FAMILY TO FAMILY: RECONSTRUCTING FOSTER CARE

A Program of The Annie E. Casey Foundation
and
The States of Alabama, Maryland, New Mexico, Ohio, and Pennsylvania

February, 1994

The Annie E. Casey Foundation

The Annie E. Casey Foundation was established in 1948 by Jim Casey, a founder of United Parcel Service, and his sister and brothers, who named the Foundation in honor of their mother. Today the Casey Foundation is the nation's largest philanthropy dedicated exclusively to improving the lives of disadvantaged children and families.

The Foundation is guided by the following set of principles which strongly influence its work:

1. Families play the single most critical role in determining a child's future. Public policies and services must be redesigned to support families in that role.

2. More flexible service delivery, targeted to the particular needs of children and their families, requires collaboration among all facets of the community representing the interests of youth.

3. More effective services for children will result from better uses of financial resources, including the reallocation of funds toward services that intervene earlier, that are community-based, and that support parents and seek to preserve families.

4. Good data on the needs of families and children is essential if community services are to be flexibly provided, while accurate data on the impact of family services and supports is essential if we are to be able to hold public systems accountable for the outcomes of their interventions.

The primary way in which the Foundation carries out its mission is to award grants to states and communities that are interested in undertaking ambitious reforms of their child-serving systems in order that they exemplify these same principles.

Family foster care, the mainstay of all state child welfare systems, constitutes a pivotal set of services in need of such serious reform.

BACKGROUND

Since the passage of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), all fifty states have been required to provide supportive services which help families stay together and, when children have to be placed in foster care, to stress reunification with the family as a primary goal of services. This legislation established a legal basis for the philosophy that the best place for a child to be raised is in a family environment, and that keeping children and families together and affirming the right of every child to have a permanent home leads to the best possible outcomes for children.

More than a decade has passed, and by their own admission public child welfare systems in this country still do not reflect these principles in practice--often because of enormous changes in the broader society over which they have no control. There are more children in foster care, with projections that the number will continue to rise, while the supply of family foster homes continues to decrease. Federal and state governments continue to spend significant portions of their child welfare budgets on children in institutional placements, with family reunification and preservation services still not funded to the extent needed.

The nation's public child welfare system's primary concern, in keeping with P.L. 96-272, should be to assist in maintaining children with their families whenever possible and to enhance services which prevent unnecessary separations. When a family is having difficulty meeting certain needs of its children, the state's child welfare system ought to assure that everything required is done to help preserve that family, including the provision of necessary services and assistance before the child is placed away from home.

There <u>are</u> emergency situations and other severe circumstances, however, that require the separation of a child from his or her family. At such times, every effort should be made to have the child live with caring and capable relatives or with another family within the child's own community--rather than in a restrictive, remote, institutional setting. Family foster care should be the next best alternative to a child's own home or to kinship care.

National leaders in family foster care and child welfare have come to realize, however, that **without major restructuring, the family foster care system in the United States is not in a position to meet many of the needs of children who must be separated from their families**. One indicator of the deterioration of the system has been the steady decline in the pool of available foster families at the same time as the number of children coming into care has been increasing. Further, there has been an alarming increase in the percentage of children in placement who have special and exceptional needs. If the family foster care system is not significantly reconstructed, the combination of these factors may result in more disrupted placements, longer lengths of stay, fewer successful family reunifications, and more damage done to children by the very system which the state has put in place to protect them.

Many states' child welfare systems are in severe crisis. State after state is experiencing serious budget deficits. Many states are facing class action lawsuits over the conditions of their child welfare systems. Such crises make this an opportune time for states to challenge themselves to rethink the fundamental role of family foster care and to consider very basic changes.

THE FAMILY TO FAMILY INITIATIVE

With the appropriate reforms in policy, in the use of resources, and in program implementation, family foster care can respond to the challenges of out-of-home placement and be a less expensive and more humane choice for children and youth than are institutions or other group settings. Family foster care reform, in and of itself, can yield important benefits for families and children, although such reform is only one part of a larger agenda designed to address the overall well-being of children and families currently in need of child protective services.

The FAMILY TO FAMILY Initiative was designed in consultation with national experts in child welfare. In keeping with the Annie E. Casey Foundation's guiding principles, the framework for the Initiative is grounded in the belief that reforms in family foster care must be focused on changes that support a more family-centered approach that is: (1) responsive to the individualized needs of children and their families, (2) rooted in the child's community (or even better the child's neighborhood), (3) sensitive to cultural differences, and (4) able to serve many of the children now placed in group homes and institutions.

The FAMILY TO FAMILY Initiative is an opportunity for states to reconceptualize, redesign, and reconstruct their foster care system to achieve **the following new system-wide goals**:

1. To develop a network of family foster care that is more neighborhood-based, culturally sensitive, and located primarily in the communities in which the children live.

2. To assure that scarce family foster home resources are provided to all those children (but to only those children) who in fact must be removed from their homes.

3. To reduce reliance on institutional or congregate care (in hospitals, psychiatric centers, correctional facilities, residential treatment programs, and group homes)--by meeting the needs of many more of the children currently in those settings through family foster care.

4. To increase the number and quality of foster families to meet projected needs.

5. To reunify children with their families as soon as that can safely be accomplished, based on the family's and children's needs--not simply the system's timeframes.

6. To reduce the lengths of stay of children in out-of-home care.

7. To decrease the overall number of children coming into out-of-home care.

With these goals in mind, the Annie E. Casey Foundations first selected and funded six states for a nine-month period to carry out a strategic planning process. **States funded through this Initiative were asked to develop family-centered, neighborhood-based family foster care service systems within one or more local areas**. Local communities targeted for the Initiative were to be those which have had a history of placing large numbers of children out of their

homes. This site or these sites would then become the first phases of implementation of the newly conceptualized family foster care system throughout the state and (hopefully) across the country. The Foundation has funded five states' FAMILY TO FAMILY plans for implementation beginning September, 1993 (**Alabama, New Mexico,** and **Ohio)** and two states (**Maryland** and **Pennsylvania**) beginning February, 1994.

The new system envisioned by FAMILY TO FAMILY will:

- better screen children being considered for removal from home, to determine what services might be provided to safely preserve the family and/or what the needs of the children are;

- be targeted to bring children in congregate or institutional care back to their neighborhoods;

- involve foster families as team members in family reunification efforts;

- become a neighborhood resource for children and families and invest in the capacity of communities from which the foster care population comes.

The Foundation's role has been to assist states and communities with a portion of the costs involved in both planning and implementing innovations in their systems of services for children and families, and to make available technical assistance and consultation throughout the process. The Foundation will provide funds for development and for transitional costs that accelerate system change. The states, however, are expected to maintain the dollar base of their own investment and sustain the changes they implement when Foundation funding comes to an end. The Foundation is also committed to accumulating and disseminating both lessons from states' experiences and information on the achievement of improved outcomes for children. We will therefore play a major role in seeing that the results of the FAMILY TO FAMILY Initiative are actively communicated to all the states and the Federal government.

The states selected to participate in the planning process are being funded to create major innovations in their family foster care system--to **reconstruct** rather than merely supplement current operations. Such changes are certain to have major effects on the broader systems of services for children, including other services within the mental health, mental retardation /developmental disabilities, education, and juvenile justice systems, as well as the rest of the child welfare system. In most states, the foster care system serves children who are also the responsibility of other program domains. In order for the planning process to be successful (to ensure, for example, that children are not inadvertently "bumped" from one system into another), representatives from each of these service systems will need to be involved in every stage of planning and implementation at both the state and local level. These systems will need to commit to the goals of the Initiative, as well as redeploy resources (or priorities in the use of resources) and may have to alter policies and practices within their own systems.

As a result of the reform, family foster care services should also become a neighborhood resource for children and families, investing in the capacity of communities from which the foster care population comes.

In summary, the FAMILY TO FAMILY Initiative is founded on a few key value judgments: Reforms in family foster care must be directed to producing a service that is **less disruptive** to the lives of the people it affects, more **community-based** and **culturally-sensitive**, more **individualized** to the needs of the child and family, more available as **an alternative to institutional placement**, and in general more **family-centered**. Further, an enhanced family foster care system also can be consistent with an increased emphasis upon developing alternatives to out-of-home placement for children in the first place. Family foster care can be constructed to serve as a less restrictive setting for children that can speed reunification and assure that out-of-home placements which are made are not undertaken until all reasonable efforts to preserve families have been explored.

THE REFORM EFFORT

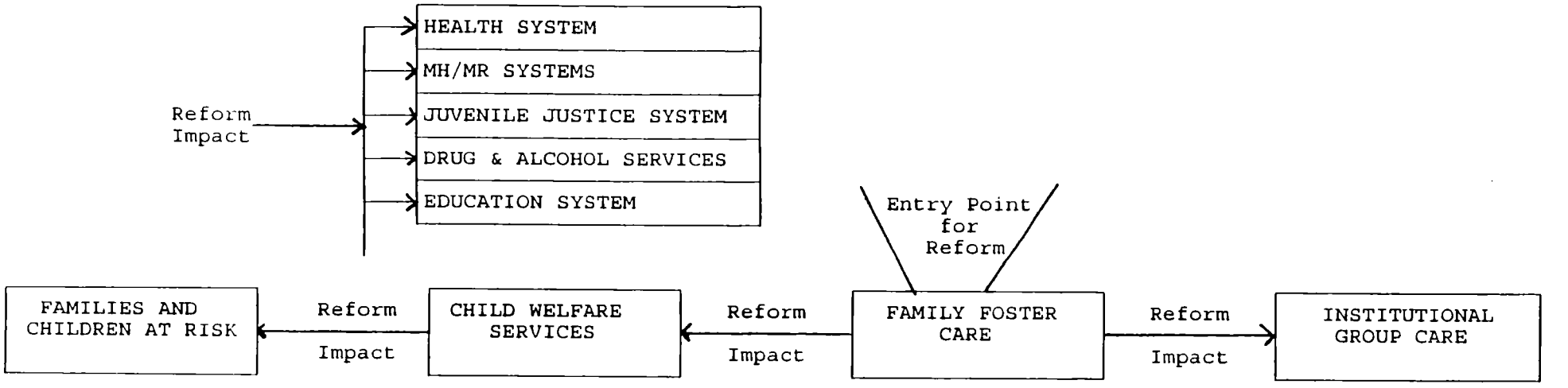
The chart on the following page attempts to depict graphically the reform design of the FAMILY TO FAMILY Initiative. THE FAMILY FOSTER CARE SYSTEM in each of the Initiative states is seen as the key entry-point for reform. By targeting this portion of the state's children services system as a focus for change, we anticipate a **rebuilding effort** for family foster care: In order for this rebuilding to be successful, new and better training, recruitment, retention, and support systems will need to be put in place within the family foster care system. Foster care workers will need reasonable caseloads if they are to be available 24-hours a day, 7-days a week. New treatment foster homes will need to be developed. Foster families' roles need to be enhanced to make them part of the service team and to make them available as service resources to birth families.

If the family foster care system is reformed, we believe that many more children currently served in institutional and group care will be able to be served in family foster care.

However, if **only** family foster care is enhanced, real reform will not have occurred. Family foster care can only be truly reformed if the child welfare and child protection systems are reformed as well. For this enhanced reform to occur, better gatekeeping systems need to be put in place within the child protection system, to make sure that only those children who must be removed from their families are entering the foster care system. Otherwise a more robust family foster care system will actually attract higher rates of placement. The child welfare system as a whole, therefore, will need to play a role in the reform as well: comprehensive child and family assessments will need to be put in place, family preservation efforts increased, community-based services created, etc.

If these systemwide reforms occur, less children will be removed from their families. Those children who **must** be removed will be better cared for and will be in foster families within their own communities. Reunifications will occur more quickly, and the pattern of neighborhood services available to families at risk will improve. These improved outcomes for families and children can only occur, however, if other service systems take part in the reform as well. Mental Health and Substance Abuse agency services, for example, will need to be made available to families at risk in a timely manner, if placement is to be avoided or reunification to occur more quickly. The FAMILY TO FAMILY Initiative, therefore, envisions family foster care as an entry-point to broader reform of the entire system of services for families in each state.

