

**IMPROVING PROGRAMS DESIGNED
TO PROTECT AT-RISK YOUTH**

HEARING
BEFORE THE
SUBCOMMITTEE ON HUMAN RESOURCES
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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THURSDAY, JUNE 16, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:02 a.m. in Room B-318, Rayburn House Office Building, the Honorable Geoff Davis [Chairman of the Subcommittee] presiding.
[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Davis Announces Hearing on Improving Programs Designed to Protect At-Risk Youth

Thursday, June 16, 2011

Congressman Geoff Davis (R-KY), Chairman of the Subcommittee on Human Resources, Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on improving programs designed to protect youth at risk of abuse and neglect. **The hearing will take place on Thursday, June 16, 2011, in Room B-318 of the Rayburn House Office Building, beginning at 9:00 A.M.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include a representative from the Administration for Children and Families, the Federal agency with oversight over child welfare services programs, along with other experts on these issues. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The authorizations for two of the child welfare programs under the Subcommittee's jurisdiction (the Stephanie Tubbs Jones Child Welfare Services program and the Promoting Safe and Stable Families program) expire at the end of fiscal year 2011. The last reauthorization of these programs, the Child and Family Services Improvement Act of 2006 (P.L. 109-288), made significant changes such as requiring that foster children be visited at least once per month, ensuring that states consult with medical providers in assessing the health and wellbeing of children in care, and helping States better address caretaker substance abuse issues. This law also extended the authorization of the Mentoring Children of Prisoners program as well as the Court Improvement Program.

The 2006 legislation also provided funds to support monthly caseworker visits and to improve outcomes for children affected by a parent's or caretaker's substance abuse. In addition to these changes, the law also increased accountability by requiring States to report expenditure data for the first time and by limiting the amount of child welfare services program funds States could spend on administration.

In announcing the hearing, Chairman Davis stated, "This hearing provides an important opportunity to review how key aspects of our nation's child welfare system are working. These two programs are designed to play a significant role in protecting children from abuse and neglect. We need to review recent changes to see if they are working to improve the lives of kids in foster care and those at risk of entering care. We also need to evaluate these programs to determine whether other changes are needed to ensure children are protected from abuse and neglect."

FOCUS OF THE HEARING:

The purpose of this hearing is to review recent changes to the Stephanie Tubbs Jones Child Welfare Services program and the Promoting Safe and Stable Families program, as well as consider whether additional changes should be made in legislation to reauthorize these programs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage,

<http://waysandmeans.house.gov>, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. Attach your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, June 30, 2011**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721 or (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and **MUST NOT** exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov/>.

Chairman DAVIS. Good morning. Before we begin the opening statement, I would like to note that our line-up on the Republican side has changed a bit, due to Mr. Heller's move over to the United States Senate, and his departure from the People's House. Today I would like to welcome Tom Reed from New York, both to the subcommittee and to the committee, for his first hearing. Thanks for joining us; we look forward to your perspective. He replaces Mr. Smith of Nebraska, who now becomes a distinguished alumnus of our subcommittee.

In today's hearing we are going to review several programs under our jurisdiction that are designed to help ensure the safety and well-being of children at risk of abuse and neglect. The majority of Federal child welfare spending is used to reimburse states for supporting and overseeing children while they are in foster care.

However, the two programs we will focus on today, the Child Welfare Services program and the Promoting Safe and Stable Families program, are designed to prevent the need for foster care in

the first place, as well as to help foster children return home safely or be placed with adoptive parents as soon as possible.

These two programs were last authorized in 2006, and both expire at the end of the fiscal year. The 2006 reauthorization made significant changes, such as requiring that foster children be visited at least once per month, ensuring that states consult with medical providers in assessing the health of foster youth, and helping states better address caretaker substance abuse issues.

The purpose of our hearing today is to review the effects of those changes, and to consider other changes that may be needed to promote the well-being of children at risk of abuse and neglect. While we will primarily focus on these two programs, we should also draw attention to the patchwork way in which child welfare programs currently operate.

In our prior hearing on the program duplication, I noted that this subcommittee has jurisdiction over nine different child welfare programs, each with different purposes, spending requirements, and funding mechanisms. We need to ensure that these programs help and do not hinder states' efforts to serve families in need. We also must make sure we understand how this taxpayer money is used, and whether it is achieving its intended purpose.

Amazingly, until 2006, there was no requirement that states report how they actually spend child welfare service program funds. In other words, for that program's first 70 years, the public had no way of knowing how this money was spent, and this is not a way to run a government.

I look forward to hearing from our witnesses this morning on what we have learned from the recent changes to these programs, as well as what we can do to ensure more children remain safely in their own homes. Joining us today will be a mix of experts from Congress, the Administration, states, and outside groups. We look forward to all of their testimony.

And I particularly want to single out one group that is not represented here today, possibly in the room, but one that my wife and I have long affiliation with, and that is CASA. I have done a lot of work through the years—really, over the last 25 years—with families on the edge, and particularly our years of affiliation with CASA have been a great blessing. And I appreciate not only CASA's contribution, but all of the advocates, and especially the front-line volunteers and folks that are working directly with children, with the families, trying to bring stability and order.

Without objection, each Member will have the opportunity to submit a written statement and have it included in the record at this point. And now I would like to recognize our distinguished Ranking Member from Texas, my friend, Mr. Doggett.

Mr. DOGGETT. Well, thank you, Mr. Chairman. We share a similar interest in CASA. I have worked with several of the groups in the central Texas area, and they do outstanding work with able volunteers, as well as some of the other groups that are represented here this morning. And I am hopeful that we share not only that interest, but an interest in seeing that we put every taxpayer dollar to the most effective and efficient use possible to provide some of our most vulnerable children the services that they need.

As you have noted, the funding for the Child Welfare Services program and the Promoting Safe and Stable Families program will expire—the authorization for it—at the end of September, unless we take action to renew them. These programs have been renewed, and have enjoyed bipartisan support in the past. And I hope that we can work together to extend and improve these services.

The Child Welfare Services and the Promoting Safe and Stable Families initiatives provide about \$700 million to the states this year for early intervention and family services designed to help our most at-risk families. These funds are a critical part of the efforts to ensure that children are raised safely in their homes. And when that is not possible, to find a permanent home with a relative or an adoptive family.

In my home state of Texas, the Promoting Safe and Stable Families program has provided funds to help children in my home town in Travis County that are affected by substance abuse in the home. This program has enabled our county to develop a flexible, comprehensive continuum of services that is aimed at promoting recovery, and ensuring that children have a safe home free of drug addiction and abuse.

We know that an investment in front-end services not only saves lives, but also can reduce the long-term cost of removing a child from a family home and placing them in foster care. We have seen in Texas how mindless budget cutting can hurt these same children. In Texas there was a proposal in the State Legislature that would have the effect of cutting services to prevent child abuse and neglect by almost half in the current legislature. And legislatures across the country, whether through the pressures of budgets or indifference, are faced with similar kind of cuts. That is why what we do here is especially important this year.

I am troubled that the original Republican budget resolution considered earlier this year in the House would have cut the Social Services Block Grant program by \$1.7 billion to the states, eliminating grants that would jeopardize protective services for almost 2 million at-risk children.

Mr. Chairman, our committee does have a history of working together on these issues, and I look forward to cooperating and working with you and other Members of the Committee. I am pleased we have a couple of colleagues here to offer us insight, along with the experts from the field on this today. And I am sure it will be a productive hearing. Thank you.

Chairman DAVIS. Thank you very much, Mr. Doggett. Before we move on to our testimony, I would like to remind our witnesses on both panels that oral statements are going to be limited to five minutes. However, without objection, all of the written testimony will be made part of the permanent record.

On our first panel we will be hearing from two of our distinguished colleagues. First, the Honorable Denny Rehberg, my friend from Montana since I have been in the Congress, and the Honorable Karen Bass, who is joining us from California, a long-time advocate on these issues.

Mr. Rehberg, please proceed with your testimony.

**STATEMENT OF THE HONORABLE DENNIS R. "DENNY"
REHBERG, A REPRESENTATIVE IN CONGRESS FROM THE
STATE OF MONTANA**

Mr. REHBERG. Thank you, Mr. Chairman. And I appear today not only on my own behalf, and as the representative of the State of Montana, as the chairman of the appropriations subcommittee, called labor, health and human services, and education.

I have got a long history of interest in these issues, and have been in many of your states, both as a Shriner and as a national vice president of the Montana and national Muscular Dystrophy Association, as well as having co-founded and co-chaired the Baby Caucus with Rosa DeLauro, for the specific purposes of looking for areas of interest to keep families together, and the struggles that are placed in their way for doing that.

I also want to thank you for the opportunity to talk about an issue that is of great importance to me in my home state of Montana, that of addressing the methamphetamine crisis, and the importance of family-based drug prevention treatment.

Much of my activity in Montana meth is as a result of an individual by the name of Tom Sibel. He had owned Sibel Systems, eventually sold to Oracle, and he personally has put, at the last count that I was aware of, in the public-private partnership \$60 million of his own money to create meth projects in states like Arizona, Colorado, Georgia, Hawaii, Idaho, Illinois, Montana, and Wyoming. And those of you who represent those states would recognize the Georgia meth, Montana meth, Arizona meth project.

All rural areas of our nation have struggled with the devastation caused by rampant meth use, and Montana has been no exception. I have long supported the efforts of organizations that are in the forefront of drug prevention and treatment efforts in our states. In Montana, we do have the Montana meth project, an organization that does outstanding work conducting research and running statewide multi-media public awareness campaigns aimed at significantly reducing first-time meth use.

The meth project's campaign of preventing kids from using meth, not even once, has led to a dramatic shift in the perception of meth use, and led to a 33 percent decrease in teen use of meth between 2007 and 2009. The meth project's campaigns have also led to more frequent parent-child communications about the dangers of meth, an important component of educating kids on the dangers of this addictive drug from a young age.

While I think we have come a long way in improving efforts to combat drug use in the first place, I think we can still improve in the way we provide treatment for those who are struggling with substance abuse issues. I strongly advocated for family-based meth treatment, an approach which dramatically increases the effectiveness of long-term recovery, employment, and educational enrollment. This kind of treatment yields consistently positive outcomes in child well-being, family stability, and lower recidivism rates. Family-based treatment centers provide essential needs for the entire family, including children, rather than just the parent.

I appreciate the fact that 2006 reauthorization of the child welfare programs under this committee's jurisdiction provided dedicated funds for states to work with parents and caregivers with

meth and other substance abuse issues. And I am especially thankful that two of those grants went to Montana organizations.

The bottom line? Families provide the best support systems, so making family the center of addiction treatment whenever possible just makes common sense.

The purpose of today's hearing is to evaluate how key pieces of our nation's child welfare system are working. I hope that, as you develop and delve into the specific programs under your jurisdiction, like the Promoting Safe and Stable Families program, that are designed to address child safety and stability of families face substance abuse uses, you will focus on opportunities for family-based prevention and treatment whenever possible. My hope is that one day I will be able to report that meth addiction is no longer an issue in rural America.

Until then, I thank the committee for the opportunity to share my perspective, and for—and its time on this incredibly important issue for families and communities elsewhere. Thank you, Mr. Chairman.

Chairman DAVIS. Thank you, Mr. Rehberg, for your testimony on this critical issue, also a big issue in the Commonwealth of Kentucky right now.

Ms. BASS. You could give your testimony.

[The prepared statement of Mr. Rehberg follows:]

**Statement of Rep. Denny Rehberg to the Ways and Means Subcommittee
on Human Resources
Hearing on “Improving Programs Designed to Protect At-Risk Youth”
June 16, 2011**

Chairman Davis and Ranking Member Doggett, thank you for the opportunity to speak today on an issue that is of great importance to me and my home state of Montana – that of addressing the methamphetamine crisis and the importance of family-based drug prevention and treatment.

All rural areas of our nation have struggled with the devastation caused by rampant meth abuse, and Montana has been no exception. I have long supported the efforts of organizations that are at the forefront of drug prevention and treatment efforts in our states. In Montana, I have worked closely with the Montana Meth Project, an organization that does outstanding work conducting research and running statewide multi-media public awareness campaign aimed at significantly reducing first-time meth use. The Meth Project’s campaign of preventing kids from using meth “not even once” has led to a dramatic shift in the perception of meth use, and led to a 33% decrease in teen use of meth between 2007 and 2009. The Meth Project’s campaigns have also led to more frequent parent-child communications about the dangers of meth – an important component of educating kids on the dangers of this addictive drug from a young age.

While I think we have come a long way in improving efforts to combat drug use in the first place, I think we can still improve in the way we provide treatment for those who are struggling with substance abuse issues. I have strongly advocated for family-based meth treatment – an approach which dramatically increases the effectiveness of long-term recovery, employment, and educational enrollment. This kind of treatment yields consistently positive outcomes in child well-being, family stability, and lower recidivism rates. Family-based treatment centers provide essential needs for the entire family, including children, rather than just the parent.

I appreciate the fact that the 2006 reauthorization of the child welfare programs under the committee’s jurisdiction provided dedicated funds for states to work with parents and caregivers with meth and other substance abuse issues, and I’m proud that two of these grants went to Montana organizations. The bottom line is that families provide the best support systems, so making the family the center of addiction treatment whenever possible is just plain common sense.

The purpose of today’s hearing is to evaluate how key pieces of our nation’s child welfare system are working. I hope that as you delve into specific programs under your jurisdiction, like the “the Promoting Safe and Stable Families program” that are designed to address child safety and the stability of families facing substance abuse issues, you will focus on opportunities for family-based prevention and treatment whenever possible. My hope is that one day I will be able to report that meth addiction is no longer an issue for rural America. Until then, I thank the committee for the opportunity to share my perspective, and for its time on this incredibly important issue for families and communities everywhere.

STATEMENT OF THE HONORABLE KAREN R. BASS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. BASS. Yes. Good morning, Chairman Davis and Ranking Member Doggett. Thank you for the opportunity to testify here before the committee today. I appreciated hearing your testimony about the meth problem.

Actually, I became involved in the child welfare issue about 20 years ago. I started an organization in Los Angeles that was addressing the crack cocaine crisis which, if we look at both of those

drug epidemics, it was certainly when we had a spike in child welfare cases. And, frankly, it is one of the key policy areas that I hope to work on while I am in Congress.

In California, we have made enormous strides with reforming our child welfare system. In 1999, there were 140,000 children and youth that were removed from homes in California and placed in foster care. Today they are 57,000. In Los Angeles County there were 55,000 children removed from their homes, and today there are 15,000.

But the fact remains that there is certainly still enormous work to do to improve our system to help at-risk children and families prevent entry into foster care. By providing help to families to prevent the spiral into abuse and neglect, we would avoid the substantial cost of foster care, avoiding the trauma of removal, and help families stay together.

To the contrary, the current child welfare system, the primary focus is on families that have already been identified with child abuse or neglect issues. This ends up with families being separated, children in foster care, costly efforts at reunification, and a system that has more failures than successes. The fact that title IV-E funding cannot be used for prevention or post-reunification services has created a significant challenge to achieve better safety outcomes and finding permanent homes for children.

However, in jurisdictions like Los Angeles County, some of these challenges have been mitigated because of the availability of Title IV-E flexibility. Funding waivers allows the county to implement prevention strategies outside of funding constraints and dollars chiefly tied to out-of-home removal.

Given the limited number of IV-E waivers, the Promoting Safe and Stable Families, PSSF, funding is essentially the only resource currently available that can finance support services to families. These funds can be used to provide a continuum of services that support families that have entered the child welfare system and are working towards reunification, as well as expanding efforts to prevent families from entering the system, or diverting them when they have been identified. But we know that PSSF funding is not sufficient to provide the amount of services necessary to truly affect change in existing structure.

I wanted to mention a couple of promising practices that the committee, I am sure, is aware of, but I think should be highlighted at this point in time. We know that there is many examples of programs that have been successful, and certainly my colleague mentioned a couple.

One promising practice is the differential response framework, which offers a broad set of strategies for working with families at the first signs of trouble, based on their level of need or risk that is identified. Differential response is an evidence-based approach to prevent child abuse and neglect by ensuring child safety through expanding the ability of child welfare agencies to respond to reports of child maltreatment.

Because of the effectiveness of the model, in California there is an effort to expand this response to families that are at risk of being involved in the system because of issues such as substance abuse, mental health, and domestic violence.

Another one is up-front assessments. In 2004 Los Angeles County Department of Children and Family Services implemented a pilot program to address the high number of children in foster care. Point of engagement is a process that attempts to engage the family as soon as possible after the referral to the department in order to assess the family and provide services that allow the family to avoid child detainment all together.

I want to give an example. There is a program in Los Angeles County called Shields for Families, and this is a program that was started at the height of the crack cocaine epidemic. I sat through one of the point of engagement responses that was done where the family members sat around and identified what the weaknesses, what the strengths were, and how to intervene in this situation. And I think it is an example of where they have been able to reduce the number of children that are in the system, all together.

In conclusion, I would ask my colleagues to consider, of course, that prevention—an ounce of prevention, we all know, is certainly worth a pound of cure. As we work to reauthorize the Promoting Safe and Stable Families Act, these tried and proven community strategies are not only effective, but cost effective. And I encourage you to use prevention and early intervention models such as the ones adopted in LA County and Shields to inform your decision-making.

