file: KinshipCare

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Family Care or Foster Care? How State Policies Affect Kinship Caregivers

by

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Number A-34 in Series, "New Federalism: Issues and Options for States"

This series is a product of Assessing the New Federalism, a multi-year project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs and their effects. In collaboration with Child Trends, the project studies child and family well-being.

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Extended family members have long played a role in caring for children when their parents were unavailable to do so, a practice commonly referred to as "kinship care." While the state, through the child welfare system, has only recently begun to rely on relatives as foster parents for children at risk in their own homes, the practice grew substantially in the past decade. This growth, and federal legislation encouraging states to place foster children with family members, has thrust kinship care into the policy spotlight, igniting debates within the child welfare and welfare systems about how to publicly support kinship care families.

When the Adoption and Child Welfare Act of 1980 was passed, forming the basis of the federal foster care law, it was almost unheard of for a child's relative to act as a foster parent. More than two million children in the United States now live in kinship care arrangements; 10 percent of these, or approximately 200,000, are foster children. [1] Much of the growth in the use of kin as foster parents occurred in the late 1980s and early 1990s; for example, between 1986 and 1990 the proportion of children in state-supported kinship care increased from 18 to 31 percent.[2] Though experts cannot pinpoint the cause of the increase-whether more children are entering kinship care arrangements or more kinship care arrangements are being formally recognized by the state-the upward trend continues, with the majority of states reporting that the proportion of the foster care caseload accounted for by kinship care has increased since 1994.[3]

This growth and the high cost of foster care, which averaged $6,000 per child in 1996, pushed policymakers to take note of kinship care.[4] However, it was the 1996 welfare reform act that officially encouraged states to give relatives first priority in providing care for foster children, solidified the role of kinship care as a federal policy issue, and provoked discussion among policymakers as to how welfare policy would affect kinship care.[5]

During the 1996 welfare reform debate, child advocates pointed out potential unintended consequences of the welfare reform legislation that could influence the receipt of kinship care. Specifically, they noted that one particular type of welfare payment for which kinship care families were eligible, child-only grants, would not necessarily fall under the proposed new work requirements and time limits. Advocates raised the concern that parents might leave their children with relatives to avoid the new welfare requirements but still preserve assistance in the form of child-only grants.[6] They also worried that kinship care providers, who used to care for children informally, would seek assistance from the child welfare system if forced to meet welfare requirements.[7]

In 1997, the Urban Institute surveyed state foster care administrators to gather information on state policies for identifying, licensing, and financially supporting kinship care families. Previous to this study, little information existed on state kinship care policies.

Defining the Term "Kinship Care"

Because kinship care has many forms, it is helpful to think of it as a continuum of interventions and support. At one end are private kinship care families, with no contact at all with the child welfare system. In the middle are kinship care families known to the system but not formally a part of it, some of whom may be receiving support services. At the other end are families caring for children in state custody and receiving ongoing attention from the child welfare system. For the purposes of this brief, a "public" kinship care child refers to a child whose placement was arranged by child welfare authorities, whether or not the child was taken into custody by those authorities.

Policies Affecting Public Kinship Care Families

Our survey reveals the variations state child welfare agencies have developed in their policies for public kinship care. States can differ in three primary ways: (1) who they consider eligible caregivers, (2) how they license or approve family members for caregiving, and (3) how they support kinship families within the child welfare system.

Eligible Caregivers

The types of relatives who can provide care for foster children vary by state. Of the 50 states whose administrators responded to the Urban Institute kinship care survey on this question, 26 stated that their policies mandate that family members must be related to a child by blood or through marriage to a blood relative. Twenty include a variety of additional categories such as neighbors, godparents, and other adults who have a close relationship with the child, and the other four have no formal definition. Regardless of how states define kin, almost all give preference to relatives over non-kin foster parents, and many actively work to recruit family members to care for children in the foster care system.[8]

Licensing Caregivers

In order to care for a child in state custody, foster caregivers must first be licensed, or approved, by the state child welfare agency. The standards upon which kinship caregivers are assessed for licensure vary (figure 1). In states with the most stringent requirements, kinship families are subject to the same standards that govern non-kin foster families-they must be "fully licensed." Almost all states (44 out of 50 responding) reported that these families receive visits by caseworkers who provide supervision and intervention, just like non-kin foster parents. Fully licensed families are often eligible for all the benefits and supports available to a non-kin foster parent, including foster care maintenance payments, respite child care, and other support services.

Other states maintain less stringent requirements. For example, some kinship families meet all except a few of the licensing standards. States often waive specific licensure requirements

(such as physical space or training) for kinship families, as long as they do not jeopardize the safety of the child. Other states license kinship families under a set of criteria established especially for them. Usually these standards are less stringent, focusing more on child safety and family support than on regulations that are difficult for some kin to meet and could prohibit a family from staying together. Some states allow relatives to care for children with minimal standards and minimal supervision-sometimes called unlicensed kinship care.

To clarify the different ways in which they evaluate kinship families, we asked states to specify the available options for licensing relative caregivers within their state. Most states (including the District of Columbia) offer more licensing options to kin than to non-kin foster parents. In 41 of the 51 states, for example, relatives have at least one licensing option besides the licensing standard applied to nonrelative foster care providers. In the remaining 10 states, family members can only care for children in state custody if they comply with all state policies for foster caregivers.

Many of the 41 states with more flexible requirements for kinship foster care have more than one licensing option for kinship homes. For instance, Maryland has two other options available for relatives besides a fully licensed standard: They can either get licensed by the foster care agency under less stringent criteria (and receive a foster care payment), or they can be considered an unlicensed home, meet even less stringent requirements (usually only safety requirements), and apply for welfare benefits. The licensing option a kinship caregiver chooses can be a function of family preferences as well as state policy.

Supporting Caregivers

Payment of kinship foster caregivers varies according to the licensing a caregiver receives (table 1). When relatives have the same licensing as non-kin caregivers, the vast majority of states allow them a full foster care payment.[9] As seen in figure 2, of the 41 states that offer a less stringent standard, 22 still provide a foster care payment to kinship caregivers. In the 19 states that do not provide foster care payments to these families, usually the only compensation available is some type of cash welfare grant, which in almost all states is less generous than a foster care payment.

Some states require kinship caregivers to meet additional criteria. For example, in California, no matter what licensing standard a family meets, if the children in the relative home are not from a poor family (as defined by the welfare eligibility of the home they left), the relative family cannot get a foster care payment, regardless of the relative family's own income. Missouri has even more complicated criteria for foster care payment eligibility. It specifies that all grandparent caregivers can receive a foster care payment, but any other type of relative can receive foster care payments only if they are caring for children who come from a poor family (also defined as welfare eligible). In both these states, all other kinship care families must rely on welfare for financial assistance.

Future Policy Challenges

Many factors determine how a kinship care family is treated. Policies vary from state to state, and even within a state different families may receive a wide range of care. The survey of state child welfare administrators underscores that kinship families in most states (41) are held to a less stringent standard for foster family eligibility than nonrelative foster families. However, about half these states do not provide foster care payments to the kinship families meeting a lower standard, leaving them to apply for welfare or other government assistance, which is typically less generous.

Because foster care payments are usually higher than welfare grants, these payment differences result in stark differences in the resources provided to public kinship care families within and across states. For example, in Maryland, a child being cared for by a relative licensed as a foster caregiver would have received $535 to $550 a month for care in 1996. A

similar child in the same state being cared for by a welfare-assisted relative would have received only $165 a month for a basic child-only grant. These differences become even greater when there are multiple siblings in care; the welfare payment is prorated on a declining scale when there are multiple children, whereas foster care payments per child remain constant regardless of the number of children in the household. Two children living in Maryland with relatives licensed by the foster care system would have received $1,070 to $1,100 a month, but two children financed by that state's Aid to Families with Dependent Children (AFDC) program in 1996 would have received $292 a month.[10]

Further, a public kinship care family might be paid a foster care payment in one state while the same family licensed by the same standards might only be eligible for welfare in another state. In New Jersey (like California), for example, relatives caring for children who did not come from a poor home cannot receive foster care payments; they can only obtain welfare (averaging $162 for one child in 1996), regardless of what licensing standards they are qualified to meet. In New York, the same family can apply for licensing and, if they meet the standards, receive a foster care payment (averaging $439 to $474 per child in 1996) for the children in their care.

Since the federal government began providing states with foster care funds, it has carefully regulated states' foster care practices, detailing what states must do to receive federal reimbursement for certain state expenditures. The federal government has not developed specific regulations on whether or how states can treat kinship care families who are eligible for foster care differently from those who are not. As this brief has illustrated, many states have used the flexibility within existing federal foster care regulations to design different kinship care licensing standards.

Federal and state kinship care policies are in flux. Since our survey, additional states have created or are considering creating alternative kinship care licensing standards and payment options. Some states have created new kinship care financing schemes through their Temporary Assistance for Needy Families programs.[11] At the same time, many states are urging the federal government to reform federal regulations to allow states greater flexibility in serving kinship care arrangements while maintaining eligibility for foster care reimbursement. In 1997, as part of the Adoption and Safe Families Act, Congress instructed the U.S. Department of Health and Human Services to convene an advisory panel on kinship care, produce a report that documents the extent to which children in foster care are placed in the care of a relative, and recommend any necessary federal policy changes. In addition to altering foster care regulations, Congress is also considering block granting all federal child welfare funds, giving states more discretion in spending these funds. In this rapidly changing policy environment, states will likely continue to face a complex array of options and incentives for financing both public and private kinship care.

Notes

1. U.S. Census Bureau, March 1998, and Urban Institute analysis of data from the 1998 National Survey of America's Families.

2. Kusserov, Richard. 1992. *Using Relatives for Foster Care*. Office of Inspector General. Based on results from 25 states that reported data.

3. Urban Institute survey, 1997.

4. Geen, Rob, Shelley Waters Boots, and Karen C. Tumlin. 1999. *The Cost of Protecting Vulnerable Children: Understanding the Complexities of Federal, State, and Local Child Welfare Spending*. Washington, D.C.: Urban Institute Press.

5. Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, states shall "consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant state child protection standards."

6. In the Notice of Proposed Rulemaking for implementation of the Temporary Assistance for Needy Families (TANF) program, the U.S. Department of Health and Human Services notes that it was "concerned that states might be able to avoid the work participation rates and time limits by excluding adults (particularly parents) from the eligible cases. Given the flexibility available to states under the statute and regulations, it appears possible that states could protect themselves from the requirement and associated penalty risk by converting regular welfare cases into child-only cases."

7. Under the enacted federal welfare reform legislation, states have the flexibility to decide whether to continue to provide child-only grants to kinship care families and whether to require kinship providers to meet work requirements and be subject to time limits.

8. In placing children in foster care, 49 states report that they give preference to kin over non-kin foster parents and 31 states report doing so for more than five years. Results from 1997 Urban Institute survey.

9. Only a few states (California, Oregon, New Jersey) make an exception to this rule-prohibiting families who do not care for children coming from a poor home from receiving the full foster care payment. Instead, these families usually receive assistance in applying for AFDC. In Michigan, counties decide whether or not to allow kin caring for noneligible children to be fully licensed.

10. Data from an annual benefit survey by the Congressional Research Service and from Urban Institute tabulations of AFDC state plan information.

11. For example, under a 1996/1997 component of their welfare waiver, Wisconsin developed a kinship care payment system separate from its foster care system, which provides an ongoing subsidy to kinship families. Wisconsin's Kinship Care Program is funded through the state income maintenance program and allows the state to support public and private kinship caregivers. Under the program, families are still subject to a review every 12 months to ensure that safety issues are properly addressed. In Florida, TANF dollars are being used to fund the Relative Care Giver Program, which allows kin caring for children who may otherwise go into the foster care system to receive payments of up to 80 percent of the foster care rate.

Tables and Figures

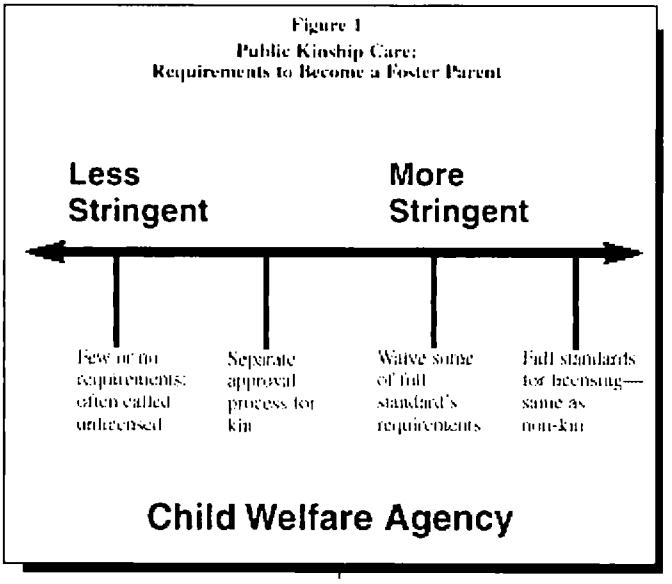
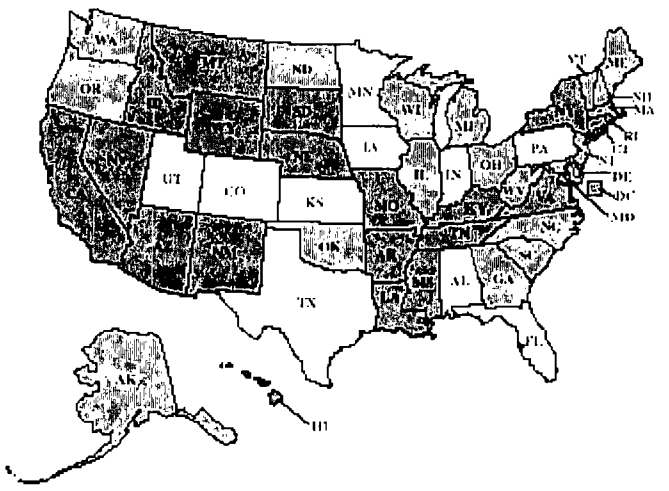


Figure 2
Licensing Standards and Payments for Kinship Foster Parents



Less stringent licensing option for kinship care. Receive foster care payments.

Less stringent licensing option for kinship care. Payment is generally lower than foster care rate.

Kin must meet all foster care requirements to care for a child in the foster care system. Receive foster care payment.

Table 1
1996 State Kinship Care Payments

State	Kinship caregivers subject to less stringent licensing standard receive foster care payment. Foster Care Payment ($)*	Alternative Payment ($)**	Kinship caregivers subject to less stringent licensing standard receive AFDC payment. Those who meet regular foster care requirements receive foster care payment. Foster Care Payment ($)*	Alternative Payment ($)**	Kinship caregivers who are "fully licensed," or meet regular foster care requirements, receive foster care payment. Foster Care Payment ($)*	Alternative Payment ($)**
Alabama					225	225
Alaska			577	452		
Arizona	422	422				
Arkansas	433	433				
California	410	293				
Colorado					384	384
Connecticut	597	597				
Delaware			383	201		
Dist. of Columbia	467	262[b]				
Florida					331	331
Georgia			325	155		
Hawaii	529	529				
Idaho	279	279				
Illinois			380	269		
Indiana					462	462
Iowa					411	411
Kansas					332	332
Kentucky	330	330				
Louisiana	348	72				
Maine			359	118		
Maryland			350	163		
Massachusetts	441	441				
Michigan			388	276		
Minnesota					456	456
Mississippi	260	60				
Missouri	257	136				
Montana	375	952				
Nebraska	394	394				
Nevada	324	324				
New Hampshire			353	484		
New Jersey			329	362		
New Mexico	339	339				
New York	439	439				
North Carolina			365	181		
North Dakota			371	110		
Ohio			544	308		
Oklahoma			360	112		
Oregon			329	209		
Pennsylvania					395	395
Rhode Island	294***	327				
South Carolina			252	118		
South Dakota	377	132[b]				
Tennessee	328	328				
Texas					462	462
Utah					349	349
Vermont			115	337		

Sources: Average foster care payment rate represents the average payment in 1996 across ages 2, 9, and 16 as cited in the American Public Welfare Association's W-Memo, January-February 1998. AFDC rates are for one child, based on data from an annual benefit survey by the Congressional Research Service and from Urban Institute tabulations of AFDC state plan information. Notes:

* Per child per month.
** Maximum 1996 AFDC rate for one child, except where otherwise noted. Unlike foster care payments, AFDC payments are prorated based on the number of children.
*** Amount for 1995; 1996 unavailable.
a. Kinship caregivers can receive foster care payment if children come from a poor home. All others are unlicensed and can receive AFDC.
b. In addition, kinship caregivers can choose to be unlicensed and receive AFDC.
c. Less stringent licensing pays AFDC standard-of-need rate.
d. Those who meet regular foster care requirements receive foster care payment if children come from a poor home. Counties have the option to pay regular foster care payment to kinship caregivers for children not from poor homes.
e. Respondents from New Hampshire said that although the full AFDC amount can be up to $414 per child, most kin are not eligible for the shelter costs portion of the AFDC grant. Instead, families receive a benefit level of $171 per child for a child-only grant. Therefore, for many families in New Hampshire, there might have been a financial incentive to receive foster care rather than AFDC.
f. Those who meet regular foster care requirements receive foster care payment if children come from a poor home.
g. Less stringent licensing pays AFDC plus $100 for a maximum of six months.

About the Authors

Shelley Waters Boots was a research associate in the Urban Institute's Population Studies Center. Her research focused on child welfare, child care, child support, and welfare reform. For the *Assessing the New Federalism* project, she led a team that collected and analyzed the kinship care data used in this policy brief. Ms. Boots is currently the director of research for the California Child Care Resource and Referral Network.

Rob Geen is a research associate in the Urban Institute's Population Studies Center, specializing in child welfare and related child, youth, and family issues. He directed the Child Welfare Survey and is also leading other child welfare-related research conducted as part of the *Assessing the New Federalism* project.

Kinship Care and Foster Care/Child Care

- The Administration has been looking into policy issues relating to kinship care and the public child welfare system, in which children eligible for foster care assistance are cared for, but not adopted by, relatives.

- In December, 1996, the President issued an executive memorandum on adoption aimed at moving children in foster care more quickly to permanent homes, with a goal of doubling, by the year 2002, the number of children adopted each year. He specifically asked HHS to report to him with "plans examine alternative permanency arrangements, such as guardianship, when adoption is not possible."

- HHS reports that more information is needed to understand fully the factors which shape decisions about adoption and guardianship by relatives, before pursuing any federal policy changes. They caution against creating unintentional incentives to shift children into guardianship arrangements when an adoption could be achieved or families kept together. HHS is using its demonstration authority to work with states to gain better information on how guardianships are currently used; the relationship among guardianship, relative care and adoption; and the important ways in which guardianship differ from adoption.

- Several child welfare demonstration projects relate to kinship care. Maryland, for example, is testing paying guardians half the monthly rate paid to foster care providers.

- Also to better understand the issues relating to kinship care and child welfare, HHS commissioned and recently released a study, *Informal and Formal Kinship Care,* which examines the characteristics of families formed through kinship care arrangements [Bourdette sent ther report to Rep. Waters, report Executive Summary and "Dear Colleague" letter attached].

- HHS has an Adoption Opportunities program to fund approximately four initiatives (3 years of $200,000/yr) designed to increase adoptions of children in relative foster care.

- The Child Care Bureau at HHS has committed to hosting a special convening on the topic of intergenerational care to help frame the issues relating to child care and the elderly and to look at promising intergenerational models.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

Dear Colleague: JUL 1997

For your information, attached is a copy of a study entitled *Informal and Formal Kinship Care*. A small but significant number of children are now being raised by relatives other than their parents, but little has been known about these "no parent families." This study takes a step towards understanding their characteristics. It was conducted by researchers at the Chapin Hall Center for Children at the University of Chicago and the Urban Institute, under contract to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Some of these kinship care situations have been arranged formally, through child welfare agencies, but far more are informal arrangements organized by the families themselves. This study uses several data sources, including the Current Population Survey, the 1990 U.S. Census, and several states' administrative data regarding their foster care and welfare programs, to examine the characteristics of informal kinship care arrangements and, where possible, to compare them with those initiated through and/or subsidized by the child welfare system. Among other findings:

- In 1994, approximately 2.15 million children, or just over 3% of all children in the United States, were estimated to have lived in relatives' homes without a parent present. Roughly two-thirds of kinship caregivers are the child's grandparent.

