, abandonment or any other reason. in reunification with their families". The procedures further describe the reunification "should be based on an assessment of the child's and family's needs and situation, in order to reintegrate the child back into the community*" (MoSVY 2011).

Other experts have described that the process of reunification and reintegration are two separate and interlinked processes. Reunification is the physical reuniting of a child and his or her family or previous caregiver with the objective of this placement becoming permanent. Reintegration is the process of a separated child making an anticipated permanent transition back to their family and community (usually of origin) in order to receive protection and care and to find a sense of belonging and purpose in all spheres of life (Wedge 2012).

In this study, all service providers were working on or contributing to family reunification and reintegration. Family reunification was prioritized based on their own organizations knowledge and priority for care in the birth family. All service providers also reported being guided by the priorities of the Policy on Alternative Care.

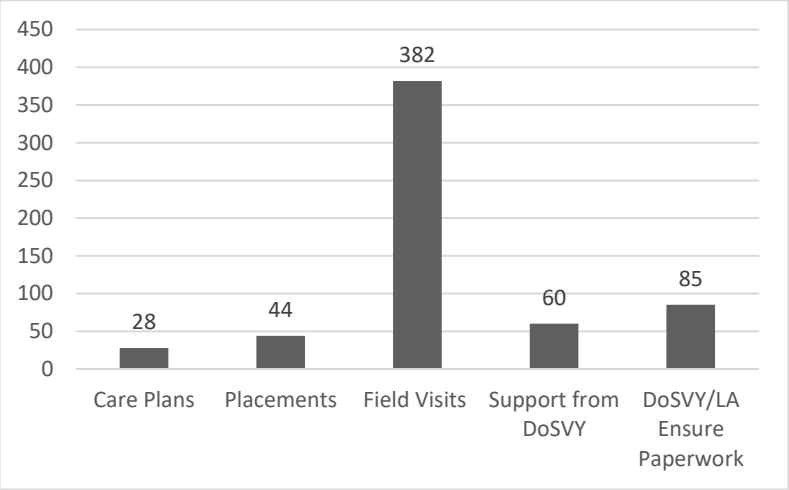

FIGURE 19: REINTEGRATION: (SOURCE: PROJECT REPORT FEBRUARY 2018)

Based on project reporting for family reintegration by February 2018, 28 care plans had been completed, 44 placements and 382 field visits. Sixty cases were implemented with support of DoSVY and in 85 cases the paperwork was done in compliance with DoSVY and Local Authorities (See Figure 19).

Support and Services

The children that had been reunified were either from an RCI or foster care. For these families the most common services were material support and health care followed by education support. After the reunification some families continued to receive education support and other support as needed. Home visits and follow-up continue as well. Case workers reported initially after the reunification going to visit the family more often (sometimes even weekly) and later monthly or quarterly. Sometimes follow-up is also done by phone.

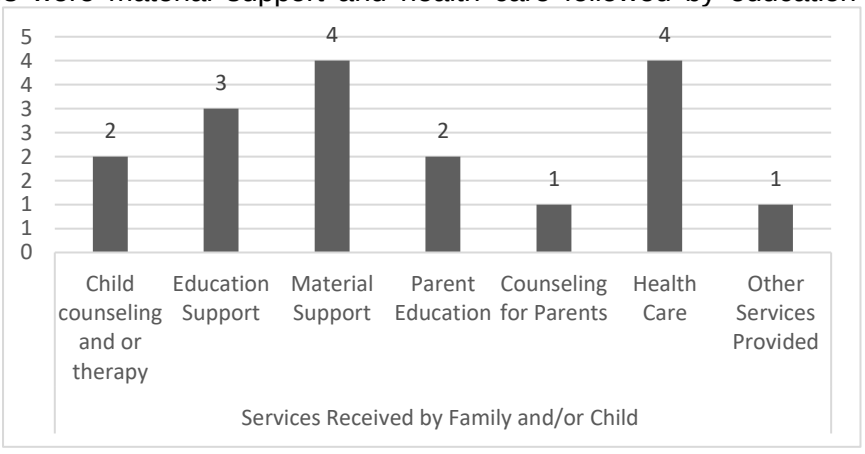

FIGURE 20: FAMILY REUNIFICATION AND REINTEGRATION: SERVICES RECEIVED N=4 MULTIPLE RESPONSES PERMITTED (SOURCE CASE WORKER INTERVIEW)

Families that had been reunified were asked about their satisfaction with services (See Figure 21). The majority of families were not satisfied with the home visits and guidance and support for caring for the child. With communication about the families carers report being satisfied with services.