Thank you for the opportunity to give testimony today.

Chairman DAVIS. Thank you very much. I would like to thank both Mr. Rehberg and Ms. Bass for investing time to come in and share their insights. Does anyone have any questions from our colleagues?

Mr. MCDERMOTT. Mr. Chairman, I want to commend you on getting the appropriator here, so that he can get an early buy-in on our authorization.

[Laughter.]

Chairman DAVIS. I appreciate the gentleman's perspective. It begs the fellowship—

Mr. REHBERG. It—

Chairman DAVIS [continuing]. Of the Appropriations and Ways and Means Committee, since the ratifying of the Constitution.

Mr. REHBERG. Mr. Chairman, in response, I knew I was probably being set up by being here, so—

[Laughter.]

Mr. REHBERG [continuing]. Duly noted.

Chairman DAVIS. Great. Thank you both very much. And that concludes our first panel.

[Pause.]

Chairman DAVIS. For our second panel, we will be hearing from the Honorable Bryan Samuels, commissioner of the administration on Children, Youth, and Families, Administration for Children and Families, from the United States Department of Health and Human Services.

Mr. Samuels, please proceed with your testimony.

[The prepared statement of Ms. Bass follows:]

U.S. House of Representatives
Ways and Means Committee
Subcommittee on Human Resources

Hearing on "Improving Programs Designed to Protect At-Risk Youth"
June 15, 2011

Testimony by:
The Honorable Karen R. Bass of California

Good morning Chairman Davis, Ranking Member Doggett, and distinguished Members of the Committee. Thank you for the opportunity to testify here today regarding the critical issue of improving programs designed to protect at risk youth and prevent placement in foster care.

I represent the 33rd district of California covering South and West LA. I ran for public office after my experiences in the community founding and running a nonprofit and witnessing the struggles of families with the emergence of the crack cocaine epidemic. I became aware that many relatives were providing care for grandchildren removed from parents unable to care for them, and I came first to the California Legislature and now Congress determined to address problems with our system and to fix them.

And in California we've made enormous strides with reforming our system. In 1999 there were 140,000 children and youth removed from their homes and placed into foster care. Today, there are 57,000. In Los Angeles County there were 55,000 children removed from their homes – today there are about 15,000.

I am proud to say that as Speaker of the California State Assembly, we took a big step to help the older youth last year by opting in to the federal Fostering Connections to Success Act by passing my Assembly Bill 12. As you know, the Fostering Connections Act was unanimously passed by Congress in 2008 and signed into law by President George W. Bush. We are very excited about implementing our state legislation and putting our youth on a path to education, self-sufficiency, and contributing members of our communities.

But the fact remains there is still enormous work to do to improve our system to help at risk children and families prevent entry into foster care. By providing help to families to prevent the spiral into abuse and neglect we would avoid the substantial costs of foster care, avoid the trauma of removal, and help families stay together.

To the contrary, in the current child welfare system the primary focus is on families that have already been identified with child abuse and/or neglect issues. This ends up with families being separated, children in foster care, costly efforts at reunification, and a system that has had more failures than successes. The fact

that Title IV-E funding cannot be used for prevention or post-reunification services has created a significant challenge to achieving better safety outcomes and finding permanent homes for children. However, in jurisdictions like Los Angeles County, many of these challenges have been mitigated because of the availability of Title IV-E flexible funding waivers allow the county to implement prevention strategies outside of funding constraints and dollars chiefly tied to out-of-home removal. And because of the efforts of this committee, the House recently passed legislation introduced by Rep. McDermott and Mr. Davis to expand HHS' authority to grant waivers to 10 more states.

Given the limited number of IV-E waivers, the Promoting Safe and Stable Families (PSSF) funding is essentially the only resource currently available that can finance support services to families. PSSF funds can be used to provide a continuum of services that support families that have entered the child welfare system and are working towards reunification (family preservation programming), as well as expanding efforts to prevent families from entering the system or diverting them when they are identified. However, PSSF funding is not sufficient to provide the amount of services necessary to truly effect change in the existing structure.

Until the financing of child welfare is "reformed" to enable States to have flexibility in their response to families, it is essential that PSSF funding be increased to allow for the expansion of services that can help families to remain intact and reduce the use of foster care as an answer to family problems that can be resolved if intervention is provided. States also need to be offered guidance and incentives for expanding services that focus on prevention and early intervention for families at risk of child abuse and neglect.

Throughout the country, there are many examples of programs that have been successful in keeping families out of the system or maintaining the family unit while addressing the concerns of child abuse and neglect. One promising practice is the Differential Response Framework which offers a broad set of strategies for working with families at the first signs of trouble based on their level of need or risk that is identified. Differential Response is an evidence-based approach to preventing child abuse and neglect by ensuring child safety through expanding the ability of child welfare agencies to respond to reports of child maltreatment. Because of the effectiveness of the model, in California, there is an effort to expand this response to address families that are "at risk" of being involved in the

system because of issues such as substance abuse, mental health and domestic violence.

California's decision to incorporate prevention and early intervention is based on the success achieved through programs funded by PSSF and Waiver funding. In Los Angeles County alone, these services: (1) reduced the number of children in foster care from 50,000 in 1999 to less than 14,000 in 2011; (2) reduced the length of stay in foster care from 2 years to 1; (3) saved the system over \$15 million in funding because of the reduction in foster care costs.

At SHIELDS for Families in South Los Angeles, PSSF (and Waiver) funding has been utilized to pioneer programming that has effectively kept families out of the system or been able to rapidly address family issues while keeping children at home. Under the direction of Kathy Isenhower, SHIELDS has been providing services to the entire family unit, with specific programs for children ages 0-18, since opening its first substance abuse program, Genesis, in 1990. Since 2002, over 1200 children have been served in conjunction with their mothers. Their models have been used throughout Los Angeles County and the Country to inform prevention and early intervention efforts for high risk families and could serve as a model for PSSF funding guidance. These include the following:

Up Front Assessments: In 2004, the Los Angeles County Department of Children and Family Services (DCFS) implemented a pilot program to address the high number of children in foster care. Point of Engagement (POE). POE is a process that attempts to engage the family *as soon as possible* after referral to the Department in order to assess the family and provide services that might allow the family to *avoid child detention altogether*. The project also represented a paradigm shift from a focus solely on child safety to looking at the family and their caretaking ability.

SHIELDS provided the Up Front Assessment component of POE for the two offices that piloted the program: Wateridge and Compton. Working with both offices, SHIELDS developed a standard program for implementing the Up Front Assessments, focused on families that experienced issues with substance abuse, mental health and/or domestic violence. SHIELDS worked in collaboration with DCFS to send a Clinical Assessor to conduct a home visit with the family immediately following their first contact with child welfare in order to assess the

capacity of the parents to care for the child(ren), to determine the family members' needs for services, and to link the family with the needed services.

Up Front Assessments have proven to be successful at providing families with the services they need in order to keep children at home with their parents. To date, SHIELDS has conducted over 6000 assessments for families, keeping approximately 9,201 children in their homes. All of these cases were high risk or

Comparing the costs of Up Front Assessment with those of child detainment:

Cost per assessment= \$350

Cost for 1 year of Foster Care= \$20,000

Estimated savings= \$104,020,000

very high risk and would have resulted in detention prior to the implementation of the pilot program. Of the families assessed, only 5 percent have resulted in detentions and subsequent dependency court cases—and in these cases, the amount of time that children are out of the home has been reduced to less than a year (previously close to two years). Instead, the majority of the families assessed became volunteer cases, avoiding the court and reducing the time the case is under DCFS jurisdiction (approximately six months).

The Point of Engagement Pilot has demonstrated that assessing families at the front end of their involvement with DCFS—and immediately linking them to the services they need—can significantly reduce the numbers of DCFS detentions and reduce the amount of time that families are under DCFS jurisdiction altogether. This means that more children remain in their homes, and that those few who are removed, are able to return home sooner. Through POE, all of this has been provided with no cost to the individual families. Due to the success of the original pilot, Up Front Assessments were implemented County-Wide in 2009.

ASK Prevention Initiative Demonstration Program: SHIELDS for Families ASK (Ask, Seek, Knock) program provides a continuum of accessible and seamless services utilizing a “one-stop” model located at four Family Resources Centers throughout South Los Angeles through funding provide the Los Angeles County Department of Children and Family Services. Through the co-location of eight core partnering agencies, the ASK program leverages resources and capacity support to address high-need areas targeting families referred by DCFS as well as any community member who seeks assistance. Through ASK, SHIELDS and its partners provide six

main services at each Resource Center: (1) resource navigation, (2) vocational and educational training, (3) visitation centers, (4) supportive services, and (5) legal services. Vocational and educational training includes high school diploma classes, after-school tutoring, computer training, job readiness and placement, as well as a certified Fiberoptics Technician Training program and employment opportunities in the telecommunications industry. A Legal Services Coordinator works in collaboration with Public Counsel Law Center, the Los Angeles County Region V GAIN office, and the Los Angeles County Child Support Services Department to provide legal services and education to the community on criminal record and traffic ticket expungement, child support, special education, adoptions and guardianships, and immigration. Implemented in 2008, to date we have served 7,244 families, logged over 50,000 hours of participation in classes and community workshops, and given over 20,264 successful referrals in 36 categories of need. In addition, over 300 individuals were placed in the work force and over 1000 families received free legal services.

Based on the evaluation conducted by Casey and USC, ASK has been successful in reducing the number of families referred or re-referred to the child welfare system with participation in the program. According to data analyzed on "re-referrals to DCFS after receiving PIDP services" during the program period (between June 2008 and July 2010), Emergency Response families (N=130) who accessed the ASK Centers in Compton were significantly less likely to be re-referred to DCFS. About 12 percent had re-referrals compared with 23 percent of the randomly selected comparison group. The PIDP group had a significant advantage over the comparison group for both subcategories of families (new referrals to DCFS and re-referrals on existing open cases). It should be noted that the Compton office experienced re-referrals on 31 percent of families referred to ER during this same period, a rate that was even higher than the experience of the comparison group. In addition, the group of 31 children in foster care whose families took advantage of ASK Centers were more likely to have planned positive "permanency exits" from foster care compared to children with open cases in the comparison group (100% vs. 83%).

Exodus Family Centered Treatment Program: The SHIELDS for Families' Exodus Program, is a unique model in which comprehensive family-centered treatment, follow-up and related social services are provided within an 86 unit apartment complex. It is currently the only program in the United States that allows for the

entire family unit to live in the treatment environment in individual family apartments. Treatment, child development and youth services (Heros and Sheros), case management and vocational services are offered on-site at the facility. A maximum of 45 families are active in treatment at any given time, with approximately 170 children enrolled in program services on-site. After completion of treatment services (12-24 months), families are able to remain in their housing for a transitional period of up to one year, allowing for adequate time to develop vocational, educational and/or supportive systems necessary for ongoing recovery and family maintenance.

Since the program was implemented in 1994, outcome data has been closely monitored. During the initial stages of the program (1994-1999), Exodus was part of a national evaluation through the Center for Substance Abuse Treatment, in addition to a local evaluation through SHIELDS. National evaluation results established the program as a best practice model for the federal government in 2001. Evaluation outcomes of the program over the past five years (2002-2007) conducted through SHIELDS Research Division include:

- **An 81.2% completion rate (national average = 25%).**
- **Family reunification rates of 85%.**
- **An average of 646 days in treatment (national average = less than 90 days).**
- **All clients obtained a high school diploma.**

In the past 5 years, a total of 236 children ages 0-5 (95%) have received at least 1 developmental screening. Overall, 85% of children received scores that fell within the normal range of development, and 15% of children were identified with potential delays and referred for additional assessment and specialized services. Evaluation outcomes of the child development component include:

- **Increase in parental knowledge of child development and parenting skills with parents scoring an average of 90% on post-test scores.**
- **Over 200 parents received completion certificates for parenting and child development classes.**
- **Success in achieving low rates of Very Low Birth Weight among infants born to enrolled mothers (average= 4.5% over the last six years, 0% in the last year).**
- **High rates of entry into prenatal care (average=67% over the last six years, 72% in past year).**

- *Immunization rates among enrolled children averaged 80% in the past 5 years*
- *Of a total of 264 infants who were born in the program in the past 6 years, less than 6% had positive toxicology screens.*

Outcomes for Hero and Shero youth, ages 6-18, have been monitored through the use of seven standardized assessments, which are administered on a quarterly basis. Results indicate that the program has had a positive impact on participating youth:

- *60% of participants improved attitudes towards school and education;*
- *75% of participants improved grades in math and English;*
- *77% of participants improved self esteem and self confidence;*
- *77% of participants improved cultural awareness/identity and community mobilization skills;*
- *80% of participants improved awareness of substance abuse related issues and made a commitment to live drug free.*

In conclusion, I would ask my colleagues to consider that an ounce of prevention is worth a pound of cure. As you work to reauthorize the Promoting Safe and Stable Families Act and IV-B provisions, these tried and proven community strategies are not only effective but cost effective and I encourage you to use prevention and early intervention models adopted by SHIELDS to inform your decision making.

Thank you for your work on these issues and I look forward to working with you all to continue to improve the lives of children and families.

I am happy to answer any questions you may have.

STATEMENT OF BRYAN SAMUELS, COMMISSIONER, ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES, ADMINISTRATION FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. SAMUELS. Great, thank you. Good morning, everyone. Chairman Davis, Ranking Member Doggett, Members of the Subcommittee, I appreciate the opportunity to speak to you today.

Title IV-B is an essential program in the child welfare system. The work of Congress over the last 14 years has made a huge difference in the lives of children. Today there are 25 percent fewer children in foster care, 14.5 percent less are entering care, and 7.5 percent more children are exiting care. And over the last 14 years we have seen an increase of 57 percent in the number of adoptions achieved through foster care.

I was the child welfare director in the State of Illinois from 2003 to 2007. The children of Illinois benefitted greatly from the reforms that Congress made. Today, Illinois has 65 percent fewer children in out-of-home care than they did just 14 years ago. However, my state struggled to meet the social and emotional needs of children, both in out-of-home care and in in-home care.

In order for us to meet the needs of children in the foster care system, we need a strategy that is more trauma-informed and developmentally focused. In my experience, the four categories of Safe and Stable Families are the right ones. Children and families are served well by family preservation, family support, reunification, and adoption.

I have seen the value of consistent case worker visitation, particularly the value it has for ensuring safety. In 2010 nearly 75 percent of children were visited by their case worker each month. We expect these improvements to continue, and we will monitor them through the child and family services review.

The Federal investment in meth also was a critical area of focus as the earlier panel discussed. We have seen declines in meth, overall, nationally. In Illinois we had a great fear that meth would be the crack cocaine epidemic for the 1990s. I am glad to report that, during my tenure, that did not occur, and that the number of children entering foster care because of meth declined. That said, not every community has benefitted from a reduction in meth use.

More importantly, a recent study of children reared in homes where meth was used showed that they had substantially higher rates of post traumatic stress disorder (PTSD), and were exposed to multiple experiences of trauma and violence. Given the impact that trauma has on children and their development, we recommend, through the reauthorization of title IV-B, that you focus resources on improving the social and emotional well-being of children.

In Illinois, 25 percent of children entering care had an elevated level of traumatic stress that warranted professional intervention. Child welfare research clearly shows that focusing on trauma could have a significant impact on the long-term well-being of children. Children who are exposed to trauma have learning and language difficulties, and they do poorer in school. Trauma creates disturbed attachment, aggressive behavior, loss of regulation in areas of sleep, food, and self-care, feelings of self-hate, and chronic ineffectiveness.

The data for older children in foster care have a diagnosis of mental illness shows that 14 percent of them are diagnosed with PTSD, 20 percent with attention deficit hyperactivity disorder (ADHD), 27 percent with major depression, and 47 percent with conduct disorder or oppositional defiance at some point in their life.

Moreover, children who are diagnosed with a mental illness are prescribed psychotropic medications at substantially higher rates than the general public. Child welfare directors are gravely concerned about this issue. There is an emerging consensus that non-medical-based interventions, such as cognitive behavior therapy, behavioral management, and family skills training are needed, sometimes in addition to psychotropic medications.

As a child welfare director, meeting the social and emotional needs of children in foster care was my biggest challenge. Today I believe that that is still the biggest challenge across the country in child welfare. I urge the committee to take into consideration the social and emotional needs of children as you make your decisions, going forward. Thank you.

[The prepared statement of Mr. Samuels follows:]



Testimony of

Bryan Samuels, Commissioner

Administration on Children, Youth and Families

Administration for Children and Families

U.S. Department of Health and Human Services

Before the

Subcommittee on Human Resources

Committee on Ways and Means

U.S. House of Representatives

June 16, 2011

Chairman Davis, Ranking Member Doggett, and members of the Subcommittee, I appreciate the opportunity to testify before you today as you consider the reauthorization of title IV-B – subpart 1: the Child Welfare Services Program and subpart 2: the Promoting Safe and Stable Families Program (PSSF). These programs in the Social Security Act are essential as they are the primary source of dedicated Federal child welfare funding to help State and local child welfare agencies support the critical services needed by children who are at-risk of or have been abused and neglected and their families.

