Children in Long-Term Foster Care in Washington:
Preliminary Findings

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Document Number: 01-02-3901

WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY

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The Institute's mission is to carry out practical research, at legislative direction, on issues of importance to Washington State. The Institute conducts research activities using its own policy analysts, academic specialists from universities, and consultants. New activities grow out of requests from the Washington legislature and executive branch agencies, often directed through legislation. Institute staff work closely with legislators, as well as legislative, executive, and state agency staff to define and conduct research on appropriate state public policy topics.

Current assignments include projects in welfare reform, criminal justice, education, youth violence, and social services.

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LEGISLATIVE DIRECTION

The 2000 Legislature directed the Washington State Institute for Public Policy (Institute) to compare placement decisions and funding methodologies for residential care services for children in long-term foster care and to examine the best practices in other states (EHB 2487). This report addresses the state's funding methodologies. A separate report covers innovative practices and a literature review.[1]

The reported data are preliminary as they are based on half the anticipated sample. In order to provide necessary protection to both children in foster care and their caregivers, researchers followed informed consent procedures that extended the study's time frame. A final report will be produced by the end of March 2001.

[1] Lee Doran and Lucy Berliner, *Placement Decisions for Children in Long-Term Foster Care: Innovative Practices and Literature Review* (Olympia, WA: Washington State Institute for Public Policy, January 2001), Document Number 01-02-3902.

I. FOSTER CARE: CONNECTING CHILDREN'S NEEDS WITH PLACEMENT TYPE

Most children in long-term foster care carry at least some emotional or behavioral consequences of their maltreatment and their parents' inability to resolve conditions that led to placement. Some of these children have significant developmental, emotional, and behavioral problems and have impaired functioning at home, at school, in the community, or in relationships with others. Depending on the degree of these problems, children require different services or placement types.

Despite the effects of their experiences, many children adjust fairly well in foster care, and placement is successful. Some children, however, go through multiple placements. The most common factor associated with placement disruption is the presence of serious emotional and behavioral problems that impair children's functioning. Placement failure can also cause problems in children who were previously functioning adequately.

The types of problems that most often interfere with a foster child's placement in a family home are *externalizing* behaviors such as defiance, disobedience, anger outbursts, poor impulse control, destructiveness, sexual behavior problems, aggression, and delinquency. *Internalizing* problems such as anxiety, depression, and low self-esteem are also common in foster children but less often significantly disrupt family life.

Effective treatments for children's emotional and behavioral problems are available; different interventions work for different problems. With internalizing problems, individual and family counseling work well. When children have significant externalizing behavioral problems, however, the demonstrated effective treatments require the active involvement of caregivers. For these treatments, caregivers are the primary agent for changing children's behavior, and adjustments to ordinary family life are often necessary. Rather than transporting the child to a counselor, the caregiver is the person carrying out a structured behavioral intervention that requires daily attention and focus.

Foster parents have varying capacities to handle this responsibility. Family foster care is more likely to fail when foster parents cannot commit to the necessary involvement, when appropriate home-based services are unavailable, or when the child's problems are extreme. In these cases, a therapeutic setting providing round-the-clock supervision and treatment-oriented care is often necessary. This level of care is best provided in treatment foster homes or in residential facilities.

How Is Out-of-Home Care Organized?

In Washington State, out-of-home care is structured into three reimbursement rates that correspond to the degree of treatment and supervision. (Some children are in kinship care with relatives who are not licensed foster parents. In these situations, the children are eligible for Temporary Assistance for Needy Families (TANF), but the families do not qualify for foster care reimbursement.)

Family Foster Care. Here, families receive a basic foster care rate. Children may or may not be receiving services from local mental health and social service agencies.