- On average, children in kinship care are older, more likely to be members of minority groups, and more likely to live in the South than are children living with their parents. They are also more likely to be poor and to receive assistance through government social welfare programs.

- The percentage of children living in kinship care varies widely among the states. Much of this variation follows regional lines, with the southern states consistently showing the highest levels of kinship care arrangements. In every state, older children (age 6-17) are much more likely to live in kinship settings than are younger children (age 0-5).

- The care arrangements for children who do not live with either parent vary widely by state, but informal kinship care situations vastly outnumbered kinship foster care arrangements in every state examined. For instance, in Missouri 2.7% of children living in kinship care in 1990 were placed there as a formal foster care arrangement, while in New York 22.5% of such children were in foster care.

I hope you find the report useful. If you have questions, contact Laura Feig at 202-690-5938.

Sincerely,

Ann Rosewater

Ann Rosewater
Deputy Assistant Secretary
for Human Services Policy

EXECUTIVE SUMMARY

FORMAL AND INFORMAL KINSHIP CARE

Report for ASPE Task Order HHS-100-95-0021
"Characteristics of Informal Kinship Care"

The Urban Institute and Chapin Hall Center for Children

This report presents the results of work pursued by analysts at two separate research institutions in a collaboration designed to describe the population of American children living in **kinship care** arrangements.

The Task Order was to examine existing national data sources in order to describe the characteristics of children in kinship living arrangements, and to identify recent trends in the pattern of kinship caregiving. Particular importance was attached to developing information that could support comparison between **formal kinship** care arrangements (i.e. care provided by relatives as foster care under auspices of the state) and **informal kinship** arrangements (all other caregiving provided by relatives in the absence of a parent).

Kinship foster care has attracted much attention in recent years within the context of the child welfare system. The extensive placement of children with relatives has created a new, rapidly growing, and poorly understood segment of the child welfare caseload that has great impact on the size and nature of the foster care population in many states. Children in formal kinship placements can be viewed as a subgroup of a broader category of family-based alternatives to parental care -- the population of all children living in kinship care settings across the country. Most American children who live in kinship care arrangements are not foster children. We cannot yet determine whether most current kinship foster care placements are "formalizations" of kinship arrangements that would likely exist without agency intervention, or whether these are mostly new arrangements created as a result of recent child welfare practices. But it is clear that children in informal kinship settings are potentially of crucial importance for the child welfare system -- as a reference group, as a potential "feeder" population, and as an alternate model of caregiving.

By virtue of the similarity between formal and informal kinship arrangements, any policy actions directed towards one of these groups is likely to affect the other in a parallel or reactive manner, whether or not this is intended by those who frame these actions. Even though our understanding of the recent interdependence between these two kinship subgroups is weak, the importance of anticipating their future interrelationship becomes increasingly apparent -- especially as our questions move from the strict realm of child welfare policy into the broader arena of family supports and welfare reform.

This report presents the results of four separate, and relatively independent, research tasks, each approaching these questions with a different set of information tools. Taken as a whole, they provide us with a greatly improved picture of kinship care in the United States, and provide an enriched context for discussing these issues. The first task was produced by the Urban Institute, the remaining three by the Chapin Hall Center for Children at the University of Chicago. A brief

description of each task and a summary of substantive findings from each follows.

I. National Patterns and Trends in Kinship Care:

Section I describes the population of children in kinship care settings in the United States, the characteristics of these children and their caretakers, and trends that have been observed since 1983. These descriptions are based on information drawn from 12 years of the Current Population Survey (CPS), a large and ongoing national sample of the full United States population. At the national level, the CPS provides the richest and most reliable information available about children's living arrangements and households -- including identification of kinship care relationships. Information is collected about the children, their relative caretakers, and the families which they share. The following are among the key findings reported in this section.

About Children in Kinship Care:

- In 1994, approximately 2.15 million children, or just over 3 percent of all children in the United States, were estimated to live in the care of relatives without a parent present.

- Nationally, the prevalence of kinship care probably increased between 1983 and 1993, and it certainly did not decrease. There is no evidence of any increase in kinship care among the white (non-Hispanic) children in recent years; all observed growth in kinship care has been among white Hispanic and non-white sectors of the population.

- Non-Hispanic white children are substantially less likely to live without their parents in the care of relatives than are the children of any other racial/ethnic group. African American children are most likely to live in kinship care settings, at levels four to five times as great as those for white non-Hispanic children. The gap between African Americans and the other ethnic groups widened throughout the 12 year period examined.

- Kinship care has been more prevalent in the South, for children living outside of Metropolitan areas, and for older children, although the size of the differences due to each of these factors has diminished gradually over the 12 years studied.

About Kinship Caregivers:

- Roughly two-thirds of kinship caregivers are the child's grandparent. About half of the kinship caregivers are currently married, while over 85 percent of the single kinship caregivers are female.

- The kinship caregiver population is much older than the parent caregiver population. Although over 95 percent of the parents who live with their own children are below the age of 50, over one-half of all kinship caregivers are 50 years of age or greater.

- Compared to parents who live with their own children, kinship caregivers tend more often to be currently unmarried, to be less-educated, to be unemployed or out of the labor force, to live in poverty, and to receive benefits through government social welfare programs.

The portrait of kinship care that emerges from the CPS is of a population of children that live in arrangements with strained resources of many types. This population is disproportionally

composed of minority children being cared for by relatives that, as a group, show fewer advantages than own-parent caregivers.

II. Living Arrangement Patterns by State: 1990

Section II describes the living arrangement patterns for all children state by state. This analysis is based on data made available from the 1990 Census of Population. The census does not provide as much substantive detail as the Current Population Survey, but the estimates it provides are reliable for much smaller geographic areas.

- The national pattern of child living arrangements in 1990 showed most American children living with at least one of their own parents. Over 70 percent lived with two parents, 20 percent with their mother only, and 4 percent with their father only. Just over 2 percent of all children lived with relatives (parent absent), and just over 2 percent in the care of unrelated persons.

- Although this fundamental pattern persists across all states, substantial variation in the distributions is seen between states. The percentage of children living with two parents varies from under 62 percent to over 83 percent. For kinship care, state percentages varied from under 1 percent of all children to well over 3 percent. Much of this variation follows regional lines, with the southern states consistently showing the highest levels of kinship care arrangements.

- In every state, older children (6-17) are more likely to live in kinship care settings than are younger children (0-5).

- In general, kinship care levels across states tend to be positively associated with levels of mother-only care, and weakly or negatively associated with father-only and unrelated care. The levels of kinship care and mother-only care also each vary directly with the total percentage of children not living with two parents, while father-only and unrelated arrangements do not.

A tentative argument is developed that higher levels of mother-only care and relative care appear to be direct products of higher levels of social disruption and family disorganization, because they consistently vary strongly and inversely with the proportion of children living within a traditional two-parent family structure.

III. Formal and Informal Kinship Care Patterns: Four States

Section III introduces data developed directly from administrative foster care records in four states: California, Illinois, New York, and Missouri. Kinship foster care counts obtained from these child welfare records are used to split the census-based counts of children living with relatives into the separate categories of formal and informal kinship care. This information becomes available in the form of aggregate counts for the four states and certain sub-state places.

Findings include the following:

- Informal kinship care is far more common than formal kinship care. In the four states combined, only 15.5 percent of all kinship children were in a formal foster care placement.

- Levels of informal kinship care are rather similar across each of these four states, while the levels of formal kinship foster care vary dramatically.

- Younger children in kinship care are more likely to be in foster care than are older kinship care children. Formal kinship levels were 58 percent higher for 0-5 year olds than for 6-17 year olds, while informal kinship levels were over twice as high for 6-17 year olds as for 0-5 year olds.

Within each state, the analysis compares the "primary urban place" (*i.e.* Los Angeles County; Chicago City; St. Louis City; and New York City) to the "balance," or remainder, of the state.

- In two states, New York and Missouri, formal kinship foster care appears almost exclusively in the primary urban place, and is virtually absent across the balance of the state. In California and Illinois, formal kinship is still concentrated in the primary urban place and a few other counties.

- Informal kinship care is also consistently higher in the primary urban places than in the balance of each state, although it is distributed far more evenly than formal kinship care.

- In larger cities, where formal kinship care is most common, there appears to be an inverse relationship between the levels of formal and informal kinship care. This might suggest that the children in the two types of kinship care are drawn from the same pool of children, and that the observed differences in formal versus informal care levels between cities are mostly due to different agency practices involving the use of formal kinship care.

Looking only at formal kinship foster care:

- In each of the four states, African American children are more likely to experience kinship foster care than are children from other racial or ethnic groups. Overall, African American children are about eight times as likely as all others to be in formal kinship placements. The racial effect holds across regions and across age groups.

- This racial effect and the "primary urban place" effect become compounded because of the high representation of African American children in the primary urban places in each state. The interaction can be huge: for example, African American children in New York City are one hundred times more likely to be in a kinship foster care placement than are non-African American children in the remainder of New York State.

- In California and Illinois, the race appears to be a stronger predictor of kinship foster care levels than primary urban place. In New York, the "urban place" factor appears to be a stronger predictor of kinship foster care than race.

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To gain at least one "window" for comparing characteristics of children in formal and informal kinship care settings, information was accessed from the Illinois Child Multiservice Database that

is being developed at Chapin Hall. Individual-level records were examined for all recent (1990-95) child AFDC grant recipients and all foster children in the state. The population of AFDC children living in kinship care arrangements is treated as a biased sample of all Illinois children in informal kinship care -- sort of a "semi-formal" kinship group.

Looking at characteristics of these groups:

- Compared to the AFDC/Relative group, the formal kinship care group is younger, overrepresents African Americans, and is disproportionally comprised of children from Cook County (Chicago). No gender differences are apparent. Both of these groups are younger and more likely to live in Cook County than the remainder of Illinois's informal kinship care population.

- Compared to AFDC/Parent cases, the AFDC/Relative cases are more likely to have two or more adults present and the caretaker is more likely to be currently married. But, the relative caretakers are significantly older, and four out of five are the child's grandparent.

- The Illinois formal kinship care group more than tripled (from 8,000 to 27,000) between 1990 and 1995, while the AFDC/Relative group remained constant at 16,000 children.

- Within each racial category, the prevalence of AFDC/Relative cases is similar for children from Cook County and children from the remainder of Illinois, while the prevalence of formal foster care is more than twice as high in Cook County than for the balance of the state. For both types of care, the prevalence of kinship care for African American kinship exceeds that of "all others" combined by ten times or more.

It was possible to track movements of individual children between these statuses across the 5-year time period (via annual snapshots).

- Most children "stay" in their current status from year to year. Over 70 percent of AFDC/Relative children and 80 percent of formal kinship children can be expected to remain in their current status after a given one-year period.

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- Even though less than 1 percent of AFDC/Parent children are expected to move into kinship foster care in the course of one year, over one-half of all new children in kinship foster care moved into this status from AFDC/Parent settings.

- Children who move between the different AFDC and kinship settings tend to be younger, while children who "stay put" or who leave the system entirely tend to be older.

V. Summary, Observations, and Potential Next Steps

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Some of the issues discussed include:

- The difficulty of clearly defining family relationships, as opposed to just the relation of members to the household head, in much data collected through surveys. Presence or absence of a child's parent is often not identifiable for complex households.
- Kinship care arrangements are relatively uncommon, so only censuses, very large population surveys, or specially targeted surveys can enumerate a sufficient number of kinship care cases to support a meaningful comparative analysis.
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Some possible next steps include:

- Maintaining a baseline of information on kinship care by continuing to monitor the annual CPS results and by supporting more detail in the analyses created from them.
- Extending the aggregate reporting from census data to provide more detailed information on the living arrangements of children, particularly to classify reported data by race/ethnicity.
- Extending the work in formal kinship care to more than four states, possibly by accessing the new AFCARS data being reported directly to HHS by the states.
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DEPARTMENT OF HEALTH & HUMAN SERVICES

2

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
330 C Street, S.W.
Washington , D.C. 20201

FACSIMILE COVER SHEET

DATE: 7-23-97

TO: Nicole Rabner

FAX No. 456-9412

FROM: **MICHAEL W. AMBROSE**

Phone: (202) 205-8740
Fax: (202) 260-9345

No. Pages (including cover sheet) 7

Message: Executive Summary of Formal and Informal Kinship Care report, at Samara's request.

Child Welfare Waiver Demonstration Projects

Relating to **Kinship Care**

1) Delaware will test a small-scale guardianship project, aimed at achieving permanency for certain children who would otherwise remain in foster care. The Demo is aimed at children who cannot be adopted and who will not be reunited with their parent(s). It will involve both kinship and non-relative guardianship placements. The State expects to learn whether children are better served and their placements are more stable, whether their relationships with their families are affected, and whether there are more economical or more strategic ways to spend State and federal child welfare funds for such children. Delaware's project was approved in June, 1996 and is well underway.

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3) Maryland is also testing a Statewide guardianship project, under which the State will offer to pay guardians half the monthly rate paid to foster care providers. The Maryland project, intended to be exclusively a kinship project, was approved in April, 1997. The State is still completing the final evaluation and implementation plans for HHS review.

4) North Carolina is offering a guardianship option to counties which are testing an intensive services project aimed, among other things, at reducing the length of time children spend in foster care. The North Carolina project was approved in November of 1996. The counties and the State are now finalizing the Demo workplans.

5) Oregon, approved for a "System of Care" intensive services project in November of 1996, negotiated a provision which anticipates an amendment to the waiver Terms and Conditions to provide for a guardianship Demo in the State. Oregon is interested, among other things, in grandparents who are serving as guardians. The State has begun discussions with HHS about proposing such an amendment.

Several other States with which HHS is now discussing a demonstration are interested in kinship guardianship projects.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

June 26, 1997

Catherine Akins
Office of Representative Maxine Waters
U.S. House of Representatives
Washington, D.C. 20515

Dear Catherine:

Just a quick note to follow up on our phone conversation. It was very helpful to hear more about Representative Waters' concerns in the area of kinship care.

I have pulled together some materials describing recent HHS activities in this area, including the just-released report *Informal and Formal Kinship Care,* information on Maryland and Delaware child welfare waivers which include provisions for assisted guardianship placements, program announcements for demonstrations which include kinship care activities, and some additional fact sheets. I have also enclosed a 2-page summary and analysis of Representative Waters' Grandparent and Family Caregiver Support Act prepared by our policy division.

I hope you find these materials useful. Again, I found it very helpful to discuss these issues with you and look forward to being in touch.

Sincerely,

Mary

Mary Bourdette
Deputy Assistant Secretary
for Human Services Legislation

GRANDPARENT AND FAMILY CAREGIVER SUPPORT ACT (H.R. 1646)

Summary

The Grandparent and Family Caregiver Support Act of 1997 would prohibit States from applying the work requirements and time limits in the welfare reform law to grandparents and other family caregivers. The proposal contains the following provisions:

- *Work Requirements*. States would be barred from using their TANF grant to impose work requirements on families headed by a relative caregiver. These families would not be included in the calculation of the work participation rates and could not be required to work after two years. States could not sanction these families for refusing to work. If a State used the grant to require these families to work or penalized these families, the Secretary could reduce a State's TANF grant by 5 percent.

- *Time Limits*. States would be prohibited from establishing time limits for relative caregivers. In addition, in determining the number of months of assistance received, States would be required to disregard any months of assistance received by a family head who is a relative caregiver. If a State violated these provisions, the Secretary could reduce a state's TANF grant by 5 percent.

- *Grants to States*. States providing support for grandparent and other family caregivers would be eligible to receive a federal grant equal to the amount expended by states to provide assistance to these caregivers.

Background

The background information provided with the legislative proposal discusses 3.5 million children living in relatives' households. This figure overstates the issue somewhat, because in between one-third and one-half of these households the children's parents are also present. A much smaller, although still quite significant, number of children are living with relatives without a parent present. Multi-generational, extended family households are somewhat different from households in which a relative has taken over primary responsibility for the children and the parent is not present. (All the figures below are from an ASPE study to be released soon entitled *Informal and Formal Kinship Care*.)

In 1994, an estimated 2.15 million children lived with relatives and without their parents. This includes 1.8% of white children, 8.0% of African American children and 3.4% of Hispanic children. Just under half of all U.S. children in relatives' care (without a parent present) live in the South, as defined by the Census Bureau. Since the early 1980s the number of such families has grown significantly among African Americans and has remained reasonably stable among whites. Relatively few of these children are in formal foster care arrangements with relatives. Most relative care consists of informal arrangements organized by the families themselves.

As the Congresswoman's background sheet on the bill points out, many relative caregivers are older than parents. Two thirds of the children in relatives' care live with grandparents. Of the relatives caring for children when parents are not present, 27% are age 60 or over; 29% are age 50-59; 24.5% are 40-50 years old; and 18% are under 40. Nearly 60% of these caregivers are employed, but nearly 40% of the children in relatives' care live in families with incomes below the poverty line. Approximately 27% of kinship care children live in families that receive public assistance or welfare, 31% receive Food Stamps, 14.5% receive SSI, nearly half receive free school lunches, and 35% live in households which receive income from Social Security.

Analysis

The needs of relative caregivers are real and important. Several aspects of this proposal, however, could have significant unintended consequences and are inconsistent with the President's proposals on welfare reform. In addition, current law and guidance provided to the States on maintenance of effort and the operation of separate programs with state-only money gives them flexibility to use their own funds to support relative caregivers should they choose to do so.

Potentially Weakens Family Stability. We must take care not to encourage parents to abandon their children. In the same way the welfare system has been accused of driving men out of families and contributing to the explosion in single parent households, making a single parent's departure from the household the key to continued family assistance may inadvertently create additional no-parent families. For a single mother facing the loss of assistance benefits because of time limits, work requirements, or other restrictions, abandoning her children to a relative's care may seem like the best option. In addition, States would have an incentive under this proposal to encourage this possible trend given that they would receive additional funding when assistance is provided to relative caregivers rather than parents.

Significant Costs. This proposal would have significant budgetary implications, given that States would receive Federal reimbursement for the full amount of assistance they provide to relative caregivers. States would have a strong incentive to use this new funding stream to maximum advantage.

Reduces State Flexibility. This proposal reduces State flexibility by banning States from establishing time limits or requiring work, even if States find that such requirements would be appropriate in certain circumstances. States currently have the flexibility to ease time limits for grandparents or other relative caretakers by including them under the 20 percent extension, by using State dollars to provide assistance, or by only providing assistance to the children in the family.

Weakens Work Emphasis. In many instances, it may be appropriate to require relatives to work in order to help them make the move to self-sufficiency. In circumstances where it may not be appropriate to require work because of age or disability, the State can choose under current law to exempt these individuals from the work requirements (and meet the rates by targeting other individuals) or serve them in separate State programs.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

Dear Colleague: JUL 1997

For your information, attached is a copy of a study entitled *Informal and Formal Kinship Care*. A small but significant number of children are now being raised by relatives other than their parents, but little has been known about these "no parent families." This study takes a step towards understanding their characteristics. It was conducted by researchers at the Chapin Hall Center for Children at the University of Chicago and the Urban Institute, under contract to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Some of these kinship care situations have been arranged formally, through child welfare agencies, but far more are informal arrangements organized by the families themselves. This study uses several data sources, including the Current Population Survey, the 1990 U.S. Census, and several states' administrative data regarding their foster care and welfare programs, to examine the characteristics of informal kinship care arrangements and, where possible, to compare them with those initiated through and/or subsidized by the child welfare system. Among other findings:

- In 1994, approximately 2.15 million children, or just over 3% of all children in the United States, were estimated to have lived in relatives' homes without a parent present. Roughly two-thirds of kinship caregivers are the child's grandparent.