FIGURE 21: FAMILY REUNIFICATION N=4 (SOURCE CARE PROVIDER INTERVIEW)

Again, this was because the service was reported to be 'not enough', not because they did not want the service.

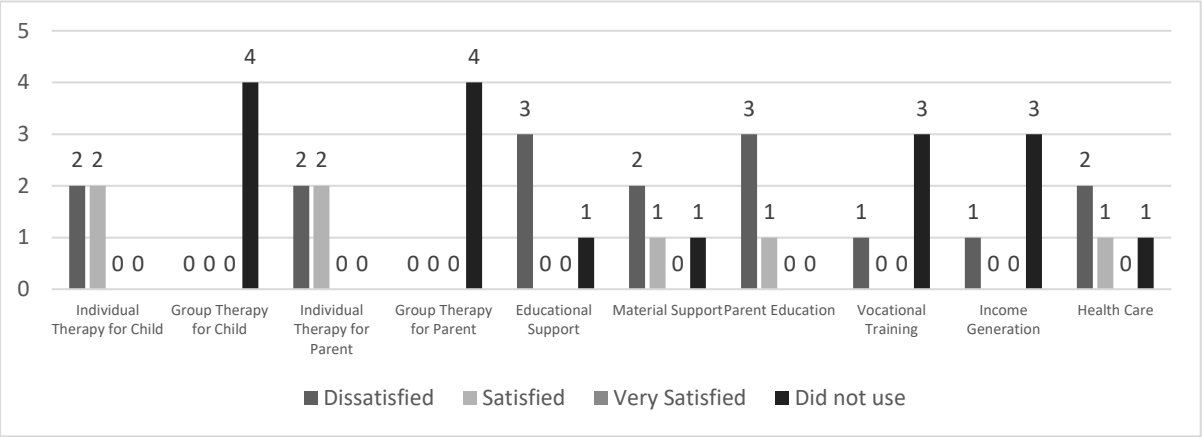

FIGURE 22: FAMILY REUNIFICATION: SATISFACTION WITH SERVICES N=4 (CARE PROVIDER INTERVIEW)

Families most commonly had not received other services except for individual therapy for child, educational support, material support and health care. About half were satisfied with individual therapy for child and parent. But generally, families were not satisfied with the services. This was described again that the services were not enough. Families want more help.

Other Care Settings and Services

Three children that were interviewed were also living currently in residential care. The facilities were small facilities. The children were there because of a protection need or for housing during vocational training. One other type of care that some children had resided in was a transitional shelter. Data was collected on these types of care, but not analyzed in detail as this was not the focus of the research.

Case Management Processes

Case management is a systematic framework for guiding permanency planning for children. Permanency planning is defined in the Prakas on Procedures to Implement the Policy on Alternative Care for Children as *"the effort to provide a permanent family for a child using permanent kin placement, domestic guardianships and adoptions and intercountry adoption*" (MoSVY 2011).

To better understand how the framework for permanency planning is being implemented case workers were interviewed about their case management processes. The case workers and program staff were interviewed by type of care; however, the findings are that there are not significant differences in case management processes by type of care to warrant a description separately, thus this overview of case management processes.

All service providers use some type of systematic case management system. OSCaR is a case management toolset supported by FCF and its implementation is being led by one of the partners in this research. The OSCaR system includes the Child Status Index Assessment Module, the Case Note Module and the Task List. Three of the seven partners are now using OSCaR and at least one report they plan to use it in the future. Others have their own case management systems and one organization had used OSCaR and has reverted to their own system again.

Intake and Assessment

Intake and assessment is the process of receiving the case and identifying the needs and strengths of the child and family. All service providers were asked about their intake, child and family assessment processes. Overwhelmingly all organizations reported are guided by and use the MoSVY intake and assessment forms, based on the Prakas on Procedures to Implement the Policy on Alternative Care for Children. Some agencies also had additional processes, assessment tools or forms they use, particularly for child and family assessments.

For those using OSCaR the system guides the user through use of the Child Status Index as a tool for paraprofessionals to assess the status of a child in its six domains and provides indicators to monitor, or act based on the responses. Service providers have in few cases documented their process for different types of care in operational manuals – Foster Care Manual, Family Preservation Manual, Family Reintegration Manual etc. The guidance provides tools that case workers use in assessment.