THE FAMILY TO FAMILY REFORM DESIGN



- Less children removed
- Less time in placement
- More families reunited; sooner
- Stronger neighborhood services and stronger neighborhoods

- Better gatekeeping/ screening for placement
- Comprehensive child/ family assessment
- Family preservation services
- Realistic reunification goals
- Agency takes lead in reunification work
- Truly community-centered services
- Enhanced training for staff

- Neighborhood Foster Care
- Foster Families team w/birth families
- Enhanced training for foster families
- Reasonable caseloads
- Fewer cross cultural placements
- Fewer sibling splits
- Adequate reimbursement
- Better recruitment/ retention
- Enhanced specialized family foster care

- Less children in group
- Reduction in lengths of stay for children in group care

THE PLANNING EFFORT

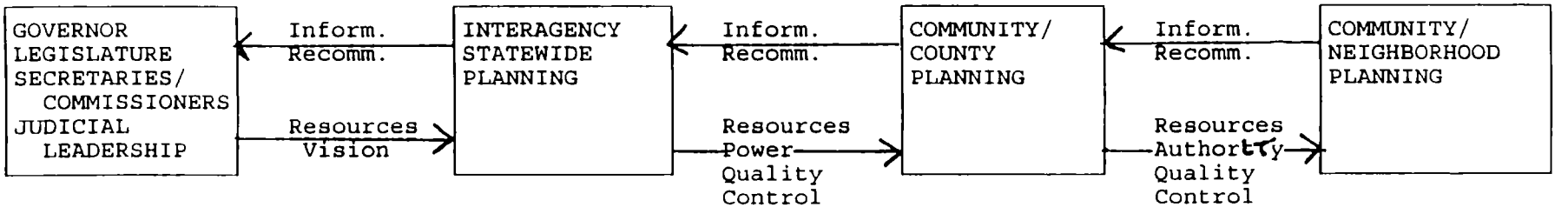
The chart on the following pages attempts to describe how each state's planning effort might unfold in FAMILY TO FAMILY.

The Foundation provided up to $75,000 for planning purposes to each of the states involved in the Initiative's planning effort. Between September of 1992 and January 15 of 1994, the various states worked to develop their own unique plans for implementing FAMILY TO FAMILY. During that same period, the Foundation provided the states with our understanding of the status of foster care across the country and our vision of how reform could occur. A range of technical assistance was also offered to each state, so that it could develop the kind of comprehensive plan needed to achieve real reform in its family and children services system.

Working through the state's family and children services system leadership, Foundation staff directly supported the states' strategic planning efforts. Each state formed an interagency planning group involving key leaders from all those departments or divisions who play a role in services to families and children. The responsibility to develop a plan for substantive reform of the system was to be vested in this group (and especially its leadership) by the state's governor, legislative leaders, etc. The commitment to reform and the vision for what such reform would entail had to come from the very top.

Just as important, however, is the involvement of local community leaders in the planning process. While state leadership need to offer direction and provide the flexible funding and policy changes for reform, the day-to-day agenda for change needed to be designed at the local level. Further, while programs were to be designed and funded at the county/community level, the decisions about actual service delivery should be brought as close to the community/neighborhood level as possible. Throughout the planning process, mechanisms should be developed (and continually improved) to ensure that there is meaningful and ongoing involvement of those most directly affected by family foster care in the design and improvement of that system.

THE FAMILY TO FAMILY PLANNING EFFORT



- State's Vision
- Commitment to Change
- Commitment to cross-system reform
- Commitment to cultural responsiveness

- Leadership
- Authority to change
- Policies follow the vision:
  a) flexible
  b) priority front-end
- Regulations track policies
- Staffing supports goals
- Cross-system collaboration

- Family Preservation policies/programs
- Gatekeeping Systems
- Family assessment
- Caseload sizes reduced
- Interagency conflicts mitigated
- Service Integration
- Training

- Neighborhood-based services
- Responsive to changing community needs
- Community ownership

STRATEGIC PLANNING, TECHNICAL ASSISTANCE, AND SELF-EVALUATION

The chart on the following page summarizes the various kinds of assistance which the Foundation made available to each state in the development of its plan for implementing the FAMILY TO FAMILY Initiative.

The Annie E. Casey Foundation staff assigned to the Initiative will be available to each state for guidance and advice regarding strategic planning and the goals of the Initiative. Further, the Foundation has contracted with the Research Triangle Institute to help states design a reform plan that they can **self-evaluate** as that reform is implemented--so that mid-course corrections can occur in a timely manner throughout the Initiative. RTI will also be conducting the overall evaluation of FAMILY TO FAMILY.

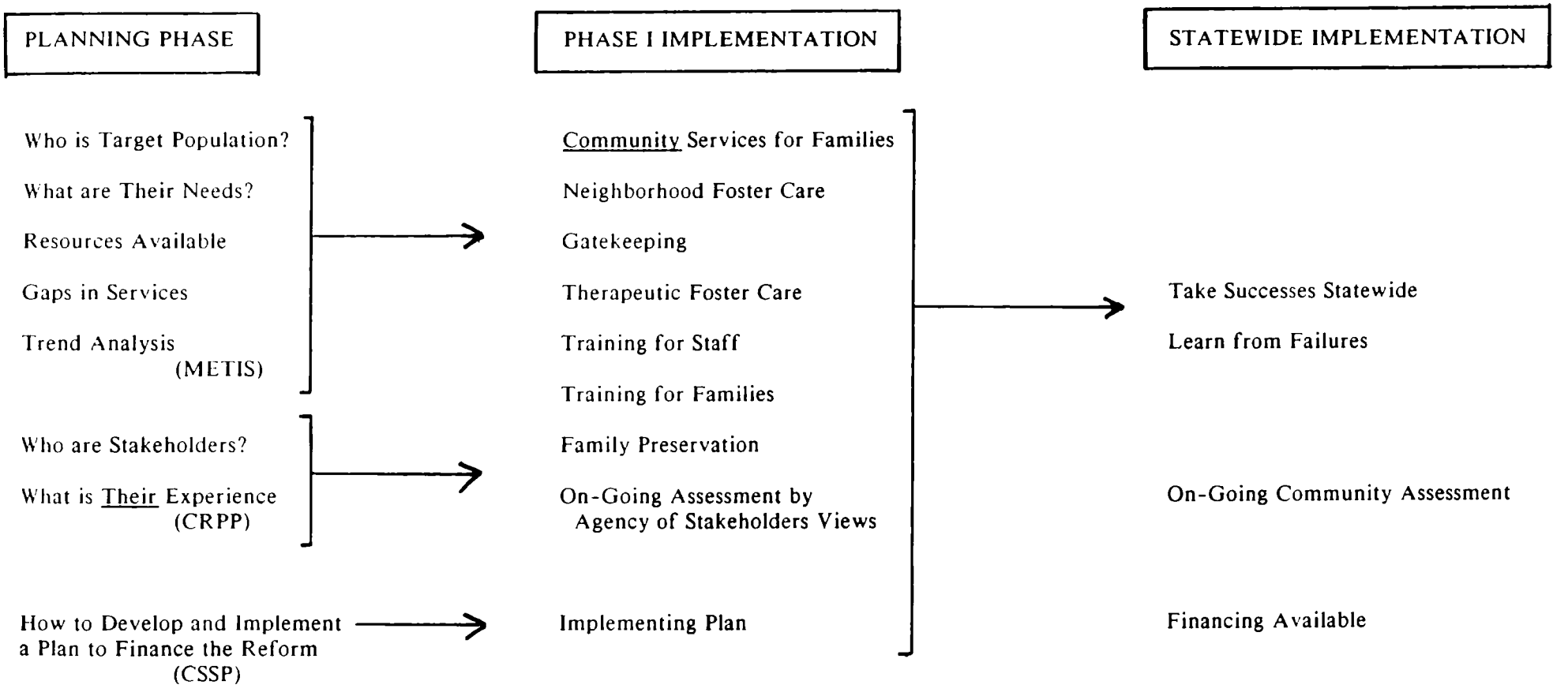
Metis Associates assisted states in their efforts to determine what they already know from their current management information systems about children and families at risk, **and** what more they needed to know.

The Center for the Study of Social Policy was available to assist states to develop a plan for financing the reform, both during the initial (Phase One) implementation stage in a few communities and statewide after the initial period.

The Center for Research and Public Policy was available to teach state leaders how **to listen to what their systems are telling them** about what's working and what's not in the reform effort.

The Center for Family Life in Sunset Park, Brooklyn was available for visits from state and community leaders interested in learning how neighborhood family services work, including family foster care.

TECHNICAL ASSISTANCE PLAN



THE OUTCOMES OF FAMILY TO FAMILY

States participating in the FAMILY TO FAMILY Initiative have committed themselves to achieving the following outcomes:

1. A reduction in the number of children served in institutional and congregate care.
2. A shift of resources from congregate and institutional care to family foster care and family-centered services across all child and family-serving systems.
3. A decrease in the lengths of stay in out-of-home placement.
4. An increase in the number of planned reunifications.
5. A decrease in the number of unplanned re-entries into care.
6. A decrease in the number of placement disruptions.
7. A reduction in the total number of children served away from their own families.

Finally, as a result of the reform, family foster care services should also become a neighborhood resource for children and families, investing in the capacity of communities from which the children are currently coming into care.

Briefing Paper for Gaynor McCown

Treatment Foster Care and the Foster Family-based Treatment Association

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Executive Summary

Treatment foster care (TFC) is a method of caring for vulnerable populations, principally children as an alternative to more intensive residential treatment utilizing family-based placements surrounded by intensive professional supports. It is being used with an increasing number of target population groups, facilitates family preservation, and is finding its place within the managed care environment. It is largely publicly funded. The Foster Family-based Treatment Association is the professional association that represents TFC in the U.S. and Canada. TFC provides a partial solution to the escalating cost of residential care for vulnerable populations and provides better care in the process. It can make significant contributions to improving the current publicly operated foster care system.

Part I: Treatment Foster Care

Definition of Treatment Foster Care: The Foster Family-based Treatment Association (FFTA) formally defines treatment foster care as:

> a program for children, youth and their families whose special needs can be met through services delivered primarily by treatment foster parents trained, supervised and supported by agency staff. Each of the key persons and components identified in this statement is essential to any application of treatment foster care as a service model or program type.[1]

Essentially, TFC is a model of caring for vulnerable populations, predominantly children, outside of their home that combines the strengths and technology of residential treatment with the benefits of family-based placement. Treatment foster care is distinguished from traditional foster care by:

- more stringent requirements of foster parents
- more intense, required pre-service and ongoing training of foster parents
- higher reimbursement payments to foster parents based on the comprehensiveness of the treatment program and the skills required of the foster parents to carry it out
- intensive supervision of foster homes by highly qualified (usually Master's level) social workers with small caseloads

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[1] Foster Family-based Treatment Association, (1991). *Program Standards for Treatment Foster Care.* New York: Foster Family-based Treatment Association.

- highly individualized treatment planning for each child often accompanied by an agency-implemented treatment program according to a particular clinical modality

- intensive therapeutic supports and specialized services to children, foster and primary families provided by agency professional staff, available on a 24-hour, 7-day per week basis

- more intensive attention paid to the questions of permanency in the child's life, attention to primary family, and follow-through in achieving the goals of the treatment plan

- the fact that most, but not all, treatment foster care is delivered by private, community-based agencies, usually, though not always, not-for-profit corporations. Most traditional foster care is directly operated by state or local government

The Place of Treatment Foster Care in the Continuum of Services: By and large, treatment foster care has been used as an alternative to residential treatment. It is considerably less expensive, though not necessarily less treatment intensive than the residential treatment it is designed to replace. The economic advantage of the modality is due to the absence of physical plant costs and to the relatively low cost of foster parent reimbursement (particularly considering the 24-hour nature of their commitment) compared to salaries for shift staff in a residential treatment setting. Research to date shows the results to be as good, if not better than residential treatment.[2] Placing one or two children per home allows for a much more individualized treatment plan than is possible in group settings, without the danger of contamination from other disturbed children. The typical child in a treatment

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[2]Fanshel, D., Finch, S., & Grundy (1990), *Foster Children in a Life Course Perspective.* New York: Columbia University Press.

Colton, M. (1988). *Dimensions of substitute child care.* Aldershot, England: Avebury.

Hawkins, R., Almeida, C. & Samet, M. (1989) Comparative evaluation of foster-family-based treatment and five other placement choices: A preliminary report. In A. Algarm, R. Friedman, A. Duchnowski, K. Kutash, S. Sliver, & M. Johnson (Eds.) *Children's Mental Health Services and Policy: Building a Research Base* (pp.98-119). Proceedings of the 2nd Annual Research Conference, Research and Training Center for Children's Mental Health, University of South Florida, Florida Mental Health Institute, Tampa, FL.

Chamberlain, P., & Reid, J. (1991) Using a specialized community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology,* 19, 266-276.