- On average, children in kinship care are older, more likely to be members of minority groups, and more likely to live in the South than are children living with their parents. They are also more likely to be poor and to receive assistance through government social welfare programs.

- The percentage of children living in kinship care varies widely among the states. Much of this variation follows regional lines, with the southern states consistently showing the highest levels of kinship care arrangements. In every state, older children (age 6-17) are much more likely to live in kinship settings than are younger children (age 0-5).

- The care arrangements for children who do not live with either parent vary widely by state, but informal kinship care situations vastly outnumbered kinship foster care arrangements in every state examined. For instance, in Missouri 2.7% of children living in kinship care in 1990 were placed there as a formal foster care arrangement, while in New York 22.5% of such children were in foster care.

I hope you find the report useful. If you have questions, contact Laura Feig at 202-690-5938.

Sincerely,

Ann Rosewater

Ann Rosewater
Deputy Assistant Secretary
for Human Services Policy

EXECUTIVE SUMMARY

FORMAL AND INFORMAL KINSHIP CARE

Report for ASPE Task Order HHS-100-95-0021 "Characteristics of Informal Kinship Care"

The Urban Institute and Chapin Hall Center for Children

This report presents the results of work pursued by analysts at two separate research institutions in a collaboration designed to describe the population of American children living in **kinship care** arrangements.

The Task Order was to examine existing national data sources in order to describe the characteristics of children in kinship living arrangements, and to identify recent trends in the pattern of kinship caregiving. Particular importance was attached to developing information that could support comparison between **formal kinship** care arrangements (i.e. care provided by relatives as foster care under auspices of the state) and **informal kinship** arrangements (all other caregiving provided by relatives in the absence of a parent).

Kinship foster care has attracted much attention in recent years within the context of the child welfare system. The extensive placement of children with relatives has created a new, rapidly growing, and poorly understood segment of the child welfare caseload that has great impact on the size and nature of the foster care population in many states. Children in formal kinship placements can be viewed as a subgroup of a broader category of family-based alternatives to parental care -- the population of all children living in kinship care settings across the country. Most American children who live in kinship care arrangements are not foster children. We cannot yet determine whether most current kinship foster care placements are "formalizations" of kinship arrangements that would likely exist without agency intervention, or whether these are mostly new arrangements created as a result of recent child welfare practices. But it is clear that children in informal kinship settings are potentially of crucial importance for the child welfare system -- as a reference group, as a potential "feeder" population, and as an alternate model of caregiving.

By virtue of the similarity between formal and informal kinship arrangements, any policy actions directed towards one of these groups is likely to affect the other in a parallel or reactive manner, whether or not this is intended by those who frame these actions. Even though our understanding of the recent interdependence between these two kinship subgroups is weak, the importance of anticipating their future interrelationship becomes increasingly apparent -- especially as our questions move from the strict realm of child welfare policy into the broader arena of family supports and welfare reform.

This report presents the results of four separate, and relatively independent, research tasks, each approaching these questions with a different set of information tools. Taken as a whole, they provide us with a greatly improved picture of kinship care in the United States, and provide an enriched context for discussing these issues. The first task was produced by the Urban Institute, the remaining three by the Chapin Hall Center for Children at the University of Chicago. A brief

description of each task and a summary of substantive findings from each follows.

I. National Patterns and Trends in Kinship Care:

Section I describes the population of children in kinship care settings in the United States, the characteristics of these children and their caretakers, and trends that have been observed since 1983. These descriptions are based on information drawn from 12 years of the Current Population Survey (CPS), a large and ongoing national sample of the full United States population. At the national level, the CPS provides the richest and most reliable information available about children's living arrangements and households -- including identification of kinship care relationships. Information is collected about the children, their relative caretakers, and the families which they share. The following are among the key findings reported in this section.

About Children in Kinship Care:

- In 1994, approximately 2.15 million children, or just over 3 percent of all children in the United States, were estimated to live in the care of relatives without a parent present.

- Nationally, the prevalence of kinship care probably increased between 1983 and 1993, and it certainly did not decrease. There is no evidence of any increase in kinship care among the white (non-Hispanic) children in recent years; all observed growth in kinship care has been among white Hispanic and non-white sectors of the population.

- Non-Hispanic white children are substantially less likely to live without their parents in the care of relatives than are the children of any other racial/ethnic group. African American children are most likely to live in kinship care settings, at levels four to five times as great as those for white non-Hispanic children. The gap between African Americans and the other ethnic groups widened throughout the 12 year period examined.

- Kinship care has been more prevalent in the South, for children living outside of Metropolitan areas, and for older children, although the size of the differences due to each of these factors has diminished gradually over the 12 years studied.

About Kinship Caregivers:

- Roughly two-thirds of kinship caregivers are the child's grandparent . About half of the kinship caregivers are currently married, while over 85 percent of the single kinship caregivers are female.

- The kinship caregiver population is much older than the parent caregiver population. Although over 95 percent of the parents who live with their own children are below the age of 50, over one-half of all kinship caregivers are 50 years of age or greater.

- Compared to parents who live with their own children, kinship caregivers tend more often to be currently unmarried, to be less-educated, to be unemployed or out of the labor force, to live in poverty, and to receive benefits through government social welfare programs.

The portrait of kinship care that emerges from the CPS is of a population of children that live in arrangements with strained resources of many types. This population is disproportionally

composed of minority children being cared for by relatives that, as a group, show fewer advantages than own-parent caregivers.

II. Living Arrangement Patterns by State: 1990

Section II describes the living arrangement patterns for all children state by state. This analysis is based on data made available from the 1990 Census of Population. The census does not provide as much substantive detail as the Current Population Survey, but the estimates it provides are reliable for much smaller geographic areas.

- The national pattern of child living arrangements in 1990 showed most American children living with at least one of their own parents. Over 70 percent lived with two parents, 20 percent with their mother only, and 4 percent with their father only. Just over 2 percent of all children lived with relatives (parent absent), and just over 2 percent in the care of unrelated persons.

- Although this fundamental pattern persists across all states, substantial variation in the distributions is seen between states. The percentage of children living with two parents varies from under 62 percent to over 83 percent. For kinship care, state percentages varied from under 1 percent of all children to well over 3 percent. Much of this variation follows regional lines, with the southern states consistently showing the highest levels of kinship care arrangements.

- In every state, older children (6-17) are more likely to live in kinship care settings than are younger children (0-5).

- In general, kinship care levels across states tend to be positively associated with levels of mother-only care, and weakly or negatively associated with father-only and unrelated care. The levels of kinship care and mother-only care also each vary directly with the total percentage of children not living with two parents, while father-only and unrelated arrangements do not.

A tentative argument is developed that higher levels of mother-only care and relative care appear to be direct products of higher levels of social disruption and family disorganization, because they consistently vary strongly and inversely with the proportion of children living within a traditional two-parent family structure.

III. Formal and Informal Kinship Care Patterns: Four States

Section III introduces data developed directly from administrative foster care records in four states: California, Illinois, New York, and Missouri. Kinship foster care counts obtained from these child welfare records are used to split the census-based counts of children living with relatives into the separate categories of formal and informal kinship care. This information becomes available in the form of aggregate counts for the four states and certain sub-state places.

Findings include the following:

- Informal kinship care is far more common than formal kinship care. In the four states combined, only 15.5 percent of all kinship children were in a formal foster care placement.

- Levels of informal kinship care are rather similar across each of these four states, while the levels of formal kinship foster care vary dramatically.

- Younger children in kinship care are more likely to be in foster care than are older kinship care children. Formal kinship levels were 58 percent higher for 0-5 year olds than for 6-17 year olds, while informal kinship levels were over twice as high for 6-17 year olds as for 0-5 year olds.

Within each state, the analysis compares the "primary urban place" (*i.e.* Los Angeles County; Chicago City; St. Louis City; and New York City) to the "balance," or remainder, of the state.

- In two states, New York and Missouri, formal kinship foster care appears almost exclusively in the primary urban place, and is virtually absent across the balance of the state. In California and Illinois, formal kinship is still concentrated in the primary urban place and a few other counties.

- Informal kinship care is also consistently higher in the primary urban places than in the balance of each state, although it is distributed far more evenly than formal kinship care.

- In larger cities, where formal kinship care is most common, there appears to be an inverse relationship between the levels of formal and informal kinship care. This might suggest that the children in the two types of kinship care are drawn from the same pool of children, and that the observed differences in formal versus informal care levels between cities are mostly due to different agency practices involving the use of formal kinship care.

Looking only at formal kinship foster care:

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DEPARTMENT OF HEALTH & HUMAN SERVICES

2

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
330 C Street, S.W.
Washington , D.C. 20201

FACSIMILE COVER SHEET

DATE: 7-23-97

TO: Nicole Rabner

FAX No. 456-9412

FROM: **MICHAEL W. AMBROSE**

Phone: (202) 205-8740
Fax: (202) 260-9345

No. Pages (including cover sheet) 7

Message: Executive Summary of Formal and Informal Kinship Care report, at Samara's request.

Mike

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1) Delaware will test a small-scale guardianship project, aimed at achieving permanency for certain children who would otherwise remain in foster care. The Demo is aimed at children who cannot be adopted and who will not be reunited with their parent(s). It will involve both kinship and non-relative guardianship placements. The State expects to learn whether children are better served and their placements are more stable, whether their relationships with their families are affected, and whether there are more economical or more strategic ways to spend State and federal child welfare funds for such children. Delaware's project was approved in June, 1996 and is well underway.

2) Illinois is testing a similar approach, but on a larger scale. The Illinois Demo emphasizes but is not limited to kinship placements for guardianships. The Demo parallels a State-financed guardianship program. Illinois, like DE, expects to pay a somewhat lesser amount to guardians than is paid to foster care providers; and both States will supply basic support services to maintain the guardianship placements, even though they will no longer monitor the families or conduct case reviews. There is an excellent evaluation design for this statewide project. The Illinois project was approved in September of 1996, and is being implemented now.

3) Maryland is also testing a Statewide guardianship project, under which the State will offer to pay guardians half the monthly rate paid to foster care providers. The Maryland project, intended to be exclusively a kinship project, was approved in April, 1997. The State is still completing the final evaluation and implementation plans for HHS review.

4) North Carolina is offering a guardianship option to counties which are testing an intensive services project aimed, among other things, at reducing the length of time children spend in foster care. The North Carolina project was approved in November of 1996. The counties and the State are now finalizing the Demo workplans.

5) Oregon, approved for a "System of Care" intensive services project in November of 1996, negotiated a provision which anticipates an amendment to the waiver Terms and Conditions to provide for a guardianship Demo in the State. Oregon is interested, among other things, in grandparents who are serving as guardians. The State has begun discussions with HHS about proposing such an amendment.

Several other States with which HHS is now discussing a demonstration are interested in kinship guardianship projects.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

June 26, 1997

Catherine Akins
Office of Representative Maxine Waters
U.S. House of Representatives
Washington, D.C. 20515

Dear Catherine:

Just a quick note to follow up on our phone conversation. It was very helpful to hear more about Representative Waters' concerns in the area of kinship care.

I have pulled together some materials describing recent HHS activities in this area, including the just-released report *Informal and Formal Kinship Care,* information on Maryland and Delaware child welfare waivers which include provisions for assisted guardianship placements, program announcements for demonstrations which include kinship care activities, and some additional fact sheets. I have also enclosed a 2-page summary and analysis of Representative Waters' Grandparent and Family Caregiver Support Act prepared by our policy division.

I hope you find these materials useful. Again, I found it very helpful to discuss these issues with you and look forward to being in touch.

Sincerely,

Mary

Mary Bourdette
Deputy Assistant Secretary
for Human Services Legislation

GRANDPARENT AND FAMILY CAREGIVER SUPPORT ACT (H.R. 1646)

Summary

The Grandparent and Family Caregiver Support Act of 1997 would prohibit States from applying the work requirements and time limits in the welfare reform law to grandparents and other family caregivers. The proposal contains the following provisions:

- *Work Requirements*. States would be barred from using their TANF grant to impose work requirements on families headed by a relative caregiver. These families would not be included in the calculation of the work participation rates and could not be required to work after two years. States could not sanction these families for refusing to work. If a State used the grant to require these families to work or penalized these families, the Secretary could reduce a State's TANF grant by 5 percent.

- *Time Limits*. States would be prohibited from establishing time limits for relative caregivers. In addition, in determining the number of months of assistance received, States would be required to disregard any months of assistance received by a family head who is a relative caregiver. If a State violated these provisions, the Secretary could reduce a state's TANF grant by 5 percent.

- *Grants to States*. States providing support for grandparent and other family caregivers would be eligible to receive a federal grant equal to the amount expended by states to provide assistance to these caregivers.

Background

The background information provided with the legislative proposal discusses 3.5 million children living in relatives' households. This figure overstates the issue somewhat, because in between one-third and one-half of these households the children's parents are also present. A much smaller, although still quite significant, number of children are living with relatives without a parent present. Multi-generational, extended family households are somewhat different from households in which a relative has taken over primary responsibility for the children and the parent is not present. (All the figures below are from an ASPE study to be released soon entitled *Informal and Formal Kinship Care*.)

In 1994, an estimated 2.15 million children lived with relatives and without their parents. This includes 1.8% of white children, 8.0% of African American children and 3.4% of Hispanic children. Just under half of all U.S. children in relatives' care (without a parent present) live in the South, as defined by the Census Bureau. Since the early 1980s the number of such families has grown significantly among African Americans and has remained reasonably stable among whites. Relatively few of these children are in formal foster care arrangements with relatives. Most relative care consists of informal arrangements organized by the families themselves.

As the Congresswoman's background sheet on the bill points out, many relative caregivers are older than parents. Two thirds of the children in relatives' care live with grandparents. Of the relatives caring for children when parents are not present, 27% are age 60 or over; 29% are age 50-59; 24.5% are 40-50 years old; and 18% are under 40. Nearly 60% of these caregivers are employed, but nearly 40% of the children in relatives' care live in families with incomes below the poverty line. Approximately 27% of kinship care children live in families that receive public assistance or welfare, 31% receive Food Stamps, 14.5% receive SSI, nearly half receive free school lunches, and 35% live in households which receive income from Social Security.

Analysis

The needs of relative caregivers are real and important. Several aspects of this proposal, however, could have significant unintended consequences and are inconsistent with the President's proposals on welfare reform. In addition, current law and guidance provided to the States on maintenance of effort and the operation of separate programs with state-only money gives them flexibility to use their own funds to support relative caregivers should they choose to do so.

Potentially Weakens Family Stability. We must take care not to encourage parents to abandon their children. In the same way the welfare system has been accused of driving men out of families and contributing to the explosion in single parent households, making a single parent's departure from the household the key to continued family assistance may inadvertently create additional no-parent families. For a single mother facing the loss of assistance benefits because of time limits, work requirements, or other restrictions, abandoning her children to a relative's care may seem like the best option. In addition, States would have an incentive under this proposal to encourage this possible trend given that they would receive additional funding when assistance is provided to relative caregivers rather than parents.

Significant Costs. This proposal would have significant budgetary implications, given that States would receive Federal reimbursement for the full amount of assistance they provide to relative caregivers. States would have a strong incentive to use this new funding stream to maximum advantage.

Reduces State Flexibility. This proposal reduces State flexibility by banning States from establishing time limits or requiring work, even if States find that such requirements would be appropriate in certain circumstances. States currently have the flexibility to ease time limits for grandparents or other relative caretakers by including them under the 20 percent extension, by using State dollars to provide assistance, or by only providing assistance to the children in the family.

Weakens Work Emphasis. In many instances, it may be appropriate to require relatives to work in order to help them make the move to self-sufficiency. In circumstances where it may not be appropriate to require work because of age or disability, the State can choose under current law to exempt these individuals from the work requirements (and meet the rates by targeting other individuals) or serve them in separate State programs.

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June 3, 1997

Hillary Rodham Clinton
Office of the First Lady
The White House
1600 Pennsylvania Ave
Washington, DC 20500

Dear Mrs. Clinton,

It has been wonderful to watch your agenda for children unfold and emerge from ideas and policies, to real life solutions for vulnerable children and their families. It is not possible to thank you enough for your commitment and perseverance. In your busy schedule, I hope at least once in awhile you get to touch the stories yourself and realize what a difference you are making.

I am enclosing a journal called "Creating Kinship" that was just published by the Edmond S. Muskie School of Public Service at the University of Southern Maine. The journal and the work of the Kinship Center was supported by a Federal Adoption Opportunities grant. I just received an advance copy and am excited that this work has truly captured what I believe are some of the most salient and current issues in adoption and foster care reform. I hope you will be as impressed as I was.

On Election Day in Little Rock, you mentioned your interest in meeting during one of my trips to Washington to discuss issues of child welfare and adoption. I want to confirm my desire to meet with you at your convenience. I am pleased to accommodate your schedule and am not limited to meeting you in Washington DC, if another location is more convenient and timely.

Again, I want to express my appreciation to you for your leadership in addressing needed action and change for children at a national level. It is re-energizing and validating to have you insist that these concerns be priorities. It is reassuring, and most importantly, it elevates children to the forefront where they belong.

Thank you.

Sincerely,

Susan Soon-Keum Cox

The State of the Children: An Examination of Government-Run Foster Care

by
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and
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Institute for Children

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Executive Summary

More than 650,000 American children will spend all or part of 1997 in government-run foster care — in foster homes, group homes, children's shelters and other institutions. Most will enter due to substantiated abuse or neglect. Although the foster care system was designed to provide *temporary* care, all too often children remain in state custody for years. This year some 15,000 foster children will leave the system — without permanent families — by reaching the age of majority.

With the lives of the nation's most vulnerable children hanging in the balance, policymakers are attempting to untangle the bureaucratic complexities of foster care. However, they are doing so without the benefit of even the most basic information, such as the number of children in foster care in every state. The Adoption Assistance and Child Welfare Act of 1980 required that every state establish an information system to collect data on children in foster care, but the federal government did not specify what data had to be collected.

This study is the result of a two-year undertaking by the Institute for Children to gather accurate data on three of the most pressing questions in child welfare: (1) How many children are in foster care? (2) How many of these children are legally free to be adopted? (3) How well are the states doing at finding adoptive homes for children? Among the findings:

- As of the close of fiscal 1996, 526,112 children were in state-run substitute care.
- Although 22,491 children were adopted from foster care last year, another 53,642 — one in 10 foster children — were legally free for adoption but still in state care at year-end.
- Even in the six states with the highest number of foster child adoptions, there were more children awaiting adoptions at the beginning of 1997 than had been placed for adoption during the entire 1996 fiscal year.

The failures of the current system are costly in more ways than one. The nation will spend more than $12 billion on public agency child welfare this year. There are also indirect social costs that can extend for years after a child leaves the system. For example, foster children who turn age 18 in care are overrepresented among welfare recipients, prison inmates and the homeless.

While about two-thirds of children in foster care eventually return to their biological families, thousands of others become legally free for adoption when the rights of their biological parents are terminated by a court. Why are states not doing a better job at placing them in new families? One reason may be that public foster care agencies are driven by reverse financial incentives. The federal government reimburses states for foster care costs based on the number of children in foster care per day. There are no

Government-Run Foster Care: An Overview

For most of America's history, the care of parentless children was handled by private, often faith-based, entities. This was to the benefit of needy children. Privately funded organizations must prove their efficacy to stay in business; funders will cease to support a charity that is failing its constituents. By contrast, today's government-run foster care is essentially funded to fail. The system has developed into a monopoly run by state and county bureaucracies, but substantially directed through funding by the federal government. Government-operated child welfare is charged with the care of the nation's most vulnerable citizens. One major aspect of child welfare is foster care, a system of "temporary" substitute care designed to protect children whose biological parents cannot or will not provide safe homes for them.[1] More than half a million American children are in government-run foster care today. About 650,000 children will spend all or part of 1997 in this system, placed in foster homes, group homes, children's shelters or other institutions.[2] [See the sidebar on What Is Foster Care?]