Children and families were commonly referred from a variety of sources. Some were referred because of the closure of RCIs, others from local authorities or other organizations. Because of the limited scope of this research, it is difficult to identify gaps in gatekeeping or intake referral processes. All organizations report complying with government requirements and processes.

Care providers were asked how they engage with the family, child and other duty bearers in the intake and assessment process. Commonly information was gathered during the assessment process from the child and the birth family. For the child, the input was dependent on the age of the child. For the birth family, input was more common in family preservation,

family reunification and short-term foster care. These are cases where the family is still engaged in the process. Since long-term foster care is considered a permanent placement, it is not surprising that the birth families are less engaged in this process of placement. Case workers also report that dependent upon the case, they also gather input from other family members, local authorities, DoSVY or others deemed relevant.

Family Tracing

Family tracing is the process to identify relatives to establish a family connection and sometimes for identifying a permanent placement for the child if the child is in alternative care and the child cannot be reunified with the birth family.

Overall, family tracing had occurred in about half the cases in this research. Family tracing was most commonly used to identify kinship care providers or to reunify children from RCIs. Common procedures for family tracing were to seek information from local authorities or known family members. Tools such as genograms or other family mapping tools were used to identify family members.

Care Plan

The Care Plan is the documentation of the goals and next steps for a child and family based on a comprehensive assessment. On the basis of this assessment, the care plan should outline what is needed, who will meet those needs, what the follow-up should be and the appropriate time frame for each action. Immediate and longer-term goals should be identified. Care planning should involve the participation of children, parents and other relevant stakeholders and should be a written document which is regularly updated and reviewed by all those involved in the plan (Inter-agency group on Children's Reintegration 2016)

Generally, all service providers report developing a care plan based on the assessment of the child and family. Generally, however, it was observed in this research that care plans are sometimes based on the services that can be provided or are provided by the agency and not entirely tailored to meet the needs of the child and family. Service providers are aware of this challenge and identify that in some cases services are not available that a family or child require.

Service Provision

As noted in the review of different types earlier in this research a variety of services are provided to children and families. This will not be further covered here in detail.

However, it is important to note that birth family and kinship care providers are least satisfied with the services. The carers reported this is because they believe the services provided are not enough to help to stabilize the family and enable them to provide adequately for the child. Concerns were raised for education and material support particularly. And while families note that services are not enough to stabilize families, there were few services around income generation. While social workers are not likely to have the capacity to provide this service adequately, this could be an important area for referral to other service providers. Other options such as increasing cash transfers should also be considered.

In review of different types of care there were also noted high number of homes visits. This is a critical service provided to the children and families. Ensuring that case workers have full capacity to provide interventions is important to ensuring adequate permanency planning services.

During the process of service provision, if children were in an alternative care placement, they were permitted and even encouraged to maintain contact with the birth family during the service provision process. Each organization had different processes. At a minimum, national holidays such as New Year's and Pjum Ben were common visiting times. Some organizations worked out visiting schedules that were more often particularly if the child was going to be reunified.

Another observation was the linkages between organizations. Referral patterns have and are developing between organizations where organizations are referring for specific types of care, or specialized services that are not available in their own organization. This is a good practice that should be promoted through communities of practice.

Case and Care Plan Review, Closing Cases

Case workers were asked about review of cases and care plans. A range of responses were provided. Case workers described regular meetings with their teams to review cases and gather input and also with their supervisors (see supervision). Different case management systems initiative a time for case review. For example, OSCaR prompts a case review and assessment every six months. Case workers did not distinguish between case review and care plan review.

The majority of cases were not closed, even if the organization had been providing services for more than a year.

Supervision

Case workers all described some system for supervision in their agency. There were weekly case review meetings in some, and individual meetings with supervisors to review cases. These were timed differently in different organizations. Some were scheduled weekly, bi-weekly or monthly. All case workers highly appreciated the supervision. In fact, some wanted their supervisors to have additional training, so they could provide better support with difficult cases.

Links to Relevant Authorities in Current Work

Case workers were asked how relevant authorities were engaged in the process of case work for permanency planning. As demonstrated earlier in the review of types of care, all service providers are attempting to implement their work in line with the Procedures to Implement the Policy on Alternative Care for Children.