Chamberlain, P. (1990). Comparative evaluation of specialized foster care for seriously delinquent youths: A first step. *Community Alternatives,* 2, 21-36.

foster home has two foster parents, a caseworker, a therapist, and a variety of other agency staff in his/her life. Thus the child is surrounded by health, supervision and role models, rather than pathology. Furthermore, children are socialized to live in more normal, caring, non-restrictive settings rather than institutions. Put another way, advocates claim that a child can only learn family values as part of a family.

Treatment foster care is more intensive and *seemingly* more expensive than traditional foster care due to the higher staff to foster family ratio required to deliver the necessary support and supervision and due to the higher payment made to foster parents. However, the true cost of traditional foster care is difficult to calculate. Traditional foster care is usually delivered by county or state government. A fair estimate of the full cost of traditional foster care would factor in the cost of local welfare and probation department personnel and the program's share of governmental overhead. Public sector social workers are often paid higher salaries and receive higher benefits, especially retirement benefits, than their private sector counterparts.

Developments in the Field: There are three trends discernable in the current development of TFC - increasing diversity of target populations; accommodation to and blending with family preservation; development of TFC as a "step-down" option for seriously disturbed children in a managed care environment.

Target Populations: As mentioned, TFC developed originally as an alternative to residential treatment within the child welfare, mental health, and juvenile justice systems. As the model proliferated, it has been adapted to specialized subsets such as pregnant teens/teen moms; medically fragile children; children needing short-term emergency shelter; and adjudicated juvenile delinquents. An increasing use of TFC has been with developmentally delayed children. Some FFTA members offer TFC to developmentally delayed adults, adults with brain injuries (as an alternative to rehabilitation facilities) and to geriatric populations (as an alternative to board and care/rest homes). An interesting adaptation currently being experimented with in some agencies is "whole-family" or "shared-family" care wherein the entire family, parents and children are taken into care and placed with a foster family. This modality has been applied in drug treatment situations (as a means of keeping parents and children together while the parents undergo drug treatment); and homelessness prevention (instead of removing the children of homeless adults and placing them into foster care and leaving the adult on the street, the family unit is kept intact, placed with a foster family, and given services to help the family get on its feet).

Family Preservation: Direct work with the primary family typically begins as soon as the child enters treatment foster care. Many FFTA members have found that the supports they provide to their treatment foster families are

identical to those utilized by primary families in family preservation programs. This provides an entree for programming that helps children exit the foster care system. Support staff to foster parents can "go home" with the children when they are reunified. The continuity of care helps to ensure that the reunification is successful. Conversely, the presence of staff who work with the primary family has made placement-oriented staff more willing to support family reunification.

Managed Care Step-down: Intensive and often restrictive residential treatment programs serving seriously emotionally disturbed children have begun adding TFC programming as a response to pressure from managed care companies that they shorten stays in the more expensive facilities. This services allows children to be "stepped-down" into foster homes with high levels of in-home support. As the child improves, the support can be withdrawn gradually as appropriate, without interfering with the bond between the child and foster parent. This aspect of TFC may be the fastest growing part of the field, and is of increasing interest to large proprietary, hospital corporations and managed care companies.

The Funding of Treatment Foster Care: The vast majority of treatment foster care is publicly funded. Funding and rates paid vary among the states. With regard to federal funds, nearly all publicly funded programs take some Title IV-E funds. An increasing number of agencies fund large portions of their programs with Title XIX Medicaid dollars, particularly in those states electing the Rehab Option, though the manner and mechanisms vary dramatically. Some programs have been able to access EPSDT, though this is more the exception than the rule. In addition to local match, many programs augment with private foundation and voluntary dollars.

Part II: The Foster Family-based Treatment Association

The Foster Family-based Treatment Association (FFTA) was founded in 1988. It has grown rapidly and now is comprised of 302 agencies that operate treatment foster care programs. Two hundred eighty-six of these agencies are located in the United States, twenty-six in Canada. Members represent a wide spectrum of agency profiles from small agencies providing homes to ten children, to large multi-state agencies with program capacity in the hundreds of beds. Similarly, some Association members offer treatment foster care only, while others are multi-service agencies offering a continuum of services including residential treatment, family preservation, day treatment, on-grounds school, and a full range of related mental/behavioral health services.

The purpose of the association is to promote and enhance the provision of treatment foster care services to children; set professional standards for the delivery of these services; encourage the development of programming expertise, including an

emphasis on research, evaluation and outcome measurement; offer resources and support to the providers of treatment foster care services; and act as the North American voice in behalf of treatment foster care.

Much of the Association's efforts in its early years was dedicated to the development of written practice standards for treatment foster care. The primary intent of this effort was to ensure the quality of programming by concretely specifying the nature and intensity of services required for a program to be able to call itself Treatment Foster Care. The secondary intent was to provide a measure of continuity in the field to assist policy development on the state, provincial and federal levels in U.S. and Canada. The development process took almost three years and involved extensive contributions from the rank and file through a series of local meetings held all over North America feeding back to a centralized process. Standards of practice were published in 1991. The first revision of these standards are due to be published this year. The Association operates a national conference annually, and publishes a quarterly newsletter for its members.

Within the past three years the Association has undertaken the formation of local chapters for the purpose of delivering training to members and promoting advocacy in behalf of treatment foster care. Currently FFTA operates chapters in California, New Mexico, Minnesota, Nebraska, Illinois, Michigan, Indiana, Ohio, Kentucky, West Virginia, Maryland, Pennsylvania, Delaware, District of Columbia, Virginia, New York, Alberta and Ontario.

Part III: Public Policy Issues

Most Important Global Issue: Maintain the open ended entitlement for foster children. These children have been made children-of-government by court action. Government's responsibility to these children is fundamentally different than it is toward other constituencies as it has assumed the role of parent and legal guardian. Funding for foster care needs to be recognized as the health and safety issue it is, not a welfare issue as some would have it. The First Lady has been terrific on this point. To us, a carve-out for dependent children from welfare reform and block grant is not dissimilar to the "except for rape and incest" carve-out that even the most adamant pro-lifers were usually willing to put in their anti-abortion bills. That is, protecting vulnerable dependent children should be advanced as a bi-partisan principle of fundamental humanitarianism.

Privatizing Foster Care, Outcome Monitoring, and Permanency For Children: While a full evaluation of the public sector foster care system is beyond the scope of this paper, the advantages the private sector has in efficiency, flexibility, and accountability are generally recognized. Currently, public agencies both contract with for services and compete with the services they contract with. A less conflicted

arrangement would have the public agencies continue to be responsible for case management, court reporting, and holding the direct service providers accountable, while the private sector handled the direct provision of services. Thus, privatization would enhance the prospect of "outcomes monitoring" (i.e. measuring status of child/family at discharge) which could be required as part of the private agency's contract. Accountability of outcome is particularly difficult to mandate in the public, civil service environment. The goal of these contemplated changes would be to achieve permanency for children, reduce the number of children in the system, increase the number of adoptions. Aggressive efforts on the federal level would be helpful in achieving this goal.

Blended and Flexible Funding: Current funding follows the "system" that identifies the child. If the child comes through child welfare, access to IV-E/IV-A is easy, and this is the way most TFC is funded. Access to mental health funding is more available to children identified by the mental health system. Jurisdictional licensing and certification rules complicate service delivery. It would be enormously useful if funding that is now restricted to children could be applied to the child's family, or that IV-E funding could be expanded beyond "care and supervision" to include treatment services. While some states have taken the initiative to blend funding streams so that services can be targeted to children and their families based on assessment of need rather than the label - "runaway," "delinquent," "dependent," "patient," "student," etc, federal leadership is needed to spotlight decategorization efforts that are working, provide technical assistance and consultation, and most importantly clear away the red tape.

Managed Care: Inasmuch as managed care is providing a needed impetus to rely more on innovative service delivery and less on inpatient care, managed care is a fresh wind blowing out the cobwebs of institutional care. It holds promise not only for cutting costs of mental health treatment, but also for demystifying and normalizing the mental health delivery system. The threat, however, is in the fact that managed care companies focus on acute interventions (a holdover from the hospital culture) and don't like to consider the needs of longer-term populations. In the coming years there will probably be a move to include traditional child welfare services into the managed care arrangements that states and counties are embracing for health and mental health care. When the Health Care/Insurance Reform is enacted, statutory and regulatory protection must ensure that children are not disqualified for services because of their chronicity (i.e. they are kids and it takes time to grow up); and that community-based facilities are allowed in as service providers.

Problems with Medicaid: To date, TFC still is not well recognized as a valid modality. Many jurisdictions require discrete TFC service components to be billed in 15 minute units. In some jurisdictions MA funding requirements have distorted the TFC concept by requiring certified mental health professionals to intervene in the

homes when they were not really needed to provide the treatment. TFC is *not* a traditional foster care bed with periodic mental health services patched in. That is like saying residential treatment should be funded for bed-cost only with staff intervention billed by the minute. In actuality, both residential treatment and TFC are *programs* of services (including staff requirements, training, technology, etc.). Medical assistance works well for TFC when is allows for a "bundled" or generic TFC rate based on an average set of service costs.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUL 26 1996

Transmitted by Fax

To: Andy Tomlinson
Domestic Policy Council

From: Carol W. Williams, D.S.W.
Associate Commissioner
Children's Bureau

Data Request

In response to your request for data on child welfare expenditures, I am forwarding the following documents:

(1) Title IV-B.1 Allotment for States & Tribes FY95

(2) Title IV-B.2 Grantee Obligation Report FY95

(3) Title IV-E Foster Care Expenditures FY96

(4) Title IV-E Adoption Assistance Expenditures

All of these documents come from ACF's Office of Program Support and are based on payments to grantees.

In addition, I am enclosing the executive summary and information tables from the Family Preservation and Support Implementation Study which provides more detail on how IV-B.2 dollars were to be spent. The enclosed tables indicate how States planned to use money in FY95.

We have also sent our most recent report on child abuse and neglect to Lynn by mail. If you have any questions, please feel free to contact the following:

Financial Data	John Gaudiosi 205-8625
FPS Implementation Study	Helen Howerton 205-3604
National Study of Child Abuse and Neglect	Gail Collins 205-8087

Enclosure
cc: Joan Gaffney
Gail Collins
Helen Howerton

ADMINISTRATION FOR CHILDREN AND FAMILIES
ADMINISTRATION FOR CHILDREN, YOUTH AND FAMILIES
CHILDREN'S BUREAU
330 C. STREET, SW, SWITZER BLDG., ROOM 2070
WASHINGTON, DC, 20201-0001
*OFFICE***202-205-8618 FAX***(202)260-9345*

**********FAX COVER SHEET**********

DATE: 7/26/96

TO: Andy Tomlinson

ORGANIZATION: _____

RECIPIENT'S FAX NUMBER: _____

FROM: Carol Williams

TELEPHONE NUMBERS: OFFICE****(202)205-8618
FAX*******(202)260-9345

NUMBER OF PAGES, INCLUDING COVER SHEET: 3

REMARKS: _____

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REMARKS:

ACKNOWLEDGMENTS

First, James Bell Associates wishes to thank Helen Howerton, our Project Officer, for her ongoing assistance and guidance. We also want to acknowledge the contributions of Sharon Rothman King and Tonya Howell, ACYF Central Office staff, for their help in providing us with the state plans and updates submitted to ACYF.

In addition, staff from each of the ACYF Regional Offices provided invaluable insights into states' FP/FS planning efforts. Without the Regional Office input, much of this analysis would not have been possible.

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EXECUTIVE SUMMARY

The 1993 legislation that added a new subpart 2 to title IV-B of the Social Security Act[1] provided new federal entitlement funding for services to strengthen and support families, enabling them to provide a safe and nurturing environment for their children. Services are aimed at reducing the risk of out-of-home placement and family disintegration. The statute, Family Preservation and Family Support Services, expands both the current array of services that may be provided and the characteristics of families served. States have considerable latitude to plan and implement family preservation and family support services that will meet the needs of children and families.

In September 1994, the Administration for Children and Families (ACF) awarded a contract to James Bell Associates (JBA) and its subcontractor, Westat, Inc., to conduct the "Family Preservation and Family Support Services (FP/FS) Implementation Study." In March, 1995, JBA submitted a report analyzing and synthesizing the FY94 FP/FS planning grant applications submitted by the states in June, 1994. This document updates the previous report by providing a synthesis and analysis of the five-year FP/FS plans submitted by the states in June, 1995.