The system is expensive. In fact, Americans spend more on the foster care "industry" than we spend on major league baseball.[3]

- This year America will spend $12 billion on public agency (that is, government-operated) child welfare.[4]
- A year in foster care costs an estimated $17,500 — not including counseling and treatment programs for biological parents or foster and adoptive parent recruitment.[5]
- The Child Welfare League of America estimated in 1994 that the annual per-child cost for group home care was $36,500.[6]
- In Michigan, per-year, per-child costs for institutional placements can average $42,000.[7]

"By most accounts, the government-run foster care system is failing."

By most accounts, the system is failing. The well-publicized stories of child death in foster care offer the most vivid examples of this failure; an Arizona newspaper called a stay in foster care more dangerous than being a fighter pilot.[8] Far more frequent, however, are the stories of loving foster parents who want to adopt a child who has been a part of their family for years, but are turned down because their race does not match that of the child, or the stories of generous, compassionate families willing to adopt an older or handicapped child who are turned away by a state system that is too inefficient to respond to their interest.

The data on foster care outcomes paint a dreary picture of a childhood in limbo, or sometimes lost. Despite a 1980 Congressional mandate that every foster child have a "permanency plan" — for reuniting the foster child with the biological family, or preparing for adoption or another outcome — estab-

What Is Foster Care?

A child is placed in foster care when the situation in the biological parents' home becomes unsafe for the child's continued residence. The Child Protective Services (CPS) unit (sometimes otherwise named) of the public child welfare agency is called in to investigate allegations of abuse or neglect. If the allegations are substantiated and the circumstances are determined to pose an immediate threat, a child can be removed from the biological parents and become a ward of the state, court or county. Some children are placed in foster care because of what are termed "parental conditions" including illness, drug addiction, incarceration, mental illness, homelessness, etc. In some instances — even in cases of substantiated abuse or neglect — state social workers will leave a child with the biological parents, but pursue a course of rehabilitative or corrective action with the parents.

Once a child is removed from the home by the state, he or she is placed in either a family foster home or a group home facility. Family foster home caregivers are individuals or couples who agree to take in a foster child for an unspecified amount of time while the child's biological parents undergo treatment, counseling or rehabilitation. These caregivers are paid a stipend by the state to care for the child. Some family foster homes are "kinship care" homes — that is, the caregivers are biological relatives of the child (often grandparents or aunts and uncles) who agree to care for the child temporarily; kinship caregivers are also paid by the state.

While a youngster is in foster care, his or her social workers develop a "permanency plan," which stipulates whether the child is intended to return to the biological parents once they meet certain requirements (about two-thirds of foster children are "reunified" with their biological parents), or whether the child is to be adopted, assigned to a guardian or left in long-term foster care. Before a child can be placed for adoption, the court must hold a termination of parental rights (TPR) hearing to approve severance of legal ties with the biological parents.

financial incentives to move children out of foster care. Further, the federal government does not require states to actively seek adoptive homes for all free-to-be-adopted children. As a result, they are all too often assigned instead to a series of foster homes, group homes or institutions, or enrolled in the federally funded Independent Living Program (where they are supposed to be taught how to live on their own).

Is it possible that there are too few families willing to adopt foster children? The evidence suggests otherwise. In the private sector, adoption is flourishing. Not including adoptions by relatives, an estimated 60,000 children will be adopted this year, with the majority placed through private adoption agencies and independent attorneys. By everyone's reckoning, demand exceeds supply. While detractors often claim that Americans are interested only in adopting healthy white babies, a national survey commissioned by the Institute for Children found that 71 percent of Americans, if adopting, would be willing to adopt a foster child.

Both federal and state governments must reduce the barriers to adoption of foster children through private agencies. Further, the system must reward efforts to increase adoptions and penalize laggard performance.

- At both the federal and state levels, the goal should be a 12-month maximum stay in foster care before the child is either reunified with the biological family or adopted.
- The loosely used and overused term "special needs" must be redefined to mean only children with physical or other types of handicaps that would either require ongoing medical attention or otherwise result in increased cost to adoptive families.
- States should be required to report publicly each year the number of foster children in state care, the number free to be adopted but not in pre-adoptive placements and the number of state-approved adoptive families who have been recruited and are seeking to adopt.
- The federal government should base payments to the states on the tangible outcomes listed above rather than on program growth.

Creating a workable adoption system for foster children is possible. The key components are already in place. Private, community-based organizations are providing foster and adoptive parent recruitment and support. Businesses are contributing time, talent and treasure to promote adoption. Individuals are spearheading efforts to assist children through mentoring programs for foster teens. Combined with needed public policy reforms, these private endeavors can create a more efficient and more humane system for America's foster children.

lished within 18 months after the child enters substitute care, permanency planning has not guaranteed permanent homes for children.

- The American Civil Liberties Union reported in 1993 that one in four foster children remains in care 4.3 years or more; one in 10 stays in care longer than seven years.[9]
- About 30 percent of foster children who were in care at the end of fiscal 1990 had experienced three or more different placements (different foster homes, group homes or shelters) during the preceding three years.[10]
- Although most foster children who leave the system return to their biological families, about one-third of those children eventually reenter the system.[11]
- Some 15,000 youngsters will reach the age of majority this year and leave foster care without a permanent family — for example, New York City alone will discharge some 4,000 foster care "graduates" out of the system when they reach the age of majority.[12]

Why Children Enter Foster Care. Entry rates are driven in part by the number of substantiated cases of child abuse and neglect. According to the National Committee of Prevent Child Abuse, reports of abuse and neglect increased steadily during the past 10 years (45 percent nationwide since 1987), but increased by only 1 percent between 1995 and 1996.[13] In 1996, 31 percent of the reports, or an estimated 969,000 cases, were substantiated — that is, abuse or neglect was found to have occurred and thus led to the involvement of a child in protective services (including in-home care such as family preservation and out-of-home foster care).[14] The number of substantiated cases fell from 1994 to 1995, and again from 1995 to 1996; in fact, the 1996 figure was the lowest since 1991.[15]

"Child abuse, neglect and drug use by parents account for much of the foster child population."

An oft-cited reason for the growth of the foster care population is increasing rates of drug use among women. The Massachusetts Department of Social Services Internet site attributes the heightened numbers of children in foster care to "an explosion of substance abuse and domestic violence."[16] In 1990 the House Committee on Ways and Means reported that officials in New York City attributed a 300 percent increase in child abuse and neglect by substance abusing parents to the introduction of crack cocaine.[17] A longitudinal study of foster care in Oregon found that 54 percent of parents whose children entered care between 1991 and 1993 were abusing drugs or alcohol.[18] A National Institute on Drug Abuse survey designed to estimate the drug use of women who gave birth in 1992 found that "221,000, or 5.5 percent of the women used some illicit drug during pregnancy," including an estimated 34,800 who used crack.[19] The American Public Welfare Association reported that in 1990:[20]

- Just over 50 percent of children who entered foster care entered because of abuse or neglect.
- Another 20 percent of children entered the system due to parental abuse or parental condition such as incarceration, drug addiction and/or illness.
- Only 2 percent entered due to a handicap or disability of the child, and 11 percent due to status offense (such as truancy) by the child.
- The other 15 percent entered for other or unknown reasons.

How the System Has Expanded. The size and scope of America's public agency child welfare system has grown exponentially in the past three decades. As of 1990, the number of children in substitute care was growing at a rate 33 times greater than the U.S. population of children in general.[21] As Figure I shows, the substitute care population grew from 262,000 at the end of fiscal 1982 to 468,000 at the end of fiscal 1994.[22] The Institute for Children found that on the final day of fiscal year 1996, with all states reporting, there were 526,112 children in substitute care.[23] As noted above, we believe that 650,000 children will spend all or part of this year in foster care.[24]

"Fewer children are leaving foster care than are coming in."

Fewer children are leaving foster care than are coming in. For each of the years from 1983 to 1994, more children entered than exited the system.[25] The American Public Welfare Association has documented how the growth in the substitute care population has been influenced more by declines in exit rates than increases in the number of children entering care.[26]

A Growing Proportion of Racial Minorities. The Children's Bureau reports that girls and boys are represented almost equally in foster care. Of those who entered care in fiscal 1990, 47 percent were white, 31 percent were black and 14 percent were Hispanic.[27] Minorities are becoming an increasing proportion of children in care. In a study of 12 states, the APWA found that although the actual numbers of black and Hispanic children who left care between 1984 and 1990 increased, the rate of exit "consistently lagged behind the rates of exit among white children throughout the period."[28]

The Chapin Hall Center for Children at the University of Chicago studied foster care trends in five states (California, Illinois, Michigan, New York and Texas) in which almost half the nation's substitute care population is concentrated. The study found that controlling for variables, black children could be expected to stay in foster care 32 percent longer than white children. In California, black children could be expected to stay 41 percent longer.[29]

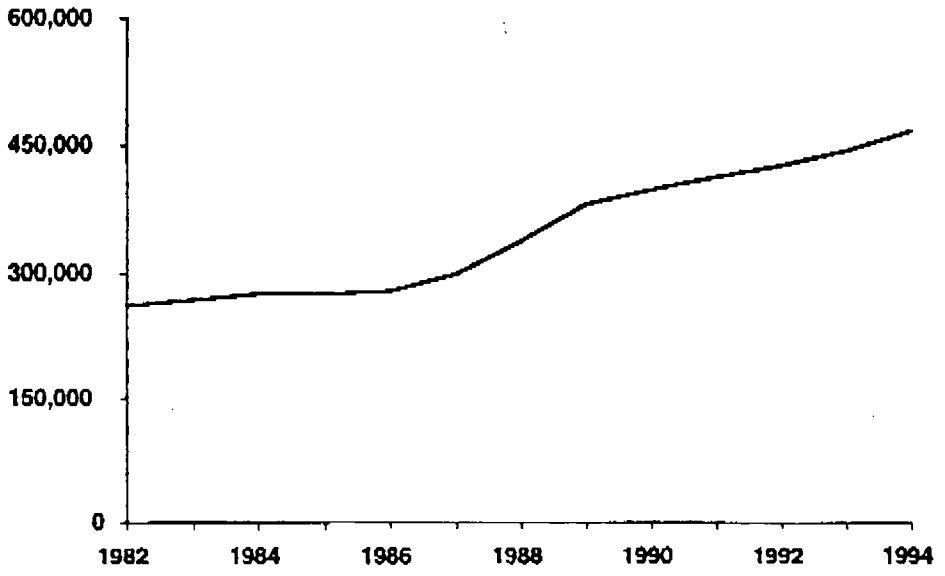
Younger Children, Longer Stays. The average age of children in foster care is declining — and an increasing proportion of foster children are infants.

"The substitute care population grew from 262,000 at the end of fiscal 1982 to 468,000 at the end of fiscal 1994."

FIGURE I

Children in Foster Care

(Last Day of Fiscal Year)



Source: American Public Welfare Association.

- The median age of children in foster care has declined steadily from 12.6 years in 1982 to 11.5 in 1986 to 8.6 in 1990.[30]
- The Chapin Hall study found that, controlling for variables, children who entered foster care as infants could be expected to stay 22 percent longer than children entering at ages 1 to 5, and 20 percent longer than those entering at ages 6 to 8.[31]

In other words, infants, who would be expected to leave sooner, are likely to stay in longer than older children entering foster care.

Poor Prospects for Graduates of the System. The social costs of foster care's poor outcomes are staggering. In New York City, more than 60 percent of the homeless population in municipal shelters are former foster children.[32] The costs are especially high for youngsters who leave the system at age 18 (or another age determined by the state) without having been adopted.

Westat, Inc., of Rockville, Md., found that 2.5 to four years after youths left foster care, "46 percent had not completed high school, 38 percent had not held a job for more than one year, 25 percent had been homeless for at least one night and 60 percent of young women had given birth to a child. Forty percent had been on public assistance, incarcerated or a cost to the community in some other way."[33]

The Exit to Adoption Is Blocked

More than 50,000 foster children are legally free to be adopted, yet remain in the uncertainty of so-called temporary foster care. These are children for whom the TPR ("termination of parental rights") decision has already been made: they became legally free for adoption when a court terminated the rights of their biological parents.[34] This process is so time-consuming that it can take the better part of a childhood to complete. The U.S. Department of Health and Human Services (HHS) estimated that in 11 states studied it takes, on average, from 12 months to 78 months between the point a child enters foster care and completion of the termination of parental rights.[35] Once legally freed, a child will not return to his family of origin. Family preservation and family reunification services have ended, and thus the legal barriers to adoption are gone. However, other barriers remain.

- In the states studied by HHS, children who are adopted from foster care leave the system between 3.5 and 5.5 years after they enter.[36]
- Almost half (46 percent) of the children awaiting adoptive placement in 16 states at the end of 1990 had spent two years or more waiting for a permanent family.[37]
- Another 21 percent of children had waited for one to two years.[38]

The most troublesome obstacles to foster-child adoption are: (a) a federal funding scheme that compensates states for keeping children in care; (b) the failure of states, including the court system, to expedite adoptive placements; (c) overuse of the "special needs" categorization; and (d) a lack of public awareness about the number of children in foster care who are legally free for adoption but not in pre-adoptive homes.[39]

"The way the federal government reimburses states rewards growth in program size instead of effective care."

The federal government reimburses states for foster care costs on a per-day, per-child basis – even after children are legally free for adoption – rewarding growth in program size instead of effective care. Additionally, federal law requires that in order to secure foster care funding through Title IV-E (this year states will claim an estimated $3.6 billion for Title IV-E foster care), states must meet "reasonable efforts" to preserve at-risk families and to reunify abused and neglected children with their biological parents.[40] In practice, this is one of the factors that has resulted in a bias toward reunifying children with even the most abusive and neglectful biological parents.[41]

States are failing to expedite the adoption of foster children who are legally free for adoption. The federal government does not require states to finalize foster child adoptions expeditiously, and even its attempts to do so have proved impotent. For example, although the 104th Congress tried to eliminate adoption delays caused by race-matching, a social work preference for same-race adoption is still practiced in many jurisdictions.

While a few bellwether states use private adoption agencies, most states maintain a monopoly on the adoption process. The federal government does not require that states actively seek adoptive homes for all free-to-be-adopted children. Many of these children are often assigned instead to long-term foster care and/or the federally funded, $70 million per-year Independent Living Program. This program has been criticized by adoption advocates; as one put it: "To a kid in foster care, Independent Living means 'I'm homeless at 19.'"

Major Findings State-By-State

The federal government acknowledged 17 years ago that accurate tracking data on children in substitute care would be important in addressing the particularities of the system, but its mandates for information have largely gone unfulfilled. Many states could not easily report basic, broad details about their foster care caseloads. Some of the most important statistics are largely uknown — like the number of children who have had their biological parents' rights terminated and are legally free to be adopted. Today, most national estimates fall well below the mark of the true number of children who need homes. President Clinton's Adoption 2002 plan calls for 54,000 adoptions from foster care in the year 2002 — a goal that is barely adequate to meet the need for homes for children who are parentless and legally free to be adopted today. Recognizing that policymakers and the public did not have this basic information on child welfare, the Institute for Children, over a two-year period, gathered, updated and confirmed data for each state and the District of Columbia. [See the Sidebar on Methodology of the State-by-State Study.]

"53,642 foster children were legally free for adoption at the start of fiscal 1997."

As shown in Table I, the Institute found that:

- At the close of fiscal 1996, 526,112 children were in state-run substitute care.
- More than half of these children were concentrated in seven states.
- Based on written documentation from 47 states, 53,642 foster children were legally free for adoption.
- The actual number of legally free children was higher, since Connecticut and Montana reported that the number was "not available" and Arizona and the District of Columbia left the survey question blank.
- 22,491 foster child adoptions were finalized in 47 states in fiscal 1996.

Methodology of the State-By-State Study

To conduct its two-year study of public agency child welfare, the Institute for Children (IFC) designed a survey template that could be used for all 50 states and that addressed a number of critical questions about child welfare. IFC researchers then identified the most appropriate recipient ("contact person") for the survey within each state's child welfare agency. Surveys were sent to the contact person in each state, and the IFC subsequently contacted every state and secured updates and verification. Many states were initially reluctant to divulge information and others had difficulty synthesizing the requested data. Some states were unable to procure certain figures, leaving sections or individual questions blank or marked "NA." However, upon completion of the study, written verification on key questions was secured from all 50 states.

States' tracking methods and fiscal years vary. Therefore the statistics reflected in this report are limited to what states could provide in writing and within the study deadlines. Furthermore, the number of children in care changes daily; the figures reflected here were the most current available upon completion of the study in May 1997.

States' procedures for termination of parental rights also vary. Most states petition for legally freeing a child for adoption when it becomes clear that he can never return to his biological family. However, a few states will not file a petition or consider a child free to be adopted until an adoptive placement has been found. This practice leads to slow transitions from foster care to adoption. Thus the number of children legally free for adoption as indicated by the states and cited in this report is likely lower than the number of children who will soon need an adoptive home and who could be considered ready to be adopted.

States had difficulty supplying data. Thirty-one states changed contact persons during the two-year study. The District of Columbia was unable to provide any data for 1996; all calls and faxes during 1997 went unanswered. Four of the states with the highest prevalence rates could not identify the number of free-to-be-adopted children for whom the state was actively seeking an adoptive home. North Carolina's figure for finalized adoptions is not reliable as it includes adoptions finalized in previous years. New York, with the highest number of foster children legally free for adoption, could not provide the number of 1996 finalized adoptions. South Dakota does not keep records on the number of children whose adoptions were finalized in the last fiscal year; the same is true for Tennessee. Contacts in several states indicated that they did not have reporting systems in place that would provide all the data requested by the IFC, which was far less comprehensive than the data required by the federal government.

TABLE I

State of the Children, Fiscal Year 1996

State	Substitute Care Population	Foster Child Adoptions Finalized During FY 96	Foster Children Legally Free for Adoption at Start of FY 97	Children in Care/1000 Children
Alabama	3,901	158	698	4
Alaska	1,880	93	204	10
Arizona*	5,666	333	left blank	5
Arkansas	2,238	76	212	3
California	93,985	3,845	7,209	11
Colorado	13,448	454	769	14
Connecticut*	6,679	142	not available	8
Delaware	925	48	74	5
D.C.**	2,558	97	left blank	22
Florida	10,440	1,397	1,796	3
Georgia	17,053	420	1,224	9
Hawaii	2,495	60	565	8
Idaho	801	57	100	2
Illinois	51,728	1,961	2,266	17
Indiana	9,650	464	803	6
Iowa	5,369	380	500	7
Kansas	5,086	386	1,045	7
Kentucky	7,912	198	449	8
Louisiana	6,034	350	788	5
Maine	2,550	113	428	8
Maryland	7,694	400	450	6
Massachusetts	12,463	1,124	1,305	9
Michigan	17,003	2,189	3,790	7
Minnesota	17,561	275	1,056	14
Mississippi	3,210	107	324	4
Missouri	10,172	374	499	7
Montana*	1,921	77	not available	8
Nebraska	3,440	202	377	8
Nevada	3,198	110	117	8
New Hampshire	1,551	64	60	5
New Jersey	8,282	613	917	4
New Mexico	1,655	221	186	3
New York*	52,369	left blank	12,027	12
North Carolina	6,848	783	466	4
North Dakota	1,663	325	11	10
Ohio	18,420	1,201	3,568	6
Oklahoma	6,000	417	970	7
Oregon	9,660	558	367	12
Pennsylvania	21,329	352	1,966	7
Rhode Island	1,803	260	320	8
South Carolina	5,250	175	340	6
South Dakota*	722	not available	108	4
Tennessee*	12,500	not available	756	10
Texas	15,573	582	1,430	3
Utah	2,326	124	108	3
Vermont	1,413	34	118	10
Virginia	7,201	278	700	4
Washington	10,552	422	880	7
West Virginia	3,132	180	757	7
Wisconsin*	9,681	not available	507	7
Wyoming	1,122	12	12	8
Totals:	526,112	22,491	53,642	8

* States with INCOMPLETE DATA

** 1995 data used; 1996 not provided

See Appendix for details on data in the table.