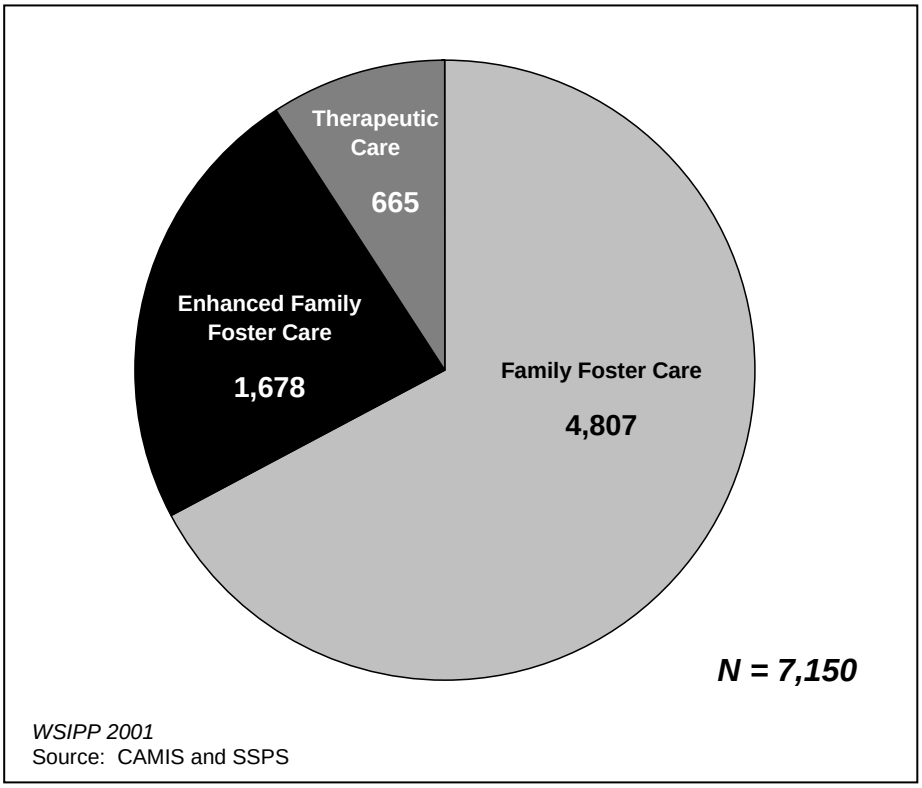
Enhanced Family Foster Care. In this category, the family receives higher payments; families are often receiving services beyond mental health treatment for the children. Case aides, home-based services, and respite care might be included. Extra payments are used in some cases to hire staff to supervise children or provide respite.

Therapeutic Care. Services are contracted with community agencies through Behavioral Rehabilitation Services (BRS) and paid at higher rates. Agencies may offer residential facilities, group homes, and/or treatment foster care. Treatment foster care is a family home where the parents receive special training and have supervision and support to provide a therapeutic milieu that is not institutional.

Study Sample

For this study, a "snapshot" of children in long-term foster care was examined using April 2000 data. The distribution of Washington State's long-term foster care population by these categories is shown in Exhibit 1.

Exhibit 1
Distribution of Children in Long-Term Foster Care by Type of Care



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Source: CAMIS and SSPS

The initial analysis of data revealed the following distributions of children by demographics, placement history, and costs.

Exhibit 2
Demographics of Children in Long-Term Foster Care in Washington State*

Level of Care	Total Population		Age	Gender
	N	Percent	Mean	Percent Female
Family Foster Care	4,807	67	7.1	51
Enhanced Family Foster Care	1,678	24	9.4	44
Therapeutic Care (BRS)	665	9	13.3	30
Total	7,150	100	8.2	48

*Preliminary results
Source: CAMIS and SSPS

Exhibit 3
Placement History of Children in Long-Term Foster Care*

Level of Care	Prior Placements	
	Mean	Median
Family Foster Care	2.9	2.0
Enhanced Family Foster Care	4.0	3.0
Therapeutic Care (BRS)	6.6	6.0
Total	3.5	3.0

*Preliminary results
Source: CAMIS and SSPS
N = 7,150

Exhibit 4
Cost of Foster Care by Type of Care*

Level of Care	Cost per Month	
	Mean	Median
Family Foster Care	$390**	$344**
Enhanced Family Foster Care	$889	$639
Therapeutic Care (BRS)	$3,758	$3,417
Total	$1,042	$490

*Preliminary results
** N = 7,150 except for Family Foster Care where N = 2,278; remaining cases had no payment information either because the child was in kinship/relative care without state payment or because of variations in timing of the payment.
Source: CAMIS and SSPS

II. DECISION-MAKING FOR PLACEMENT

This section summarizes findings from the data analysis, focus groups held with caseworkers and foster care providers, as well as research literature.