Before I speak to the specifics of those two subparts and our proposal for reauthorizing title IV-B following the principles for child welfare reform set forth in the President's FY 2012 Budget request, I want to acknowledge and applaud how this Subcommittee, and Congress as a whole have operated in a bipartisan manner when it comes to issues impacting child abuse and neglect. It demonstrates a clear recognition that vulnerable children and families deserve our best collective efforts to improve their chances for success. We especially appreciate your work to extend State child welfare waiver authority. These waivers will serve as a complementary tool to the Administration's child welfare proposal to spur innovation and develop more robust evidence-based practices.

Title IV-B, subpart 1 – Stephanie Tubbs Jones Child Welfare Services Program

The Stephanie Tubbs Jones Child Welfare Services Program helps State and Tribal child welfare agencies develop and expand their child and family services programs by: (1) protecting and promoting the welfare of all children; (2) preventing the neglect, abuse or exploitation of

children; (3) supporting at-risk families through services that allow children, where appropriate, to remain safely with their families or return to their families in a timely manner; (4) promoting the safety, permanence and well-being of children in foster care and adoptive families; and (5) providing training, professional development and support to ensure a well-qualified child welfare workforce.

Services are available to children and their families without regard to income. Funds are distributed to States and Tribes as formula grants, based on the population of children under age 21. The non-Federal match requirement is 25 percent. Funding for the program in FY 2011 is \$281,181,000.

Title IV-B, subpart 2 – Promoting Safe and Stable Families

The primary goals of the Promoting Safe and Stable Families (PSSF) program are to prevent the unnecessary separation of children from their families; improve the quality of care and services to children and their families; and ensure permanency for children by reuniting them with their parents, placing them with an adoptive family or in another permanent living arrangement. States and eligible Tribes (funded out of a three percent set-aside) are to spend most of the funding for services that address four service categories: family support, family preservation, time-limited family reunification and adoption promotion and support. PSSF is funded by both mandatory and discretionary funding streams. Funding for PSSF in FY 2011 is \$428,184,378 (\$365,000,000 in mandatory funds; \$63,184,378 in discretionary funds).

In addition to providing PSSF formula grants to States and Tribes, this program also sets aside funding for evaluation, research, training and technical assistance projects (\$6 million mandatory, 3.3 percent of discretionary). Funds also are set-aside for State Court Improvement Programs (\$30 million mandatory, 3.3 percent discretionary); and \$40 million in mandatory funds split between State formula grants to improve the quality and quantity of caseworker visits with children in foster care and competitive discretionary regional partnership grants to work with children and families impacted by a parent's or caretaker's methamphetamine or other substance abuse.

The Four Categories of PSSF

The four categories of PSSF are family preservation services; family support services; time-limited reunification services; and adoption promotion and support services.

The following are examples of the work States are doing within these categories:

- **Family Preservation Services** – Kentucky uses its PSSF funding to focus on two areas – preventing at-risk children from being removed from their homes and assisting children to reunify safely and successfully with their families. To these ends, Kentucky provides intensive assistance including using “Families and Children Together Safely” (FACTS) for at-risk families with children who may be in the home or returning from out-of-home care by providing in-home therapy and community-based prevention/intervention services.

- **Family Support Services** - In North Dakota, Nurturing Parent Programs are evidenced-based group programs in which both parents and their children participate. This program helps parents learn nurturing behaviors, communicate in non-threatening ways and use alternatives to physical discipline. Nurturing Parent programs offer two modules – one for families with children under age five and one for families with children age 5-12.
- **Time-limited Reunification Services** - The Nebraska State child welfare agency contracted with five family-serving organizations to provide one-on-one mentoring and support services to families whose children are in foster care, parents who are involved with the child welfare agency and parents whose children have been diagnosed with a serious emotional disturbance and substance dependence disorders. Services include one-on-one mentoring and coaching of parents, advocacy, support groups for parents and youth, and community referrals.
- **Adoption Promotion and Support Services** - The Tennessee child welfare agency has utilized funds to provide specialized pre-adoptive counseling services to help children grieve loss and prepare them to accept a new family.

State Caseworker Visit Grants

The 2006 reauthorization of PSSF sought to ensure that all States would visit at least 90 percent of children in foster care on a monthly basis by FY 2011. Quality caseworker visits are essential

to ensuring the safety of children in foster care. States have chosen a variety of ways to increase caseworker visits and improve their quality. California and Maryland offer good examples of how funds are being used to further progress toward the 90 percent goal.

In FY 2010, California allocated funds to all 58 counties to perform activities designed to support more monthly caseworker visits to children in foster care; to improve caseworker retention, recruitment and training; and to improve the ability of caseworkers to access the benefits of technology.

Maryland utilizes additional funds to support monthly casework visits with children in foster care by funding travel for caseworkers to visit foster children in out-of-State placements, and allocating funds for supplies, books, toys, and tools for caseworkers to enhance the content and quality of visits.

Grants for Children Affected by Methamphetamine and Other Substance Abuse

The impact of methamphetamines has been a concern in the child welfare community since the drug emerged in the 1990s. Given this trend, Congress chose to target funds in PSSF during the last reauthorization to build effective approaches over a five year period to combat the effects of methamphetamine on child welfare. Congress created a targeted grant program to regional partnerships for the purpose of improving permanency outcomes for children affected by methamphetamine or other substance abuse. In October 2007, 53 Regional Partnership

Grants (RPGs) were awarded to applicants across the country. The three- and five- year grant awards ranged from \$500,000 to \$1,000,000 per year.

The grants address a variety of common systemic and practice challenges that are barriers to optimal family outcomes including: recruitment, engagement, and retention of parents in substance abuse treatment; conflicting time frames across the systems to achieve outcomes; and chronic service shortages in both child welfare services and substance abuse treatment systems. Program strategies to address these barriers include the creation or expansion of family treatment drug courts, expanded and timely access to comprehensive family-centered treatment, in-home services, case management and case conferencing, the use of evidence-based practice approaches such as motivational enhancement therapy and parenting programs, parent partners, mental health and trauma informed services, and strengthening of cross-system collaboration.

Based on information we received from grantees, the Federal investment has served to establish and advance cross-systems collaboration and service integration, as the legislation intended. Additionally, various State, regional and local governmental and community partners are contributing their own financial and human resources to help sustain these collaborative activities and services beyond the grant period, also as envisioned by the legislation. Approximately one-third of RPG services strategies are currently supported primarily by other community resources. Through the RPG program efforts, child welfare systems now have additional tools to use to continue to address the impacts of methamphetamine and other substances.

The use of methamphetamine has declined in this decade. According to the 2009 National Survey on Drug Use and Health¹¹, the number of past-month methamphetamine users decreased between 2006 and 2009. The numbers were 731,000 (0.3 percent) in 2006 and 502,000 (0.2 percent in 2009).

As reauthorization of these funds is considered in light of the current landscape of child welfare, we would suggest that there may be a diminished need for meth-specific programming providing an opportunity to target some funds towards driving innovation in other areas.

Court Improvement Program

Statutory language sets aside both mandatory and discretionary funds to support three State Court Improvement Program (CIP) formula grants. The Basic grant is funded at approximately \$12 million annually (\$10 million mandatory funds; 3.3 percent of discretionary funds); the Data and Training grants each receive \$10 million in mandatory funds annually. All 50 States, Puerto Rico and the District of Columbia receive CIP funds.

Courts play a critical role in the child welfare system. However, historically few courts and judges have possessed specialized child welfare knowledge. The CIP has begun changing this by helping courts become more effective partners in promoting the safety, permanence and well-being of children involved in dependency cases and building their capacity to do so.

Since the CIP was created, judges and attorneys have become better trained, more aware of the needs of families and children and far more engaged in all aspects of child abuse and neglect cases. Judges and attorneys have emerged as leaders in the child welfare field and agencies and courts are working together to implement innovative data-sharing systems and evidence-based practices. CIP funding has been and continues to be a catalyst for promoting improved outcomes for children and families involved in child welfare. For this reason, we strongly urge you to reauthorize the CIP grant program.

Evaluation, Research, and TA Funds

Since its inception in 1993, the PSSF program has reserved funds to be used by HHS for evaluation, research, and technical assistance in the amounts of \$6 million in mandatory funds and 3.3 percent of discretionary funding.

The bulk of these reserved funds are used to provide technical assistance to States in response to findings from the Child and Family Service Reviews (CFSRs). When weaknesses are identified in a program through the CFSR, the State is offered technical assistance to help them address that weakness from a national network of training and technical assistance providers including the Children's Bureau's National Resource Centers (NRCs), several national clearinghouses, and selected grants to local entities. For example, if a State is found to be in nonconformity with child safety, the National Resource Center for Child Protective Services can be deployed to help the State implement safety decision making. Research activities supported by PSSF funds are intended to support the development of an evidence base to guide program implementation at the

national, State, and local levels. These activities are regularly carried out in partnership with HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE), as well as through other partnerships within HHS, such as the National Institute on Alcohol Abuse and Alcoholism, and other Departments, such as the Department of Justice, to support studies addressing areas of mutual interest. Projects supported in FY 2010 examined such issues as collaborations between child welfare and TANF, the intersection of domestic violence and child maltreatment, and early childhood-child welfare partnerships.

Today's Child Welfare Landscape

From 1982 to 1995, the number of children in foster care increased by 63.2 percent. During this same period, Federal expenditures grew from \$309 million to \$3.05 billion. Congress recognized these unsustainable trends and began a concerted effort that led to more than two decades of reforms in the child welfare field beginning with the passage of the bipartisan Adoption and Safe Families Act (ASFA) in 1997 (P.L. 105-89). The guiding principles of ASFA were:

- The safety of children is the paramount concern that must guide all child welfare services.
- Foster care is a temporary setting and not a place for children to grow up.
- Permanency planning efforts should begin as soon as a child enters the child welfare system.
- The child welfare system must focus on results and accountability.

- Innovative approaches are needed to achieve the goals of safety, permanency, and well-being.

Congress recently spurred another wave of child welfare reforms with the passage of the bipartisan Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351). This legislation provided a focus on promoting permanency and improving outcomes for children in foster care by supporting permanent family connections through guardianship assistance; increasing educational stability; encouraging health care oversight and coordination; extending supports for older youth beyond age 18; providing incentives and assistance for adoption; and providing new authority for Tribes to directly manage title IV-E funds. With the changes these and other laws have supported over the past 14 years, the child welfare system has made tremendous progress:

- Since 1998, the number of all children in foster care has decreased by 25 percent, due both to improved permanency outcomes for children in foster care and increased support for at-risk families preventing entry into foster care in the first place.
- Thirty-two out of 52 States (including DC and Puerto Rico) had a reduction in the number of children entering care between 2002 and 2009.
- Nationally, child welfare systems brought 14.5 percent fewer children into foster care in 2009 than in 2002; during the same time period, 12 percent more children exited foster care to permanency.
- The number of children adopted from foster care has been increasing steadily from year-to-year. In 1998, 37,000 children were adopted from foster care while in 2008, 57,500

children were adopted from foster care. This represents a clear sign that the message Congress has sent about adoption promotion is being heard in the field.

The goals of safety, permanency and well-being have been foundational to the work of child welfare. The progress made has primarily been in the areas of safety and permanency. Sustaining and furthering this progress will be a critical consideration in the revisions that the Administration is planning for the CFSRs, which are anticipated by the end of 2012. While further progress in safety and permanency is possible and important, the reauthorization of title IV-B provides an opportunity to focus on improving well-being in children who have experienced child maltreatment.

Opportunities in Reauthorization to Move the Child Welfare Field Forward

Well-being is a complex and multifaceted construct. As such, there are many aspects that can be considered when determining where to target limited resources. The research suggests that a focus on the social-emotional well-being of children who have been maltreated would have a significant impact as it would address both the fundamental reason that children come to the attention of the child welfare system and the potential to positively impact adult outcomes.

The research is clear that the experience of abuse or neglect leaves a particular traumatic fingerprint on the development of children that cannot be ignored if the child welfare system is to meaningfully improve the life trajectories of maltreated children, not merely keep them safe from harm.

When I was in Illinois, my response to this problem was to institute a universal assessment using the Child Behavior Checklist for all children entering care and then determine which interventions would be most likely to improve the functioning of the largest number of children. It became apparent that these children were deeply affected by the trauma they had experienced and many presented with a complex array of needs. We acknowledged that the complex nature of maltreatment required a multi-faceted approach and we took steps to build a system equipped to meet the constellation of children's social-emotional needs. There are many opportunities for taking a similar approach to build a Federal response to the social and emotional needs of children and their families.

Once abuse or neglect is substantiated and it has been determined that a child can either safely receive in-home services or that he/she should come into foster care, the focus shifts primarily to ensuring stability (in-home cases) or achieving permanency (out-of-home). This is and should remain an essential function of the child welfare system. However, this imperative often glosses over the responsibility we have to provide effective and timely services that lead to healing and recovery for children and families whose lives have been deeply impacted by the abuse or neglect they have experienced. The data show that the act of achieving permanency – whether it be through in-home services, reunification, guardianship or adoption does not by itself lead to improved life outcomes for children who have often experienced chronic and complex trauma due to the abuse or neglect that has occurred.

The research on the impacts of maltreatment on the social-emotional, behavioral, and mental health needs of children has grown over the years and informs the Administration's FY 2012 child welfare proposals. I would cite several key examples:

- Studies consistently find that a maltreated child is more likely than not to have psychological difficulties of sufficient scale or severity to require mental health services, regardless of their placement history.¹
- Maltreated children endure poorer physical health, higher prevalence of learning and language difficulties, and poorer educational outcomes than other children.²
- Although children adopted from care enjoy greater placement stability than those who remain in care, studies suggest as many as 60 percent of children manifest mental health difficulties six years after being adopted from care.^{3 4}
- While specialized mental health services for child welfare populations have been developed, we have not developed an integrated model of clinical practice that adequately addresses their complex psychopathology, which is often characterized by attachment difficulties, relationship insecurity, problematic sexual behavior, trauma-related anxiety, inattention/hyperactivity, and conduct problems and defiance.⁵
- A pattern of spiraling deterioration in mental health and social functioning, serial placement breakdowns and increasingly unstable living arrangements is more commonly observed among children who arrive in care in middle childhood or later, following chronic exposure to abuse and emotional deprivation. Fewer of these youth are adopted from care.⁶

- The systems in place today are largely piecemeal. The most visible shortcoming in the provision of effective mental health services for children in care, as well as those adopted from care, is insufficient capacity.⁷
- Moreover, the current system services are poorly matched to the service needs of a child population presenting with complex attachment- and trauma-related symptoms, and unstable living arrangements. These children require greater continuity and certainty of care than typical acute care services are designed to provide.⁸
- Generic treatment interventions are also mostly designed for discrete disorders rather than complex bio-psycho-social phenomena. Children in care are more likely to present with complex and co-occurring disorders that are less likely to respond to psychological treatments developed for discrete disorders.^{9 10}

Children known to the child welfare system have often experienced multiple traumas related to child abuse and neglect, domestic violence, and community violence. The research on trauma and child abuse and neglect is clear in demonstrating that these co-occurring adverse childhood experiences have a compounding and corrosive effect on the developmental, social and emotional trajectories of these children. Trauma can manifest itself in many ways including disturbed attachment patterns, aggressive behavior towards others, loss of regulation in the areas of sleep, food and self-care, self-hatred and chronic feelings of ineffectiveness.¹¹

Figures 1 and 2 below provide data on the mental health and behavioral health experiences of children known to child welfare. Figure 1 shows the percentage of children known to child welfare by age who exhibit either externalizing behaviors such as aggression, defiance, etc. or

internalizing behaviors such as somatic complaints, self-esteem problems, thought problems and relationships difficulties, etc. Figure 2 shows the percentage of children (at age 17) who have a mental health diagnosis at any point in their lives, before they enter foster care, and/or during the past year; age of onset is also provided, which ranges from age 4.85 to age 12.17 and is far younger than typically understood by the general population. The data are remarkable also insofar as at least a third and up to over a half of children in the foster care system had a diagnosable mental health need prior to entry into foster care.

Figure 1: Social and Emotional Needs of Children Known to Child Welfare¹²

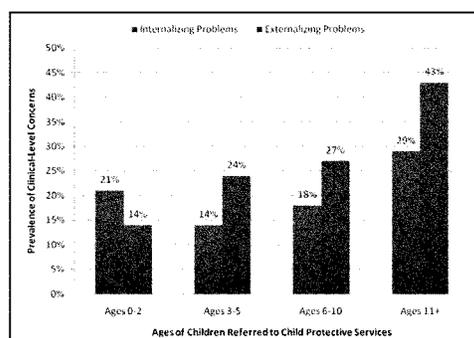


Figure 2: Onset and Prevalence of Major Psychiatric Disorders for the Past Year, Lifetime, and Before Entrance Into the Foster Care System¹³

Psychiatric Disorders	Onset and Prevalence			Prevalence
	Past Year	Lifetime	Before Entrance	
Mania	6%	33%	12.17	6%
Posttraumatic Stress Disorder	14%	42%	10.48	8%
Attention Deficit Hyperactivity Disorder	20%	75%	4.85	10%
Major Depression	27%	35%	11.82	18%
Conduct Disorder/Oppositional Defiant Disorder	47%	57%	9.65	17%

The table and graph above show the significant extent of both diagnosable mental health needs and the clinical-level social and emotional needs of children who do not meet the criteria or threshold for a diagnosis. Their functioning has been impaired due to their life circumstances, and we know there are effective ways to intervene. These data also help us understand that these needs span the full age range and increase as children get older.