However, engagement with DoSVY or Commune Committee on Women and Children in the service delivery process was less universal. Referrals are very common, but they do not work closely in the delivery of service. Challenges identified were the lack of resources and capacity of the relevant authorities to engage adequately in the process.

Case Workers

To better understand the people delivering services background data was collected on case workers. The case workers interviewed were providing services to the sample of children in the research. A total of 19 case workers were interviewed.

Education and Training

The majority of the case workers had a bachelors' degree. Out of 19, only three did not have a bachelors. Common degrees were management, accounting, information technology, English, etc. Only one case worker had a degree in social work.

All had participated in significant training. Some organizations required an orientation and specific training upon engagement. Others provide periodic or annual trainings. Trainings were on sexual abuse, case management, stress management and self-care, crisis intervention, domestic violence, trauma informed care, suicide and crisis intervention, conflict resolution, boys first training, Wounded Heart, short courses in foundation for counseling, parenting, alcohol training, working with children with disabilities, nutrition, first aid, health care, trafficking, and others. Trainings were typically a few days, but some were described as short courses.

Case Workers Responsibilities

Case workers reported their responsibilities were primarily around the tasks of case management. This included intake, assessment, case planning, providing counseling, service provision, training, follow-up, documentation, and linking with authorities or other agencies. Case workers had a range of experience. Some with less than a year, others had been doing their job for 10 years. Less than half had prior similar experience in another job.

Caseloads had a broad range from seven cases to 45 cases. Because of the varied responsibilities and stage of cases it is difficult to make any assessment of the size of caseload based on the numbers. However, some case workers did report that they had a lot of work and were not always able to keep up and found managing caseloads very stressful. Some also reported that because of the mix of cases they were able to manage. The mix of cases would include new cases that require more attention, cases close to closure, or cases that were not demanding because the needs of the family were limited.

Case workers also reported that sometimes it is stressful for them in managing the paperwork. Some using the new system do not have access to the information when they are doing home visits, so they write notes in a notebook. Others report not having enough time doing all the paperwork. Case workers showed examples of incomplete paperwork including assessment tools such as genograms.

Supervision

Case workers reported they regularly have supervision. The supervision is most commonly every two weeks or once a month. Case workers find the supervision very helpful. Sometimes when the supervision is delayed because of scheduling conflicts the case worker finds it difficult. Case workers noted the importance of supervision and suggested that their

supervision providers have more training themselves, so they can better provide support on difficult cases.

Indicators of Successful Placements

The research tried to identify the indicators of success for placements into different types of permanency. Case workers were asked for the program interview and for each placement what were indicators of success. The indicators listed were summarized and categorized and presented at the validation workshop for further refinement. Success areas were categorized as follows:

Physical health and emotional well-being of the child:

- Child has adequate food and shelter
- Child is well cared for
- Child has adequate food and shelter
- Children have access to health care
- Physical development is good
- Children are recovered from trauma

Child Parent Relationship and Community Acceptance

- Child is well care for
- Child is accepted in the family and community
- Child is loved
- Reattachment is achieved

Education, Access and Achievement

- Child has improved life skills and development
- Child is attending school
- Children have a job when they graduate from grade 12
- Children have good morals and life skills

Child Protection and Safety

- Safe and happy
- Safe in the family – Children are protected safe and secure
- Child is adopted (by long-term foster family)
- Parents care the child for their whole lifetime not just to 18 (permanent)

Outcomes for Children

In order to understand the outcomes for children, caregivers, case workers, and children themselves (above eight years old) were interviewed. Case workers were asked about the services the child and family received and the current status of the child. Care providers were asked about the child's well-being based on the categories in the Child Status Index. Children were asked about their daily lives, school participation, living arrangements, health, friends,

and family. The interview data from the different source was cumulated to complete the Child Status Index on each child.

The Child Status Index is a qualitative tool that provides a framework for identifying the needs of children, creating individualized plans to promote the well-being of children and program level monitoring and planning (O'Donnell, et al. 2014). The Child Status Index was used as it provides a snapshot of child well-being. Table 2 provides summary data on each of the different categories of care, and the average score of child well-being. The highest score is 4, representing the criteria in the category is fully met. A score of three indicators a need to monitor and under 3 requires some action.

The cumulated and averaged totals of the Child Status Index show that generally children in care are doing well, with some need to monitor the situation. The need to monitor is appropriate for children separated from families or newly returned, so the scores are acceptable. The areas of concern are the scores below 3. It is important to note that these scores have been averaged, so that means some children scored higher and some children scored lower. Because of the small numbers one low score can bring down the average. In one case the child had run away, in another a child had just been moved without planning.