Factors Influencing Caseworkers

- Federal and state legal mandates—the most influential factor is that children must be placed in the least restrictive setting.
- Availability of a placement that will accept the child.
- Cost—therapeutic care is more expensive and less available.

Source: Focus Groups. Consistent with clinical and scientific literature.

Influence on Decision-Making

- Placements are often made without planning or matching children and foster parents.
- Foster parents are not always fully informed about the children's history or problem behaviors.
- Children's psychosocial needs are not routinely taken into account.
- Children must repeatedly fail before their level of care increases.
- Some children's behavior deteriorates as a consequence of disrupted placements.

Source: Focus Groups. Consistent with clinical and scientific literature.

What Do We Know About Children in Long-Term Care?

For this study, a sample of children in long-term care was identified, and caregivers (foster parents, residential staff) were interviewed by telephone. The children's functioning was assessed using a standardized measure—the Child and Adolescent Functional Adolescent Scale (CAFAS). This instrument measures the level of functional impairment at home, at school, in the community, and in relationships with others.

The determination relies on *specific behaviors* as reported by the caregiver. The instrument allows researchers to classify children in four levels; these levels have been found to correlate with the necessary intensity of services and type of placement setting.

Functional Impairment and Services

- None/Minimal: No treatment or outpatient treatment only.
- Mild: May need additional services beyond outpatient.
- Moderate: Likely needs care which is more intensive than outpatient and/or includes multiple sources of supportive care.
- Severe: Likely needs intensive treatment, possibly in residential setting.

Exhibit 5
Examples of Children's Impairment Measured by CAFAS

LABEL	BEHAVIOR
MILD	• Occasionally disobeys school rules • Frequently fails to comply with reasonable rules and expectations • Frequently engages in behaviors that are frustrating or annoying • Single incidents of vandalism/shoplifting • Poor judgment/impulsive behavior difficulties in peer interactions • Often anxious, fearful, or sad, very self critical, low self-esteem, feelings of worthlessness
MODERATE	• Suspended from school due to behavior • Persistently disruptive and needing specialized program at school • Failing at least half of classes • Persistent failure to comply with reasonable household rules • Repeatedly plays with fire such that damage could result • Inappropriate sexual behavior • Frequent displays of anger toward others • Frequently mean to animals • Involved with gangs • Behavior typically inappropriate
SEVERE	• Expelled from school • Failing almost all classes • Harmed or made serious threat to hurt another • Behavior and activities must be constantly monitored to ensure safety of others • Deliberate and severe damage to property outside the home • Attempted or completed sexual assault • Behavior consistently bizarre or extremely odd • Depression associated with academic incapacitation or suicidality

Exhibit 6

Relationship Between Children's Functional Impairment and Placement*

Level of Care (children 4 years and older)	None/Minimal Impairment		Mild Impairment		Moderate Impairment		Severe Impairment		Total	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
Family Foster Care	7	24	11	38	8	28	3	10	29	21
Enhanced Family Foster Care	8	12	19	28	18	27	22	33	67	48
Therapeutic Care (BRS)	1	4	9	38	6	25	8	33	24	17
Group Home or Residential (BRS)	1	5	3	16	4	21	11	60	19	14
Total	17	12	42	30	36	26	44	32	139	100

*These data are preliminary, based on half the anticipated sample.

For children younger than 4 years old, an alternative instrument was used. Of this group, 52 percent had a high probability of developmental problems.

Source: Interviews with caregivers using standardized assessment measure.

III. SUMMARY

At present in Washington State, like most other states, placement decision-making is not based on matching children to services and settings that are specifically designed to meet their needs and ensure stability. Decision-making about services and level of placement is instead driven by legal mandates, scarcity of placements, available community services, and cost. Systematic assessment of children is not routine, and their psychosocial needs are not specifically weighed in decision-making.

Most foster care children in Washington State are in family foster homes that receive basic payments. Less than 10 percent are in therapeutic care (treatment foster care or residential settings). Preliminary results reveal that the children's level of impairment in long-term placement generally reflects the level of care. However, a majority of children, even those in family foster care, have levels of impairment that are likely to require extensive services or a therapeutic environment. A third of parents providing enhanced family foster care rate children in their care as being severely impaired. It is likely that some children in family foster care have levels of impairment that cannot be addressed with ordinary outpatient services and require significantly more services, treatment foster care, or residential care.