Building a System that Meets the Needs of Maltreated Children

These mental health, behavioral health and social and emotional needs are the core challenge before us. If we are to put children who have been maltreated and exposed to trauma on a positive life trajectory, we must build a child welfare system that responds effectively to these compelling and complex needs.

A sophisticated, multifaceted clinical and behavioral approach is needed to meet their needs as the traditional mental health strategy is inadequate to address the complexity common to this population. If we are to improve the life outcomes of children known to child welfare - not just in the short term but into and throughout adulthood - we must take an approach that is supported by clinical research and has been shown to be effective. Our policies, programs and funding must be aligned with the reality these children face every day.

The child welfare system in partnership with the mental health system responds primarily to children with diagnosed mental health disorders and to those children who exhibit externalizing behaviors. The traditional array of services used, however, does not fully address their unique needs given the trauma and maltreatment they have experienced. Additionally, children who do not meet the criteria for a mental health diagnosis and exhibit *internalizing* behaviors are often underserved or receive services that are inappropriately matched to their clinical needs. These systemic gaps result in children struggling unnecessarily with social and emotional needs. Intervening in their lives to improve their overall functioning is an imperative we cannot overlook.

For those children who do have a mental health diagnosis, there is a high rate of use of psychotropic medications – substantially higher than in the general population - reflecting the clinical complexity of these children. One study focusing on the use of psychotropic medication in Texas found that the prevalence of any psychotropic medication for Medicaid-enrolled youth in foster care was 34.7 percent. Of the children in foster care receiving psychotropic medications, 17 percent were receiving two psychotropic drug combinations and 60 percent

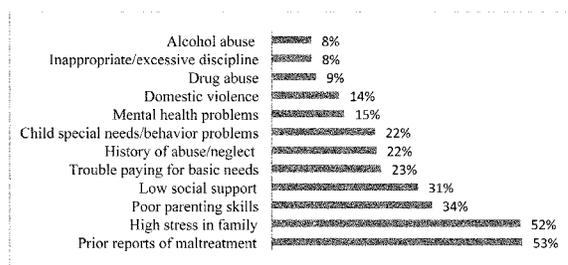
receiving five or more concomitant psychotropic drug classes.¹⁴ There are significant variations across States in the rate of psychotropic medication use among children in foster care, suggesting that far more work needs to be done to identify best practice in the use of these medications with this population. Recent studies have found that older age and clinical need, as measured by the Child Behavior Checklist, were associated with higher rates of psychotropic medication use, findings similar to those previously reported in the literature.¹⁵

There is emerging consensus and research evidence that a more responsive service array for this population should include non-medication based interventions such as cognitive behavioral therapy, behavior management, and family skills training – sometimes in addition to psychotropic medications, which can provide significant help for some children. However, these non-medication, evidence-based interventions that are known to be effective are underutilized for this population due to a number of variables including lack of adequate assessment of needs, lack of practitioners, and lack of consistent funding streams. Many of these interventions include the involvement of families (i.e. Parent-Child Interaction Therapy), which is clearly supported through the PSSF goals of family preservation and family support.

As PSSF acknowledges the importance of parents and families in the lives of children, attention must be paid to the array of needs that are specific to caregivers as well. Data in Figure 3 below clearly demonstrate the high prevalence of issues that impact caregivers' ability to provide safe, stable home environments for children: use of inappropriate or excessive discipline, low levels of social support, mental health problems and caregivers' own history of experiencing abuse or neglect. Given the child welfare system's emphasis on preventing removal when possible and

reunifying children in foster care with their parents when it is safe and appropriate, the constellation of physical, mental, social, and concrete needs that their caregivers encounter must be addressed.

Figure 3: Risk Factors in Parents Involved with Child Welfare



The President's FY 2012 Proposal

The recognition of the risk factors in parents and the mental health, behavioral health and social and emotional needs of children provides a real opportunity to develop a critical area of focus during the reauthorization of both subparts of title IV-B by strengthening the child welfare system's ability to identify, develop, train, and implement interventions that meet these needs and support effective strategies that improve outcomes for children.

Title IV-B, Subpart 1 (Child Welfare Services Program)

The Administration supports the reauthorization of the title IV-B Child Welfare Services Program for five years with total funding set at the same level, as specified in the President's Budget proposal. This continued support will allow States and Tribes to fund child welfare services and build on the progress made relating to caseworker visits with children in foster care. Under subpart 1, all States are required to visit at least 90 percent of children in foster care on a monthly basis by FY 2011. The provision of the law relating to submission of caseworker visit data has prompted improved State performance in the frequency of caseworker visits and the proportion of visits conducted in the home of the child. The law has also led to improvements in the accuracy of State data in this area. The baseline data submitted by States indicated that initial State performance ranged from a low of two percent to a high of 94 percent, with a mean of 42 percent in FY 2007. Most States have made improvements, and preliminary figures indicate that the national average rose to 50 percent in FY 2008 and 73 percent in FY 2010. We expect that improvements will continue and we will continue to monitor this through the Child and Family Services Reviews.

We would also recommend clarifying that implementation and/or expansion of effective clinical, trauma-focused treatments for both children and families are an allowable expenditure under this subpart.

Court Improvement Program

The Administration's proposal requests that the State Court Improvement Program (CIP) grants be reauthorized for five years.

CIP has provided an opportunity to invest in improved data collection and collaboration between courts and child welfare agencies, the infrastructure built through these funds now allows for a return on investment that can help to focus on the following key areas:

- *Raising the visibility for concurrent planning.* Only four percent of children who were in foster care in FY 2009 were placed in a pre-adoptive home. The Adoption and Safe Families Act (ASFA) requires child welfare agencies to begin concurrent planning upon entry into foster care. The statute should be revised to support strategies that allow courts to support the increased use of placements that facilitate concurrent planning.
- *Reducing the time to adoption after parental rights have been terminated.* ASFA appropriately focused on reducing the time to a determination of the termination of parental rights. However, only 14 percent of children who were awaiting adoption (meaning their parental rights had been terminated) in FY 2009 were placed in a pre-adoptive home. This could be accomplished by further revising the statute to support the development of strategies that allow courts to help with the reduction of the time to adoption after the termination of parental rights.

- *Broadening policies that provide for more opportunities for youth to participate in child welfare hearings.* Youth have much to contribute to the placement, treatment and other decisions that significantly impact their lives and we believe the statute should support development of policies that provide for more opportunities for youth to participate in child welfare hearings.
- *Improving the understanding of the impacts of trauma:* Children who are served by dependency courts have experienced complex trauma and we believe the statute should support training judges and other legal personnel on the effects of trauma due to maltreatment.

Tribal CIP

The Administration also proposes the creation of a Tribal Court Improvement Program to be used to support Tribal court improvement efforts as Tribes begin to operate their own title IV-E programs as was authorized under the Fostering Connections Act. The Fostering Connections to Success and Increasing Adoptions Act of 2008 allows Tribes, for the first time, to apply for title IV-E funds to support their child welfare activities. It is a priority of the Administration to reach out and engage the Tribes to support them in achieving better outcomes. Currently, 11 Tribes are receiving support to plan and prepare to operate their own title IV-E program.

Title IV-B, Subpart 2 (Promoting Safe and Stable Families)

The Administration supports the reauthorization of the title IV-B Promoting Safe and Stable Families Program for five years with total funding set at the same level, as specified in the

President's FY 2012 Budget proposal. We would also recommend repurposing the \$40 million in mandatory funds that previously supported discretionary regional partnership grants focused on methamphetamine and other substance use and formula grants to States to improve caseworker visits with children in foster care. We suggest that instead these funds could better be used as an initial step to support incentivizing State improvement in a range of key outcomes that would address the most pressing child welfare issues including mental health, behavioral health and social and emotional needs of children as outlined in my testimony. These funds should be available for interventions that work in improving the help provided to children who have been abused and neglected and suffer from the fingerprint such trauma leaves as well as training to support a clinically competent workforce.

This concept is derived from the principles outlined in the President's FY 2012 budget to: create financial incentives to improve child welfare in key areas; improve the well-being of children and youth in the foster care system; reduce costly and unnecessary administrative requirements; use the best research currently available on child welfare policies and interventions; and expand our knowledge base by allowing States to test innovative strategies that improve outcomes for children and reward States for efficient use of Federal and State resources. The President's Budget proposed \$250 million in additional mandatory funds for these purposes.

Fiscal incentives would be provided to States that demonstrate real and measureable improvements in permanency, safety and service delivery for children known to the child welfare system and those in foster care. This proposal seeks to create financial incentives to improve

child outcomes in key areas, by reducing the length of stay in foster care, increasing permanency through reunification, adoption, and guardianship, decreasing rates of maltreatment recurrence and any maltreatment while in foster care, and reducing rates of re-entry into foster care.

The purpose of this incentive fund, which States would have to earn based on their performance, is to expand the reach of Federal support and build additional infrastructure and capacity within States. A methodology that incorporates the goals of accuracy, transparency, continued quality improvement and fairness would be used to determine how States would earn the funds. Eligibility for incentive funds would be based on the number of measures for which States have demonstrated improvement on both a core set of outcome measures and a core set of quality measures.

States would be able to use the funds to focus on three areas of importance to the Administration: post-permanency services designed to improve the success rate of permanent placements; services that address the social, emotional, and mental health needs of children that can foster better permanency outcomes; and services designed to reduce the number of children who age out of foster care.

Child welfare systems serve some of America's most vulnerable children. The Federal Government should be helping States to help those children achieve safety, permanency, and success in life. Current law, however, can discourage investment and innovation that would serve children's best interests. The Administration looks forward to working with Congress on this effort, including incorporating a complementary incentive structure in Promoting Safe and

Stable Families to align with the direction the President's broader FY 2012 proposal would take us in moving toward meaningful reform in child welfare.

Conclusion

The title IV-B funding streams are a crucial component of the child welfare system charged with supporting the safety, permanency, and well-being of maltreated children. The flexibility of these funds allows for the support of the services that can lead to the much-needed healing and recovery of children and families who have experience with child abuse and neglect. Given data that demonstrate the significant impact of a focus on meeting the social-emotional, behavioral and mental health needs of children on the child welfare system as a whole, this reauthorization provides an opportunity to strategically target funds to begin incorporating and further building a more clinically sophisticated child welfare system that is responsive to the complex needs of children who have been maltreated.

Thank you and I look forward to working with the Subcommittee on these proposals. I am happy to take any questions.

ENDNOTES:

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- ⁵ Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry, 21*(4), 345-349.
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- ⁸ Leslie, L.K., Hurlburt, M.S., Landsverk, J., Rolls, J.A., & et al. (2003). Comprehensive assessments for children entering foster care: A national perspective. *Pediatrics, 112*(1), 134-42.
- ⁹ Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry, 21*(4), 345-349.
- ¹⁰ National Institute for Clinical Excellence (NICE). (2008). Cognitive behavioural therapy for the treatment of common mental health problems: Commissioning Guide.
- ¹¹ van der Kolk et al. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389-399.
- ¹² National Survey of Child and Adolescent Well-Being. USDHHS. Analysis courtesy of C. Simmel, Rutgers University School of Social Work. Sample: 5,501 children and youth referred to child protective services.
- ¹³ McMillan, C.J; et al. (2005). The prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*:88. Sample: 373 17-year-old youth in foster care in one Midwestern State. Percentages indicate lifetime prevalence.
- ¹⁴ Zito, JM et al. (2008). Psychotropic medication patterns among youth in foster care. *Pediatrics, 121*(1).
- ¹⁵ L.K. Leslie et al. 2011; Breland-Noble et al., 2004; Raghavan et al., 2005; Zima et al., 1999

Chairman DAVIS. Thank you very much, Mr. Samuels. Now we will turn to questions. First, I would like to ask you a question related to streamlining administrative requirements.

In April 2011, your agency announced it was reviewing the Child and Family Service Review process, which is how states are held accountable for the operation of their child welfare programs, including the two programs we are focusing on today. This announcement noted that you would consult with various stakeholders, consider changes to make sure that the reviews make sense, and really help states to make kids safe.

Several states we have spoken with have told us—and I think our expert panel later this morning will address this—that the many different child welfare reviews, audits, and plans have become a very large bureaucratic burden on the states. Now, your own testimony on page 24 mentions your goal to “reduce costly and unnecessary administrative requirements,” and hopefully integrating and streamlining the process to get same critical data.

What is your agency doing to make sure that Federal oversight is useful, and that it holds states accountable for things we care about, and that it doesn’t divert state resources from helping children at risk of abuse and neglect?

In addition, what else is the Agency doing to streamline the way child welfare programs are managed? And I was wondering if you can consolidate some of the many audits and other administrative requirements.

Mr. SAMUELS. I will start with the child and family service review (CFSR). As you know, that is a regulatory process, by which we monitor the overall activities of child welfare systems across the country. We are in the middle of soliciting comment on that review process.

Without violating the basic communications around the regulatory process, I can share that we are focused on three areas in looking at how to improve the child and family service review.

The first is around the methodology. It is both cumbersome and at times inappropriately used. We are trying to make sure that the strategies of reviewing data, reviewing case files, and reviewing the performance of states, are methodologically sound.

Second, we are concerned that the CFSR focuses on too many issues. As a result, state agencies are not clear about the most important issues. We would hope to reduce the focal points for the CFSR so that states are comfortable in being held accountable, and do the work required.

And third, we think it is important to be accountable. Sanctions are one way of encouraging accountability. We think there are probably others, and we are actively reviewing all possible examples of oversight that move beyond just sanctioning states.

We think by doing those three things, and doing those in the context of very active public involvement, we can create a system of review that is refined, targeted, and holds states appropriately accountable for their obligation under Federal law.

Chairman DAVIS. I appreciate you sharing that. We will look forward to working with you more on that. One concern that I have, having seen both in health care and a number of other issues related to this, that every hour filling out paperwork or redundant reports by front-line personnel is one less hour they are actually spending doing their job, and it has a rather constricting effect on capacity for service delivery.

Are there things that Congress can do to limit this fragmentation, and the administrative complexity, while making sure states achieve the performance goals that are laid out for them by the Agency?

Mr. SAMUELS. I think there are a couple of things that could be done. First, I think there is great value in accountability. As you know, part of the President’s proposal for 2012 was an increase of

\$250 million, specifically targeting improving the overall performance of states and, secondly, making investments in three specific areas. I am going to focus on the accountability issue.

Under the proposal, we would elevate the expectation around performance, using a set of factors, outcome and quality measures, that states would be held accountable for on an annual basis.

As you know, the child and family service review occurs on a three-year cycle, with about two years in between one round and the next. So, in terms of accountability, the child and family service review occurs in states once every five years. We think that should be elevated. The measures ought to be reviewed on a more regular basis. Our proposal would be to do a targeted review of states on an annual basis, and then use the CFSR to really drill down on the limited number of outcomes where states aren't performing well.

We think continued quality improvement is absolutely essential, and we think that it should be an annual, and not every five years.

Chairman DAVIS. Okay, thank you. Mr. Doggett?

Mr. DOGGETT. Thank you very much. Thank you for your testimony and your important work.

There is something of a tension between our desire to give maximum flexibility for innovation and creativity and adapting these services, and our need to get accountability and ensure that these monies are being spent in the way that the Federal law intends. And I don't think—I know this is true in my state—we can always assume that, left without any accountability, that the state will get the job done correctly and in the most effective way, any more than we would assume we can do without accountability in other areas.

Let me focus in on promoting safe and stable families, and the Administration's proposal to incorporate an incentive-based structure there to address the social, emotion, and health-care needs of children. Why is it necessary to create a separate model to address these issues?

Mr. SAMUELS. When you look at the current use of title IV-B, both subpart I and subpart II, there is a limited amount of funding that actually goes into service interventions that specifically address the social and emotional needs of children in foster care.

Again, I think it is important to recognize that maltreatment has a significant impact on a child's ability to function. In many instances, the impact of maltreatment doesn't rise to the level of a mental health diagnosis. Today, if you don't have a mental health diagnosis, states have a limited pool of funds to be able to address your needs.

Trauma is a great example. Traumatic stress in a child has really significant impact. Child trauma is not, in and of itself, a diagnosis. Therefore, most children who would be served in a strategy to address their trauma would have to be served through funding other than Medicaid. It is our belief that there are insufficient funds to drive quality of service improvements needed to achieve good outcomes.

I gave you the example of what we did in the state of Illinois, when I was a child welfare director. I was concerned about the developmental issues that children had in foster care, and their trauma. So we introduced an integrated assessment on the front end of every child within 45 days of entering care. It was a comprehen-

sive review. We were able to know, from the very beginning, what they needed.

In addition, we trained our case workers and our foster parents to recognize signs of trauma, and to address them. And we expanded three evidence-based strategies across all age groups, so that we could address those needs. I can tell you 6 years ago that cost me more than \$30 million.