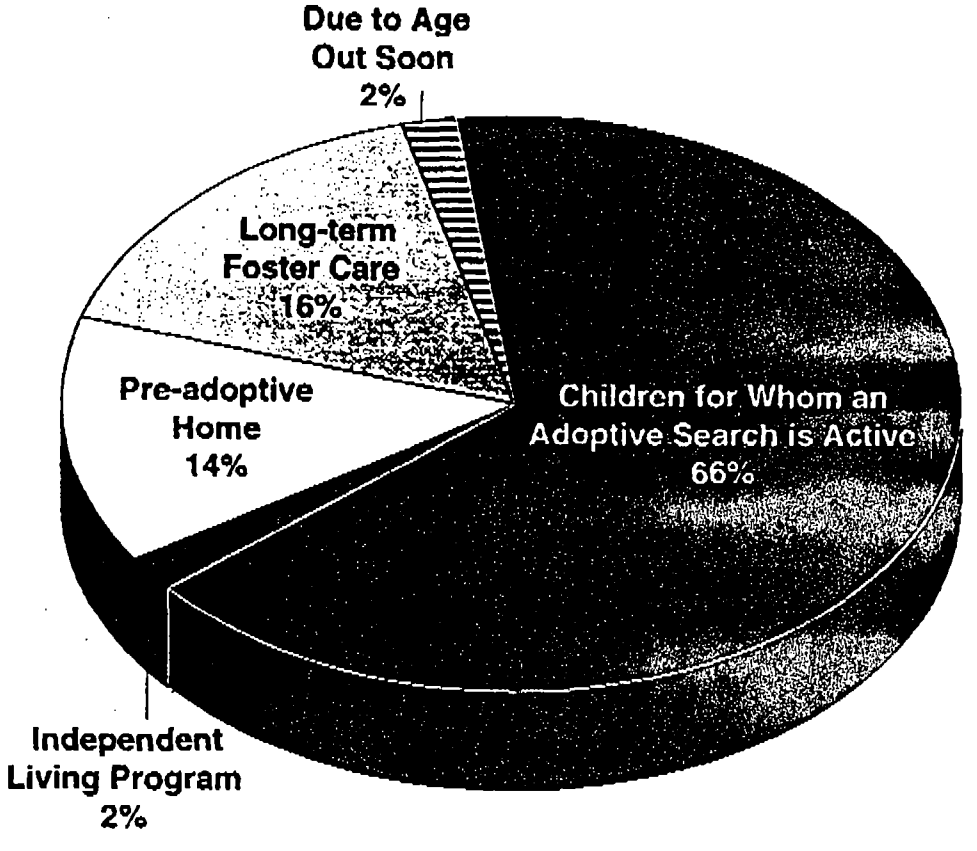
Source: Institute for Children.

Because the foster care population is constantly in flux, the numbers reported here are changing daily. Some of the children reported as free to be adopted at the end of 1996 were already in pre-adoptive homes; others have since been adopted. In the meantime, newly freed-for-adoption children have joined the ranks of foster children who wait for permanent families. The Institute for Children asked the states to provide a breakdown of the status of children who were legally free to be adopted. Many were already in pre-adoptive homes, but for a significant number of others, adoption was not a goal, despite the fact that their biological parents' rights had been terminated. Figures II, III and IV show the status of TPR children in three diverse states: Maine, California and Wisconsin.

"No effort was being made to place for adoption 20 percent of free-to-be-adopted children in Maine."

FIGURE II

Status of Free-To-Be-Adopted Children in Maine

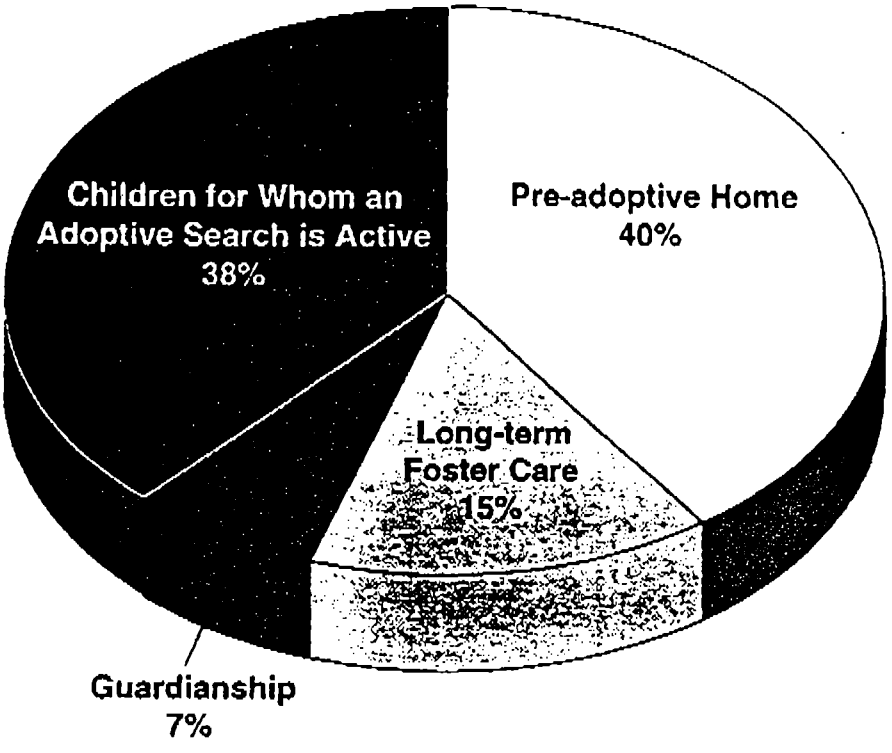


Source: Institute for Children.

"California was making no effort to place for adoption 15 percent of its free-to-be-adopted foster children."

FIGURE III

Status of Free-To-Be-Adopted Children in California



Source: Institute for Children.

- No effort was being made to place for adoption 20 percent of the free-to-be-adopted children in Maine and 15 percent in California.[42]
- By contrast, only 4 percent of free-to-be-adopted children were in long-term foster care or an Independent Living Program in Wisconsin.

As Table I shows, nationwide, eight of every 1,000 children were in substitute care at the end of fiscal 1996. In some states, the prevalence of foster care placement was much higher than the national average. In Illinois, it was 17 of every 1,000; Colorado and Minnesota reported that 14 of every 1,000 children were in foster care; and the District of Columbia, reporting for 1995, had a prevalence rate of 22, almost three times the national average. Interestingly, substitute care prevalence rates do not seem to be predicated on the size of the state's total child population or by the presence of large urban centers. Included among the 10 states with the highest prevalence rates were California, New York and Illinois, which have extremely large child populations. Also included among the 10 jurisdictions with the highest prevalence rates were North Dakota, Vermont and the District of Columbia, which have

very small child populations. Rural states (Oregon, Alaska) were just as likely to have high prevalence rates as jurisdictions with large urban centers (New York, District of Columbia).

More than twice as many children were legally free to be adopted at the beginning of fiscal 1997 as were adopted in all of fiscal 1996. The six states with the highest numbers of adoptions in 1996 all began the 1997 fiscal year with greater numbers of free-to-be-adopted foster children still needing adoptive placements than the total placed during the prior year. For example, Ohio finalized 1,201 adoptions during 1996, but began the new fiscal year with another 3,588 foster children legally free for adoption. [See Figure V.]

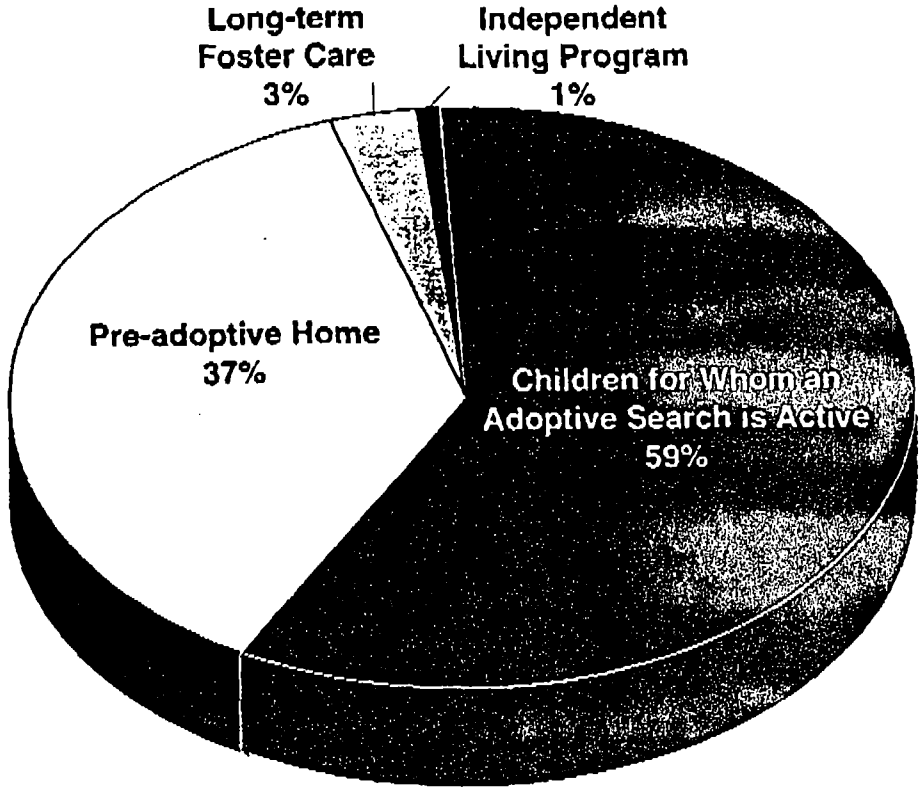
Many Would Adopt Foster Children

There is no shortage of Americans who would consider adopting a foster child. A survey commissioned by the Institute for Children and conducted by The Polling Company in Washington, D.C., found that 71 percent of

"In Wisconsin, only 4 percent of free-to-be-adopted children were in long-term foster care or an Independent Living Program."

FIGURE IV

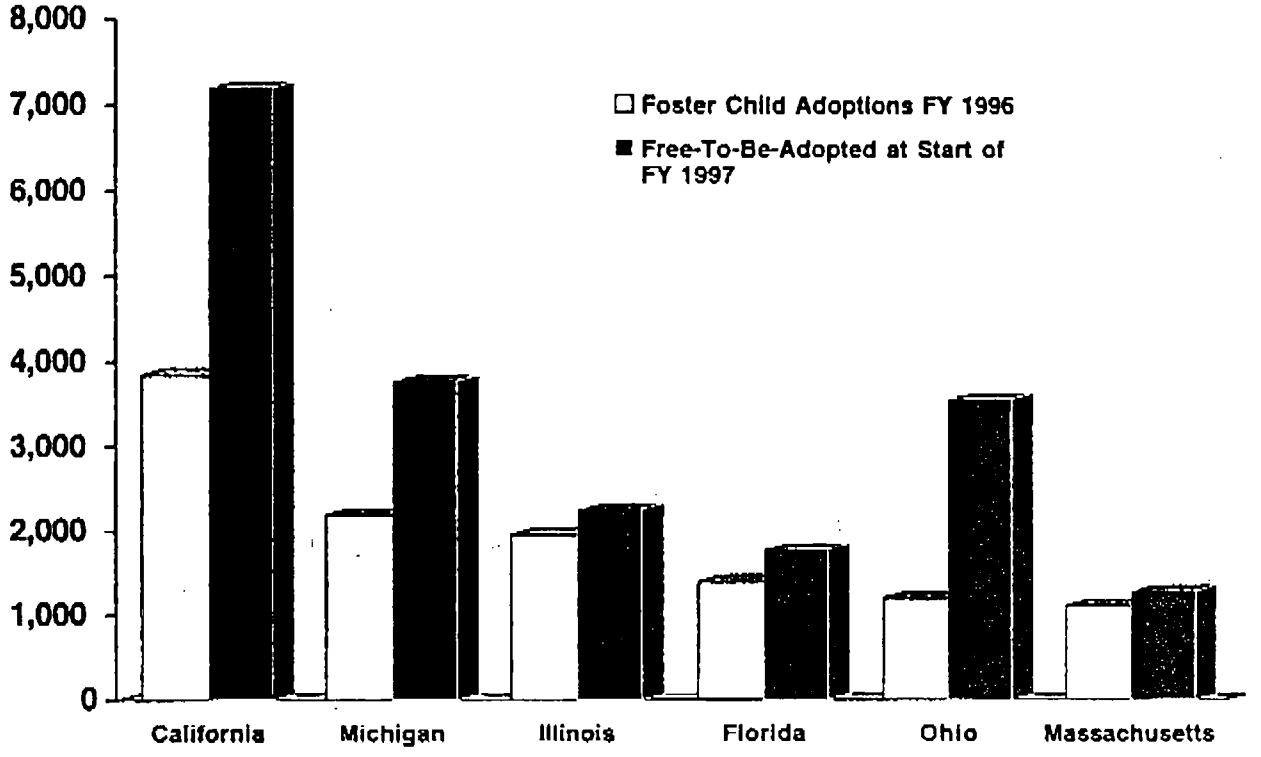
Status of Free-To-Be-Adopted Children in Wisconsin



Source: Institute for Children.

FIGURE V

Foster Child Adoptions in Fiscal 1996 and Free-To-Be-Adopted Children at Start of Fiscal 1997



Source: Institute for Children.

"71 percent of those polled said they would consider a foster child if adopting."

individuals polled would, if deciding to adopt, consider adopting a child who had spent time in foster care.[43] Support for adopting a child who had been in foster care was high among all groups, regardless of income, geographical location, race or political affiliation.

Among Generation Xers, 76 percent responded favorably. So did 73 percent of baby boomers. Even 71 percent of pre-retirees and 62 percent of senior citizens said if they *were* adopting, they would consider a foster child.

- Those from high socioeconomic backgrounds and low socioeconomic backgrounds were equally likely to consider adopting a foster child (79 percent and 78 percent, respectively).
- Middle-class respondents were still very willing to consider adopting a foster child, but at a slightly lower level of enthusiasm (69 percent).
- Eighty-one percent of women under age 50 were willing to consider a foster child, compared to 68 percent of men under age 50.

"The 'special needs' designation has been broadened to become almost meaningless."

Some will argue that the reason foster children are not adopted is that so many of the children awaiting adoption have "special needs." This assertion paints an inaccurate and unfair picture of the children in foster care. Formal recognition of the need for adoptive placements for children with disabilities extends at least as far back as the 1955 National Conference on Adoption. Even 40 years ago, professionals recognized that some children were being subjected to "foster care drift" when they could instead be adopted.[44] When the Title IV-E Adoption Assistance Program was authorized by Congress in 1980, its intent was to encourage adoption — rather than long-term foster care — for children with special needs. A child was to be so categorized only after the state had determined that the child could not be adopted without the federal funding triggered by categorization as having special needs. In part because states can garner extra federal funds for special needs children, the designation has been broadened to become almost meaningless.

- In 1993, all but three states used "race" or "race plus age" as a trigger for special needs categorization.[45]
- In the same year 20 states used "emotional ties to foster parents" as a trigger for labeling a child as having special needs.[46] This means that if a child is growing up and forming attachments to the people who care for him, and he is a foster child, in 20 states he is classified as special needs.
- Some states use religion as a trigger for special needs categorization.[47]
- In 1993, Florida, Louisiana and Wisconsin reported that 100 percent of public agency adoptions were special needs adoptions.[48]

There are many consequences to this practice. More than two-thirds of all foster children awaiting adoptive placement at the end of fiscal 1990 had been categorized as having special needs.[49] Special needs children are wrongly viewed as less desirable, sometimes even called "unadoptable." Prospective adoptive parents, unaware of the overuse of the term, may be dissuaded from the adoption process. Meanwhile, the needs of severely disabled children are downplayed, as they become included in the same category as a child who is biracial or has a sibling.

The notion that certain children are not adopted from foster care because would-be adoptive parents are interested only in healthy white babies is a myth. Evidence shows that no child is unadoptable. For example, Jim Jenkins of the Children with AIDS Project in Phoenix — a nonprofit group that takes no government funding — has recruited more than 1,000 parents to adopt AIDS orphans and HIV-positive babies. California's Child SHARE (Shelter Homes: A Rescue Effort) is an entirely privately funded nonprofit

organization that works through a network of religious communities in Los Angeles County to recruit foster and adoptive parents. Child SHARE provides training workshops, parent-led support groups, emergency child care and baby-sitting. It also maintains church-based co-ops to provide clothes, toys and other supplies for foster children. With its comprehensive support mechanisms, Child SHARE achieves remarkable results that lead to stability and permanency for children: 70 percent of children in Child SHARE homes stay until they are reunited or adopted, eliminating the trauma of multiple placements; additionally, more than 15 percent of children in care are adopted by their Child SHARE foster family. The success of these private efforts makes the public child welfare bureaucracy appear by comparison even more ineffective.

Reshaping the Foster Care System

With more than 50,000 foster children legally free for adoption, a favorable attitude by a preponderance of Americans toward considering the adoption of a foster child and a large number of families seeking to adopt, why are more foster children not adopted? Why are so many reaching age 18 and exiting the system, still without a permanent home?

"Both federal and state governments must reduce the barriers to adoption of foster children through private agencies."

The system itself must bear much of the blame because of the flaws cited previously in this study. Both federal and state governments must reduce the barriers to adoption of foster children through private agencies. Further, the system must reward efforts to increase adoptions and penalize laggard performance.[50] The federal government should:

- Base payments to states on program efficacy, with emphasis on how effectively the states secure safe, permanent homes for children — either in the biological or an adoptive family.
- Require states to follow a 12-month timetable from the day a child enters foster care until he is either reunified with his biological family (with a one-time extension to 24 months) or adopted, and grant funding accordingly.
- Redefine "special needs" to mean children with physical or other types of handicaps that would either require ongoing medical attention or otherwise result in increased costs to adoptive families.
- Require states to report publicly each year the number of foster children in state care, the number free to be adopted but not in pre-adoptive or guardianship placements and the number of state-approved adoptive families who have been recruited and are seeking to adopt.
- Give greater autonomy over foster care to the states to encourage more initiatives in the private, voluntary sector.

States in turn should:

- Enact policies and practices that have as their goal a 12-month maximum stay, so that foster care is viewed as a truly temporary form of caring for vulnerable children.
- Grant biological parents no more than 12 months to prove their fitness to resume custody of their children.
- Give unwed noncustodial biological parents 30 days from the birth of a child to formalize their parental rights or forfeit the right to contest adoption.
- Prohibit race-based delays in adoption.
- Terminate parental rights for abandoned children after 30 days and allow adoption through private agencies without placement in foster care.
- Require Departments of Social Services (or equivalent agencies) to practice concurrent planning from the first day a child enters foster care; this way, by the time a child has been freed for adoption, an adoptive home should have been identified.
- Require Departments of Social Services (or equivalent agencies) to secure adoptive homes for children within 30 days after the termination of parental rights or contract the adoption process out to a private agency.

"The focus should be on the well-being of children rather than the growth of state-run programs."

Child welfare policy must shift away from reliance on government programs, toward an expanded role for the private, charitable sector. The focus should be on the well-being of children, rather than the growth of state-run programs. Since no program can ever replace the love and commitment of a caring family, the ultimate goal *must* be a permanent home for every one of America's children.

The authors express their gratitude to Ted Kulik, Shamim Nielsen, Amory Downes, Angelica Marin, Kirby Files, Marya Klugerman, Adriana Best and Tim Cull for their valuable contributions to the two-year Institute for Children study of public child welfare agencies. The Institute for Children gratefully acknowledges the dedication and attention to detail of The Polling Company, Washington, D.C.