But generally, the averages show that the lowest scores are in Family Preservation, Kinship Care, Long-Term Foster Care and Reintegration. Children in short term foster care are doing better. It is difficult to generalize, however, because of the small numbers (See Table 2). Following is a summary of care with highlighted low scores by types of care.

- In Family Preservation the score for *Child has stable shelter that is adequate, dry and safe is 2.75.*
- In Kinship Care *Child is cooperative and enjoys participating in activities with others and other children* is 2.77.
- In Long Term Foster Care and in Reintegration *Child is progressing well in acquiring knowledge and life skills at home, school, job training or age appropriate school* is 2.75.
- In Reintegration *Child is growing well compared to others his/her age in the community is* 2.75

In some domains children are doing well across all types of placements: Sufficient food and nutrition, at least one adult to care for the child, child has access to legal protection services, child is physically health, child can access health care services, child is happy and content with a positive and hopeful outlook, and child is enrolled in and attends school.

	Overall Average	CR/C (RCI)	FP	KC	LTFC	RE	STFC
1 Food and Nutrition							
1A Goal: Child has sufficient food to eat at all times of the year	3.59	3.58	3.25	3.46	3.7	3.25	4
1B Goal: Child is growing well compared to others his/her age in the community	3.43	3.67	3.25	3.54	3.33	2.75	3.86
2 Shelter and Care							
2A Goal: Child has stable shelter that is adequate, dry and safe	3.41	4	**2.75**	3.31	3.56	3.50	3.86
2B Goal: Child has at least one adult (age 18 or over) who provides consistent care, attention and support	3.41	4	3	3.23	3.89	3	4
3 Protection							
3A Child is safe from any abuse, neglect or exploitation	3.61	**2.67**	3.13	3.46	3.89	3.50	4
3B Child has access to legal protection services	3.30	4	3.68	3.46	3.89	3.25	3.86
1. Health							
4A. Child is physically healthy	3.50	4	3.25	3.38	3.56	3.50	3.71
4B Child can access health care services including medical treatment when ill and preventive care	3.45	3.67	3.13	3.23	3.67	3.75	3.57
5 Psychosocial							
5A Child is happy and content with a generally positive mood and hopeful outlook	3.36	4	3.13	3.23	3.56	3.25	3.57
5B Child is cooperative and enjoys participating in activities with others and other children	3.32	3.67	3.25	**2.77**	3.56	3.75	3.57
6 Education and Skills Training							
6A Child is progressing well in acquiring knowledge and life skills at home, school, job training or age appropriate school	3.08	4	3.	3.11	**2.75**	**2.75**	3.29
6B Child is enrolled and attends school or skills training or is engaged in age-appropriate play, learning activity or job	3.42	4	3.	3.22	3.25	3.25	3.86

TABLE 2: CHILD STATUS INDEX AVERAGE SCORES OF CHILDREN BY CARE CATEGORY: LOWEST SCORES ARE BLACK

In addition, children were asked to respond to the following statements, thinking about their lives in the last week. The statements were read, and children could respond never (1), one

day (2), on a few days (3), most days (4), and every day (5). These were adapted from A Guide to Measuring Child Well-Being (Action for Children 2009).

For the statements presented in the following chart the higher the score the more positive response from children. The only category with a low score is family preservation with a score of 2.5 on *I felt happy.* Generally, children themselves are reporting they are happy, they have energy, get along with family and friends, fit in their school and community and feel good about themselves.

HIGH SCORE IS POSITIVE	Family Preservation	Kinship Care	Short Term or Emergency Foster Care	Long Term Foster Care	Re-integration	RCI
I felt happy	2.5	3.5	3	4	3.5	3.5
I enjoyed my school work	5	4.9	5	4.2	4.25	3.5
I had lots of energy	3.5	3.1	5	3.3	3.5	5
I got along with my friends and family	4.5	3	5	4.7	3.25	3.5
I felt like I fit in at my school	4	4	5	3.7	4.25	4
I felt like I fit in my community	4	4	3	4.2	4.25	5
I felt good about myself	4.25	4.25	4.5	4.5	3.25	5
AVERAGE	3.96	4.2	4.36	4.09	3.75	4.21

In the second set of statements the lower the answer the better result. Again, the only high score is with family preservation with a score of 3 in *I felt sad,* and a 4 in *I kept waking up in the night.* Again, it is important to note that it is hard to generalize because of the small numbers of children.