Mr. DOGGETT. You used somewhat clinical terms. But if I understand what you are saying, if you have a child who has been beat up, and beat up a number of times, but they are not to the point that a psychiatrist or other health care worker diagnoses their having a mental limitation or diagnosis, then there is some services you cannot provide to them that would prevent them from getting to that more critical level.

Mr. SAMUELS. I think that is right. I think what we know from the literature and the science is that there are interventions that make a huge difference. We introduced three of them in the child welfare system while I was director in Illinois.

I even had the opportunity to introduce two of them in the Chicago public schools, when I was the chief of staff there. We had a rash of student deaths. Over a two-year period of time we had over 500 children who were shot, and 85 that were killed, and there were lots of young people who were showing up to school every day, clearly demonstrating signs of traumatic distress.

We were able to introduce two group-based trauma interventions that were evidence-based into schools throughout the city, because we knew that that was going to be the most effective way to reduce anxiety, to reduce stress, and to get better performance from children who were extremely vulnerable.

Mr. DOGGETT. You mentioned a \$250 million increase in your proposal. It is difficult here these days to avoid a \$250 million or more decrease. Why do you need the \$250 million increase? What will you do with it? What would be done with that money?

Mr. SAMUELS. The President's \$250 million performance-incentive proposal has 2 components to it. The first one, which is critical, is that states would actually have to perform better than they perform today to receive any of the funds. So this would be a performance-based distribution. So states would have to, using historical data, improve on an annual basis against themselves.

We are not comparing one state to another, we are comparing states to their historical performance. And what we would be saying is states that demonstrate better performance, receive additional funds so that they can continue to invest in their system. States that don't improve would not have access to those funds. So it would be a performance-based strategy.

In addition to that, there are a range of services that states currently cannot provide. We identify three areas. I will name them very quickly.

Chairman DAVIS. If you could do that in one sentence, that will be helpful.

Mr. SAMUELS. One, social and emotional well-being; two, post-permanency services—children from adopted foster care face a struggle long after they leave out of home care and achieve permanency; and third, reducing the number of children who age out of

the system. We think if you can move upstream, target those children earlier, we can reduce the sad and troubling effects of a child aging out.

Mr. DOGGETT. Thank you so much.

Chairman DAVIS. Thank you. Mr. Paulsen?

Mr. PAULSEN. Thank you, Mr. Chairman, and thank you, Mr. Samuels. It is pleasant to hear your passion. Based on your experience, that sounds like some very troubling and difficult situations dealing with children that you are trying to protect and give a good chance in the future.

I just have a question because, you know, the last reauthorization was several years ago. And, as we learned in the opening testimony, and as I am just learning as a new Member of this subcommittee, some of the provisions of the law required the visits of at least 90 percent of foster children each month. And we have seen the data, that almost all the states have certainly improved in this measure, and no doubt as a result of this requirement and the money specifically provided to help with these visits now.

But if you look across these states, it sounds like there is a wide variation of how they are actually performing, ranging from, like, a low of 18 percent all the way up to 96 percent of kids that are actually being visited each month.

What is your agency actually doing to help all the states meet the goals for the targeted 90 percent standard? Is there a penalty? You talked about sanctions earlier. Is there a penalty if you don't hit the 90 percent standard? Are you recommending one, specifically?

Mr. SAMUELS. Under the statute, there is a penalty. States that don't meet their goals are subject to a penalty. Goals are established on an annual basis.

However, states can invest their own dollars back into the system in a way that allows them to forego the penalty. I know of only one state that actually had to pay their penalty.

But let me make two quick points—

Mr. PAULSEN. And what is the penalty?

Mr. SAMUELS. The penalty is between one and five percent of their allocation within the Safe and Stable Families allotment.

You see across the country dramatic changes. There are some states that were in the single digits, in terms of the number of children that they visited. And today, 4 years later, you see them in the 70 and 80 percent.

My experience is that if you shine a light on an issue, and you tell people that you are actually going to track them and hold them accountable, most people step up. That is certainly the case in child welfare. We think the child and family service review is the appropriate place to monitor ongoing improvement. States know we are watching them, and they have demonstrated that they are going to put the resources in place.

I would welcome the opportunity to come back to Congress on a regular basis and report to you the progress that is being made. I think there is little doubt that states have figured out how to do this, and as long as we hold their feet to the fire, I think they will continue to do that.

Mr. PAULSEN. And let me ask you this, too, because you were just testifying just a little bit ago about the increased request for additional funds——

Mr. SAMUELS. That is right.

Mr. PAULSEN [continuing]. Of 200-some million dollars. And, you know, in a tough budget environment, obviously——

Mr. SAMUELS. It is.

Mr. PAULSEN [continuing]. You have got to justify that. But what about the thought of just with existing funds going to that performance-based, you know, with level funding, or changes in funding structure, going to the performance-based model just in itself?

Mr. SAMUELS. I think part of that would require congressional action.

The work that we have been doing around looking at incentives, and particularly the indicators that we would track, suggest that there are opportunities to introduce such a system within the child and family service review. The downside is simply that we do not have funding to support state reinvestments. It is my experience that, to get better, you have to invest in your infrastructure.

Today, if you get better with your infrastructure, you produce greater rates of permanency. The results are that you have fewer children in care, and therefore, you get less support, federally. We need funding for states to invest in their infrastructure, so that the quality progress that they have already made, can be continued. And the services that they have in place that are producing good results can remain in place.

Mr. PAULSEN. Well, Mr. Chairman, I know, as we look at this reauthorization, that is one of our challenges, obviously, is that reform always costs money. And I think we are going to have to look at ways of how we are going to bring forward reform, knowing we are in tough budget situations to have those resources available.

Chairman DAVIS. I agree. So much of this is going to be addressing the process and the overhead that is driven by that.

The chair now recognizes Mr. Reed from New York.

Mr. REED. Thank you, Chairman. Appreciate it. Thank you, Mr. Samuels, for your testimony today.

I want to follow up on your point that there would be a need for an act of Congress to implement this performance-based review. What act of Congress are you exactly looking for, or could that—be recommending to us to pursue, if we want to implement——

Mr. SAMUELS. In the context of the \$250 million we proposed in the Fiscal Year 2012 budget, funding would be available to address state performance. They could earn the money if they performed well. If they did not perform well, they earn no money, but we do not take money from them.

Mr. REED. That is the additional \$250 million?

Mr. SAMUELS. That is correct. If the suggestion is that we ought to implement the performance-based standards by themselves, we could do that. But we could not take any further action against states than what Congress has already given us the authority to do.

I think it would be difficult, in this context, to both say we are going to elevate these new performance standards to drive states,

but without new authority and new money through which you are able to do that.

I appreciate the need to hold them accountable. Congress has given us authority to do that.

Chairman DAVIS. Would the gentleman suspend for a second?

Could we either ask the folks in the hallway to be quiet, or close the door, one or the other?

Mr. SAMUELS. So, let me answer the question a different way.

Mr. REED. Yes, please.

Mr. SAMUELS. As a former child welfare director, I felt absolutely confident that the Federal Government was using all of its authority to hold me accountable. And I think, today, we are.

So, if you want to push states beyond where they are at today, you either need additional resources, or you need additional authority.

Mr. REED. Well, I guess what I am trying to say, Mr. Samuels, is I associate myself with the comments from Mr. Paulsen, in that the performance-based mechanism that you are recommending with the additional \$250 million of additional authorization makes sense to me. And as my colleague indicated, these are difficult fiscal times, and the likelihood of getting that type of—

Mr. SAMUELS. Absolutely.

Mr. REED [continuing]. increased funding is probably going to be slim to none, in my opinion. But taking the concept of what you are recommending as a good performance-based strategy to—the expenditure of these funds, I would encourage the Administration to continue to pursue that. And if there is anything you need from Congress in order to make sure you have the authority to do that with the existing funding levels that you have, please know that we would be very supportive or interested in those efforts.

I would like also to ask—you had indicated there was a penalty, a financial penalty to states, when they didn't meet their 90 percent visitation levels for foster care. And then you—in your testimony you had indicated something—you are only aware of one state that actually paid the penalty, and states have been able to avoid that penalty by engaging in some sort of practice. Could you illustrate to me a little bit further as to what you are referring to for those states that avoid the penalty?

Mr. SAMUELS. Sure.

Mr. REED. What are they doing, and how are they doing it?

Mr. SAMUELS. Currently, the way a state could avoid paying the penalty is simply by raising their level of match. Most states match at a rate much higher than required. States are spending more money than they are obligated to spend under Federal law. As a result, states just demonstrate that they are actually spending more money—and are able to avoid the penalty.

So, it is simply a mechanism where states are putting out more money than they are claiming. Because of that, when they do run into trouble, they simply put up more money, and they are able to avoid the penalty.

Mr. REED. Okay. So what they are essentially doing is allocating more money from their own coffers to avoid paying the Federal Government the penalty—

Mr. SAMUELS. That is correct.

Mr. REED [continuing]. That is being assessed by the Federal Government.

Mr. SAMUELS. That is correct. So it is not that they are avoiding the penalty, per se, they are simply raising the rate at which they are demonstrating to the Federal Government that they are meeting the need.

Mr. REED. Very good. I yield back. Thank you. Thank you, Mr. Chairman.

Chairman DAVIS. Thank you, and the chair now recognizes Mr. McDermott from Washington.

Mr. MCDERMOTT. Thank you, Mr. Chairman, for having this hearing. And, Mr. Samuels, I want to go to your experience before you got in the Federal Government, when you were in Illinois, and talk to you about the training of the workers, the front-line workers, how long it takes, how much you spend, what you try and teach them.

And the second part of that is many of these kids are—it is suggested that they be put on pharmaceuticals for a variety of behavioral problems. Who makes the decision about whether the child is put on those pharmaceuticals? Is it the parent, the foster parent, or is the worker who authorizes—in other words, where is the—

Mr. SAMUELS. Sure.

Mr. MCDERMOTT [continuing]. Informed consent? If it is my child, and I take my child to a physician, the physician says the child needs pharmaceuticals, I authorize it and take the responsibility. Where does the responsibility lie for the putting of kids on pharmaceuticals?

Mr. SAMUELS. Sure. Currently, states are basically responsible for determining who has the capacity and the authority to consent.

Mr. MCDERMOTT. There is no national standard—

Mr. SAMUELS. There is no national standard on who has the authority to sign off on psychotropics.

In Illinois, the case worker can sign off on a psychotropic.

Mr. MCDERMOTT. Can?

Mr. SAMUELS. Yes. However, every prescription is reviewed by an independent contractor. So, a case worker could go into a doctor and a determination could be made that a child needs a psychotropic. They can sign off on that. But then they have to submit both the diagnosis, as well as the prescription, to a review process. Through that review process, if we determine that there is an inappropriate use of psychotropics, we can intervene, and we can intervene with a doctor who has the authority and the clinical expertise to do so.

We are also, at least in Illinois, were able to monitor children as long as they are on a psychotropic. So we have the ability to know when they started and when they stopped. That is important, because it is sometimes the case that a child will go to one physician, and as a result, get a psychotropic and go to a different physician at a different time and receive a second prescription. Those may have interaction effects.

In Illinois, we were able to track every psychotropic that the child is on to assure that there is no interaction effect. We could monitor issues around the unintended consequences of psychotropics. There are side effects to almost every drug. And so,

being able to monitor and make sure that the prescription and the amount does not have a side effect that creates concern was also part of the system.

And ultimately, what we had is a system where every child had a guardian in Illinois. And that guardian can intervene if they believe that psychotropics are inappropriate or ineffective for the child that they are representing.

Mr. MCDERMOTT. Now, how long does it take to train a front-line worker? You take a young woman or man out of college, they have had maybe a social work—at best a social work degree, or maybe a history degree or something else, and they take a job at the Department of Health and Human Services of the state of Illinois. How long does it take you to bring them up to the point where they can operate independently?

Mr. SAMUELS. In the state of Illinois, a worker would go through about a two-month set of training. After that two months they would then be paired with an experienced case worker. Through that case worker, their progress would be monitored over the next six months. And during that six months, there are intermittent circumstances where we bring them in for additional training.

The experience in Illinois is that if you load up all the training up front in a classroom setting, and young people do not have the chance to practice and figure out where their strengths and weaknesses are, then you do not get the kinds of impact that you want, in terms of clinical competency and understanding of policies and programs.

Mr. MCDERMOTT. So, the case load starts at two months—

Mr. SAMUELS. That is right.

Mr. MCDERMOTT [continuing]. After that first sort of educational block—

Mr. SAMUELS. That is right.

Mr. MCDERMOTT. Then you put them with actual patients?

Mr. SAMUELS. That is right. It varies from state to state. So each state has their own training program for front-line workers. Now—

Mr. MCDERMOTT. Now you have moved up to this Federal level. Do we need a national standard that emulates Illinois or something similar? Or—

Mr. SAMUELS. So the position that I would take on that is that what we need is a national standard around the competencies that front line workers need to be effective in child welfare, more than we need a standard that says, “Every state has to train every worker in the exact same way.” But we ought to have a standard, and every state ought to meet that standard.

Chairman DAVIS. Thank you very much. The gentleman’s time has expired. Mr. Berg?

Mr. BERG. Thank you, Mr. Chairman. Mr. Samuels, again, I want to thank you for your passion, and also your experience, really, from the ground up. I don’t really care how big a school district is, 85 deaths a year just astounds me.

But, you know, on the last reauthorization we required states to report how they are spending this money for the first time. And I am a big believer from learning from our past. What have we

learned from that reporting on the states since the last reauthorization on how they spent their money? And what are the—again, I look at the states as the laboratory. What are the effective things that have come out of that?

Mr. SAMUELS. To be honest, as a part of the last reauthorization, there was an increased effort to have states report. So, prior to the reauthorization, the standard was states had to submit a plan that said how they would spend the money. Today they also have to submit a plan about how they actually spent the money.

That is the progress. We don't just have this kind of general understanding of what they said they would spend it on; they come back and actually have to report what they did spend the money on.

Mr. BERG. Well, just so I am clear, so have any of those states given us that second part on how they spent the money?

Mr. SAMUELS. They have.

Mr. BERG. And then what have we done with that? I mean is there a matrix or measurement? Are we—

Mr. SAMUELS. Primarily what happens with that information is that it is reviewed to make sure that states are using funds appropriately. We are looking at how they actually spend the money in accordance with the authority, to make sure that states aren't inappropriately moving money from one part of the budget to the other, one service to the other.

Mr. BERG. So, really, it is a—is it appropriate, not whether it is an effective—

Mr. SAMUELS. That is right, yes.

Mr. BERG. So I guess I am assuming that people are honest with these expenditures, and I think we have to, obviously, have accountability, I mean, if we are going to get this turned around.

So, maybe that is my other question. Do we have measures for each state? I mean I see some matrixes that you are using. Do we have measures, so we can evaluate a state?

Mr. SAMUELS. We do have measures. Again, those measures and requirements are part of the child and family service review. And, as a result of that, we look at those measures every five years.

Mr. BERG. Okay. What I would like to see is, if you would, bring a chart that would show each state.

Mr. SAMUELS. Yes.

Mr. BERG. And on those things that you are measuring—

Mr. SAMUELS. Sure.

Mr. BERG [continuing]. So we can look at each state and understand.

The other question—I appreciate what you are saying, in terms of having accountability, asking states to improve from the prior year, and only would receive money if they do improve. You know, having said that, I think there is a certain level that we ought to expect. And if we have one state that is at the absolute bottom, making zero effort, and we have another state that is really doing outstanding service, you know, I would hate to see the state that is doing outstanding service receive nothing, not any incentive, and the state at the bottom just making a casual effort that gets them up one step and then another step and another step.

And so, I just want to—you don't need to respond to that, I would just like to make that noted, that, again, as you are taking about that money, we cannot forget that people are out there doing a great job, and we need to support those.

The final question I had really related to—we talked about the penalty, the one five percent—again, it is—states are smart. I am kind of disappointed that they are getting around this. So my question to you is, how are we going to fix this? I mean, truly, if we want them to do what we feel is going to help kids, what is our stick, or how are we going to improve that stick to hold them accountable?

Mr. SAMUELS. I am hesitant to make a proposal today. I certainly would be willing to go back and consider that question and give you a more complete answer. What I can say today is simply that in a 4-year period of time, you have had about 40 percent of them meeting their visitation requirements to now close to 75 percent. Even though they are not actually paying a penalty, states are making substantial progress towards that 90 percent standard.

I would be glad to come back with you to make a proposal. But the data clearly demonstrates that, even under the current system, progress is being made, and I think it is reasonable to assume that if we keep the light shining on this, states will get to that 90 percent, and they will get to it in the near term.

Mr. BERG. Thank you. I will yield back.

Chairman DAVIS. Thank you. The chair now recognizes Dr. Price from Georgia.

Dr. PRICE. Thank you, Mr. Chairman. Thank you, Mr. Samuels, for your work.

Serving four terms in the state legislature in Georgia, we have had some significant challenges in our state. And everyone hurts sincerely when kids fall through the cracks. And it seems that, often times, kids do. So I commend you for the work that you are doing.

As a physician, my gut tells me that often times in these situations we are treating the symptoms and not the disease. So I want to address two specific areas of maybe not getting at the right area. One is the issue of waste within the system itself. Have you identified—with all the programs that are charged under your charge and elsewhere within the Federal Government, have you identified any redundancies in charge or in mission of specific programs that might be streamlined and better utilized, the limited resources that we have?