Notes

[1] "Substitute care" is out-of-home placement under the supervision of a public child welfare agency. In this report, the term "foster care" is used as an umbrella term for out-of-home, government-run substitute care, including care in foster families (including kinship care foster families), group homes and other institutions. The term does not refer to children who are receiving family preservation services in their biological family home. The American Public Welfare Association reported that at the end of fiscal year 1990, 74 percent of children in substitute care were in foster homes, 3 percent were in non-finalized adoptive homes (that is, they were already with their adoptive families but the formal process was not yet complete), 16 percent were in group homes or emergency care, less than 1 percent were living independently, and 6 percent were in "other" living arrangements. Toshio Tatara, *Characteristics of Children in Substitute and Adoptive Care* (Washington, DC: American Public Welfare Association, 1993), pp. 95-96. This finding based on 28 states reporting, accounting for 276,355 children, about 68 percent of the total substitute care population at the end of fiscal year 1990.

[2] In-care-today figure from original research on all 50 states conducted by the Institute for Children, Cambridge, MA. All-or-part-of-this-year figure based on: (1) In 1994, 698,000 children spent at least part of the year in state-run substitute care. American Public Welfare Association, figures revised July 1996. Committee on Ways and Means, U.S. House of Representatives, *1996 Green Book* (Washington, DC: U.S. Government Printing Office, 1996), p. 743; and (2) In an APWA survey of 53 jurisdictions, 62.3 percent of respondents indicated that "substitute care population will increase." Toshio Tatara, "U.S. Child Substitute Care Flow Data for FY 92 and Current Trends in the State Child Substitute Care Populations," *VCIS Research Notes No. 9*, American Public Welfare Association, Washington, DC, August 1993, p. 10. Note on APWA figures: several states indicated that they included status offenders and juvenile delinquents in the substitute care data submitted to the APWA. Tatara, *Characteristics of Children in Substitute and Adoptive Care*, p. 17.

[3] *The American Almanac 1996-1997* Statistical (Austin, TX: Hoover's, 1996), p. 257; and "Average Baseball Ticket Up to $11.98," Associated Press dispatch, March 28, 1997.

[4] *1996 Green Book*, p. 695; Robyn Lipner and Belinda Goertz, "Child Welfare Priorities and Expenditures," *W-Memo*, vol. 2, no. 8, American Public Welfare Association, p. 3.

[5] Children's Rights Project, "Children's Rights Fact Sheet," American Civil Liberties Union, January 1995, p. 1.

[6] *1996 Green Book*, p. 707.

[7] U.S. General Accounting Office, *Foster Care: Services to Prevent Out-of-Home Placements Are Limited by Funding Barriers*, GAO/HRD-93-76, June 1993, p. 62.

[8] Daryl Bell-Greenstreet, "Foster Care Review Board Fails in its Duty Toward Children," *The Arizona Republic*, May 2, 1995, p. B4.

[9] Children's Rights Project, *A Force for Change* (New York: American Civil Liberties Union, 1993), p. 2.

[10] Tatara, *Characteristics of Children in Substitute and Adoptive Care*, p. 106, with 15 states reporting and accounting for 208,125 children or about 51 percent of total substitute care population at the end of fiscal 1990.

[11] *Federal Register* (1987). Cited in "Effectiveness of Family Reunification Services: An Innovative Evaluative Model," *Social Work*, vol. 37, no. 4, July 1992.

[12] National figure based on (1) Tatara, *Characteristics of Children in Substitute and Adoptive Care*, pp. 71-72; this finding based on 24 states reporting, accounting for 106,713 children, about 53 percent of the total estimated number of children exiting substitute care during fiscal year 1990; and (2) Tatara, "U.S. Child Substitute Care Flow Data for FY 92 and Current Trends in the State Child Substitute Care Populations," p. 10 (APWA survey data of 53 jurisdictions, with 62.3 percent of respondents indicating that "substitute care population will increase"). New York figure based on interview with Pat O'Brien, You Gotta Believe! New York, February 12, 1996.

[13] Deborah Daro and Ching-Tung Wang, "Current Trends in Child Abuse Reporting and Fatalities: NCPCA's 1996 Annual Fifty State Survey," National Committee to Prevent Child Abuse. Available on the Internet at http://www.childabuse.org/5096sum.html. Data based on information from 39 states.

[14] Ibid. Data based on information from 37 states.

[15] Ibid.; "Child Abuse Rates Remain High," National Committee to Prevent Child Abuse. Available on the Internet at http://www.child abuse.org/rsrchl.html; and David Wiese and Deborah Daro, "Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1994 Annual Fifty State Survey," National Committee to Prevent Child Abuse, April 1995, p. 5.

16 "Consider Foster Parenting," Massachusetts Department of Social Services. Available on the Internet at http://www.state.ma.us/dss/foster.html.

17 *1996 Green Book*, p. 734. The period during which the reported increase took place was from 1986 to 1988.

18 *Cohort Two: A Study of Families and Children Entering Foster Care 1991-93*. Available on the Internet at http://www.ncn.com/~rilg/CWP/cohort2/cohort.htm.

19 *1996 Green Book*, p. 735.

20 Tatara, *Characteristics of Children in Substitute and Adoptive Care*, pp. 56-57. This finding based on 19 states reporting, accounting for 112,726 children, about 46 percent of the total estimated number of children entering substitute during fiscal year 1990.

21 Ibid., p. 23.

22 American Public Welfare Association, figures revised July 1996. Cited in *1996 Green Book*, p. 743.

23 For the District of Columbia only, a 1995 figure of 2,558 was used. The District of Columbia did not provide 1996 data.

24 The American Public Welfare Association's figures show that fiscal 1994 began with 444,000 children in care; during the year 254,000 entered the system and 230,000 exited, making a total of 698,000 children served. American Public Welfare Association, figures revised July 1996. Cited in *1996 Green Book*, p. 743. The 650,000 figure for 1997 is a conservative estimate, considering that when the 50 states, the District of Columbia, Guam and Puerto Rico reported to the APWA on trends in substitute care growth, 33 of the jurisdictions stated that their substitute care populations would grow and another 11 predicted their substitute care populations would remain the same. Of the nine states that reported that their substitute care population would decrease, none stated that it would decrease by more than 10 percent. See Tatara, "U.S. Child Substitute Care Flow Data for FY 92 and Current Trends in the State Child Substitute Care Populations," p. 10 (APWA survey data of 53 jurisdictions, with 62.3 percent of respondents indicating that "substitute care population will increase").

25 American Public Welfare Association, figures revised July 1996. Cited in *1996 Green Book*, p. 743.

26 Toshio Tatara, "A Comparison of Child Substitute Care Exit Rates Among Three Different Racial/Ethnic Groups in 12 States, FY 84 to FY 90," *VCIS Research Notes No. 10*, American Public Welfare Association, June 1994, p. 1.

27 Tatara, *Characteristics of Children in Substitute and Adoptive Care*, pp. 51-52. This finding based on 23 states reporting, accounting for 121,879 children, about 50 percent of the total estimated number of children entering substitute care during fiscal year 1990.

28 Tatara, "A Comparison of Child Substitute Care Exit Rates Among Three Different Racial/Ethnic Groups in 12 States, FY 84 to FY 90," p. 6.

29 Robert M. Goerge et al., *Foster Care Dynamics 1983-1992: A Report From the Multistate Foster Care Data Archive*, The Chapin Hall Center for Children at the University of Chicago, 1994, p. 10, pp. 40-41.

30 Tatara, *Characteristics of Children in Substitute and Adoptive Care*, p. 90.

31 Robert M. Goerge et al., *Foster Care Dynamics 1983-1992: A Report From the Multistate Foster Care Data Archive*, pp. 40-41.

32 Coalition for the Homeless, "Blueprint for Solving New York's Homeless Crisis," New York City, a report to Mayor David Dinkins, p. 101, cited in Pat O'Brien, "Youth Homelessness and the Lack of Relational Planning for Older Foster Children," You Gotta Believe! not dated.

33 *A National Evaluation of Title IV-E Foster Care Independent Living Program for Youth: Phase II Final Report*, vols. I and II (Rockville, MD: Westat, Inc. 1991), cited in U.S. General Accounting Office, *Child Welfare: Complex Needs Strain Capacity to Provide Services*, GAO/HEHS-95-208, September 1995, pp. 14-15.

34 In a small percentage of cases, parents voluntarily relinquish their rights.

35 Office of Inspector General, *Barriers to Freeing Children for Adoption*, Department of Health and Human Services, February 1991, pp. 7-8.

36 Ibid., p. 10.

37 Tatara, *Characteristics of Children in Substitute and Adoptive Care*, pp. 148-149. accounting for 9,173 children or 46 percent of the total estimated number of children awaiting adoptive placement at the end of fiscal 1990.

[38] Ibid.

[39] Pre-adoptive homes are typically those of foster families who have been identified as potential adoptive parents for children currently in their care.

[40] Public Law 96-272, *The Adoption Assistance and Child Welfare Act of 1980. 1996 Green Book*, p. 695.

[41] For other causes of this bias, see Conna Craig, "What I Need Is A Mom: The Welfare State Denies Homes to Thousands of Foster Children," *Policy Review*, Summer 1995.

[42] Guardianship, shown in the California figure, is legal custody.

[43] The "1996 Post-Election Survey" was administered by The Polling Company in Washington, DC. A comprehensive survey including 74 questions was administered by telephone to 1,200 respondents November 5-7, 1996. The sample consisted of 800 actual voters, 259 registered nonvoters and 141 nonregistered adults. The margin of error for the entire sample is ±2.8 percent at the 95 percent confidence level. The margin of error for the voting subsample is ±3.5 percent at the 95 percent confidence level. Participants in the survey were asked the following question devised by the Institute for Children: "Assume for a moment that you have decided to adopt a child. In so doing, would you consider a child who is, or has been, in foster care? Would you strongly consider, somewhat consider, consider only a little bit or not at all consider adopting a child who had spent time in foster care?" The Polling Company factored as positive responses only "strongly consider" and "somewhat consider" into its conclusions; the answer "consider only a little bit" was coded as a negative response.

[44] Michael Shapiro, *A Study of Adoption Practice* (vol. III): *Adoption of Children with Special Needs*, cited in Katherine A. Nelson, *On The Frontier of Adoption: A Study of Special-Needs Adoptive Families*, (New York: Child Welfare League of America, 1985), pp. 2-3.

[45] Patrick Curtis et al., *Child Abuse and Neglect: A Look at the States* (Washington, DC: Child Welfare League of America, 1995), pp. 86-87.

[46] Ibid.

[47] *1996 Green Book*, p. 713.

[48] Patrick Curtis et al., *Child Abuse and Neglect: A Look at the States*, pp. 90-91.

[49] Tatara, *Characteristics of Children in Substitute and Adoptive Care*, pp. 143-145. Data are from 18 states, accounting for 9,134 children, or 46 percent of the total estimated number of children awaiting adoptive placement at the end of fiscal 1990.

[50] The Institute for Children has presented the recommendations listed here, beginning in 1993, in key states whose governors are making foster care reform a top priority, as well as to members of Congress.

Appendix

Notes to Table I

The most critical and complete data from the states is presented in Table I. Some of the additional information provided by the states is summarized in the following notes.

Alabama

Fiscal year ended: 30 September 1996. Data reported as of: 30 September 1996. The Alabama Department of Human Resources reported that of the 698 children who were legally free for adoption, an adoptive home search was active for approximately 200; the department did not report the reasons that a search was not active for the remaining free-to-be-adopted children. Contact: Ms. Carole Burton, Alabama Department of Human Resources, S. Gordon Persons Building, 50 Ripley Street, Montgomery, AL 36150; phone: (334) 242-1374; fax: (334) 242-0939.

Alaska

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Alaska Department of Health and Social Services reported that about 9 percent of the state's free-to-be-adopted children for whom an adoptive search was not active were assigned to "long-term foster care." Contact: Ms. Suzanne Maxson, Alaska Department of Health and Social Services, Division of Family and Youth Services, P.O. Box 110630, Juneau, AK 99811-0630; phone: (907) 465-3631; fax: (907) 465-3397.

Arizona

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Arizona Department of Economic Security left blank the IFC survey question on the number of children who were legally free for adoption. However, the Department reported that, as of 30 June 1996, 612 children had had their parental rights terminated and that an adoptive home search was active for 137 foster children. Contact: Ms. Carole Linker, Arizona Department of Economic Security, 1717 W. Jefferson, P.O. Box 6123, Phoenix, AZ 85005; phone: (602) 542-3981; fax: (602) 542-3330.

Arkansas

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Arkansas Department of Human Services/Division of Children and Family Services reported that there were 212 foster children legally free for adoption and that an adoptive home search was active for 209 of these children. Contact: Mr. Alden Roller, Department of Human Services/Division of Children and Family Services, P.O. Box 1437, Little Rock, AR 72203; phone: (501) 682-8462; fax: (501) 682-8991.

California

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The California Department of Social Services reported that relating to the figure for children in foster care, "only the children in the custody of county welfare departments are included. Children in the custody of other agencies, principally delinquents and status offenders in the custody of county probation officers, are not included." Of the 3,845 reported adoptions, "3,254 were of children who had been in the custody of public adoption agencies and 591 were of children who had been in the custody of private adoption agencies. Probably about 70 completed public adoption agency cases were unreported. This total does not include Independent Adoptions or Intercountry Adoptions." Also, the actual number of finalized adoptions was "slightly higher due to incomplete reports." Contact: Mr. Joseph Magruder, California Department of Social Services, 744 P Street, M.S. 1967, Sacramento, CA 95814; phone: (916) 323-0524; fax: (916) 445-9125.

Colorado

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Colorado Department of Human Services reported as "NA" the number of children for whom an adoptive home search was active, as well as the number of children for whom the state was not seeking adoptive homes. Contact: Ms. Donna Pope, Colorado Department of Human Services, 1575 Sherman Street, 2nd floor, Denver, CO 80203; phone: (303) 866-5976; fax: (303) 866-4191.

Connecticut

Fiscal year ended: 30 June 1996. Data reported as of: 31 December 1996. The Connecticut Department of Children and Families responded "Not Available" to the IFC survey question on the number of foster children legally free for adoption. The Department reported in April 1997: "We do not have any other info available. Our new computer system reporting capability has yet to produce this info." Contact: Ms. Jean Watson, Department of Children and Families, 505 Hudson Street, Hartford, CT 06106; phone: (860) 550-6463; fax: (860) 566-3453.

Delaware

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Delaware Department of Children and Their Families reported that of the 74 children legally free for adoption, 31 were in pre-adoptive homes at the close of fiscal 1996. Contact: Ms. Mary Anne Kenville, Delaware Department of Children and Their Families, 1825 Falkland Road, Wilmington, DE 19805; phone: (302) 633-2655; fax: (302) 633-2652.

District of Columbia

Fiscal year ended: 31 December 1995. Data reported as of: 31 December 1995. During the study, the District of Columbia Department of Social Services was in receivership. The Institute for Children received only one response to its many inquiries, which provided three figures for fiscal 1995: 2,558 children in substitute care, 721 children in foster family care, 97 adoptions finalized in fiscal 1995. Contact: Mr. Jesse Winston, District of Columbia Department of Social Services, 609 H Street N.E., Washington, DC 20002; phone: (202) 724-2023; fax: (202) 727-9460.

Florida

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Florida Department of Children and Families reported that less than half of the children who had a goal or permanency plan for adoption were legally free to be adopted. Contact: Ms. Gloria Walker, Florida Department of Children and Families, Family Safety and Preservation, Permanency Planning Unit, 2811-E Industrial Plaza Drive, Tallahassee, FL 32301; phone: (904) 487-2383; fax: (904) 488-0751.

Georgia

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Georgia Department of Human Resources reported that of the 1,224 children who were legally free for adoption, the state was "still looking for home[s]" for 203 children. Contact: Ms. Liz Bryant, Georgia Department of Human Resources, 2 Peachtree Street, N.W. Suite 13-400, Atlanta, GA 30303; phone: (404) 657-3552; fax: (404) 657-3624.

Hawaii

Fiscal year ended: 30 June 1996. Data reported as of: 31 December 1996. The Hawaii Department of Human Services reported that of the 565 children legally free for adoption, 289 were in pre-adoptive homes. However, for 163 free-to-be-adopted children, the state was not seeking adoptive homes because those children had been assigned to long-term foster care. Contact: Ms. Lynn Mirikidani, Hawaii Department of Human Services, 810 Richards Street, Suite 400, Honolulu, HI 96813; phone: (808) 586-5698; fax: (808) 586-5700.

Idaho

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Mr. Don Corbridge, Idaho Department of Health and Welfare, Division of Family and Community Services, P.O. Box 83720, Third Floor, Boise, ID 83720. phone: (208) 334-5700; fax: (208) 334-6699.

Illinois

Fiscal year ended: 30 June 1996. Data reported as of: 28 February 1997. Illinois Child and Family Services reported that the figures for children in substitute care and children legally free for adoption were as of 28 February 1997; the reporting period for the number of foster children adopted was fiscal 1996. Contact: Mr. John Hamm, Illinois Child and Family Services, 406 East Monroe Street, Springfield, IL, 62701; phone: (217) 785-1700; fax: (217) 524-0014.

Indiana

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Indiana Division of Family and Children left blank the IFC survey question on the number of free-to-be-adopted children for whom an adoptive home search was active. Contact: Ms. Kaye Clark, Division of Family and Children, Indiana Department of Family and Social Service, Indianapolis, IN 46204; phone: (317) 233-1743; fax: (317) 232-4436.

Iowa

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Mr. Jeff Terrell, Iowa Department of Human Services, Hoover Building, Des Moines, IA 50319; phone: (515) 281-4625; fax: (515) 281-4597.

Kansas

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Janet Kuntzsch, Kansas Department of Social and Rehabilitation Services, West Hall, 300 SW Oakley, Topeka, KS 66606; phone: (913) 296-8138; fax: (913) 296-4649.

Kentucky

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Brooke Thomas, Kentucky Cabinet for Human Resources, 275 East Main, 6 West, Frankfort, KY 40601; phone: (502) 564-2147; fax: (502) 564-9554.

Louisiana

Fiscal year ended: 30 June 1996. Data reported as of: 31 December 1996. The Louisiana Department of Social Services reported that the figures for children in substitute care and children legally free for adoption were as of 31 December 1996; the reporting period for the number of foster children adopted was fiscal 1996. Contact: Ms. Sandra C. Schucker, Louisiana Department of Social Services, 333 Laurel Street, P.O. Box 33318, Baton Rouge, LA 70821; phone: (504) 342-4043; fax: (504) 342-9087.

Maine

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Maine Department of Human Services reported the figure for finalized foster child adoptions in fiscal 1996 as "tentative." Contact: Ms. Dana E. Hall, Maine Department of Human Services, Bureau of Child and Family Services, State House Station 11, Augusta, ME 04333; phone: (207) 287-5060; fax: (207) 287-5282.

Maryland

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Stephanie Pettaway, Maryland Department of Human Resources, 311 W. Saratoga Street, Baltimore, MD 21201; phone: (410) 767-7506; fax: (410) 333-0127.

Massachusetts

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Massachusetts Department of Social Services reported that of the 656 free-to-be-adopted children for whom an adoptive search was active, "649 children had been matched to an adoptive family." Contact: Ms. Phyllis Ward, Department of Social Services Library, 24 Farnsworth, Boston, MA 02210, phone: (617) 727-0900; fax: (617) 261-7438.

Michigan

Fiscal year ended: 30 September 1996. Data reported as of: 30 September 1996. The State of Michigan Family Independence Agency reported that the reason the state was not seeking adoptive homes for 237 free-to-be-adopted foster children was "long-term foster care." Contact: Ms. Julie Tubbs-Lott, State of Michigan Family Independence Agency, 232 Grand Avenue, P.O. Box 30037, Grand Tower, Lansing, MI 48909; phone: (517) 373-8376; fax: (517) 241-7047.