Given the extensive new planning requirements in the law, federal guidance and policy documents issued by ACF encouraged states to spend FY94 funds on planning, up to $1 million. Any funds over that amount could be used for services. The planning effort was to lay a base for expanded coordination, lead to the development of a five-year plan, and have other positive effects on FP/FS implementation. States followed federal guidance by conducting a comprehensive and inclusive planning process, resulting in the following:

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[1] Omnibus Reconciliation Act of 1993 (42 U.S.C. 620-628).

- **Establishment of comprehensive goals and objectives:** States included representatives from a range of agencies in the planning process (e.g., health, education, public assistance, mental health, substance abuse, domestic violence). Their involvement in the process is reflected in the goals and objectives states established. The goals selected by states not only reflect the traditional goals of child welfare agencies (e.g., reduction in foster care placements) and the principles of family-centered service delivery, but other outcomes critical to strengthening and supporting families. Goals and objectives were developed that pertained to helping families achieve economic independence, improved health status, and better educational outcomes for children.

- **Development of service plans that reflect the needs of families and communities:** Most states established FP/FS program goals and then shared or delegated responsibility for determining specific services with counties and communities. They provided technical assistance to counties in conducting needs assessments, holding public hearings, and implementing other activities designed to include a range of non-traditional stakeholders in the planning process. Special efforts were made to include parents and consumers in the process. Day care was often made available at meetings and travel stipends were arranged. One state provided leadership training to assist parents in feeling confident at planning sessions. Regional Office staff noted that the slightly higher percentage of funds allocated to family support services in many states was the direct result of parents' input during the planning process.

- **Identification of multiple funding sources for family preservation and support programs:** FP/FS funds were intended to assist states in expanding existing programs or developing new types of FP/FS services. They were not intended to replace existing funding sources or become the primary vehicle for funding FP/FS services. Data in the state plans indicate that title IV-B Subpart 2 monies account for only 6 percent of all expenditures for family preservation services and 8 percent of all family support funds. More than half of the funds for both services were secured through a combination of federal programs including the Social Services Block Grant and title IV-A Emergency Assistance; however, the single largest funding source for both types of services is state/local government.

- **Development of coordinated efforts to support service delivery:** Several states plan to institutionalize the comprehensive planning bodies created for FP/FS or create other interagency management structures to continue planning, monitor progress toward goals, and oversee the implementation of FP/FS services. States also noted plans to pool funding from different state and federal sources to support programs, improve the ability of their management information systems to share information and monitor progress toward goals, and provide interdisciplinary technical assistance and training to front-line staff in human services agencies.

The comprehensive and inclusive nature of the planning process did have some temporary drawbacks. The Regional Offices noted that many states expressed concern that the planning period was not long enough to allow them to complete all of their planning activities, especially at the local level. As a result, less is known about the specific service delivery interventions selected by the counties and communities as well as plans to monitor and evaluate them. Because of the relatively short planning period, the current state plans should be viewed as "works in progress," with more detailed information expected in amendments or annual updates to the plans.

Of the states providing information about services, 32 plan to fund family support program models (including family centers and home visiting programs) and family support services (including parent skills training, respite care, child care, parent support, and information and referral services). In addition, 24 states plan to provide family preservation services including intensive services, a variety of other family preservation services (e.g., parent education, substance abuse treatment, domestic violence prevention services), and reunification services. Nevertheless, detailed descriptions including information on target populations, service providers, means of accessing services or the nature, intensity or duration of services is lacking at this time.

In addition, review of the state plans and discussions with the Regional Offices identified some areas where state have requested additional guidance or clarification. These include:

- Defining the specific dimensions of service delivery that should be included in descriptions of services funded (e.g., target population, types of providers);
- Providing an operational definition of community-based organizations;
- Providing assistance in maintaining parent/consumer involvement throughout the planning and implementation effort;
- Establishing measurable objectives and benchmarks, and

- Developing evaluation plans for specific service intervention strategies.

In summary, implementation of FP/FS to date is consistent with federal legislation and guidance. State child welfare agencies have reached out to other state agencies, counties, communities, and parents, and involved them in the FP/FS implementation process. The results of these efforts can be seen in the broad range of goals and objectives established, funding sources identified, and the systems planned to support service delivery. The efforts undertaken by states thus far provide a foundation for implementing changes in service delivery to children and families that will assure safety and improved well-being for vulnerable children and families, particularly those experiencing or at risk for child abuse and neglect.

TITLE IV-B.1 ALLOTMENT AFTER REALOT
FOR FISCAL YEAR: 95, CAN: 5G998000
DATE: 07/25/96

STATE	FULL_NAME	NEW ALLOTMENT	OLD ALLOTMENT	TOTAL COMMITTED	DIFFERENCE
AL	Alabama	5,511,765	5,511,765	5,511,765	0
AL	AL Poarch Creek	188	188	188	0
AK	Alaska	678,230	664,532	666,054	13,698
AK	AK Tanana Chiefs	12,589	12,589	12,589	0
AK	AK Asa'carsarmiut	958	958	0	0
AK	AK Assoc Vil Coun Pres	20,868	20,868	20,868	0
AK	AK Artic Slope NA	5,312	5,312	5,312	0
AK	AK Fairbanks Nat. Assn	7,213	7,213	7,213	0
AK	AK Orutsaramuit	4,706	4,706	4,461	0
AK	AK Tlingit & Haida	13,029	13,029	13,029	0
AK	AK Bristol Bay	5,337	5,337	5,337	0
AK	AK Chugachmiut	1,458	1,458	1,458	0
AK	AK Cook Inlet NA	20,384	20,384	20,065	0
AK	AK Kawerak	0	0	0	0
AK	AK Copper River	0	0	0	0
AZ	Arizona	4,868,514	4,857,291	4,858,538	11,223
AZ	AZ Navajo	119,642	119,642	119,642	0
AZ	AZ Gila River	24,630	24,630	24,630	0
AZ	AZ Hopi	8,358	8,358	0	0
AZ	AZ Hualapai Nation	1,247	1,247	0	0
AZ	AZ Salt River	4,784	4,784	4,784	0
AZ	AZ San Carlos Apache	9,699	9,699	9,699	0
AZ	AZ Tohono O'odham	10,744	10,744	10,744	0
AR	Arkansas	3,386,737	3,386,737	3,386,737	0
CA	California	31,581,547	31,577,533	31,577,979	4,014
CA	CA Yurok	446	446	0	0
CO	Colorado	3,898,545	3,898,545	3,898,545	0
CO	CO Southern Ute	2,382	2,382	2,382	0
CO	CO Ute Mountain	2,752	2,752	2,752	0
CT	Connecticut	2,076,549	2,076,549	2,076,549	0
DE	Delaware	720,092	720,092	720,092	0
DC	District of Columbia	426,908	426,908	426,908	0
FL	Florida	13,095,674	13,095,674	13,095,674	0
GA	Georgia	8,417,800	8,417,800	8,417,800	0
HI	Hawaii	1,204,766	1,204,766	1,204,766	0
ID	Idaho	1,718,872	1,718,872	1,718,872	0
IL	Illinois	11,634,207	11,634,207	11,634,207	0
IN	Indiana	6,832,308	6,832,308	6,832,308	0
IA	Iowa	3,401,783	3,401,783	3,401,783	0
KS	Kansas	3,033,606	3,033,606	3,033,606	0
KY	Kentucky	4,960,940	4,960,940	4,960,940	0
LA	Louisiana	6,410,904	6,410,904	6,410,904	0
LA	LA Chitimacha	765	765	765	0
ME	Maine	1,442,056	1,442,056	1,442,056	0
ME	ME Houlton Band of Malise	3,026	3,026	3,026	0
ME	ME Passa. Indian Township	2,689	2,689	2,689	0
ME	ME Passa. Pleasant Point	3,778	3,778	3,778	0

TITLE IV-B.1 ALLOTMENT AFTER REALOT
FOR FISCAL YEAR: 95, CAN: 5G998000
DATE: 07/25/96

STATE	FULL_NAME	NEW ALLOTMENT	OLD ALLOTMENT	TOTAL COMMITTED	DIFFERENCE
ME	ME Penobscot	3,749	3,749	3,749	0
MD	Maryland	4,291,240	4,291,240	4,291,240	0
MA	Massachusetts	4,596,516	4,596,516	4,596,516	0
MA	MA Wampanoag of Gay Head	388	388	388	0
MI	Michigan	10,613,340	10,613,340	10,613,340	0
MI	MI Sault Ste. Marie Chipp	20,998	20,998	20,998	0
MN	Minnesota	5,074,957	5,069,800	5,070,373	5,157
MN	MN Bois Forte Chippewa	573	573	0	0
MS	Mississippi	4,238,279	4,238,279	4,238,279	0
MS	MS Choctaw	6,623	6,623	6,623	0
MO	Missouri	6,071,611	6,071,611	6,071,611	0
MT	Montana	1,116,172	1,116,172	1,116,172	0
MT	MT Conf'd Salish & Kooten	15,670	15,670	15,670	0
MT	MT Chippewa Cree	12,912	12,912	12,912	0
MT	MT No. Cheyenne	13,122	13,122	13,122	0
MT	MT Blackfeet	30,041	30,041	30,041	0
MT	MT Ft. Peck	25,862	25,862	25,862	0
MT	MT Ft. Belknap	5,735	5,735	5,735	0
NE	Nebraska	2,032,223	2,032,223	2,032,223	0
NV	Nevada	1,434,805	1,428,955	1,429,605	5,850
NV	NV Fallon Paiute Shoshone	650	650	0	0
NH	New Hampshire	1,073,714	1,073,714	1,073,714	0
NJ	New Jersey	5,193,337	5,193,337	5,193,337	0
NM	New Mexico	2,454,506	2,403,989	2,409,602	50,517
NM	NM Acoma	8,815	8,815	8,815	0
NM	NM Taos	2,327	2,327	2,327	0
NM	NM Mescalero Apache	5,613	5,613	0	0
NM	NM Santo Domingo	5,378	5,378	5,378	0
NM	NM Laguna	4,488	4,488	4,488	0
NM	NM Zuni	9,775	9,775	9,775	0
NM	NM San Felipe	3,628	3,628	3,628	0
NM	NM Jemez	2,606	2,606	2,606	0
NM	NM Isleta	3,415	3,415	3,415	0
NM	NM Navajo (AZ grant)	75,781	75,781	75,781	0
NY	New York	15,231,175	15,231,175	15,231,175	0
NC	North Carolina	8,089,603	8,079,613	8,080,723	9,990
NC	NC Cherokee (E. Band)	6,214	6,214	5,104	0
ND	North Dakota	880,311	880,311	880,311	0
ND	ND Devils Lake	9,575	9,575	9,575	0
ND	ND Three Affiliated	9,484	9,484	9,484	0
ND	ND Turtle Mountain	29,336	29,336	29,336	0
OH	Ohio	12,747,566	12,747,566	12,747,566	0
OK	Oklahoma	3,975,732	3,975,732	3,975,732	0
OK	OK Cheyenne-Arapaho	9,354	9,354	9,354	0
OK	OK Comanche	7,008	7,008	7,008	0
OK	OK Kiowa	7,853	7,853	7,853	0
OK	OK Cherokee	172,537	172,537	172,537	0

TITLE IV-B.1 ALLOTMENT AFTER REALOT
FOR FISCAL YEAR: 95, CAN: 5G998000
DATE: 07/25/96

STATE	FULL_NAME	NEW ALLOTMENT	OLD ALLOTMENT	TOTAL COMMITTED	DIFFERENCE
OK	OK Creek	112,026	112,026	112,026	0
OK	OK Osage	7,543	7,543	7,543	0
OK	OK Choctaw	36,233	36,233	36,233	0
OK	OK Sac & Fox	10,045	10,045	10,045	0
OK	OK Chickasaw	27,311	27,311	27,311	0
OK	OK Apache	1,946	1,946	1,946	0
OK	OK Citizen Band Potawatom	6,241	6,241	6,241	0
OR	Oregon	3,547,776	3,543,762	3,544,208	4,014
OR	OR Warm Springs	8,007	8,007	8,007	0
OR	OR Cow Creek Umpqua	446	446	0	0
OR	OR Klamath	2,946	2,946	2,946	0
PA	Pennsylvania	11,949,139	11,949,139	11,949,139	0
RI	Rhode Island	1,031,739	1,031,739	1,031,739	0
SC	South Carolina	4,866,961	4,866,961	4,866,961	0
SD	South Dakota	1,047,286	1,047,286	1,047,286	0
SD	SD Sisseton-Wahpeton	9,174	9,174	9,174	0
SD	SD Rosebud Sioux	13,981	13,981	13,981	0
SD	SD Yankton Sioux	6,712	6,712	6,712	0
TN	Tennessee	6,166,027	6,166,027	6,166,027	0
TX	Texas	23,796,313	23,796,313	23,796,313	0
UT	Utah	3,467,439	3,467,439	3,467,439	0
UT	UT Unitah & Ouray	4,239	4,239	4,239	0
UT	UT Paiute	532	532	532	0
UT	UT Navajo (AZ grant)	8,351	8,351	8,351	0
VT	Vermont	699,111	699,111	699,111	0
VA	Virginia	6,322,824	6,322,824	6,322,824	0
WA	Washington	5,759,760	5,725,542	5,729,344	34,218
WA	WA Makah	2,395	2,395	0	0
WA	WA Spokane	1,407	1,407	0	0
WA	WA Yakima	7,208	7,208	7,208	0
WA	WA Colville	4,146	4,146	4,146	0
WA	WA Puyallup	0	0	0	0
WV	West Virginia	2,417,214	2,417,214	2,417,214	0
WI	Wisconsin	5,949,970	5,949,970	5,949,970	0
WY	Wyoming	707,255	707,255	707,255	0
WY	WY Shoshone & Arapahoe	11,916	11,916	11,916	0
AS	American Samoa	190,319	190,319	190,319	0
GQ	Guam	345,731	345,731	345,731	0
CQ	Northern Mariana Islands	140,186	140,186	140,186	0
RQ	Puerto Rico	7,950,897	7,950,897	7,950,897	0
VQ	Virgin Islands	275,545	275,545	275,545	0
TOTAL		292,127,681	291,989,000	291,980,642	138,681