Mr. SAMUELS. We are currently going through an internal review process for that exact purpose. As you know, the President put out a memo outlining the need to both look at reducing unnecessary activities, at the same time making sure that there are accountability standards. We are actually going through a review process now, and the general public has also been invited to identify areas where they think we could reduce administrative burden or increase accountability. I would love to be able to come back to you in a couple of months and share what we have learned through that review, and additional steps that we might take.

Dr. PRICE. So your time line is a couple months on that report?

Mr. SAMUELS. I think that is correct, yes.

Dr. PRICE. And are you—you are pulling in the public. Are you pulling in state individuals who are—have identified—

Mr. SAMUELS. That is correct. I mean the—a public notice has been—a Federal notice has been put out. So folks are actively engaged in reviewing those, and making recommendations. We have also reached out to all of the interest groups here, to make sure that they know that they can submit ideas that they have about reducing the burden of administrative cost.

And so, we are beginning to see that information come in. But I haven't had an opportunity to review it, and would love to be able to come back to you and tell you more, once we have been able to analyze that information.

Dr. PRICE. I look forward to seeing that. The other issue I want to touch on is—specifically, is the root cause of the challenge that we have in this country. As I say, often times we are treating the symptoms when we identify a kid at risk, a child that has been abused. We come in and try as best we can to help the child get through that situation.

What is your agency—what are you doing to work with other areas of the Federal Government? Or are you working to identify the root cause of the challenges that kids have out there? And what are we doing to try to address that issue?

Mr. SAMUELS. I cannot say that we are currently engaged in a process that is looking at root cause. What I can say that we are engaged in is a process of looking at the intersections between Federal policies across each department.

So, we have been working closely with the Department of Education to see whether there are things that we can do different in order to get better educational outcomes for children in foster care. We have been working with SAMHSA and others to see if there is science on mental health services that we could learn from and integrate into the system.

What we have tried to do is to work closely with our sister agencies to get smarter about the most effective strategies for intervening appropriately, both to prevent as well as to deal with maltreatment. But our focus is really on getting better outcomes for kids and families, as opposed to drilling down on root cause.

Dr. PRICE. Is there any entity within the Federal Government that is looking at root cause, do you know?

Mr. SAMUELS. I would have no way of knowing.

Dr. PRICE. Wouldn't it be more wise for us, as a society, to, instead of just—instead of concentrating on treatment of the challenge when it arises, to try to prevent it from happening in the first place?

Mr. SAMUELS. I think most would agree that prevention has a critical role—it reduces the long-term burden that occurs with the development of a mental illness, or a problem from a health perspective.

While in theory, I can agree with you, I cannot, at this point, tell you that there is a way of getting at the root cause the way you describe it. I am not sure that there is a process currently in place, specifically, to do that.

Dr. PRICE. Thank you. Thank you, Mr. Chairman.

Chairman DAVIS. Thank you. The chair now recognizes Ms. Black from Tennessee.

Mrs. BLACK. Thank you, Mr. Chairman, and thank you, Mr. Samuels, for being here today. This is an area that is certainly near and dear to my heart, serving in the Tennessee state legislature. We have dealt with issues about helping our at-risk children.

And so, I want to follow up—and almost a thread—with the last three representatives asking questions about looking at prevention, root cause, evidence base. And those are probably words that those back in Tennessee were so sick of hearing me say that, that they were fed up with my asking those questions. But what I will say is that we finally, after 10 years, saw some real results. And I am very proud to say that we are, in your testimony, noted here about one of our programs.

I want to say that there are good programs out there. And I would encourage the Department to look at those that do prevention. And I am going to lift one up, a nurse family partnership, where we know that if we take these children and put them—or take these young mothers and put them with people that can mentor them at the very beginning, that we see good parenting skills, healthy children, and a lot of great outcomes.

So, I would encourage us to take a look in that area, and to start saying, “What can we do on the prevention side, so that we don’t have to treat these children for many, many, many years for things that are poor outcomes in their homes.” So—

Mr. SAMUELS. Within the administration we can point out a number of areas where prevention and evidence base has been combined.

Certainly the home visiting initiative that is in its first year—it is \$100 million, next year it is almost \$250 million—specifically targeting the prevention of the kinds of problems you have described. I think the home visiting is a good example.

There is also considerable money invested in teen pregnancy prevention. In the child welfare system we have been working with agencies to introduce home visiting related to reducing abuse and neglect, which I think moves in the right direction. And we are currently spending some of our discretionary dollars to introduce evidence based trauma informed practice as a means of getting at some of those programs you described.

Mrs. BLACK. Okay, so let me go to—I know I have limited time—let me go to my next piece on this, is that you do lift up in your testimony, in the PSSF⁷ program, where there are a number of states that you recognize for programs that they have initiated. And I know that one here in North Dakota specifically is an evidence-based program.

Mr. SAMUELS. Yes.

Mrs. BLACK. How are you using what is happening in incubators back in these states to be able to help other states to make sure that what we are using is evidence-based? Because what I have found in our state is that we spent a lot of money on programs that people said, “Oh, they are nice and they are good,” but there was not a measurement tool.

And that may be where I think that we come in, from the Federal level, in whatever the states are doing, to lead them more to-

ward evidence-based programs, as opposed to spending money on things that maybe, oh, they feel good, or somebody says they work, but we cannot measure them.

So, number one, is what are you doing to use what comes to you from other states that is evidence-based and working to get that out, nationwide?

And then, do you do anything to hold states accountable for the money that is spent in saying how is it evidence-based, are you measuring your programs—not directing them on what they necessarily have to do, because they are incubators, I understand that, but to at least say, “Whatever you are doing, you are spending the money on, you have to show that there are results on the other side that are measurable.”

Mr. SAMUELS. I would respond in two ways. One is that we certainly have integrated the evidence-based standard into much of the discretionary grants that we are currently making. There were evidence-based programs that were funded in the 2010 cycle. We would anticipate funding additional ones in the 2011 cycle.

To date, child welfare agencies have not been held accountable for how they choose to spend money. They have been held accountable for whether that money produced outcomes that we care about in child welfare. So, I think it is hard to say that today we are holding them accountable for using evidence-based practices. What we are saying is you ought to be using whatever strategies are most effective at getting to the outcomes that you are being held accountable for.

So, it is a slightly nuanced answer. We are not requiring evidence-based practices, but we are telling them that, “We are going to hold you accountable,” and we are trying to drive them in a direction of selecting and identifying evidence-based programs.

We have also tried to elevate the presence of evidence-based strategies in a number of initiatives we are engaged in. Again, I point to trauma as one example, and the mental health services as another example where we have been demonstrating to states that evidence base can advance their cause.

Chairman DAVIS. Thank you very much. The gentlewoman’s time has expired. And last, but not least, the chair recognizes Ms. Bass from California.

Ms. BASS. Thank you. Well, first of all, Mr. Chair, thank you for allowing me to ask questions, given that I am not in this committee.

But I just wanted to ask you briefly about what is going on in states. Coming from California, a state that is in a terrible economic crisis like so many others, you talked about how states are meeting their targets, in terms of requirements, that the Federal Government places. Do you find—are you seeing anywhere, given the economic crisis in the individual states, that they are going backwards?

And also, are states cutting back on their match?

Mr. SAMUELS. I am unaware of any instance in which the states are cutting back on their match. We would be glad to go back and take a closer look at that if you would like, but I am not aware of any instances where that is occurring.

I think certainly we can read about all of the reductions that are being made in state after state, and we have concerns around particularly case work ratios. We are concerned that with fewer workers doing those visits, meeting their obligations are harder to achieve. But at this point we don't have any evidence that we can specifically point at that says that, as a result of cuts, states are unable to meet their obligation.

But again, our responsibility is to monitor that on a regular basis. We are trying to do that. And if we were to find that states, as a result of cuts, aren't meeting expectations, aren't meeting requirements, we would engage with those states and make clear to them what their Federal obligation is, and how we would hold them accountable if they fail to meet their obligation.

Ms. BASS. Thank you.

Chairman DAVIS. Thank you very much for investing the time, Mr. Samuels, coming here today to share with us. We are looking forward to working with you in continuing this dialogue to structure a reauthorization that addresses efficiency in process, but most of all works to help get to the root causes and protect kids out there on the front lines.

If Members have additional questions, they will submit them to you in writing. And we would appreciate your responses back to the committee also, for the record.

This concludes our second panel, and thank you very much, again.

Mr. SAMUELS. Thank you.

[Pause.]

Chairman DAVIS. I appreciate everybody coming for the third panel, and also your patience, and also grateful to the powers that be that no votes have been called in the midst of this. I think we are going to be able to complete this without interruption on this critical subject.

We are going to have five distinguished panelists. For me, in particular, it is very exciting to have our own long-serving front-line leader, Patricia Wilson, the commissioner of the Department of Community-Based Services from the Kentucky Cabinet of Family and Human Services. And most important to me in her extensive background is not the long list of accolades or administrative leadership positions that she had, it was her many, many years of front-line experience that brings a unique perspective to the work that she is doing now in helping children in the Commonwealth. I appreciate your being here very much.

We also have: Lelia Baum Hopper, director of the Court Improvement Program for the Supreme Court of Virginia—thank you for being with us; Tracy Wareing, the executive director of the American Public Human Services Association; John Sciamanna, director of policy and government affairs, child welfare, at the American Humane Association; and Steve Yager, director of the Children's Services Administration from the Michigan Department of Human Services.

Ms. Wilson, please proceed with your testimony.

STATEMENT OF PATRICIA R. WILSON, COMMISSIONER, DEPARTMENT FOR COMMUNITY BASED SERVICES, KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

Ms. WILSON. Thank you, Chairman Davis, Ranking Member, Members of the Subcommittee. Thank you so much for this opportunity to talk to you this morning about programs that are of supreme importance to our nation's children. I am honored to speak with you about these two programs that are so critically important to our nation's children: Child Welfare Services and Promoting Safe and Stable Families. In Kentucky alone, approximately 50,000 children are touched annually by these two programs.

Most of my comments this morning are going to focus on the three key aspects that were in the last reauthorization: the monthly case worker visits, the regional partnership grants, and working with parents with substance abuse issues.

First, the monthly case worker visits. As Chairman Davis noted, I am a former front-line worker and supervisor, something I am very, very proud of. I applaud Congress for setting the benchmark that every child in foster care should be seen every month. Nothing is more important to those children to have that contact with the individuals who know their case, who know their families, who know what is happening. It is also essential, as we move those children toward permanency.

However, I would like to note that the method of calculating that performance is of concern to just not only my state, but to others. The current calculation is child-based, meaning that any missed visit to a child within a 12-month period negates all the visits that were made to that child. An alternative that could be considered would be looking at every visit counting as an event, in and of itself. And states would be given credit for all the visits that are made to children. States should be held accountable. Sanction is an acceptable means of correcting poor performance. But we also believe that states should be recognized for the performance that they do make

Funding to support the case worker visits is much needed to help off-set the rising cost of transportation. Again, in a rural state such as ours, where children are sometimes placed a distance from their home in order to receive the treatment they need, the mileage that our staff incur traveling to and from those visits is costly for the state, and we appreciate the extra compensation to address that.

The second aspect, improving outcomes for children with substance-abusing parents or caregivers. Last year in Kentucky, 60 percent of the children in substantiated reports of child abuse or neglect were found to have families exhibiting substance abuse issues. It is a tremendous problem in our state.

I do want to highlight, though, the positive impact of one of the regional partnership grants that Kentucky was fortunate to receive. Martin County, in rural Appalachia, has just over 12,000 residents in the entire county. But it leads Kentucky in the percent of the child population in substantiated reports of child abuse and neglect. Approximately 6½ children out of every 100 children in that county were found to have substantiated reports. That compares to 1½ children per 100 in the rest of the state. Half of those

children were ages six or younger. Substance abuse by the parent was a driving force in the majority of those cases.

Prior to the regional partnership grant, there was one substance abuse counselor in the entire county who provided one day of outpatient service per week. There was a four-month waiting period to even receive one hour of service per week. There were no support groups.

With the grant, we were able to replicate a—our START program. This program pairs highly-trained parent mentors with specially-trained child protective service workers to provide intensive case work services to the families, partners with substance abuse treatment professionals to ensure quick access to treatment, and partners with the court to identify options for child safety and permanency.

In the two-plus years of operation, the county has developed intensive outpatient services that are available four days and several nights per week. There are now 9 weekly 12-step meetings and a Families Anonymous meeting. There is a support group. And, very importantly, transportation is able to be provided to those individuals who need help in either accessing services, or—we have found through our evaluation accompanying the individual to the first four appointments with their substance abuse counselor is one of the most effective means of keeping them in treatment.

To date, more than 40 percent of the parents served, most of whom are young marrieds are in their 20s, and have among them more than 100 children, have been able to become sober and maintain their children safely at home. Over time, we believe the success rate in Martin County will equal that of the 67 percent success rate that we have in the other 3 counties where this program exists.

Finally, the coordination of health care needs with children. We have entered into a cooperative agreement with our commission on children for special health care needs to address those needs of children in foster care by deploying registered nurses across the state. A larger issue, though, as Commissioner Samuels noted, is the use of psychotropic medicines.

We have concerns that children who are taking multiple psychotropic meds may not have regular psychiatric consultation, that those medications may be prescribed by someone other than a child psychiatrist, and that there are children who are receiving benefit of that that could also benefit from alternative methods of behavior management.

In closing, I would offer a general comment about the 20 percent distribution, the interpretation across the 4 broad categories in Safe and Stable Families.

Chairman DAVIS. If you could, sum up quickly, please—

Ms. WILSON. Yes, sir.

Chairman DAVIS [continuing]. Your time has expired.

Ms. WILSON. With 15 years plus of experience, and data to support the assertion, states are finding there is a need to rebalance the funding within the service needs of families. Allowing states more latitude in determining the distribution of that allotment would provide increased opportunity to fully actualize the goals of Safe and Stable Families.

Chairman Davis, Members of the Subcommittee, we appreciate your support, we appreciate your concern for children and families.

We urge reauthorization, and I thank you for the opportunity to present the views.

[The prepared statement of Ms. Wilson follows:]

TESTIMONY OF
PATRICIA R. WILSON, MSW
COMMISSIONER, KY DEPARTMENT FOR COMMUNITY BASED SERVICES

before the

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HUMAN RESOURCES
US HOUSE OF REPRESENTATIVES

“Improving Programs Designed to Protect At-Risk Youth”

June 16, 2011

Good morning, Chairman Davis, Ranking Member Doggett and Members of the Subcommittee. My name is Patricia Wilson. I am the Commissioner of the Kentucky Department for Community Based Services – the agency that administers the child protection, foster care and adoption, adult protection, child care assistance, Temporary Assistance for Needy Families, Supplemental Food and Nutrition Program and Medicaid eligibility for the Commonwealth. Collectively, the programs the Department administers in each of Kentucky’s 120 counties touches the lives of approximately 1 million individuals annually; nearly 20% of the state’s population.

I am most honored to have the privilege of speaking to you about two key aspects of the child welfare system, the Child Welfare Services program and the Promoting Safe and Stable Families program. Each of these programs is instrumental to the safety and well-being of our nation’s children. In Kentucky, approximately 50,000 children and their families are touched by these two programs annually. While the specific instances I will share with you are drawn from Kentucky’s experience, the themes reflect perspectives shared by colleagues across the country.

Child Welfare Services and Promoting Safe and Stable Families, in concert with the other programs under the rubric of Title IV-B, along with Title IV-E, Foster Care and Adoptions, form the nucleus of our approach to families experiencing child abuse and neglect. Particularly since the inception of Promoting Safe and Stable Families in 1993, the acts of Congress to reauthorize and expand these two programs, along with the Court Improvement Program, have provided a sustained focus on children and families by enabling services that assist in assessing, developing and enhancing the protective capacity of families, promote the child and family’s engagement in case planning and set clear expectations about the achievement of permanency for children who are removed to foster care. The reasons for abuse and neglect are varied, ranging from a knowledge deficit, parental inattention and poor parenting skills through acts of harm fueled by the substance abuse of the parent/caregiver. Regardless of the underlying cause of the abuse or neglect, the children in those families deserve and must be afforded the opportunity for

safety and stability. It is that opportunity that the programs we speak about today seek to enable.

While both programs target the issue of child abuse and neglect and are often seen as synonymous in purpose, it is important to recognize a distinction permitted by legislation. Child Welfare Services encompasses a wider range of activities than are permitted under Promoting Safe and Stable Families (PSSF). PSSF is specific to interventions targeting four broad categories of child and family service, while a prime use of Child Welfare Services funds is for the salaries of child welfare workers engaged in the investigation of reports of abuse and neglect as well as the provision of protective services.

Any of the four broad categories – community-based services to increase the strength and stability of families; in-home services to improve parenting skills in order to prevent removal; time-limited reunification services to facilitate the safe return of children who have recently been removed from the home; and, services and activities to promote and support adoption of children experiencing foster care – are worthy of testimony; however, my comments today will focus on three aspects that were new to the last reauthorization (monthly caseworker visits, regional partnerships related to substance abusing parents, coordination of medical care) as well as offering suggestions for program improvement.