LOW SCORE IS POSITIVE	Family Preservation	Kinship Care	Short Term or Emergency Foster Care	Long Term Foster Care	Re-integration	RCI
I felt sad	3	2.3	1.5	1.7	2.5	3
I had no one to play with	2.5	1.9	2.5	1.2	2.5	2.5
I felt tired	2	2.1	2.5	2.5	2.75	2
I kept waking up in the night	4	2	1	3	1.75	4

Caregivers were asked to report on children's acceptance by extended family and by the community. Nearly 100 percent of care providers reported that children were accepted in the community and by extended family.

Gender

During the analysis, the outcomes were examined for differences for boys and girls. The differences were small and based on the sample size it was determined that this was not significantly different. This would be an area for further exploration.

Disability

Children with disability were part of the sample criteria. In this research the carers of children with disabilities raised concerns about their ability to care for the children long-term. Another issue related to children with disabilities is the lack of care options for children with disabilities.

CONCLUSIONS

Contributions to Permanency

The service providers are making significant contributions to permanency planning and better outcomes for children. Some examples are as follows:

- Children are living in family-based care;
- Children are being returned to birth families or placed with relatives;
- Families are considering adoption as an option for permanency;
- Service providers have developed their own guidelines for types of care and procedures for case management procedures;
- Children have care plans based on some type of assessment of strengths and needs
- Children are not being placed in residential care;
- Service providers are working together to refer children or other providers for care or services they cannot provide;

Policy

Additionally, policy and guideline development improve practice:

- The Procedures to Implement the Policy on Alternative Care has made positive impact promoting family based alternative care in Cambodia.
- The Explanatory Note for Domestic Adoption (2017) and the Law on Intercountry Adoption (2009) were both identified as policies that promote permanency for children.
- The development of guidelines in key areas will promote improved permanency planning. Guidelines are currently being developed to standardize and guide reintegration, foster care, and supervision.

- Another promising step is the development of Social Work Standards for Generalist Practice and Specialized Levels. These will help guide and improve social work practice which is critical to improved permanency for children.

Types of Care

Service providers are contributing significantly to development of family-based models of alternative care. Organizations have their own policies, procedures, definitions and practices. These are excellent contributions, but the challenge remains that these are not standardized amongst service providers.

Definitions of care types: The types of care are not clearly defined and consistently used. The Procedures to Implement the Policy on Alternative Care provide some definitions of types of care. However, there are some gaps. Additionally, organizations do not use consistent definitions. Kinship care, family reunification, and foster care definitions are not consistently used. The terms reintegration and reunification are used interchangeably instead of being understood as discreet processes.

Availability of care options: Alternative family-based care is not available when needed. For example, care for children with disabilities, children in need of protection, children of different ages, or in different locations is not always available.

Placements do not meet legal definition of permanent: Children are living in placements that are considered permanent that do not protect their legal rights and give them the same treatment as birth children.

Outcomes for Children: With some exceptions, children in different types of care are generally happy, receiving health care when required, well cared for, like to and are attending school, have an adult in their life that looks out for them, have friends and are accepted in their family and in the community.

Family Preservation: While not a focus of this research, the cases of family preservation identified through the random sampling process were interviewed. Families receiving services indicated a high level of dissatisfaction with services. This was because they viewed the service as 'not enough' and still felt vulnerable to challenges in caring for their child. Children in family preservation were the least happy and had less stable physical living environments.

Kinship Care: Kinship care is sought after as the first priority after birth families as a placement. However, kinship care providers are often older and report challenges in providing care. They also report dissatisfaction with services -once again that services are not enough to ensure they are able to care for the child. Children in kinship care were reported to have some challenges in cooperation and participating in activities.

Foster Care: There is not a clear definition for long term and short-term foster care. Organizations have recruitment, training, and requirements but they are not consistent across organizations. Long-term foster care is serving as a permanency option. Some families want to formalize, but the process is perceived as complicated or social norms against adoption prevent domestic adoption. Foster care providers however, unlike family preservation and kinship care providers are more satisfied with the services they receive.