SOURCE: FORGIS DATA BASE FROM GRANT APPLICATIONS, DHHS, ACF

TITLE IV-B.2 FORMULA GRANT SYSTEM
GRANTEE OBLIGATIONS REPORT FOR FY: 95
RUN DATE: 07/25/96

CAN	STATE	STATE NAME	STATE OBLIGATIONS	SUMMED TRIBAL OBLIGATIONS	TOTAL OBLIGATIONS
50996439	AL	Alabama	$ 2,880,911	$ 0	$ 2,880,911
	AK	Alaska	186,726	212,522	399,248
	AZ	Arizona	2,414,096	517,272	2,931,368
	AR	Arkansas	1,387,105	0	1,387,105
	CA	California	16,631,924	0	16,631,924
	CO	Colorado	1,480,460	0	1,480,460
	CT	Connecticut	1,067,004	0	1,067,004
	DE	Delaware	253,413	0	253,413
	DC	District of Columbia	466,814	0	466,814
	FL	Florida	6,281,986	0	6,281,986
	GA	Georgia	3,734,514	0	3,734,514
	HI	Hawaii	349,853	0	349,853
	ID	Idaho	373,451	0	373,451
	IL	Illinois	6,015,235	0	6,015,235
	IN	Indiana	2,254,046	0	2,254,046
	IA	Iowa	1,026,991	0	1,026,991
	KS	Kansas	893,616	0	893,616
	KY	Kentucky	2,600,822	0	2,600,822
	LA	Louisiana	4,534,767	0	4,534,767
	ME	Maine	586,852	0	586,852
	MD	Maryland	1,827,244	0	1,827,244
	MA	Massachusetts	2,307,396	0	2,307,396
	MI	Michigan	5,535,083	0	5,535,083
	MN	Minnesota	1,573,831	0	1,573,831
	MS	Mississippi	2,774,210	12,203	2,786,413
	MO	Missouri	2,760,873	0	2,760,873
	MT	Montana	320,101	75,350	395,451
	NE	Nebraska	560,177	0	560,177
	NV	Nevada	386,789	0	386,789
	NH	New Hampshire	226,738	0	226,738
	NJ	New Jersey	2,720,860	0	2,720,860
	NM	New Mexico	1,093,679	18,654	1,112,333
	NY	New York	9,709,736	0	9,709,736
	NC	North Carolina	2,787,548	13,693	2,801,241
	ND	North Dakota	240,076	35,866	275,942
	OH	Ohio	6,682,112	0	6,682,112
	OK	Oklahoma	1,667,194	501,079	2,168,273
	OR	Oregon	1,227,055	0	1,227,055
	PA	Pennsylvania	5,668,459	0	5,668,459
	RI	Rhode Island	453,477	0	453,477
	SC	South Carolina	1,933,945	0	1,933,945
	SD	South Dakota	306,764	77,588	384,352
	TN	Tennessee	3,187,674	0	3,187,674
	TX	Texas	12,910,748	0	12,910,748
	UT	Utah	706,890	0	706,890
	VT	Vermont	253,413	0	253,413
	VA	Virginia	2,227,371	0	2,227,371

TITLE IV-B.2 FORMULA GRANT SYSTEM
GRANTEE OBLIGATIONS REPORT FOR FY: 95
RUN DATE: 07/25/96

CAN	STATE	STATE NAME	STATE OBLIGATIONS	SUMMED TRIBAL OBLIGATIONS	TOTAL OBLIGATIONS
5G996439	WA	Washington	$ 2,254,046	$ 17,681	$ 2,271,727
	WV	West Virginia	1,373,768	0	1,373,768
	WI	Wisconsin	1,973,957	0	1,973,957
	WY	Wyoming	186,726	16,865	203,591
	AS	American Samoa	122,095	0	122,095
	GU	Guam	219,181	0	219,181
	CQ	Northern Mariana Islands	96,047	0	96,047
	RQ	Puerto Rico	3,498,785	0	3,498,785
	VQ	Virgin Islands	188,397	0	188,397
TOTAL			$137,383,039	$ 1,498,773	$138,881,812

SOURCE: FORGIS DATA BASE FROM GRANT APPLICATIONS, DHHS, ACF

FY 95 TITLE IV-E EXPENDITURES + PQ ADJUSTMENTS 1/18/96
FOSTER CARE - FEDERAL SHARE [$ in millions, Children in thousands]

State	Avg Monthly No. of Children	Payments	Administration	SACWIS	Training	Total
AL	1.041	2.065	3.979	0.319	0.926	7.289
AK	0.289	2.163	4.846	0.510	0.007	7.526
AZ	2.429	15.069	13.683	4.680	0.890	34.322
AR	0.829	6.974	11.766	3.395	8.241	30.376
CA	58.590	297.484	240.103	0.000	32.302	569.889
CO	2.455	6.652	15.636	0.012	2.123	24.423
CT	2.312	12.446	31.061	9.507	3.014	56.028
DE	0.288	0.858	2.405	1.149	0.343	4.755
DC	1.119	5.831	10.700	0.000	0.142	16.673
FL	5.535	23.166	42.307	2.038	1.857	69.368
GA	3.610	11.794	8.369	0.475	2.772	23.410
HI	0.606	2.663	5.854	0.000	0.250	8.767
ID	0.311	0.892	2.233	2.500	0.000	5.625
IL	20.802	99.977	80.370	0.000	10.112	190.459
IN	3.761	38.354	33.169	0.629	0.458	72.610
IA	1.688	7.435	4.218	2.084	0.989	14.726
KS	1.206	8.639	8.151	0.963	3.625	21.378
KY	2.275	17.585	20.015	1.652	5.119	44.371
LA	3.087	20.012	12.315	0.000	2.527	34.854
ME	1.248	12.014	1.471	0.225	1.120	14.830
MD	3.001	23.349	24.683	0.000	4.335	52.367
MA	10.170	33.607	47.128	0.510	1.211	82.456
MI	8.362	59.772	52.112	0.233	(0.416)	111.751
MN	3.652	21.721	7.666	0.150	4.339	33.876
MS	0.794	1.760	3.447	0.000	0.370	5.577
MO	4.707	17.468	15.024	0.588	5.072	38.152
MT	0.669	4.069	1.153	3.757	0.020	8.999
NE	1.144	8.566	6.561	0.134	2.229	17.490
NV	0.625	1.321	1.084	0.278	0.113	2.796
NH	0.562	3.924	3.909	0.044	0.352	8.229
NJ	4.421	15.320	13.400	0.000	0.038	28.758
NM	0.702	2.859	1.856	0.977	1.008	6.700
NY	48.341	421.517	294.035	1.071	14.505	731.128
NC	4.128	32.854	6.644	0.341	1.317	41.156
ND	0.470	2.887	3.453	0.597	0.651	7.588
OH	6.866	68.381	52.633	0.000	6.076	127.090
OK	1.091	6.408	4.802	15.322	2.429	28.961
OR	2.506	9.781	13.240	2.811	1.834	27.666
PA	16.260	138.807	41.761	0.000	6.602	187.170
RI	0.837	4.804	3.311	0.449	0.081	8.645
SC	1.713	6.081	3.690	0.405	1.909	12.085
SD	0.194	0.894	1.460	0.044	0.043	2.441
TN	6.398	15.419	7.167	0.000	1.741	24.327
TX	5.917	50.635	4.942	41.577	2.844	99.998
UT	0.542	3.956	4.486	1.094	0.953	10.489
VT	1.017	5.736	1.767	0.023	0.671	8.197
VA	2.459	6.210	11.047	0.000	2.378	19.635
WA	1.969	9.869	2.164	0.176	0.382	12.591
WV	2.872	3.863	1.389	0.064	0.562	5.878
WI	4.784	19.555	24.125	0.000	1.273	44.953
WY	0.083	0.523	0.220	0.000	0.002	0.745
Totals	260.737	1,593.989	1,213.010	100.833	141.741	3,049.573

* New Jersey 4th quarter administration is estimated.

SOURCE: IV-E 12 FINANCIAL FORM, DHHS/ACF, OFFICE OF FINANCIAL

FY 95 TITLE IV-E EXPENDITURES + PQ ADJUSTMENTS 01/21/96
ADOPTION ASSISTANCE -FEDERAL SHARE [$ in millions, Children in thousands]

State	Avg Monthly No. of Children	Payments	Administration	Training	Total
AL	0.238	0.435	1.170	0.262	1.867
AK	0.376	1.181	0.105	0.000	1.286
AZ	1.095	3.541	1.981	0.000	5.522
AR	0.317	1.020	0.519	0.003	1.542
CA	14.146	35.678	12.286	0.270	48.234
CO	1.198	2.145	1.168	0.003	3.316
CT	1.141	4.245	1.658	1.125	7.028
DE	0.181	0.408	0.127	0.001	0.536
DC	0.319	0.792	1.044	0.011	1.847
FL	3.776	10.364	5.520	0.940	16.824
GA	1.189	2.509	1.038	0.817	4.364
HI	0.159	0.413	0.194	0.000	0.607
ID	0.233	0.515	0.238	0.000	0.753
IL	5.568	12.405	4.318	0.078	16.801
IN	1.956	6.593	0.745	0.000	7.338
IA	1.204	3.907	1.015	0.054	4.976
KS	1.341	1.952	0.788	0.000	2.740
KY	0.799	2.140	0.812	0.588	3.540
LA	1.431	4.155	5.898	0.991	11.044
ME	0.521	1.702	0.622	0.470	2.794
MD	1.064	3.611	0.022	0.000	3.633
MA	2.875	7.302	1.999	0.302	9.603
MI	9.139	31.917	0.000	0.000	31.917
MN	1.121	3.088	1.296	0.840	5.224
MS	0.247	0.649	0.018	0.000	0.667
MO	2.305	4.928	1.815	0.000	6.743
MT	0.241	0.561	0.337	0.007	0.905
NE	0.607	1.686	0.085	0.000	1.771
NV	0.177	0.318	0.318	0.032	0.668
NH	0.324	0.566	0.275	0.000	0.841
NJ	2.271	5.570	3.295	0.003	8.868
NM	0.733	2.035	0.404	0.000	2.439
NY	20.518	76.861	10.026	2.929	89.816
NC	1.478	4.055	0.100	0.074	4.229
ND	0.145	0.342	0.118	0.000	0.460
OH	8.116	19.206	14.203	1.598	35.007
OK	0.579	2.628	0.353	(0.031)	2.950
OR	2.167	3.959	0.061	0.000	4.020
PA	2.591	6.643	3.396	0.234	10.273
RI	0.630	1.925	2.212	0.057	4.194
SC	0.821	1.909	1.321	0.685	3.915
SD	0.257	0.498	0.151	0.000	0.649
TN	0.974	2.532	0.398	0.690	3.620
TX	3.943	11.409	5.249	0.502	17.160
UT	0.375	0.876	0.282	0.000	1.158
VT	0.391	1.343	0.437	0.167	1.947
VA	1.296	2.759	0.238	0.001	2.998
WA	2.405	3.354	(0.355)	0.014	3.013
WV	0.160	0.358	0.104	0.030	0.492
WI	1.736	7.148	1.908	0.000	9.056
WY	0.006	0.018	0.005	0.001	0.024
TOTALS	106.880	306.154	91.317	13.748	411.219