First, monthly caseworker visits. As a former front-line worker and supervisor, I applaud Congress and the Administration for setting the benchmark for acceptable practice being a monthly caseworker visit to the child in foster care. Children removed from their home deserve to know about efforts being made to remedy the circumstances that resulted in their removal, to have their care monitored and to have the opportunity to voice their concerns and worries. Who better to listen and provide information than the person working the case? Monthly visits are critical to improving permanency outcomes for children in foster care.

It is not the intent of the legislation that is concerning, rather it is the method of calculating performance that is troubling. The current calculation is child-based, meaning that the number of months a child is in care a full month in a twelve month period counts as one unit. If the caseworker fails to visit in any one of those months, the child's case is deemed out of compliance for the entire 12 month period. For example, a child meriting 11 visits in a 12 month period was seen 10 times, but according to the current methodology, the child's case is out of compliance for the full 12 month period.

Being out of compliance has financial repercussions for the agency and a personal impact on the caseworker. For the agency, if compliance falls below an established threshold, the state must spend more its own funds under the program in order to receive its full federal allotment. States should be held accountable for performance and if progress toward the goal does not occur, sanction is an acceptable consequence of poor performance; however, it is equally important that the measure of performance be one that gives credit for all work that is done. For the worker, it is demoralizing to know that

missing one visit discredits all other visits that may be made – and that one missed visit could cost the agency financially.

There are often valid reasons for missing monthly visits. While the issue of available and accessible resources is one that child welfare agencies are ever striving to address, the fact is that a number of children in foster care must be placed some distance away from their home communities in order to receive the care and treatment they need. Particularly in rural states such as mine, inclement weather including ice and snow storms and flooding can make driving treacherous, which necessitates planned visits being cancelled, without sufficient time to reschedule within the month. Other acts of nature, whether tornadoes, hurricanes or wildfires, also contribute to missed visits.

Additionally, during these fiscally constrained times, many jurisdictions have to contend with a reduced work effort, either due to hiring freezes, layoffs or furloughs. In a child welfare agency, no responsibility weighs heavier than that of timely response to reports of child abuse and neglect. Caseworkers and supervisors often face the dilemma of juggling monthly visits with conducting protective service investigations. When that happens, the decision is to err on the side of child safety and give the investigation precedence.

A proposed alternative methodology is to make the calculation event-based. Every required visit would count as one unit. In the above example, the case meriting 11 visits would be credited with the 10 visits that were received.

To further illustrate, I use my agency as an example. Under the current methodology, there were 9,828 children in foster care at least a full calendar month over the 12 month period; 6,449 of those children were visited each of the required months for a rate of 65.6%. Under the proposed alternative of calculating the number of visits that those 9,828 children merited, in that same 12 month period, 72,379 visits were required; 64,662 of those visits were made for a rate of 89.3%. I'm quite certain this disparity is not unique to Kentucky.

Continued funding to help support the caseworker visits is much needed. As agencies raise personal vehicle mileage reimbursement rates to defray the rising cost of gasoline, we find ourselves falling further behind in our efforts to balance the expense of service with available revenue.

The second aspect I will comment on is that of **improving outcomes for children affected by their parent/caretaker's abuse of methamphetamine or another substance**. Kentucky, like many other states, finds that substance use/abuse by parents/caretakers is a predominant characteristic in the majority of its child abuse and neglect reports. Substance abuse is found to be a risk factor in the majority of the almost 40,000 investigations we conduct annually. Among children in substantiated reports of abuse and/or neglect, 60% were found to have families exhibiting substance abuse; the younger the child the higher the rate of parental substance abuse. Sadly, though, the

opportunities for treatment, especially intensive out-patient and long-term residential, are quite lacking.

Beginning in FY 2007, through a competitive grant process, 53 regional partnerships involving child welfare and other impacted agencies, such as substance abuse, mental health, local law enforcement, juvenile justice, judiciary and education, were formed to address this issue. Two of those 53 partnerships were granted in eastern Kentucky, a region that leads the nation in the illicit use of diverted prescription drugs according to two studies conducted by the University of Kentucky (Leukefeld et al., 2005) and the Carsey Institute of the University of New Hampshire (Van Gundy 2006). These studies also show that substance abuse directly or indirectly affects nearly every individual in the region, yet treatment is rarely available. Additionally, in 2008 the Office of National Drug Control Policy included a number of Kentucky counties in the High Intensity Drug Trafficking Area, with a primary emphasis on marijuana.

While there is not time to detail both programs, I would like to highlight the positive outcomes of the partnership in tiny Martin County. This county of just over 12,000 residents in rural Appalachia led Kentucky in the percent of the child population in substantiated reports of abuse or neglect in 2010 with 6.6 of every 100 children in the county having substantiated abuse compared to 1.5 in the state. Half of those children with substantiated reports were age 6 or younger. With an average family income of \$23,000, 37% of the children live in poverty.

Prior to the regional partnership, there was one substance abuse counselor who provided one day of outpatient service per week for all the clients in the county. There were 65 women waiting for services, with a 4 month wait to receive a maximum of one hour service per week. There were no support groups, such as AA, NA or faith-based. There was little hope of helping these families and addiction seemed to affect every person in the county, either directly or indirectly.

The Regional Partnership Grant enabled the child welfare agency and the state substance abuse agency to work collaboratively with county officials and residents to implement the START (Sobriety Treatment and Recovery Teams) program in Martin County. The child welfare and substance abuse agencies had successfully implemented START in three other counties across the state, but limited funding dictated the scope of the program.

START pairs highly trained family mentors with specially trained child protective service workers; partners with substance abuse treatment professionals to ensure quick access to treatment, retention in treatment, and joint decision making with the family; and, partners with the court to identify options for child safety and permanency and to promote parental capacity to care for children. In the two plus years the program has been operational (establishing the infrastructure takes time), the county now has

- Intensive out-patient services for both mothers and fathers within the county four days per week and several nights per week;
- Nine weekly 12-step meetings and a Families Anonymous meeting;

- A faith-based support group, regular town hall meetings and community partnership groups that build community supports for people in recovery;
- Transportation to services as needed. Transportation support includes accompanying the client to the first four out-patient sessions as this has been demonstrated to be important to participation retention.

Fifty-one families (98 parents), mostly married couples in their mid-20s, with 112 children, have been served. Another 61 families were referred but had to be turned away due to caseload limitations. Of those 98 parents served, 75% received treatment within 10 days of the referral (immediacy being a key to participation) and 40% have been able to achieve sobriety and maintain their children safely at home. The results from the Martin County program are not yet equal to those in the more established counties where 67% of the families have been successful, however, as the program matures, the rate of success is expected to improve. Moreover, as the county Family Court judge recently commented, “we now have hope in the community and real support for that hope”.

The Regional Partnership Grants supports rigorous program evaluation at the state and national level so that solutions to this difficult problem of parental substance abuse and child maltreatment can be clearly identified and disseminated nationally. To ensure program fidelity, the same data collected for the START program in Martin County is collected and analyzed for all of Kentucky’s START sites. Collectively, the evaluation of the four START sites in Kentucky evidences that children in families served by START are 50% less likely to enter foster care when compared to similar children. It costs \$20,000 per family to provide the treatment, family mentor services, specialized child protective service intervention, wrap around supports, program administration and evaluation.

The third aspect on which I will comment is **consultation with medical professionals and physicians in assessing the health and well-being of children in foster care, as well as determining appropriate medical treatment** for them. The first of my comments draw solely upon Kentucky’s experience. Having registered nurses on staff in central administration as well as having 10 registered nurses deployed across the state through a cooperative agreement with The Commission on Children with Special Health Care Needs provides consultation and support to frontline child welfare staff regarding medical issues of children in foster care, assessment of injuries identified during investigation, coordination of appropriate medical follow up, and insuring access to all health services including prevention and wellness programs, in addition to making face to face visits with medically fragile children in foster care. This collaboration has made consultation around children’s health issues more readily available. The primary obstacle we have experienced in obtaining routine health care for children in foster care has been children living in areas underserved by medical professionals. While this has not been a widespread issue for physical health, dental care is a much more troublesome issue as there are far fewer practitioners available. For those children needing the most intensive mental health services, the child welfare agency and the state Medicaid agency work collegially on securing the most appropriate placement.

The issue that looms large for Kentucky, and perhaps other states based on anecdotal reports, is oversight of prescription medicines, particularly psychotropics, for children in foster care. While not all abused or neglected children manifest mental or behavioral health issues, those who do may exhibit depression, aggression, anxiety, and/or self-injurious behaviors. As Kentucky approached its 2008 Child and Family Service Review, a convening of stakeholders elicited the following concerns with regard to psychotropic medications for children in foster care:

- Children who take multiple psychotropic medications should have regular psychiatric consultation;
- Psychotropic medications are often prescribed by pediatricians when child psychiatrists are not available prior to the child entering foster care; and,
- Psychotropic medications are being prescribed (possibly inappropriately) when other alternatives for behavior management have not been fully explored and used.

Kentucky is attempting to address these issues through its multi-disciplinary State Interagency Council (SIAC) composed of child welfare, behavioral health, education, juvenile justice, public health and the courts. For child welfare in general, the oversight of prescription medicines may be one of the most complex issues confronting practice. It is an area that requires thoughtful planning and collaboration among all the partner agencies. As has come to the attention of Congress and the Administration, this issue merits careful study as future policy decisions are considered.

In closing, I offer a general comment about the interpretation that a state must spend 20% of its **Promoting Safe and Stable Families allotment** on each of the four service categories. As has been documented via numerous reports, the four categories of PSSF - community-based services to increase the strength and stability of families; in-home services to improve parenting skills in order to prevent removal; time-limited reunification services to facilitate the safe return of children who have recently been removed from the home; and, services and activities to promote and support adoption of children experiencing foster care - are similar, and in some cases identical, in their purpose. While each has a different target population, such as any family in a community benefitting from the community-based services as compared to those families receiving time-limited reunification services because their child has been removed, the overarching goals are related - promoting the safety and stability/well-being of children within the context of family, whether that family is biological, foster or adoptive.

When Promoting Safe and Stable Families was authorized in 1993, there was understandably much concern from Congress and the Administration that states give equal consideration and resources to each of the four goals. Targeted funding provides direction that most generally drives results. That drive to results is perhaps no better demonstrated than in the growth of adoptions from foster care due to the promotion and support undergirded by PSSF. However, with fifteen plus years of experience and data to support the assertion, states are finding there is a need to rebalance the funding of PSSF across the service categories. For example, activities promoting adoption and adoption support have become so embedded in agency practice that the positive results can be

sustained without as much targeted funding. On the other hand, states are grasping for additional resources to prevent removals and enhance reunification.

Allowing states more latitude in determining the distribution of its PSSF allotment would provide a much needed opportunity to rebalance the funding with the service need in order to fully actualize the goals of Promoting Safe and Stable Families.

Chairman Davis, Ranking Member Doggett and Members of the Subcommittee, your attention to and concern for the welfare of abused and neglected children is most sincerely appreciated by child welfare agencies, community partners, foster and adoptive parents, advocates and most importantly, the children and families whose lives are impacted.

Thank you for the opportunity to share my views.

Chairman DAVIS. Thank you very much.
Ms. Hopper.

**STATEMENT OF LELIA BAUM HOPPER, DIRECTOR, COURT
IMPROVEMENT PROGRAM, SUPREME COURT OF VIRGINIA**

Ms. HOPPER. Good morning, Chairman Davis, Members of the Committee. Thanks for the opportunity to discuss funding by the Virginia Court System of court improvement program funding. My name is Lelia Hopper, and I am director of the court improvement program in the administrative office of the courts, under the Supreme Court of Virginia. I have worked with the court improve-

ment program since it was first authorized by Congress, and grants were made available in 1994.

The challenge for court improvement programs is to sustain the considerable energy that it takes on the part of the judiciary and professionals who carry out the reforms daily that you all have instituted. Today, excellent court practice requires that we go beyond the basics. Since 2006, when the new CIP grants for training and data collection and analysis were made available, we have been able to substantially improve upon and energize early system reform efforts.

Training grant funds since 2006, including those planned through the end of this grant year, have enabled Virginia's court improvement program to support 123 local and state training events, with more than 12,000 participants. We have also provided funding for juvenile court judges, attorneys, child dependency mediators, staff for CASA programs to attend 13 national educational events that have enhanced their skills. The large majority of these individuals would not have benefitted from these educational opportunities without CIP funding support.

In Virginia, many juvenile court judges provide leadership in their communities to provide—to improve child dependency court processes on a multi-disciplinary basis. Their involvement is supported by the best practice court program, instituted by my office in 2002, and substantially supported in the past 5 years with training grant funds.

Today there are 37 active court teams, which account for 60 percent of Virginia's foster care caseload. These teams have committed—have contributed to a 27 percent decrease in the number of children in foster care in Virginia over the past 3 years. This reduction has been accomplished as a part of a transformation of Virginia's children's services system, of which the courts have been an integral part.

The data grant. Our office produces 10 court performance measurement reports, utilizing case information that is entered by court staff into the juvenile case management system. In 2010 we began development of these reports into web-based formats, making them more interactive and user friendly. We will complete this project this September.

In 2008, we began making analyses of local juvenile court performance measures available to the courts. This analysis process is initiated by the presiding juvenile court judge, includes a written report, a meeting, and recommendations to improve court practice. To date, we have completed 15 of these court analyses.

An interface between the courts and the state department of social services is something we have been working on for quite a while. Both of our agencies recognize that an interface would improve the ability of the courts and social services to process paperwork and make timely decisions for children in foster care. And we are scheduled to begin implementation of the first phase at the end of this year.

Finally, we also have available online to our judges—and it is only to judges—something called the active foster care children report. It is updated daily and provides a snapshot of children in foster care identified by locality. It includes demographic information,

foster care placement information, funding resources, and critical hearing dates. Prior to this electronic transmission, we could only provide this information twice a year in a hard copy to the courts.

Mr. Chairman and Members of the Subcommittee, Virginia and the other court improvement programs across the country are effectively utilizing the court funds that you have provided to improve court practice. And we believe we are making a measurable difference for families and children who are under the jurisdiction of the court system.

Thank you for your time.

[The prepared statement of Ms. Hopper follows:]

Testimony of Lelia Baum Hopper
 Director, Court Improvement Program
 Office of the Executive Secretary, Supreme Court of Virginia
 lhopper@courts.state.va.us

Before the Subcommittee on Human Resources of
 Committee on Ways and Means,
 U.S. House of Representatives
 June 16, 2011

Hearing on the Reauthorization of the Child Welfare Services program
 and the Promoting Safe and Stable Families Program, including the Court Improvement Program

Good morning Chairman Davis, Ranking Member Doggett, and other members of the Subcommittee. Thank you for the opportunity to discuss the use of Court Improvement Program funding by the Virginia court system. I will share with you how this funding is enhancing the ability of our trial courts to adjudicate and dispose of child dependency cases in a manner that reunites families when that is safe and appropriate and promotes timely permanency for children.

My name is Lelia Baum Hopper, and I am Director of the Court Improvement Program in the administrative office of the courts in Virginia under the Supreme Court of Virginia. I have worked with the CIP since it was first authorized by the Congress and grants were made available to the courts in 1994. Virginia was awarded its first grant funds in early 1995. Each year since then the Virginia court system has applied for and received all available funding through CIP.

The early years of CIP in Virginia focused upon revising our laws, court procedures and forms to be in compliance with the Adoption and Safe Families Act (ASFA) and training judges, court personnel, members of the Bar, and social services professionals on the new timelines and required court findings. The challenge for CIP in Virginia and similar programs across the country is to sustain the considerable energy it requires of the judiciary and professionals who daily carry out the reforms of the late 1990's and early 2000's. Excellent court practice in the 21st Century requires that we go beyond the basics. Since 2006 when the new CIP grants for Training and Data Collection and Analysis were made available, we have been able to substantially improve upon and energize early system reform efforts.

The Basic, Training and Data Collection and Analysis Grants for the Court Improvement Program are supporting, among others, these activities:

- collaborative efforts at the local and state levels to tackle the challenges that vulnerable and troubled children and families present to the courts and human services agencies
- sophisticated local and state trainings and attendance at national educational conferences, and
- enhancements to court automated information systems that permit the tracking of child dependency cases, the measurement of court performance in these cases, and the sharing of information between the courts and social services.

In accomplishing this work, Virginia's CIP works with:

- 115 Juvenile and Domestic Relations District Court judges and their court staffs
- attorneys who represent social services agencies, parents, and children
- representatives of local social services agencies and their community partners, and
- state counterparts for these agencies.

We are inclusive of all of these key players in this court process because judges need accurate and comprehensive information about the children and families who come before them in order to make informed, effective and timely decisions on behalf of children and families. Court decisions define and refine agency actions over the life of a case and govern the lives and futures of the parties. To be effective, court decision-making requires that the state fulfill its responsibilities through the provision of services, and that parents, families and kin cooperate with these efforts on their behalf.