Minnesota

Fiscal year ended: 31 December 1996. Data reported as of: 31 December 1996. The Minnesota Department of Human Services noted that "1996 data is preliminary data based on unedited county reports." Of the 478 children for whom an adoptive home search is active, 186 "had relatives or foster families under consideration." Contact: Ms. Ruth Weidell (adoption) and Ms. Sandy Reuben (foster care), Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155-3831; phone: (612) 296-3250; fax: (612) 297-1949.

Mississippi

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Wanda Gillom, Mississippi Department of Human Services, 750 North State Street, Jackson, MS 39202; phone: (601) 359-4980; fax: (601) 359-4978.

Missouri

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Mr. Arlend Oney, Missouri Division of Family Services, Howerton Building, P.O. Box 88, Jefferson City, MO 65109; phone: (573) 751-2502; fax: (573) 526-3971.

Montana

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Montana Department of Public Health and Human Services reported that the number of children in substitute care was as of 31 July 1996. The Department did not provide figures for the number of children legally free for adoption, the number of children for whom an adoptive home search was active or the number of children for whom the state was not seeking adoptive homes. Contact: Ms. Betsy Stimatz, Montana Department of Public Health and Human Services, Division of Child and Family Services, P.O. Box 8005, Cogswell Building, Helena, MT 59604-8005; phone: (406) 444-5900; fax (406) 444-5956.

Nebraska

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Donald S. Leuenberger, Department of Social Services, P.O. Box 95026, Lincoln, NE 68509; phone: (402) 471-9125; fax: (402) 471-9455.

Nevada

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Wanda Scott, Department of Human Resources, 6171 W. Charleston Boulevard, Building Number 15, Las Vegas, NV 89158; phone: (702) 486-7633; fax: (702) 486-7626.

New Hampshire

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Catherine Atkins, Division for Children, Youth and Families, 6 Hazen Drive, Concord, NH 03301; phone: (603) 271-4707; fax: (603) 271-4729.

New Jersey

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Marylou Sweeny, New Jersey Division of Youth and Family Services, CN 700, Trenton, NJ 08625; phone: (609) 633-3991; fax: (609) 984-5449.

New Mexico

Fiscal year ended: 30 June 1996. Data reported as of: 31 December 1996. The New Mexico Children, Youth and Families Department

reported that figures for the number of children in substitute care and the number of children legally free for adoption were as of December 1996. Contact: Ms. Maryellen Strawniak, New Mexico Children, Youth and Families Department, Protective Services Division, 1120 Paseo de Peralta, Santa Fe, NM 87504; phone: (505) 827-3991; fax: (505) 827-8480.

New York

Fiscal year ended: 31 March 1996. Data reported as of: 30 June 1996. The New York State Department of Social Services left blank the IFC survey question on the number of adoptions finalized in fiscal 1996. (During calendar year 1994, 3,621 adoptions were finalized.) Contact: Mr. Paul Gavry, New York State Department of Social Services, 40 North Pearl Street, Albany, NY 12243; phone: (518) 432-2926; fax: (518) 432-2930.

North Carolina

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The reported number of adoptions finalized in fiscal 1996 may be overrepresentative. The North Carolina Department of Human Resources wrote, on 17 July 1996: "Adoption proceedings are indexed through the Final Orders, but this process does not necessarily happen for adoption cases finalized in that particular year. These adoptions may have taken place in previous years, and we had just indexed them. Therefore, this number does not reflect the number of children whose adoptions were finalized in a year, but rather the number of finalized adoptions over a course of years that have now been indexed in the state." Contact: Ms. Esther T. High, North Carolina Department of Human Resources, Division of Social Services, 325 North Salisbury Street, Raleigh, NC 27603; phone: (919) 733-3801; fax: (919) 715-3581.

North Dakota

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The North Dakota Department of Human Services reported that of the 325 adoptions finalized in fiscal 1996, 25 were categorized special needs. The figure for children who were legally free for adoption was as of 30 September 1996. Contact: Ms. Jean Doll, Administrator, North Dakota Department of Human Services, Children and Family Services Division, State Capitol Building, 600 East Boulevard, Bismarck, ND 58505; phone: (701) 328-3541; fax: (701) 328-2359.

Ohio

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Mr. Dave Hubbell, Ohio Department of Human Services, 65 East State Street, 5th Floor, Columbus, OH 43215; phone: (614) 466-7884; fax: (614) 466-6185.

Oklahoma

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Midge Woodard, Oklahoma Department of Human Services, P.O. Box 25352, Oklahoma City, OK 73125; phone: (405) 739-8000; fax: (405) 739-8132.

Oregon

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996 (TPR). The Oregon State Office for Services to Children and Families reported that the figure for the number of children in substitute care was as of "calendar year 1996;" and the number of children who were legally free for adoption was as of January 1997. Contact: Ms. Kay Toran, State Office for Services to Children and Families, 500 Summer Street NE, Salem, OR 97310- 1017; phone: (503) 945-5651; fax (503) 581-6198.

Pennsylvania

Fiscal year ended: 30 June 1996. Data reported as of: 31 December 1996. Contact: Ms. Sandy Gallagher, Pennsylvania Department of Public Welfare, Office of Children, Youth, and Their Families, P.O. Box 2675, Harrisburg, PA 17105-2675; phone: (717) 772-7044; fax: (717) 783-6354.

Rhode Island

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Mr. C. Friedman, Rhode Island Department of Children, Youth, and Their Families, 610 Mt. Pleasant Avenue, Building #8, Providence, RI 02908; phone: (401) 277-2583; fax: (401) 457-4541.

South Carolina

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Carolyn Orf, South Carolina Department of Social Services, P.O. Box 1520, Columbia, SC 29202; phone: (803) 734-5670; fax: (803) 734-6285.

South Dakota

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Diane Kleinsasser, South Dakota Department of Social Services, 700 Governors Drive, Pierre, SD 57501-2291; phone: (605) 773-3227; fax: (605) 773-6834.

Tennessee

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Ms. Gail Crawford, Tennessee Department of Children's Services, 436 6th Avenue N., 7th Floor, Cordell Hull Building, Nashville, TN 37243-1290; phone: (615) 532-5597; fax: (615) 532-6495.

Texas

Fiscal year ended: 31 August 1996. Data reported as of: 30 June 1996. The Texas Department of Protective and Regulatory Services noted regarding the IFC survey question that asks for the number of children who were legally free for adoption, that its figure, 1,430, refers to children whose parental rights had been terminated and for whom the goal was adoption, but who had not been placed in an adoptive home. Contact: Ms. Cheryl Fell, Texas Department of Protective and Regulatory Services, P.O. Box 149030, Mail Code E558, Austin, TX 78714-9030; phone: (512) 438-3127; fax: (512) 438-3782.

Utah

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Utah Department of Human Services reported that an adoptive home search was active for all 108 foster children who were legally free for adoption at the end of fiscal 1996. Contact: Ms. Marilyn Mills, Utah Department of Human Services, Division of Child and Family Services, 120 North 200 West, Suite 225, Salt Lake City, UT 84103; phone: (801) 538-4078; fax: (801) 538-4553.

Vermont

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Vermont Department of Social and Rehabilitation Services left blank the IFC survey question regarding the total number of free-to-be-adopted children for whom the state was not seeking adoptive homes. Contact: Mr. Phil Zunder, Department of Social and Rehabilitation Services, Osgood Building, 103 South Main Street, Waterbury, VT 05671; phone: (802) 241-2112; fax: (802) 241-2980.

Virginia

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. Contact: Mr. Terry Yearout, Department of Social Services, Theater Row Building, 730 East Broad Street, Richmond, VA 23219; phone: (804) 692-1294; fax: (804) 692-1284.

Washington

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Washington Department of Social Services left blank the IFC survey question regarding the number of free-to-be-adopted children for whom the state was not seeking adoptive homes. Contact: Ms. Cindy Ellingson, Washington Division of Children and Family Services, 14th and Jefferson Streets, P.O. Box 45710, Olympia, WA 98504; phone: (360) 902-7929; fax: (360) 902-7903.

West Virginia

Fiscal year ended: 30 June 1996. Data reported as of: 1 January 1997. The West Virginia Department of Health and Human Resources reported that the figures for children in substitute care and for children who were legally free for adoption were as of 1 January 1997. Contact: Mr. Tom Strauderman, West Virginia Department of Health and Human Resources, Office of Social Services, Bureau for Children and Families, State Capitol Complex, Building 6, Room 850, Charleston, WV 25305; phone: (304) 558-7980; fax: (304) 558-8800.

Wisconsin

Fiscal year ended: 31 December 1996. Data reported as of: 31 December 1996. The Wisconsin Department of Health and Family Services did not provide the number of finalized adoptions in fiscal 1996. The Department noted that for 188 children in pre-adoptive homes at the end of fiscal 1996, "This figure is underreported as caseworkers often do not change the type of placement on the database at the time a child is placed in a pre-adoptive home." Contact: Mr. Mark S. Mitchell, Wisconsin Department of Health and Family Services, P.O. Box 8916, Madison, WI 53708; phone: (608) 266-2860; fax: (608) 264-6750.

Wyoming

Fiscal year ended: 30 June 1996. Data reported as of: 30 June 1996. The Wyoming Department of Family Services noted that the figure for children legally free for adoption was "estimated." Contact: Mr. Bill Rankin, Department of Family Services, Hathaway Building, 3rd Floor, 2300 Capitol Avenue, Cheyenne, WY 82002; phone: (307) 777-3570; fax: (307) 777-3693.

About the Authors

Conna Craig is president and a trustee of the Institute for Children, Inc. She graduated with honors from Harvard College, where she wrote her honors thesis on the relationship between research and legislation on child abuse. Ms. Craig has advised legislators and scholars in China, Hong Kong, Papua New Guinea and the United Kingdom, and has spoken before numerous audiences including policymakers, foster and adoptive parents, service providers and economists. Her published articles include "What I Need Is a Mom: The Welfare State Denies Homes to Thousands of Foster Children," in the Summer 1995 issue of *Policy Review* and condensed in the November 1995 issue of *Reader's Digest*; "What Will Happen to the Children?" a written symposium of seven contributors published in the Winter 1995 issue of *Policy Review*; and various op-eds including "Adoptable children go wanting" in *USA TODAY* in 1996. Ms. Craig was named recipient of the first annual Salvatori Prize for American Citizenship in 1996; the prize recognizes "extraordinary efforts by American citizens who are helping their communities solve problems the government has been unable to solve." Adopted into a family that has to date cared for more than 100 foster children, Ms. Craig has spent her entire life involved in and very much aware of the "client" side of the foster care equation.

Derek Herbert is the Institute for Children's associate director. Mr. Herbert is the Institute's lead researcher on state and federal legislative issues. He directed the Institute's two-year examination of public agency child welfare, and is currently conducting a longitudinal study on privatization of child welfare. His published articles on foster care include "Too Many Kids Waiting for a Home" in *The Wall Street Journal* in 1997. He is a frequent guest on regional and national radio programs, and has spoken to audiences including religious leaders and state and federal policymakers.

About the NCPA

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute, funded exclusively by private contributions. The NCPA developed the concept of Medical Savings Accounts, which were part of the 1996 health care bill passed by Congress and have been adopted by a growing number of states. Many credit NCPA studies of the Medicare surtax as the main factor leading to the 1989 repeal of the Medicare Catastrophic Coverage Act.

NCPA forecasts show that repeal of the Social Security earnings test would cause no loss of federal revenue, that a capital gains tax cut would increase federal revenue and that the federal government gets virtually all the money back from the current child care tax credit. Its forecasts are an alternative to the forecasts of the Congressional Budget Office and the Joint Committee on Taxation and are frequently used by Republicans and Democrats in Congress. The Republican Contract with America included the pro-growth tax changes recommended by the NCPA and the U.S. Chamber of Commerce as early as 1990. The NCPA also has produced a first-of-its-kind, pro-free enterprise health care task force report, written by 40 representatives of think tanks and research institutes, and a first-of-its-kind, pro-free enterprise environmental task force report, written by 76 representatives of think tanks and research institutes.

The NCPA is the source of numerous discoveries that have been reported in the national news. According to NCPA reports:

- Blacks and other minorities are severely disadvantaged under Social Security, Medicare and other age-based entitlement programs;
- Special taxes on the elderly have destroyed the value of tax-deferred savings (IRAs, employee pensions, etc.) for a large portion of young workers; and
- Man-made food additives, pesticides and airborne pollutants are much less of a health risk than carcinogens that exist naturally in our environment.

What Others Say About the NCPA

"...influencing the national debate with studies, reports and seminars."

— TIME

"...steadily thrusting such ideas as 'privatization' of social services into the intellectual marketplace."

— CHRISTIAN SCIENCE MONITOR

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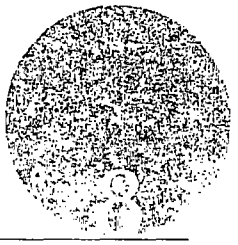
— EVANS AND NOVAK

Abuse Issues in Special-Needs Adoptions



Deborah N. Silverstein, M.S.W.

Introduction

This chapter presents a curriculum for a workshop on abuse issues and therapies in special-needs adoptions. The workshop is designed to train mental health professionals in these issues. The following curriculum, supplemented by references and other materials noted below, can be used by trainers in conducting similar workshops.

Objective

This workshop is designed to familiarize participants with 1) the lifelong issues in adoption; 2) the residual effects of child physical and sexual abuse and neglect; 3) the clinical presentation of a youngster who has suffered both traumatic separation and loss and child abuse; 4) ethnic and cultural issues relating to child abuse; 5) the potential effects on the adoptive family of the introduction of an abused child; 6) the supports that adoptive families of abused children need, and 7) the therapeutic issues in treating such children and families.

Materials Needed

Hand-outs (attached), overheads and an overhead projector, a VCR and monitor, play materials. (See notes to trainers in the curriculum for details).

Time and Format

This workshop is planned for a minimum of seven hours. The material should be presented using a variety of teaching methods, including lecture, small and large group discussion and brainstorming, video or audio presentations, and role play.

Lecture

I. Introduction of the Material

Introduce the presenter(s) and ask participants to introduce themselves either individually or by a show of hands (e.g., "How many are triad members?" "How many are adoptive parents of special-needs youngsters?" etc.). Participants should then be given a brief overview of the planned activities for the day.

II. Goals for the Day

With participants, list goals for the day. Review objectives as listed above.

III. The Seven Core Issues in Adoption

The issues are:

- Loss/separation
- Rejection
- Guilt and shame
- Grief
- Identity
- Intimacy
- Power, control, mastery

Note to Trainer: *Review handout on "Seven Core Issues in Adoption" with the goal of assisting participants to view adoption as a lifelong, intergenerational process that is always influencing the individual's and family's life-cycle development.*

The "Seven Core Issues" provides a framework for understanding and discussing both normative issues and atypical presentations in adoption. Clinical issues in adoption are often best addressed using the "Seven Core Issues" as a template.

IV. The Abused Child in Placement

Note to Trainer: *Review with participants research on the demographics of abuse.*

Many, if not most, special-needs adoptees are victims of some form of abuse and neglect. These difficulties are the children's "tickets" to removal from their birth families, and the behaviors that result from the residual effects of that abuse can place the child at peril for abuse in foster care and adoption. A history of child abuse also places the adoptive family at risk for stress, emotional difficulty, and even allegations of abuse. It has become increasingly clear in the past few years that previously unresolved abuse issues are frequently tied to subsequent problems in attachment and threaten adoptive placements. It is imperative that mental health professionals working in the arena of special-needs adoption familiarize themselves with these issues and with appropriate interventions.

There is a great disparity in the research regarding the characteristics of children who are abused and those of the abusers. For example, individuals who neglect children represent a distinct group from those who sexually abuse children. Yet far too often children placed for adoption are described generally as "abused" without specification regarding the age at which the abuse occurred, the type of abuse, the frequency, the duration, the severity, or the identity of the perpetrator. These are all vital variables in looking at both the effects of the abuse and the appropriate clinical interventions.

Note to the Trainer: *Review with participants the materials on the short- and long-term effects of abuse on children, emphasizing the effect on all spheres of development. Using the works of Finkelhor (1993), Herman (1992), Peterson (1991), and Janoff-Bulman (1992), and audience large-group brainstorming, assist participants to develop an understanding of the psychological impact of trauma on children.*

The use of a video or audio tape of youngsters discussing their own abuse may help clinicians to both deepen their understanding of this issue and provide a common case for discussion and illustration of the materials being presented.

V. Abuse and Adoption: Increased Effects

The presence of both a history of abuse and a history of traumatic separation and loss increases the effects of each factor.

Note to Trainer: *This section brings together the materials covered to this point, assisting clinicians to understand the effects of abuse and separation when combined are greater than the sum of the two. Please use the handout to review this material with participants and to lead a discussion with the large group about the implications of these observations for families, children, and mental health professionals.*

VI. Ethnic and Cultural Concerns

Note to Trainer: *The materials to be presented in this component are highly sensitive and require ample time for discussion. Using four blank overhead transparencies, head each with the name of a different non-dominant culture, e.g., "Native Americans," "African Americans," "Asian Americans," and "Latinos." In a large group format, ask participants to brainstorm racial, ethnic, and cultural stereotypes about each group that impact children, families, and society. Participants may need assistance in distancing from the topic to give them freedom to say things that are personally offensive. Upon completion of the lists, engage the group in a discussion of the impact of these stereotypes on children, birth families, adoptive families, social workers, and clinicians. Discuss in light of same-race adoption and transracial and transcultural adoption.*

Although the sexual abuse of children and adolescents has been extensively reviewed in the literature, little attention has been paid to the role of ethnicity or race. Some small studies have examined childhood sexual abuse among African Americans and/or Latinos, comparing them to Caucasians. Interviews with community-based populations and retrospective chart reviews of sexually abused children indicate differences in characteris-

tics across ethnic and racial groups. For example, a 1982 study found that African-American female victims were evaluated for sexual abuse at a younger age than Caucasian or Latino female victims and African American victims and their families were less likely to be referred for treatment. (Finkelhor, 1993; Rao, et al, 1992; Horejsi, et al, 1992)

It is important to note when assessing children and families that child-rearing practices are culturally influenced, and that familial attitudes toward sexually abused children may vary across racial and/or ethnic lines. In addition, the child's response to having been sexually abused and then having to deal with reactions from the social support system may also be swayed by ethnic factors.

Children's and families' responses to abuse also differ among and between groups. Sexual acting-out was reported least among Asian victims, possibly reflecting cultural pressures against reporting it due to a cultural bias against discussing sexual matters outside the family. Asians are more likely to express suicidal impulses and are reported to be least likely to express anger and hostility. Further, Asian families are viewed as least likely to believe victims' disclosures about abuse.

Abused Latino children are viewed in the literature to be similar to Asian children in many ways; they are described as older than African-American or Caucasian children, and most likely to be living with the assailant. Latino families are reported as less supportive of the victim than African-American or Caucasian families.

African-American victims are demographically distinct; they are the youngest, least likely to come from intact families, least likely to be victims of interracial assault, and have suffered more physically invasive forms of sexual abuse.

Growth and developmental traumas associated with repeated disruptions in care may be compounded for the African-American child as a result of both historical and institutional racism. Avenues to healing for children already damaged by abuse and neglect may be blocked by these factors as well.

It is important to remember that most research into the effects of childhood abuse speaks to generalities; "Asians," for example, represent many diverse Asian cultures, languages, and degrees of accommodation. The same is true for Latinos. Race is not predictive of abuse; poverty is seen as the single most significant predictive factor. (Jones, 1992)

Most transracial and transcultural adoptions today involve children from outside the United States, including Asia, Central and South America, and now Eastern Europe, including Russia. Mental health practitioners need a working knowledge of these cultures to intervene effectively.