SOURCE: IV-E 12 FINANCIAL FORM, DHHS, ACF, OFFICE OF FINANCIAL MG

FINAL

Report on Analysis of 1995 Five-Year State Plans

Family Preservation and Family Support Services (FP/FS) Implementation Study

March 20, 1996

Submitted to:

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Exhibit A-1
FAMILY PRESERVATION AND FAMILY SUPPORT PROGRAM
FY94 State Allotments and
Estimated State Allotments FY95-FY98

	FY94 Allotment@ 60,000,000	FY95 Allotment@ 150,000,000	FY96 Allotment@ 225,000,000	FY97 Allotment@ 240,000,000	FY98 Allotment@ 255,000,000
Alabama	1,199,639	2,880,911	4,334,445	4,646,141	4,957,838
Alaska	77,754	186,726	280,936	301,139	321,341
Arizona	1,005,253	2,414,096	3,632,104	3,893,294	4,154,484
Arkansas	577,604	1,387,105	2,086,955	2,237,031	2,387,107
California	6,925,694	16,631,924	25,023,389	26,822,863	28,622,330
Colorado	616,481	1,480,468	2,227,423	2,387,600	2,547,778
Connecticut	444,311	1,067,004	1,605,350	1,720,793	1,836,236
Delaware	105,524	253,413	381,271	408,688	436,106
District of Columbia	194,386	466,814	702,341	752,847	803,353
Florida	2,615,879	6,281,986	9,451,497	10,131,169	10,810,840
Georgia	1,555,088	3,734,514	5,618,724	6,022,775	6,426,826
Hawaii	194,386	466,814	702,341	752,847	803,353
Idaho	155,509	373,451	561,872	602,278	642,683
Illinois	2,504,802	6,015,235	9,050,160	9,700,970	10,351,781
Indiana	938,606	2,254,046	3,391,302	3,635,175	3,879,049
Iowa	427,649	1,026,991	1,545,149	1,656,263	1,767,377
Kansas	372,110	893,616	1,344,481	1,441,164	1,537,848
Kentucky	1,083,007	2,600,822	3,913,040	4,194,433	4,475,826
Louisiana	1,888,321	4,534,767	6,822,737	7,313,370	7,804,003
Maine	244,371	586,852	882,942	946,436	1,009,930
Maryland	760,882	1,827,244	2,749,162	2,946,858	3,144,554
Massachusetts	960,822	2,307,396	3,471,569	3,721,215	3,970,861
Michigan	2,304,862	5,535,083	8,327,752	8,926,614	9,525,475
Minnesota	655,358	1,573,831	2,367,891	2,538,170	2,708,448
Mississippi	1,155,208	2,774,210	4,173,910	4,474,062	4,774,214

	FY94 Allotment@ 60,000,000	FY95 Allotment@ 150,000,000	FY96 Allotment@ 225,000,000	FY97 Allotment@ 240,000,000	FY98 Allotment@ 255,000,000
Missouri	1,149,654	2,760,873	4,153,843	4,452,552	4,751,261
Montana	133,293	320,101	481,605	516,238	550,871
Nebraska	233,263	560,177	842,809	903,416	964,024
Nevada	161,063	386,789	581,939	623,787	665,636
New Hampshire	94,416	226,738	341,137	365,669	390,200
New Jersey	1,132,992	2,720,860	4,093,642	4,388,022	4,682,402
New Mexico	455,419	1,093,679	1,645,484	1,763,813	1,882,142
New York	4,043,228	9,709,736	14,608,684	15,659,216	16,709,749
North Carolina	1,160,762	2,787,548	4,193,976	4,495,572	4,797,167
North Dakota	99,970	240,076	361,204	387,178	413,153
Ohio	2,782,496	6,682,112	10,053,503	10,776,466	11,499,429
Oklahoma	694,236	1,667,194	2,508,359	2,688,739	2,869,119
Oregon	510,957	1,227,055	1,846,152	1,978,912	2,111,672
Pennsylvania	2,360,401	5,663,459	8,528,421	9,141,713	9,755,004
Rhode Island	188,832	453,477	682,274	731,337	780,400
South Carolina	805,313	1,933,945	2,909,697	3,118,937	3,328,178
South Dakota	127,739	306,764	461,538	494,728	527,918
Tennessee	1,327,378	3,187,674	4,795,983	5,140,869	5,485,755
Texas	5,376,160	12,910,748	19,424,733	20,821,595	22,218,457
Utah	294,356	706,890	1,063,544	1,140,025	1,216,506
Vermont	105,524	253,413	381,271	408,688	436,106
Virginia	927,499	2,227,371	3,351,168	3,592,155	3,833,143
Washington	938,606	2,254,046	3,391,302	3,635,175	3,879,049
West Virginia	572,050	1,373,768	2,066,888	2,215,521	2,364,154
Wisconsin	821,975	1,973,957	2,969,897	3,183,467	3,397,037
Wyoming	77,754	186,726	280,936	301,139	321,341
Total States Allotment	55,538,842	133,375,495	200,668,732	215,099,124	229,529,514
Territories	1,861,158	4,124,505	6,081,268	6,500,876	6,920,486

	FY94 Allotment@ 60,000,000	FY95 Allotment@ 150,000,000	FY96 Allotment@ 225,000,000	FY97 Allotment@ 240,000,000	FY98 Allotment@ 255,000,000
Native American Tribes	600,000	1,500,000	2,250,000	2,400,000	2,550,000
T/TA, Evaluation	2,000,000	6,000,000	6,000,000	6,000,000	6,000,000
Courts	0	5,000,000	10,000,000	10,000,000	10,000,000
Total:	60,000,000	150,000,000	225,000,000	240,000,000	255,000,000

Exhibit A-2
FP-FS BREAKDOWN AND EXPLANATION FOR FISCAL YEAR 1995 FP/FS FUNDING
(N = 51)

State	FP Amount	FS Amount	% for FP/ % for FS	Explanation for FP vs. FS
AL	1,087,500	1,687,500	39/61	Based on input received during planning.
AK	42,014	126,042	25/75	Based on input received during planning.
AZ	1,086,300	1,086,300	50/50	50% is allocated for FS and 25% for FP, 25% is flexible to meet local needs.
AR	873,877	374,518	70/30	None provided.
CA	5,632,454	9,620,269	37/63	25% allocated to each, 50% is flexible to meet local needs.
CO	335,925	1,007,775	25/75	Existing commitment to FP.
CT	533,500	533,500	50/50	None provided.
DE	63,353	190,060	25/75	Based on input received, existing commitment to FP.
DC	0	465,491	0/100	Existing commitment to FP.
FL	1,774,953	4,507,033	28/72	Based on input received during planning.
GA[1]	2,520,797	840,266	75/25	None provided.
HI[2]	121,618	162,995	43/57	Based on input received during planning.
ID	84,026	252,080	25/75	Based on input received during planning.
IL	1,904,635	3,797,865	33/67	Based on input received during planning.
IN	811,457	1,217,185	40/60	Based on input received during planning.

[1] Numbers in table reflect Georgia's overall FP/FS distribution and the total funds the state allocated for all services.

[2] Based on Hawaii fiscal year (July 1, 1995 - June 30, 1996)

State	FP Amount	FS Amount	% for FP/ % for FS	Explanation for FP vs. FS
IA	0	924,292	0/100	Existing commitment to FP.
KS	172,021	516,063	25/75	None provided.
KY	1,192,500	517,500	70/30	None provided.
LA	1,998,841	1,998,841	50/50	25% allocated to each, 50% is flexible to meet local needs.
ME	264,000	264,000	50/50	Based on input received during planning.
MD	609,987	1,038,626	37/63	Based on input received during planning
MA	0	2,057,396	0/100	Existing commitment to FP.
MI	2,164,346	2,817,229	43/57	Based on input received during planning.
MN	354,112	1,062,336	25/75	Based on input received during planning.
MS	693,553	1,803,237	28/72	Based on input received during planning.
MO	1,242,393	1,242,393	50/50	None provided.
MT	116,270	184,946	39/61	Based on input received during planning.
NE	140,044	420,133	25/75	None provided
NV	174,000	174,000	50/50	None provided.
NH	107,500	107,500	50/50	None provided.
NJ	612,193	1,836,581	25/75	Based on input received during planning.
NM	498,375	512,175	49/51	None provided.
NY	3,238,736	5,500,000	37/63	None provided
NC[3]	1,300,000	1,300,000	50/50	None provided.
ND	168,054	60,019	74/26	None provided.
OH	4,677,478	2,004,634	70/30	None provided.

[3] These numbers are based on North Carolina' FP/FS allotment and the state's total FY95 funding allocation.

State	FP Amount	FS Amount	% for FP/ % for FS	Explanation for FP vs. FS
OK[4]	842,000	842,000	50/50	25% allocated to each, 50% flexible to meet local needs.
OR	706,068	520,987	58/42	Based on input received during planning.
PA	1,275,404	3,826,210	25/75	Based on input received during planning.
RI	143,415	230,455	38/62	None provided.
SC	1,044,330	696,220	60/40	None provided.
SD	142,615	151,633	48/52	Based on input received during planning
TN[5]	0	3,300,000	0/100	Existing commitment to FP.
TX	8,714,755	2,904,918	75/25	Based on input received during planning.
UT	318,100	388,790	45/55	Based on input received during planning.
VT	190,060	63,353	75/25	None provided.
VA	1,484,320	698,504	68/32	Based on input received during planning.
WA	901,618	1,352,428	40/60	None provided.
WV	423,737	803,654	35/65	None provided.
WI	949,289	949,289	50/50	None provided.
WY	113,816	43,794	72/28	Based on input received during planning.
Total	53,846,339	68,983,015	44/56	

[4] These numbers are based on Oklahoma's FP/FS allotment and the state's total FY95 funding allocation.

[5] These numbers are based on Tennessee's FP/FS allocation and the state's total FY95 funding allocation.

Exhibit C-1
FAMILY SUPPORT PROGRAMS/SERVICES PLANNED
(N = 32)*

State	Family Centers	Home Visiting	Parent Skills Training/ Parent Education	Parent Support	Respite Care	Child Care	Info. and Referral	Other
AL	X	X	X		X	X	X	Mentoring, before and after school care, youth activities, employment services, mental health counseling, substance abuse services
AR			X					
CO							X	Family advocates
CT	X		X	X		X	X	Before and after school programs
DE						X	X	Family advocates
DC		X	X	X	X			
GA		X		X	X	X		Self sufficiency, school-based health services
HI	X		X		X			Substance abuse counseling, recreation
IL			X	X			X	Family advocates, recreation
KS			X		X	X		
KY			X	X		X		Literacy services
LA	X		X					Recreation, substance abuse, education, transportation, counseling
ME	X	X	X					
MD	X		X		X	X	X	Mentoring program
MI		X	X					
MS	X					X		
MO	X							
MT		X	X	X	X			Family violence prevention services, literacy services
NH								Community Resource Coordinators (funded through FP and FS)
NJ	X		X					
NM	X	X	X	X				
NY	X	X			X			

State	Family Centers	Home Visiting	Parent Skills Training/ Parent Education	Parent Support	Respite Care	Child Care	Info. and Referral	Other
NC	X	X	X		X			
OH	X							
OR	X	X	X	X	X		X	Family advocates
RI		X	X	X				Coordinated health and social services for teen mothers
SD		X						
TN	X	X	X			X		Early intervention services serving all parents of newborns
TX		X	X		X			
UT	X					X		Family advocates, latchkey program, before and after-school programs, counseling
VT		X					X	
WY			X			X		Recreation, counseling services
Total	16	15	21	9	11	11	8	

- Eighteen states are allowing counties/communities to determine services and did not provide information on specific family support services in their plans; one state has not yet determined the services it will provide. The information provided represents family support services discussed in state plans. Information contained in state first-year applications is presented in the **Preliminary Report: Analysis and Synthesis of First-Year Grant Applications**.