Adoption: The process for domestic adoption is seen as complicated. The process does not protect the adoptive parents, preference not to disclose the child's background to the community. Other factors such as family members not wanting the child to have inheritance rights or age of the long-term foster families prohibit domestic adoption. Intercountry adoption is not occurring.

Case Management

Case management processes are important to ensure quality and consistent practice in the provision of permanency planning services. Significant efforts by organizations have begun to establish standardized processes in case management.

Case Management Tools: All service providers use the Alternative Care Forms and some use addition forms. Case workers report they cannot get all of the paperwork completed sometimes because of time demands. As a result, some tools are not fully utilized.

Case Management Systems: Case workers using computerized case management systems report lack of access to the case information when they are in the field. As a result, some are keeping paper notes in notebooks to have client information available.

Family Tracing: Service providers are conducting tracing of children in their care. Each organization has a different system, and tracing is only done when the birth family is now known.

Care Plans: Care plans are more commonly linked to the goal of the organization than closely linked to the needs of the child/family. To develop the care plan, input is gathered from children and families but not in all cases.

Services: Supportive and family strengthening services are not adequate. Specialized services are not fully available to meet the needs of families and enable them to care for their children.

Capacity: Some cases are complex and beyond the capacity of the case worker and the relevant government authority. As a result, both authorities and other service providers do not have full capacity to fulfil their obligations to children and families.

Care Providers

Care providers are committed to caring for children. Motivations are out of love, obligation and a sense of responsibility for children. Care providers want to do a good job and have concern for the future of the children they are providing care.

Stipend: Some care providers report the stipend is not enough to cover expenses of the child. As a result, some foster parents spend more on their birth children than foster children – for example the foster parent will buy snacks for birth children and not for foster children because the budget is not sufficient.

Training: Care providers want more training on working with children with special needs and on discipline.

Satisfaction with Services: As noted earlier, foster care providers were more satisfied with the services received than other types of care providers.

RECOMMENDATIONS

The alternative care options provided by the service providers in this research evolved based on the organizations missions and priorities coupled with RGC alternative care priorities. To further standardize and improve the quality of care and permanency outcomes the following actions are recommended.

Partnership

1. Promote continued and improved partnership between RGC and civil society in the efforts to address gaps in alternative care to promote permanency for children.

Care Models

2. Clarify and standardize care definitions and models of care for foster care, kinship care, adoption and reintegration practices. Provide training and capacity building to government and civil society on these standards of care.
3. Develop consistent criteria for types of care (foster care, kinship care, etc.). This includes criteria for entering care, qualifications and training required for care providers and measures of success. This should include standardized application processes, assessment and training for care providers, building on processes being initiated by different service providers.
4. Promote domestic adoption through advocacy campaigns, clarified legal process, legal support and training to legal and permanency planning professionals.
5. Develop a standard Foster to Adopt mechanism to promote permanency for children.
6. Ensure the package of support to care providers is adequate to care for the child. The package of support should be based on the situation of the individual care provider and child.
7. Require care provider meetings (foster care, kinship care) to bring together different groups for support and learning.

Case Management

8. Ensure that all care plans are targeted to meet the specific needs of the child and family; there is only one care plan per child; and the plan has the goal that will move the child into permanency (whenever possible) in a reasonable timeframe.
9. Promote increased competency for case workers on permanency planning (including case management processes) in the government and in civil society organizations. One opportunity is the Generalist Social Work Practice Accreditation.
10. Further standardize assessment tools and ensure case workers have the competencies and time to carry them out. This includes all phases of the case

management process (intake, assessment, service provision, follow-up, and case closure).

11. Home visits are a significant tool for case workers for assessment, service provision, follow-up, etc. Case workers should have skills to effectively conduct home visits both gathering the information needed from the case worker perspective and providing feedback to the family/child.
12. In addition to case management processes, ensure case workers carrying out reintegration have the skills and capacity to assess, and provide support to ensure successful reintegration of children into families and communities.
13. Reduce caseloads when they are too much for case workers to adequately provide services.
14. Provide more support to case workers through standardized supervision.

Specialized Services

15. Provide specialized services options that address the needs of children and families. Some example of service or service modalities are positive parenting, drug treatment, mental health counseling, play therapy, group discussion, self-help groups, and others.

Research, Monitoring and Evaluation

16. Conduct future research to better understand the gender dimensions to permanency planning.
17. Conduct regular monitoring and program evaluations in each type of care.
18. Conduct research to promote better understanding of long-term outcomes for children in alternative care.

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