At present, failure in one setting is the most common trigger for a child to be moved to a higher level of care. Placement failure, however, is costly. Children's functioning further deteriorates and more intensive services become necessary, caseworkers expend time dealing with placement crises and locating new placements, foster parents have negative experiences and may decide not to continue providing care, and staff time is spent recruiting more foster parents.

The state could investigate creating a system of care that uses systematic assessment of problems and impairment as one factor in placement decision-making. This assessment process can help inform state decisions about the types of placement that are needed, and help ensure a sufficient supply of treatment foster homes and residential facilities for the minority of children in care who need them.

Policy Recommendations

- Children's Administration conducts or arranges for *systematic assessments* of children at key intervals.
    - Within 90 days
    - When higher rate payments are requested
    - When placement stability is threatened
    - Following two or more placement failures

- Assessments use *standardized measures* and specifically address:

  - Younger children: developmental status; older children: level of emotional/behavioral problems, psychiatric diagnosis, functional impairment.
  - Specific types of interventions that are proven effective for identified problems and specify the appropriate interventions for identified problems.
  - The level of care that is required (e.g., family foster care, enhanced family foster care, treatment foster care, residential care).

- Placements should be designated as *temporary* when there are concerns about placement failure or when children have already failed: this procedure would help ensure assessments can be carried out and planning for matching children to appropriate placements can occur.

- Consideration is given to establishing *homes and centers for assessment purposes*.

- *Foster parents* are *fully informed* about children's history and emotional/behavioral problems before placement, especially in homes designed to be longer term.

- Prior to all but temporary placements, *foster parents* are *specifically informed* regarding expectations for their participation in treatment to alleviate children's behavior problems.

- When children (older than pre-school age) have behavioral disturbances that require constant supervision by foster parents or necessitate hiring additional staff in the home, *immediate consideration* is given to transferring children to treatment foster care or residential care. In these situations, supervision alone will not improve children's functioning.

- *Treatment foster care* is a *viable alternative* to residential care for many behaviorally disturbed children if the family environment can provide high levels of supervision and a therapeutic setting in which behavioral intervention plans are implemented.

- *Agencies contracting for Behavioral Rehabilitation Services* should use *standardized assessments* to determine when children can safely be transferred to less intensive settings without compromising the gains in improved functioning.

Preliminary Legislative Recommendations

- Provide support to augment the Children's Administration *pilot assessment projects*.

  The existing pilot sites have established mechanisms for completing standardized assessments of children. Caseworkers do not yet have the training or experience to use the results of these assessments to leverage appropriate services from the community and to make placement decisions.

The next step is to use consultants familiar with interpretation of standardized measures and the types of proven interventions that work for particular problems. These consultants can train supervisors and caseworkers to make effective use of assessment results. Once supervisors and caseworkers acquire this knowledge, they can implement it statewide.

- Increase the *availability of Intensive Family Preservation Services* that use proven methods to improve child and family functioning for children in foster care.

  Placements that appear in jeopardy can sometimes be salvaged by acting before there is an acute crisis and adding intensive home-based services. For the services to be effective, they must be based on systematic interventions that teach caregivers to apply specific behavior management strategies.

- Increase the *availability of treatment foster care*.

  Some children currently in family foster care would be better served in treatment foster care. Children with very significant functional impairments who need constant supervision are at high risk to fail in family foster care. Their problems are much more likely to improve in a therapeutic environment.

- Evaluate whether an empirically proven approach to treatment foster care is more effective than current approaches in Washington State.

  An approach called Multi-dimensional Treatment Foster Care has been proven effective in a rigorous evaluation of an Oregon program for teenagers with serious problems. The program includes foster parents in the treatment team and teaches them to implement a structured individualized program in the home for each child, with program staff providing daily consultation and support to foster parents, skill-focused therapy to the children, and case management services to monitor progress and coordinate care. Under this proposal, an agency providing treatment foster care would apply to participate in the study, and the staff and foster parents would receive training in the approach. Outcomes for the children would be compared to outcomes of children housed in usual treatment foster care, thus testing whether the approach demonstrates advantages.