Exhibit C-2
FAMILY PRESERVATION SERVICES PLANNED
(N = 24)*

State	Intensive Family Preservation	Other Family Preservation	Reunification	Description
AL	X			Expand existing intensive family preservation services model.
AR	X			Expand intensive family preservation statewide.
DE		X		Information and referral services for substance abuse treatment for families receiving family preservation services.
GA	X	X		Expand existing intensive and other family preservation services in underserved areas.
HI	X			Focus on linking substance abusers in families receiving family preservation with needed services.
KS		X		No specifics, services to be determined at the local level.
KY		X	X	Expand current family preservation program; create intensive, statewide reunification services; develop family assessment teams.
ME			X	Design new family reunification program.
MD	X	X		Plan provides overview of services but specific services will be determined at the local level.
MT	X			Intensive, short-term family preservation services developed in two regions.
NH				Community Resource Coordinators are being funded with both FP and FS funds.
NJ		X	X	Expand existing family preservation services to underserved areas; enhance and expand therapeutic visitation, reunification and aftercare services.
NM		X		A pilot of mid-level FP services.

State	Intensive Family Preservation	Other Family Preservation	Reunification	Description
NY		X		Improve aftercare services for adoptive families; services to reduce residential placement of children with emotional disabilities.
NC		X	X	Expansion of family preservation services; one county mentions developing new, intensive reunification services.
ND	X	X		Develop full-range of family preservation services statewide including intensive in-home services, parent aide, wrap around, child care, respite care, and special needs adoption services.
OH		X		Expand existing family preservation program; develop and enhance intersystem placement diversion teams.
OR	X	X		Intensive family services and other family preservation services including respite care.
SD		X		New crisis model developed and parent aide program will be working in conjunction with one another.
TX	X	X	X	Expand existing family preservation services including crisis nurseries and respite care; develop new intensive reunification model.
UT	X	X		General categories provided in plan include intensive, home-based, family centered counseling and crisis respite care services.
VT	X			Plan to pilot "Family Group Decisionmaking Model" described as intensive family preservation services.
WI	-	-	-	Discussion of developing guidelines for intensive, home-based services pilot project; other decisions to be made at local level.

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RESEARCH REGARDING YOUNG CHILDREN IN GROUP CARE

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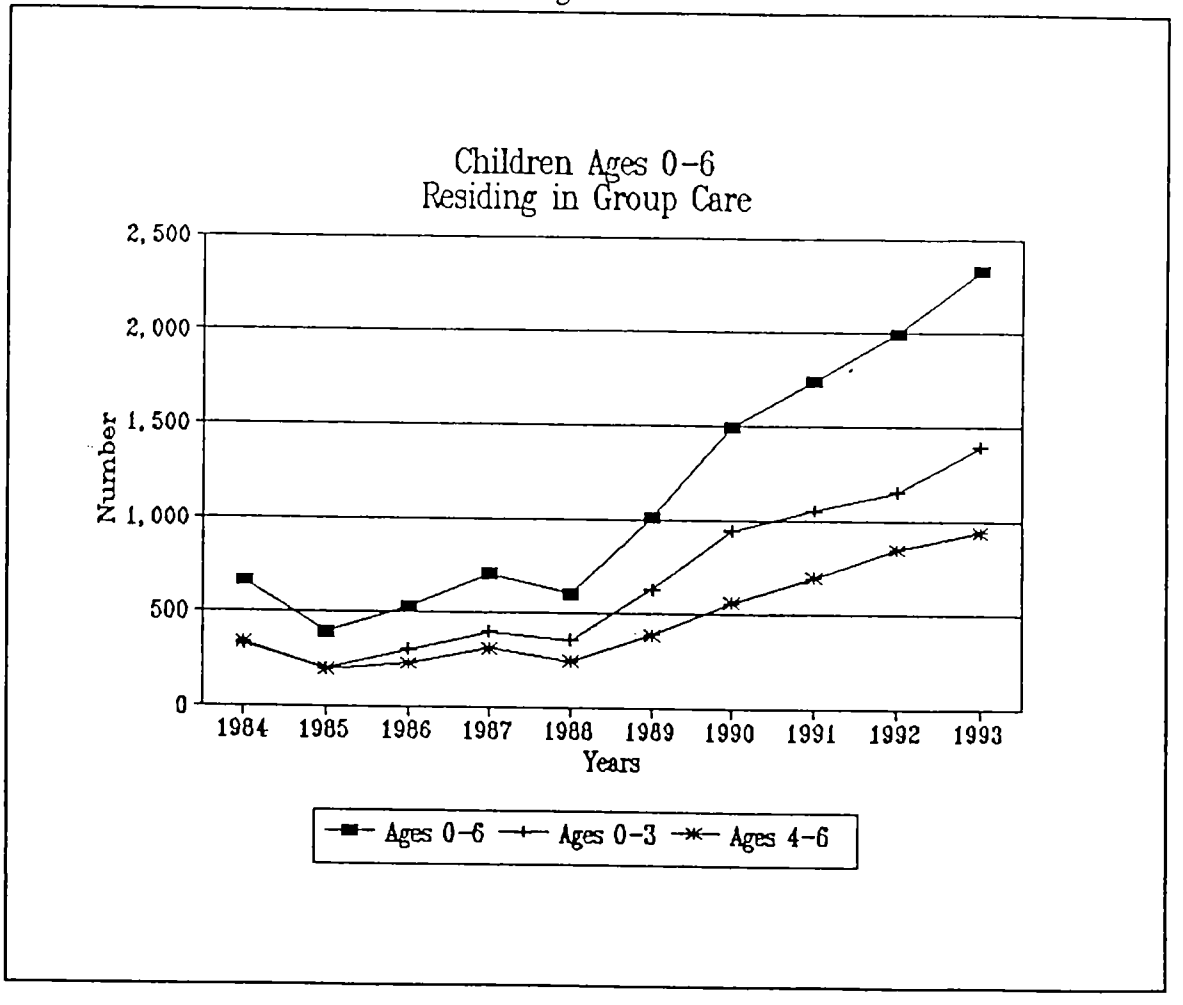
Research Regarding Young Children in Group Care

From January 1984 to January, 1993, the total number of children ages zero to six in out-of-home care increased by about three percent in California. The total number of young children residing in group care, however, increased by 56 percent. As Figure 1 suggests, growth in the population of young children placed in group care has been rather sharp. In the nine year period, children ages 0-6 increased as a percentage of all children in group care from about 11 percent to about 25 percent.

Figure 1[1]



[1] Data are provided by Statistical Services Bureau, California Department of Social Services. Data are based upon reporting by the middle of January of each year. Data include only welfare-supervised children, provided through the Foster Care Information System. "Group care" codes are determined by "facility type" variable. Matches between Community Care Licensing and the Foster Care Information System on the designation of the group home variable is modest, hence group home estimates are likely to be somewhat high.

Trends such as these should be examined critically against the goals of the child welfare services system: to protect children and provide permanency. Group care placements should be sufficiently more effective than foster family care arrangements at protecting children and facilitating their permanence (by reunifying them more rapidly or by facilitating their transition to adoption) to justify their higher cost. If group care is not demonstrably more protective and facilitative of permanency but is more costly, this calls for policies that support the replacement of group home care for young children with care in a more home-like environment. Two feasible alternatives might include foster family care and specialized foster care.

Protection

Protection involves two issues: protection of the young child's developmental capacity and physical well-being.

Developmental Issues. The best research on the effects of placement of young children in group care on children's development is the work by Tizard and Hodges (e.g., Tizard & Hodges, 1978; Hodges & Tizard, 1989). This work involved a prospective study of a group of infants placed in residential nurseries until at least two years of age. In most respects the nurseries provided a high-quality environment, but there was high staff turnover. (Children averaged nearly 10 caregivers per year.) At two years of age, children were found to be more clingy and diffuse in their attachments than children brought up in birth families. These children also vocalized more and displayed less friendliness toward others. Residential children had a mean "mental age" about two months below the norm. At four years they were still less likely than controls to show deep attachments to their caregivers and more likely to be attention seekers. At eight, they continued their attachment patterns and were also restless, disobedient, and unpopular at school. Even at 16 years of age Hodges and Tizard note:

> ...such maternal deprivation did not necessarily prevent them from forming strong and lasting attachments to parents once placed in families, but whether such attachments developed depended on the family environment, being much more common in adopted children than in those restored to a biological parent. Both these groups alike, however, were more oriented towards adult attention, and had more difficulties with peers and fewer close relationships than a matched comparison of adolescents, indicating some long term effects of their early institutional experience (1989:77).

Although care within an orphanage should not be directly compared with current practices in group care settings, earlier studies of children reared in orphanages did not provide positive results. Feinberg (1954) found orphanage children in the U.S. to have lower Stanford Achievement test scores than foster children and home-reared children. Ferguson (1966) also showed children placed in residential care performing more poorly

in school and employment. Other researchers (Conway, 1957; Pringle & Bossio, 1960; Trasler, 1955) found links between early and prolonged residential care and later breakdowns in foster placements.

Anna Freud (1951) reported language and abstract concept delays in children without a specific caregiver and Fraiberg (1977) reported increased impulsivity and lower frustration tolerance when raised without a single caregiver. Significantly, Golfarb (1954) compared institutionalized and non-institutionalized children, noting "retarded" intellect and conceptual skills in children not transferred from the institutions prior to the age of four. As with much research in this area, it is very difficult to determine whether the differences found in these children are the *result* of having spent some portion of their lives in group care, or whether these differences would have been found among these children as a result of pre-existing behavior problems or other environmental factors. This problem of interpretation is substantially mitigated for studies of young children, however, because pre-existing behavior problems generally are not longstanding nor severe.

Long-Term Outcomes. Data on the long-term outcomes of children raised within the child welfare system are sparse. No studies have been conducted which *definitively* describe differences in outcomes based upon placement type. Instead, differences seen in outcomes between children placed in group care as opposed to conventional foster family care often do not differentiate between the level of behavioral, emotional, or psychological problems the children had upon entering care. Similarly, the data do not describe the types of home environments, or the type of abuse the child sustained before placement (McDonald, Allen, Westerfelt, & Piliavin, 1993).

These significant caveats aside, most studies point to somewhat more negative effects for children who spend all or part of their childhood in group care settings as opposed to children cared for in foster homes. Although the data are now rather dated and the sample size small, Davis and Heimler (1967) assessed the satisfaction of adults who were raised in residential care. The subjects did not score well in areas of friendship, job satisfaction, outside interests or secondary family relationships.

Comparing children placed in group care and foster family care, Festinger (1983) found that children placed in group care completed fewer years of education, were more likely to have been arrested or convicted of a crime, and were more likely to indicate drug or alcohol problems as adults (also Ferguson, 1966; Jones & Moses, 1984). Group care children were less likely to have close friends (Festinger, 1983), and were also less likely to have developed informal support networks (Jones & Moses, 1984). They were more likely to live alone as adults, to be single parents, and to be divorced. Interviews with respondents also revealed lower assessments of satisfaction with their personal situation (Festinger, 1983). Children from group homes appeared to be less satisfied

with their financial situation, they were less "optimistic" about their future, and their overall assessments of their lives were more negative than for children from foster homes.

Differences between boys and girls placed in group homes and foster homes were also found. Girls placed in group homes were somewhat more likely to have problems with drugs or alcohol (Festinger, 1983); and less likely to be married. Girls were also more likely to be receiving public aid as adults than girls placed in foster homes and they were more likely to become pregnant as teens. Boys placed in group homes had higher arrest rates than boys placed in foster homes (Festinger, 1983).

Festinger's follow-up study of adults who had been in foster or group care found that for men who had been discharged from group care settings, older age at the time of initial placement was associated with a stronger sense of well-being. To the contrary, men discharged from foster homes had a stronger sense of well-being if placed there at a younger age. McDonald, Reva, Westerfelt, and Piliavin (1993) summarize the significance of these results as follows:

> This finding, coupled with the general finding that negative outcomes are associated with group rather than family settings, suggests that early placement in the right setting can be beneficial, and that early placement in the wrong setting may be damaging. (p. 128).

Quality of Care. We do not have data to indicate whether children residing in group care are better protected from harm than children placed in foster care. Studies examining child injury or deaths in out-of-home care by placement type (controlling for factors beyond the control of the provider) would begin to yield information in this area. Nevertheless, quality of care should be examined in one's assessment of the protective environment children receive while in placement. Colton (1990) compared specialized foster homes with group care facilities in Great Britain, examining each facility's child-orientation or their institutionally-oriented practices and environments. The study reviewed the home environment, routine, discipline practices and community involvement in 12 specialized foster homes and 12 residential homes. The study controlled for differences in level of child needs, presented scale validity information, and rated staff attitudes and parental attitudes. Although staff in both settings were child-oriented in their outlook, these attitudes were not adequately translated in the group home settings. Specialized foster homes scored well above group homes in their ability to communicate a child-oriented setting for children in all four areas. (The author notes that size and "bureaucratization" may be responsible for the institutional practices of the most well-meaning group home environments.) The sample size for the study was small and the children studied were over the age of 12, nonetheless, the study may point to differences in facilities that might be found for younger children as well.