Another current concern about intercountry transracial adoption is the belief held by some adoptive parents that, by adopting abroad, they can avoid dealing with birth families and also avoid adopting abused children. Both ideas are based on faulty assumptions. Parents who have adopted transracially and transculturally may try to help children adjust by minimizing all racial and cultural differences. Discounting the role of race and ethnicity in the development of identity and self-esteem, some families make little effort to become involved in organizations, churches, neighborhood associations, or adoption support groups, which would expose children to others of their racial or ethnic background. Some parents may even refuse to allow the child to discuss their heritage or their history of abuse. Whether parents do this because they think it best for the children or because they themselves are uncomfortable with differences, the denial of the child's background can leave a child feeling isolated and confused. The youngsters know that they are not Caucasian, but, simultaneously, they are not allowed to feel truly Asian, Latino, or African American. They frequently lack a secure sense of belonging to a group with whom they can identify. When the birth family was abusive, children's negative feelings may be allowed to translate to the entire culture or race, further isolating the child.

Note to Trainer: *Allow time for discussion of this material and how these issues might play out in a clinical setting. Case examples would be very helpful.*

VII. Abusive or Neglectful Birth Parents

Note to Trainer: *Participants may have many questions or concerns about abused children's ongoing contact with an abusive birth family. The goal of this*

component is to elicit that information, explore the myths and realities of those concerns, and assist clinicians to work with individual children and families who may be involved in varying degrees of contact and openness with birth families.

Frequently in adoption, society creates an absolute dichotomy of birth families as all "bad" and adoptive families as all "good," thereby creating the potential for loyalty conflicts for the adoptee. When the additional factor of childhood abuse is introduced, adopted youngsters, bonded with the abusive birth parents *by the shared mutual experience of the trauma,* may have great difficulty in attaching to the new family if renunciation of the birth family is required either overtly or indirectly. Carnes (1993), in his work on sexual addiction and trauma bonds, explains why humans bond with those who hurt them. Trauma bonds, according to Carnes, are an overlooked expression of post-traumatic stress. Carnes postulates that trauma bonds are stronger:

- When the trauma cycles are repeated so that intensity and forgiveness become reinforcing;
- When the victim believes in their uniqueness;
- When the victim mistakes intensity for intimacy;
- When the trauma endures over time;
- When there are increasing amounts of fear;
- When the new chemical reactions created by the trauma occur earlier in life when the brain is more malleable;
- When the trauma is preceded by earlier victimization;
- When the victim is surrounded by reactivity and extreme responses;
- When the betrayal of power relationships is greater;
- When the betrayal of trusted relationships is greater.

Note to Trainer: *Discuss these factors with participants using a vignette of an abused adopted child, with the goal of aiding clinicians in understanding how adoptees remain bonded to their birth families, often in negative yet enduring ways, and how such negative trauma bonds can be disrupted while simultaneously fostering positive bonds to the birth family and a strong healthy attachment to the adoptive family. Involve participants in a discussion regarding their own and society's concerns about contact and openness in the adoption of abused youngsters. Help clinicians to brainstorm proactive ways adoptive families can foster openness and ongoing contact with abusive birth families while also providing safety and security for the adoptee. Use case examples from your personal experience or practice.*

VIII. Adoptive Family Issues

Adoptive families face many of the same issues as non-adoptive families and many additional concerns and tasks. The development of the family life cycle is significantly influenced by the presence of adoption in the birth and adoptive family. The adoptee's understanding of adoption unfolds over time, and how these aspects are handled are crucial factors in the adoptee's emotional growth.

Family Life Cycle Development (as conceptualized by Rhodes, 1977):

- Intimacy versus idealization or disillusionment
- Replenishment versus turning inward
- Individuation of family members versus pseudomutual organization
- Companionship versus isolation
- Regrouping versus binding or expulsion
- Rediscovery versus despair
- Mutual aid versus uselessness

Note to Trainer: *Use handout for this model or another developmental conceptualization to discuss with participants how stages of development in the family life cycle might be affected by the presence of adoption and abuse issues.*

Brainstorm with clinicians the characteristics of adoptive families that they believe would be most likely to yield success in parenting abused youngsters. Discuss.

Adoptive families who choose to parent abused special-needs youngsters need education and training specific to these issues. This education and training are best offered in group settings where families can also develop ongoing support networks. If such programs are not available in the local community, clinicians can extend their services to include educational and group experiences. Families should also be encouraged to read materials on abuse and adoption and to attend workshops and conferences on the subject. It is important that families become comfortable in discussing abuse issues with each other in the most intimate detail.

Note to Trainer: *Borrowing and expanding the ideas of Duehn, ask participants to take a clean piece of paper and write down a "secret" that they have about their sexual experiences or their first sexual experience. While they are writing, hand out blank envelopes, asking them to place their paper in the envelope. The envelopes should be sealed and a personal identifying mark placed on the outside. Ask participants to give their envelope to someone in the room who is most different from them regarding sex, culture, race, etc. Explain that this is not an exchange, so that one person could receive many envelopes and others, none. Instruct that the envelopes are not to be opened. Debrief participants about their feelings while writing, their feelings while passing the envelopes, how they chose to whom to give the envelope, their feelings about holding someone else's "secret," what they think should be done with the envelopes, etc. Ask participants what they believe is the goal of this exercise. The goals are to enable clinicians to understand the way youngsters and families feel when they are asked to discuss intimate details of their lives; that these feelings vary if the recipient is of another sex, race, or ethnic group; that mental health professionals must "hold" these secrets with the utmost respect. Continue the discussion until the group seems comfortable. Be sure the envelopes are returned to their owners.*

It is also very important that the issues and concerns of siblings in the adoptive family be addressed. A review of the literature on family therapy with adoptive families reveals that many clinicians do not regularly include siblings in the work although siblings are greatly affected by the introduction of an abused child into the family. Siblings may take on a variety of roles vis-à-vis the adopted child, including rescuer, enabler, scapegoat, perpetrator, and caretaker. Families need assistance in engaging siblings in the process of incorporating a new child and in monitoring and possibly remediating the impact of the adoption.

IX. Working with Families Who Have Abuse Issues in Their Families of Origin

Given the high reported numbers of both men and women who are abused as children, a logical inference is that many prospective adoptive parents will either have been abused themselves or will have experienced the abuse of someone in their family of origin. Conventional social work wisdom has been to exclude these individuals from adopting in the belief that their personal issues hold the potential to confound the issues of the abused adoptee. Current thinking is to recognize that the presence of previously *unresolved* abuse issues may have significant negative impact on the adoptive placement. On the other hand, individuals with this element in their history can serve as fine adoptive parents as long as they can distinguish between their issues and the child's, seek professional consultation and assistance as needed, and are comfortable in discussing these issues with each other, the child, the social worker, and the mental health clinician. Wholesale rejection of this pool of applicants is a disservice to them and to waiting children.

X. Creating Appropriate Personal and Family Boundaries

Children who have been abused have experienced numerous violations of their boundaries and personal space. This manner of relating may be the only style with which they are familiar, and they may continue to behave in this fashion when placed into the adoptive family. Families, then, require assistance in setting and maintaining appropriate boundaries among members that provide a feeling of safety and comfort for all.

Note to Trainer: *The work of Dolan (1991) on developing a "safety scale" and an "object of safety" provides*

ways in which clinicians can assist families in achieving this goal. Participants may also wish to offer their own experiences in helping families to create boundaries and a sense of safety.

Duehn demonstrates via a role play how families must openly discuss sexual boundaries with the newly-placed child. Trainers could either show this video or participants could enact their own role play with assistance from the trainer.

Families need to develop rules, expectations, and an atmosphere of safety. Discipline in special-needs adoption of abused children varies greatly from that appropriate for non-adopted, non-abused youngsters. The issues of attachment, the seven core issues in adoption, and the potential for the child to misinterpret and provoke parents' actions must all be factored in when designing discipline strategies.

Abused youngsters frequently seek to act out previous abuse either through externalized or internalized behaviors. Among the most problematic of the externalized behaviors are those of youngsters who molest other children. There may be a large number of molested children in this country who turn around at startlingly young ages and become child molesters themselves. This is a long-unrecognized problem, primarily because social workers, clinicians, and parents prefer to see children as victims rather than as potential perpetrators of abuse. Most people choose to ignore the signs of these behaviors in children and adolescents.

Note to Trainer: *Refer participants to MacFarlane and Cunningham (1990).*

Another 90 percent of youngsters participating in a model treatment program in the Los Angeles area (the "SPARK" Program) were themselves molested. The majority are boys, but the program directors report that they are beginning to see more girls. The dominant themes for these youngsters are a desire to gain a sense of power and control and an identification with the aggressor. Parents need education about normal childhood sexual development, and they need to pay attention to behaviors that contain more than average sexual curiosity, including obsessive masturbation and more than a two-year age difference between children involved in sex play. Adoptive parents often refuse to believe what they are seeing. Studies show that 58 percent of adult sexual offenders report having begun sexually acting-out as juveniles or adolescents.

Adolescents are a particularly vulnerable population. The exact incidence of sex crimes committed by adolescents is not known. The assessment and treatment of adolescent sex offenders are broad, complex clinical areas that presently lack empirically verified evaluation or therapy techniques. Mental health professionals often underestimate the significant risks involved with adolescent sex offenders.

XI. Responding to Allegations of Abuse in the Adoptive Family

There are a variety of circumstances that can lead to allegations of current abuse in the adoptive family. Such allegations are always disturbing and difficult to discuss. Clearly, prevention is the first goal, and suggestions for education, training, establishment of appropriate boundaries, and discipline are all primary prevention interventions. Nevertheless, allegations do arise. One class of such allegations is those that are ultimately substantiated. Factors in the structure of the adoptive family may create an atmosphere where abuse can occur, including unresolved loss and grief, barriers to intimacy and trust, a diminished sense of control, and provocative, attention-seeking, and other negative behaviors of the child.

Note to Trainer: *Review with the audience the Seven Core Issues in Adoption (III above) and the Increased Effects of Abuse and Adoption (V above). Ask clinicians to discuss how these may create an abuse scenario in the adoptive family.*

The risk may increase as children unconsciously attempt to re-create scenarios from their dysfunctional birth families. Children may be exceptionally provocative and even physically abusive themselves, or they may be sexually inappropriate ei-

ther with parents or siblings. Families who simply wanted to give a child a good home and love may be caught off guard and be unable to control their own impulses, with tragic results.

A variety of factors may also cause false allegations of abuse in the adoptive family. Youngsters who have been involved in the system or who have deficits in the development of a conscience may consciously or unconsciously make reports of abuse. Some children who were severely traumatized by physical and sexual abuse may experience flashbacks that are triggered by events in the adoptive family. They may be uncertain whether they are being abused now. Older children who fear getting close or who cannot tolerate receiving love may consciously make false reports to be removed from the adoptive family. Careful investigations of all these possibilities need to occur before any judgments or decisions are made. Families can protect themselves by being open and honest with professionals and also discussing the issues within the family. Parents can also write out their child's history and give it to friends for safekeeping in case allegations arise. (See *Adopted Child Newsletter*, September, 1984.)

XII. Therapy

It is vital that mental health professionals who are asked to intervene in adoptive families of abused children clearly define their role(s). Most adoptive families were healthy, well-functioning units before the placement of the special-needs youngster. Therapy, then, often takes on more of a consultation/education function than the treatment of psychopathology. Even the dysfunction of the newly-placed child is usually best addressed in the context of family therapy. There are inherent dangers in seeing the child for any prolonged period in individual therapy, including the child's becoming attached to the therapist instead of the family, the parents feeling that the therapist believes that they are not adequate to address the child's needs, inadvertent collusion, scapegoating and blaming, divided loyalties, and dysfunctional communication.

The "successful" therapist/counselor:

- Is well-versed (through specialized training and experience) in working with adopted youngsters and their families; recognizes that adoptive families are different (not better or worse) from traditional nuclear families; has knowledge of attachment issues and techniques;
- Believes that adoption is a healthy, positive way to build families; can see over the long term, not just the immediate "crisis"; sees the adoptive family as a family for a lifetime;
- Likes children and adolescents;
- Can differentiate among normal developmental issues, normal adoption adjustment, and abnormal events;
- Is familiar with grief work in children and adults;
- Is able to use many modalities (forms) of therapy; is active and flexible;
- Is aware of and uses community resources and supports, e.g., adoptive parent groups;
- Works with adoptive parents and adoptions staff as a team;
- Can avoid rescue fantasies;
- Can be open, honest, and genuine;
- Can see family's and child's strengths, as well as areas needing work;
- Has dealt with own anger toward birth parents; and can accept and work with children's attachment to birth families and previous caretakers.

When a team of social workers, parents, educators, medical personnel, etc. decides to add a mental health professional, that person must be willing to join the team and work collaboratively. Additionally, although special-needs adoptive families may often look "crazy" as they struggle to come together and incorporate a child from another family with a variety of experiences, special-needs adoptive families are for the most part sane, although distinctive. Professionals need to avoid labeling either the family or the child as pathological, working instead to create solution-oriented, collaborative interventions.

The current solution-focused therapies (see Dolan, 1991; O'Hanlon, 1989; and deShazer 1985, 1988) hold much promise for adoption work. Based on a belief that individuals and families hold within themselves the solutions to their problems, these

therapies seek to "co-create" resolutions with therapists and clients working as collaborators. The work is for the most part time-limited, positive, and empowering. Many solution-focused therapists incorporate the hypnotic/metaphorical work of the late Milton Erikson (1976, 1979).

Any assessment of an adoptive family seeking mental health services must be directly tied to a treatment plan. The fundamental goals of the therapeutic intervention are to provide corrective and reparative experiences for the child and to assist the adoptive parents in learning how to become a "healing resource" for the child. Therapy can also provide opportunities for corrective emotional experiences. Therapists can help families provide the child with opportunities to feel safe, and learn about appropriate interactions that lead to feelings of greater safety, trust, and well-being; in other words, teaching the child about the potentially rewarding nature of human interaction.

Reparative experiences both in and outside therapy allow the child to process traumatic events in ways they can be consciously understood and tolerated. When designing a treatment plan, mental health professionals must not consider presenting symptoms in isolation, but rather maintain a multi-systems perspective that includes birth and adoptive families, school, peers, community, religious, and medical systems. The primary goal of the treatment is establishment of a home setting where the child feels safe and family interactions are corrective in nature, providing opportunities for self-exploration, adaptation, and the development of new (functional) behaviors. It is important that clinicians intertwine abuse and adoption issues, being mindful of the influence and interplay of each.

The therapeutic work must also assist the adoptee to achieve developmental tasks appropriate for his/her stage of development. Pre-adolescent issues may include inappropriate sexualization, aggression, and antisocial behaviors. Adolescent issues often reflect questions of low self-esteem, self-image, stigmatization, role confusion, and peer relations.

It is beneficial to develop home assignments that increase positive interactions among family members. Therapists must respect the child's need to proceed slowly with issues related to closeness and intimacy, especially with physical touch, but not allow the child to remain "stuck" and avoid attachment. Watch for pseudo-attachments and for reenactment of family-of-origin dynamics. When they occur, correct them immediately in session. It is also useful in session to encourage posttraumatic play, which affords opportunities for pattern interruption, interpretation, and corrective experiences. Whatever the activity in session, the therapist must be active and require the family to be active as well. Therapy will be "unfolding" and dynamic. Set concrete behavioral objectives; involve the parents and child. Allow for measurable progress and development of a sense of mastery. Monitor the child for signs of dissociation, and teach both child and parents to do so. Teach grounding techniques for use in session and at home. Include both prevention and education to repair knowledge deficits. Teach and model skill-building.

Many specific techniques are helpful in working with abused children, including clinical hypnosis, drawings, mutual story-telling, metaphors, and projective story-telling. Sand tray therapy, posttraumatic play as developed by Gil (1994), and writing techniques are all frequently productive. Adopted youngsters need to have a lifebook. If the adoptee does not have one, an important activity of the therapy can be to develop one. Timelines of the child's life and placement history are helpful for the child, family, and therapist to better understand the child's life experiences prior to the adoptive placement. Most of these techniques, although originally developed for individual child-centered play therapy, can be easily and rewardingly adapted to family therapy work. At times, the parents may serve as witnesses to the child's work; at other times, the parents may be actively involved.

There are several family therapy techniques that are also productive in working with adoptive families. Most involve play as well. Gil (1994) states that the integration of play with family therapy strengthens both therapeutic approaches. Family therapy with adoptive families focuses on the interplay between family members who are working together to form a whole or a system. It serves to facilitate that process. The use of play in a family assessment, then, gives a firsthand view of how the family is organized; of verbal and nonverbal communication skills and patterns; of how family mem-

bers negotiate issues of fairness, limit setting, and conflict; and of how the attachment is coming together and other interactional dimensions in the family. Play for the most part reduces defenses and elicits deeper levels of interaction in which fantasy, metaphor, and symbol emerge. Play brings people together in a common pleasurable task. Useful techniques include puppets, art, mutual storytelling, feeling cards, psychodrama, and sand tray (Gil, 1994).

XIII. Rituals and Ceremonies

Finally, the inclusion of rituals and ceremonies both as part of family therapy and in the home environment helps concretize important aspects of the family's development, facilitate healing transitions, and create connections. Rituals draw attention and provide an avenue to facilitate the process. Ceremonies create both a focus and a container. Most often these rites have witnesses and participants who lend their support. Symbols are important in a ritual ceremony. Symbols are concrete objects connected with ("linked symbols") or representing ("created symbols") some situation, experience, or person. They are used to externalize and concretize an internal experience. Usually there is a leader or celebrant. Often religious leaders are willing to officiate at adoption-related ceremonies. For additional ideas regarding the use of rituals see Imber-Black, et al, (1988).

Rituals fall into several categories:

- Regularly repeated rituals: Activities you can count on, daily, seasonally, or on holidays.
- Continuity/connecting rituals: Restoring previous rituals or prescribing a ritual that restores or makes connections to people or situations.
- Rituals of remembering: Helping connect people with memories, the past, and disconnected resources.
- Rites of passage: Designed to move people from one role or developmental phase to another and to have that transition validated and recognized by others in their social context.
- Rites of inclusion: Designed to make people part of a social group or relationship.
- Rites of mourning/leaving behind: Designed to facilitate or make concrete the end of some relationship or connection.

Phases of the ritual include: introduction/co-creation; preparation; performance; cleansing/respite; and integration/celebration (O'Hanlon 1993). Examples of rituals include the symbolic inclusion of an absent birth family into the adoptive family circle, claiming the newly adopted child into the adoptive family, mourning ceremonies for the child's lost past, and healing activities to reclaim and nurture the body.

XIV. Role Play

Note to Trainer: *Prepare a case or several cases for role play. Ask for volunteers to play out the case in front of the large group and then break into small groups for discussion. It is recommended that the case involve as many of the issues covered in this presentation as possible. Offer play materials to simulate play techniques in family therapy. Small groups might focus on dominant themes of the case (organized around the core issues in adoption); strengths, skills, and resources of the adoptive family; and the treatment plan. These materials can then be discussed in the large group.*

XV. Questions and Answers

Note to Trainer: *Allow for ample time to address any questions that remain. Encourage participants to make a commitment (either publicly or privately) to utilize at least one item from the material presented immediately on return to their practices.*

THE FIRST LADY'S SCHEDULING OFFICE

PLEASE DELIVER TO:

1.) ______

2.) ______

3.) ______

4.) ______

ORGANIZATION	Susan Soon-Keum Cox (of Holt International Children's Servic
EVENT	meeting w/ HRC to discuss issues of child welfare & adopti
DATE OF EVENT	open
LOCATION	~~[illegible]~~ Washington OR open
EVENT DESCRIPTION	meeting w/ HRC
CONTACT	Susan Soon-Keum Cox (541)687-22
RECOMMENDED BY	
STATUS	ACCEPT ______ LETTER ______ REGRET ______ VIDEO ______ PENDING ______
NOTES	

Patti -

It looks like she wants to do this meeting -

Julie

Nicole - where is this?

Patti

Rabner - this was think sent to me by accident

Eileen