Cohen's small-scale study (1986) of group homes in Los Angeles indicated that children received basic supervision and care. Administrators of these homes, however, rated the overall quality of group homes as either "fair" or "poor." Cohen found that the cost of care was not associated with quality nor with the difficulty of the children served. He found a surprising reversal. Children who appeared to be *more* disturbed were placed in smaller homes, where reimbursement rates were low.

A recent study conducted of group care providers in California found that staffing in group homes is somewhat problematic (Barth, Courtney, Berrick, & Albert, in press). Administrators noted that they have a number of difficulties locating and hiring qualified staff. Twenty seven percent of the sample said that there were "very few" qualified workers available to fill positions in residential care. Administrators' concerns regarding new staff is well founded. Turnover within group care settings is high. One quarter of child care workers in this study had been on staff for less than six months and another quarter had been employed for more than six months, but less than a year. The rate of turnover exceeded that noted in the National Child Care Staffing Study (Whitebook, Howes, & Phillips, 1989). (Day care staff have an annual turnover rate of about 41%.) A number of day care studies have noted the diminished quality of care that results from turnover (Anderson, Nagle, Roberts, & Smith, 1981; Phillips, 1987); high turnover within group care settings is likely to have similar effects.

In addition to these difficulties, group care administrators have some difficulty finding older, experienced staff. The typical child care worker is very young. Age confers experience, and while a youthful staff may be highly qualified in some areas, they will lack experience. Over half of child care workers in California's group homes and residential treatment agencies are between 21 and 30 years of age. In comparison, the average age of female foster parents is 46 (median and mode = 48 years), while the average age of female specialized foster parents is 43 years (median = 42, mode = 45).

Permanency

Permanency is comprised of two basic conditions: stable placements and life time placements. Group homes do not provide a permanent setting for young children under any circumstances. Nor does group home care facilitate reunification of a child or expedite the likelihood of a speedy adoption. In fact, California data do not support these arguments. Data provided in Figure 2 suggest that children ages 0-6 are less likely to be adopted when placed in group homes than if placed in foster homes. (Children placed in kinship homes have the lowest rates of adoption, however their placement with family members may mediate these effects.) Children placed in group homes are more likely to remain in care for long periods of time.

Data from the survey of group care and specialized foster care placements

support these findings (Barth, Courtney, Berrick, & Albert, in press). When asked to describe the long-term prospects for a randomly selected child in a group care setting, very few children were identified as likely to be adopted (3%). These findings were in contrast to results from the study of specialized foster parents, many of whom had adopted in the past (18%) or were eager to adopt their current foster child (38%).

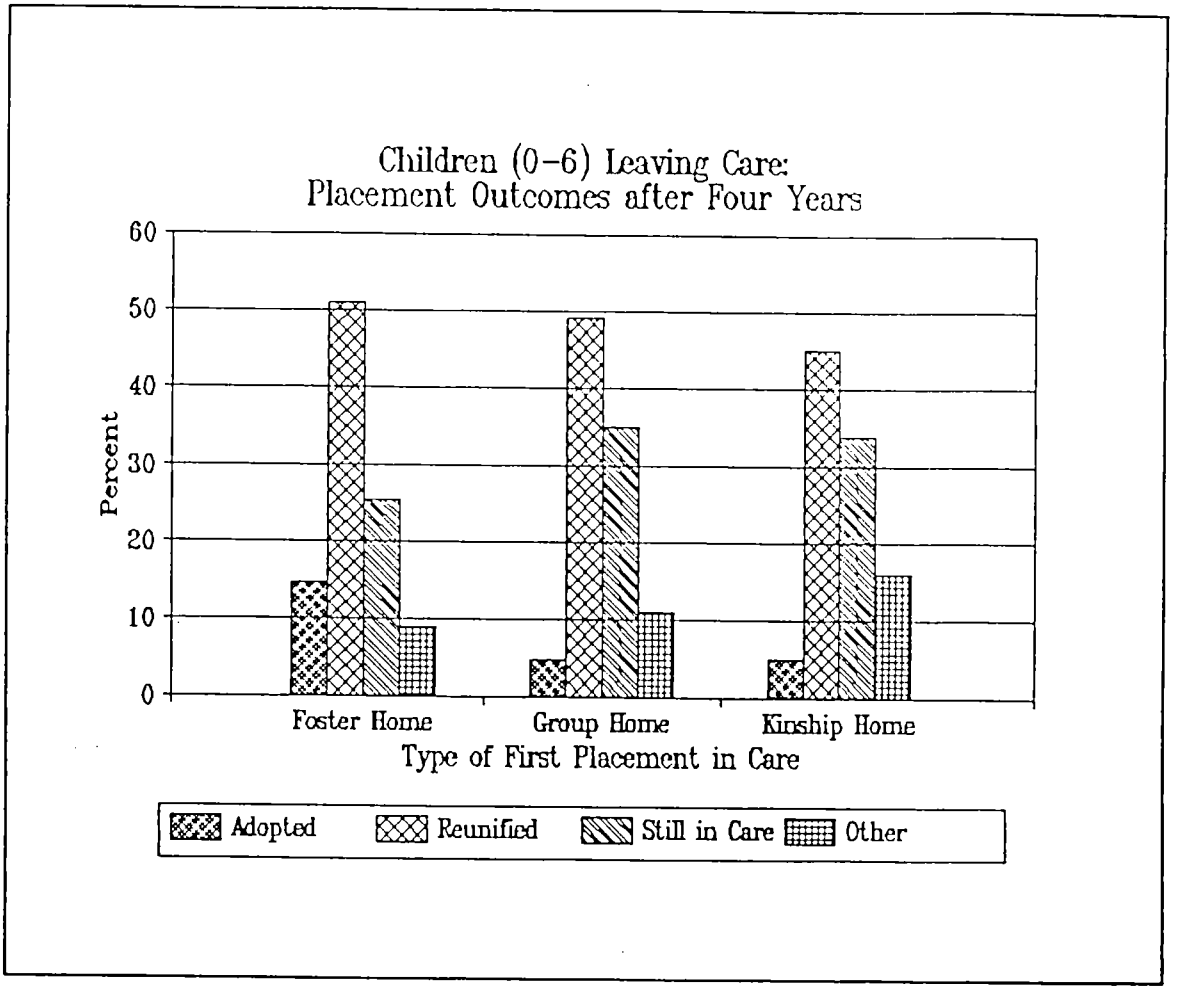
The number of children residing in group care is not only a function of the number of new placements to group care, but it is also related to their length of stay in care. Some children placed in group care settings will be quickly returned to birth parents or placed in foster family care. However, a significant number of young children continue to reside in group care for extended periods of time. The figure on the following page suggests that while young children placed in group care settings do not necessarily remain in care *longer* than children placed in other settings, the likelihood of their return to birth parents is not appreciably more rapid than the likelihood of return for children placed into foster care. The graphs depicts outcomes after four years. After one year in care, however, 57 percent of children placed in group care have not yet been reunified with their birth parents. The corresponding rate for children placed in foster care is 62 percent. After two years, almost half (47%) of all young children in group care have not been re-placed with kin or in foster care. Most significantly, these young children have not returned home. After four years, over one-third of young children placed in group care still remain in their first placement.

Is Group Care Necessary for Young Children?

Foster care, especially care in which foster parents are well trained, has been shown to be at least as effective as group care in reunification of children. An experimental study with older children (ages 9-18) who were hospitalized clearly shows this effect. In this study (Chamberlain & Reid, 1990) youth who were ready to be discharged from the hospital were randomly assigned to a specialized foster care program or, primarily, to residential treatment. At seven months, children provided with treatment foster care showed somewhat better behavior and spent significantly more days in the community as a group than the control children placed in group care. Although this study population differs from the population of concern in this paper, the ability of treatment foster care to maintain this highly disturbed group at a rate that is at least equivalent to group care suggests that the availability of group care for young children is not essential.

A study conducted by Nutter, Hudson, and Galway (1989) of specialized foster family care programs in North America sheds light on the possibilities that may exist through the use of this type of care over group care. Their study found that over two-thirds of agency administrators viewed their agencies as an alternative to group care for children. Seventy eight percent noted that about one-third of their clients would have

Figure 2[2]



been in residential care and eight percent would have been placed in a hospital setting if their agency had not taken the child. Forty percent of administrators suggested that their service was designed to prevent or shorten a more restrictive placement setting and 30 percent noted their goal as family reunification.

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[2] These data are derived from the UC Berkeley-Foster Care Database and are based upon a cohort of children entering foster care in 1988. Group care designations are derived from the "facility type" code. Matches between Community Care Licensing and the Foster Care Information System indicates modest agreement on placement type with some specialized foster care placements coded as group care. Children identified as "still in care" are those who had not been terminated from their first spell in placement as of December 31, 1992.

Group care has traditionally been reserved for difficult older children. It has the potential to focus all activities on helping change the behavior of behaviorally disordered youth so that they can be transferred to less controlled (and more family-like) settings. Group care providers and researchers describe the difficulty of their clientele in such terms, "children of action and impulse" (Ekstein, 1983; p. vii); and "their records are replete with litanies of behavior so dangerous that one marvels that they have so far survived physically intact. These are children who throw chairs at their teachers, dismantle principal's offices when sent there; and strike out with fists, rocks and teeth at other children, at parents, at grandparents" (Small et al., 1991, p. 328). These descriptions do not fit those of the very young child.

Young children placed in group care settings doubtlessly have a very high need for services, however the literature on group homes and residential treatment does not provide assurance that consistent placement criteria are used in determining whether children will be placed in foster care or group care. Placement criteria for children placed in group care settings have been categorized as "vague" (Apsler & Bassuk, 1983), and "varying widely across centers" (Marsden, McDermott, & Minor, 1977). Maluccio and Marlow (1972) suggest that placement criteria actually "defy categorization." Wells (1991) notes the importance of basing group care placement decisions upon general principles, emphasizing placement in the "least restrictive setting possible, in community-based programs, and in family-focused programs appropriate to age and development," yet she also focuses attention on the importance of "deinstitutionalization and normalization", goals which are not easily met in long-term group care environments.

Determining a minimum age at which group care might be appropriate for children is difficult. Admission criteria developed by the National Association of Psychiatric Treatment Centers for Children (NAPTCC, 1990) suggest a combination of psychobiological, psychosocial, developmental, and environmental problems. Children with severe behavioral problems fall into their criteria, however, they do not specify the age at which placement in residential care is either optimal nor acceptable. Research on the effectiveness of group and residential care cannot yet clarify whether group care is effective in providing a lasting reduction of problem behaviors; such research is far from conclusive on the ages of children who require group care (Whittaker, Overstreet, Grasso, Tripodi, & Boylan, 1988). The previously cited findings of Chamberlain argue that specialized foster care can achieve substantial benefit for children with major behavior problems even when they are adolescents.

The more general outcome literature on children's treatment indicates a strong relationship between the age of children and treatment success in non-residential settings. The ages of children is strongly associated with success of intensive family preservation services (Bath, Richey, & Haapala, 1992). In one study, children ages three to nine had only an 11% placement rate at one year whereas children between 10 and 17 had a 19%

placement rate. A meta-analysis of outpatient treatment of children and adolescents found a similarly powerful age effect (Weisz, Weiss, Alicke, & Klotz, 1987). For children between four and 12, 82% of the children who received treatment showed greater improvement than the control group; for older children the percentage improved was 72%. Taken together, these findings show that the effectiveness of services to young children is high. Children younger than ten placed in specialized foster care or in foster family care accompanied by additional services--such as parent training and behavioral treatment--should be able to achieve substantial benefits. Group care should be called on to change problem behavior only if it can be expected to offer considerably greater advantage than does placement in a supported foster care environment. The potentially powerful group care environment should be reserved for older children who may not so easily be treated in other programs.

Public Law 96-272 laid out the framework for foster care placement and encouraged placement in the most family-like environment. Group care for young children runs counter to the goals and principles of that law, but for the most exceptional circumstances. When one quarter of the total group care population consists of children under the age of six, their placement becomes normative, rather than unusual, and should be viewed with considerable skepticism. Rather than assuring permanence in a family-like setting, group care may be increasingly used as a long-term foster care placement for vulnerable children. Although research on the developmental consequences of placement in group care is not definitive, few data sources, if any, suggest positive outcomes for these children. Given that placement into group care costs more, does not speed the process toward reunification, and does not increase the likelihood of adoption for very young children, these children should not be placed in group care excepting extraordinary circumstances.

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