TRAINING GRANT

Training Grant funds awarded since 2006, including those planned through the end of this grant year, have enabled Virginia's CIP to sponsor or support with funding and staff, 123 local and state training events with more than 12,000 participants. In addition, we have provided funding for juvenile court judges, attorneys, child dependency mediators, and staff for Court Appointed Special Advocate (CASA) programs to attend 13 national educational events and institutes that have enhanced their skills in child dependency case processing and the understanding of permanency planning for children. The large majority of these individuals would not have benefited from these educational opportunities without CIP-funded support. Each of these professionals returns to their communities after these events better able to meet their obligations to the families and children with whom they work and to support an effective court process, when it is required.

There are other notable benefits to an enhanced understanding of the best practices associated with child abuse, neglect and foster care litigation and permanency planning for children among these constituencies. There are a multitude of people involved in these cases. The cases can be in court for a lengthy period of time with numerous hearings and court orders. The court case occurs simultaneously with the involvement of the local department of social services, schools, mental health agencies and other community professionals in assisting the child and family. The process is most effective when these professionals appreciate the role that each has to play in returning the child home, when that is appropriate, or securing some other safe and permanent placement for the child. Multidisciplinary trainings and meetings build trust, understanding, and lines of communication across the entourage of professionals who advise the court and serve these children and families.

Best Practice Court Program. In Virginia, many Juvenile Court judges provide leadership in their communities to improve child dependency court processes on a multidisciplinary basis. Their involvement is supported by CIP staff and funding through the Best Practice Court Program, instituted in 2002, and substantially supported in the past 5 years with Training Grant funds. Today, there are 37 active court teams which account for 60% of the foster care caseload in Virginia. These teams have contributed to a 27% statewide decrease in the total number of children in foster care in Virginia over the past three years. This reduction has been accomplished as part of the transformation of Virginia's children's services system, of which the courts were an integral part. The 39 lead judges represent 35% of Virginia Juvenile Court judges and are located in 22 of 31 Judicial Districts. The critical work of permanency planning for children is accomplished locally where judges hold court, lawyers represent children and parents, and child welfare professionals seek to protect and preserve families. Virginia's CIP is focused on supporting these efforts.

DATA COLLECTION AND ANALYSIS GRANT

Virginia began addressing issues with the tracking of child dependency cases in the Court Automated Information System in the late 1990's and identifying areas where measuring court performance would be useful and desirable. We also initiated efforts with the Virginia Department of Social Services to establish a data interface with the courts in this case area. Virginia's CIP completed a blue print in September 2000 with a multidisciplinary group entitled "Automating for Permanency." In 2004, we applied for and received a grant from the Department of Justice's Office of Juvenile Justice and Delinquency Prevention (DOJ/JJDP) to operate a demonstration project under the *Strengthening Abuse and Neglect Courts in America: Management Information Systems (SANCA-MIS)* project.

This work continued to be supported by the Data Grant awarded in 2006. Today, the Office of the Executive Secretary is able to produce 10 reports as part of this performance measurement. The reports are populated by case information entered by local juvenile court staff into the Juvenile Case Management System (JCMS). While these reports provide useful information that assists the courts in measuring performance, the programming format does not provide the end user with information to understand the data presented, or the ability to control the information viewed. In 2010, utilizing funding from the CIP Data Grant, Virginia began working with contract programmers to develop its court performance measures into web-based reports. This new format makes the reports more interactive and user friendly, allowing the end user to choose a pre-designed report, enter the specific date parameters s/he is interested in, and, where necessary, drill down into the system to review specific information about cases included in the data. Additional functionalities include the provision of data in pie charts, bar graphs or line graphs, as well as report filters. This project is scheduled to be completed by September 2011.

Analysis of Court Performance Measures for Child Dependency Cases. In 2008, CIP began to provide local juvenile courts with an analysis of their court performance measures for child dependency cases. The analysis process is initiated by the presiding judge of a local juvenile court and includes a written report by CIP staff and a meeting about the report data and recommendations to help the court improve its practices. CIP assists the judge and clerk with determining training needs for clerk's office staff on data entry requirements and on the necessity of new or additional court policies to improve court practice. To date, CIP has completed 15 court analyses.

E-Learning Programs for Judges and Clerks' Office Staff. When new judges are appointed to the juvenile court bench, or when new staff persons are hired to work in the juvenile court clerk's office, they often have limited experience working in child dependency cases. This is problematic because they are not familiar with the time lines for processing these cases, nor are they familiar with the adjudicatory or dispositional requirements of these cases. Training is offered on the law, process and use of forms applicable to child dependency cases in the court as part of the annual Pre-Bench Orientation Program for new Juvenile and Domestic Relations District Court judges, and as part of the Juvenile and Domestic Relations District Court New Employee Basic Course. However, a judge or clerk may be in their position for several weeks to several months before any substantive training is received.

In 2009, in an effort to make training on processing child dependency cases more readily available to judges and clerk's office staff, CIP developed its live training program, *Case Processing in Child Dependency Cases*, into two e-learning courses: *Foster Care Training*

Program for Judges and Foster Care Training Program for Clerks. Each course covers the following:

1. The role of the judge, clerk's office, attorneys, guardians ad litem (GAL) and local department of social services in the child dependency case process.
2. The timeliness of child dependency case hearings, including a review of Virginia's time line for abuse, neglect and foster care cases.
3. The appropriate use and proper completion of child dependency court forms in accordance with the individual stages of the child dependency case process provided in the time line.

Interface between the Court's Case Management System (CMS) and Virginia Department of Social Services' (VDSS) Online Automated Services Information System (OASIS). Discussions regarding an interface between the Court's CMS and VDSS's OASIS have been ongoing in Virginia for some time. Both agencies recognize that an interface will improve the ability of the courts and VDSS to process paperwork and make timely decisions that will promote safety and permanency for children in foster care. Staff time is also saved by the reduction in the amount of information the courts and local agencies will need to manually enter into the systems. This reduction in data entry limits the potential for errors and increases the accuracy of the data available in both systems. An Interface will also provide for more timely and accurate court-related information on the Active Foster Care List. Unfortunately, when discussions originated in 2004, an interface between the two systems was not possible. This was due, in part, to system capabilities.

In 2009, the courts and VDSS re-opened discussions on the establishment of a data interface. At that time, it was determined that there are no technical hurdles for the court or VDSS to overcome. Discussions regarding various implementation aspects, including the matching of case records, the format in which data will be exchanged, the frequency of the data exchange, and error handling are ongoing.

Implementation of this interface is scheduled to occur in two phases. Phase 1 implementation, which will include the transmission of data from OASIS to CMS, is anticipated to occur in late 2011. Phase 2 will include the transmission of data from CMS to OASIS.

Active Foster Care Children Report. While awaiting the establishment of a data interface, the courts and VDSS developed an electronic transmission from VDSS's OASIS, of the "Active Foster Care Children Report." Available online only to Juvenile Court judges, the report, which is updated daily, provides demographic and foster care placement information, as well as funding sources, for each child in foster care, identified by locality. It also supplies the date the agency took custody of a child, the child's program goal, and the child's last and next hearing date and type. Prior to electronic transmission, the report was provided semi-annually to the courts in hard-copy format.

CONCLUSION

Mr. Chairman and members of the Subcommittee, Virginia and other CIPs across the United States are effectively utilizing the grant funds Congress has appropriated to improve court practice. We believe we are making a measurable difference for children and families under the jurisdiction of the court system. Thank you for the opportunity to share Virginia's efforts with you. I would be pleased to answer any questions you may have.

**Virginia Court Improvement Program
2011 Calendar of Events**

March 8	Alexandria BPC Team, LTE
March 16	Processing Child Dependency Case Types in JDR Courts Clerk's Office Training - Fairfax
March 17	Processing Child Dependency Case Types in JDR Courts Clerk's Office Training – Richmond
March 20-22	National CASA Conference, Chicago, Illinois
March 21	Wise BPC Team, LTE
March 22-23	Processing Child Dependency Case Types in JDR Courts Clerk's Office Training – Wytheville
March 28-29	Processing Child Dependency Case Types in JDR Courts Clerk's Office Training – Hampton
March 30	Processing Child Dependency Case Types in JDR Courts Clerk's Office Training – Fredericksburg
April 4	Culpeper BPC Team, LTE
April 6	Winchester/Frederick BPC Team, LTE
April 8	Stafford BPC Team, LTE
April 12-13	CIP Conference for JDR Judges and Retired JDR Judges
April 14	Henrico BPC, LTE
April 14	Staunton/Augusta/Waynesboro BPC Teams, LTE
April 14	Roanoke FEM Training
April 15	Campbell/Bedford/Amherst BPC Teams, LTE
April 15	Abingdon FEM Training
April 29	Fredericksburg BPC Team, LTE
May 3	Loudoun Co. BPC Team, LTE
May 6	Hampton BPC Team, LTE
May 6	Virginia Beach BPC Team, LTE
May 12	Harrisonburg FEM Training
May 17	Fairfax BPC Team, LTE
May 20	Washington County/Bristol BPC Team, LTE
May 24	Northampton BPC Team, LTE
May 24	Richmond County BPC Team Community Meeting
May 25	Richmond FEM Training
May 26	Fairfax FEM Training
June 2	Campbell BPC Quarterly Training – Tumbling the Silos
June 8-10	One Child, Many Hands Conference for Child Dependency Mediators, Philadelphia, PA
June 15	Virginia Beach FEM Training
June 17	Newport News/Williamsburg/James City BPC Teams, LTE
June 20-24	NCJFCJ Child Abuse and Neglect Institute, Reno, NV
June 22	Richmond BPC Team, LTE
June 23	Franklin County BPC Team, LTE
June 24	Chesapeake BPC Team, LTE
June 29	Charlottesville/Albemarle/Nelson BPC Teams, LTE
June 30	Williamsburg FEM Training
July 13-14	2 nd National Parents' Attorney Conference, Arlington, VA
July 24-27	NCJFCJ 74th Annual National Conference, NY City, NY
August 10	Judicial Conference - CIP Day for All JDR Judges, Va. Beach
September 8-9	Sixth Statewide Best Practice Courts Conference - Williamsburg
September 23	CIP State Conference for Social Services Legal Counsel - Richmond

*BPC—Best Practice Court
LTE—Local Training Event
FEM—Family Engagement Meeting*

Note: The majority of these events are invitation only and are not open to the public.

Sustaining Energy for Permanency Planning for Children Virginia's Best Practice Courts¹

Lelia Baum Hopper, Director, Court Improvement Program, Office of the Executive Secretary, Supreme Court of Virginia

Summary: The author outlines best practice court activities and commitments and describes the extent of best practice court involvement.

Today's challenge for Court Improvement Programs is to sustain the considerable energy required of the judiciary and professionals who daily carry out reforms instituted in child welfare over the past 15 years. Excellent court practice in the 21st century requires that we go beyond the basics of teaching timelines, correct completion of court forms and "required federal findings." To be effective, court proceedings and orders must be supported by community professionals and services that respond in a holistic, therapeutic manner to child maltreatment and children at-risk of entry into foster care. Judicial leadership is essential to accomplish this result.

In 2002, requests by Virginia's juvenile and domestic relations district court judges for advanced training and assistance to support local efforts to improve permanency planning for children led Virginia's Court Improvement Program (CIP) to establish the Best Practice Courts Program. The program's core purpose is to help judges and court personnel ensure that each child's case is handled safely, expeditiously and in compliance with Virginia and federal requirements. However, there are other benefits to following the best practices associated with these case types.

Effective court processing of child dependency cases and enhanced community collaboration can have positive effects on the rest of the court's docket. Many of the same children and their families are involved in other disputes before the court, such as truancy, child in need of services, custody, support, visitation and domestic violence. Courts can pursue numerous avenues to impact their service to the public and institute long-term, institutional change. Participation as a best practice court (BPC) also offers judges the opportunity to share ideas and local initiatives with and learn from other Virginia judges and with courts of similar jurisdiction in other states. Becoming a BPC is part of a process. It is not a goal.

Activities for Best Practice Courts

- The Permanency Planning for Children Department of NCJFCJ has supported this program since its inception. Activities sponsored by Virginia's CIP for recognized BPCs include:
- Conference for new lead judges and new local teams with targeted training in judicial leadership and decision making. Six "new team" conferences have been held since 2002, with a total of 40 local teams attending.
- State conferences allowing all BPC participants to share innovative approaches to the court management, trial and community collaboration of child dependency case loads. Three such conferences have been held with 550 team members participating.
- Funding through CIP mini-grants to allow local teams to: (1) host a multidisciplinary, local training event, (2) undertake a locally-developed initiative, such as production of court videos or

¹ This article printed in "The Judges' Page Newsletter," National CASA-CASA for Children.
http://www.casaforchildren.org/site/c.mtJSJ7MPisE/b.6576993/k.9A8F/JP_4_Hopper.htm. March 2011.

publication of notebooks to guide parents through the permanency planning process, or (3) make “field visits” to view firsthand other model programs. Over 57 local training events serving more than 5,400 people and 10 special local BPC projects have been funded by CIP since 2005.

- Technical assistance and training tailored for the best practice court at its local site.
- Onsite consultation with a nationally recognized judicial consultant to Virginia’s CIP.
- Opportunities for BPC lead judges to serve as faculty in other states for NCJFCJ and to network with judges in other court systems who are addressing similar challenges.
- Participation with other model courts on the national level in trainings and cross-site visits.

Required Best Practice Court Commitments

Participation in the BPC program entails commitments from the courts, which are for a period of time into the future and not for a definitive term. Assistance from Virginia’s CIP and NCJFCJ staff is made available to accomplish some of these tasks. These commitments are:

- Identification of a lead judge(s) and core group of multidisciplinary stakeholders in the community.
- Regular core group meetings to address unique local issues and foster community collaboration.
- Examination of strengths and challenges of the court and community services system to meeting dependent children and their families’ needs.
- Incorporation in court processes of best practices from *Resource Guidelines: Improving Court Practices in Child Abuse and Neglect Cases*. (800 KB PDF)
- Exploration of local court data in child dependency cases and examination of its implications for improved practice.
- Sharing with other Virginia courts—and courts nationwide—best-practice techniques of the participating court and community.

Extent of Best Practice Court Involvement

The critical work of permanency planning for children is accomplished locally, where judges hold court, lawyers represent children and parents, and child welfare professionals seek to protect and preserve families. As of January 1, 2011, the 37 active BPC teams accounted for 60% of Virginia’s foster care caseload. BPC teams have contributed to a 27% statewide decrease in the total number of children in foster care over the past three years. The 39 lead judges represent 35% of Virginia juvenile court judges and are located in 22 of 31 judicial districts. These are noteworthy numbers to report. However, of greater significance is the opportunity the BPC program offers to sustain the momentum of reform of the child dependency court process and to nourish the enthusiasm of community partners for achieving successful outcomes for children and families.

Virginia’s best practice courts generate energy that supports localities in improving outcomes one child at a time.

Analysis of Court Performance Measures for Child Dependency Cases¹

Project Description - The intent of the Analysis of Court Performance Measures for Child Dependency Cases is to illustrate a particular juvenile court's practice based on the data contained in each of the performance measures. These measures utilize case information entered into the juvenile courts' Case Management System (CMS) by the local court.

Court Performance Measures Analyzed - The following court performance measures are included in the analysis.

- Petitions of Repeat Maltreatment
- Number of Judges per Child (includes active judges and substitute judges)
- Timeliness of Court Hearings
- Timeliness of Adjudication-Abuse or Neglect and At-Risk of Abuse or Neglect Cases
- Time to Disposition-Abuse or Neglect and At-Risk of Abuse or Neglect Cases
- Time to Termination of Parental Rights (TPR)
- Permanency Planning and TPR Cases Filed the Same Day and Heard the Same Day
- Timely Appointment of Guardians Ad Litem (GAL), Court Appointed Special Advocates (CASA), and Parents Counsel
- Presence of Parties and Counsel at Hearings
- Service of Process to Parties
- Goals and Case Closure

Completing the Analysis - The process for producing each Analysis of Court Performance Measures for Child Dependency Cases is detailed below.

1. Receive from a local juvenile court a request for an analysis of court performance measures.
2. Download each performance measure and review the data presented.
3. Write a narrative review of the report data; include, where necessary, recommendations to help the court improve practice. Includes an Executive Summary.
4. Review of the analysis with to the J&DR Court Services Team Manager and/or Court Analyst.
5. Finalize the analysis and schedule a visit to the requesting court to discuss the data and recommendations with the presiding judge and clerk of court (and the courtroom clerk, if appropriate.) Forward a copy of the analysis to the presiding judge and clerk of court for review prior to the scheduled visit.
6. Meet with the presiding judge and clerk of court to review and discuss each section of the analysis. Address any questions or concerns the judge or clerk of court may have with the data.
7. Determination by the local juvenile court of the necessity of training for clerk's office staff on data entry requirements and on the necessity of court policy to improve court practice in processing child dependency cases.

¹ Child dependency cases include the following case types: abuse or neglect, at-risk of abuse or neglect, entrustment agreement, relief of custody, initial foster care review, foster care review, permanency planning, and termination of parental rights. Also included are delinquency felony, delinquency misdemeanor and status offense cases because the court has in these cases as one of its options in ensuring that a child receives the appropriate care or treatment, transfer of custody of the child to the local Department of Social Services.

**Training On Demand:
E-Learning for Virginia's Juvenile and Domestic Relations District Court
Judges and Clerk's Office Staff**

Abstract - It is the Virginia Court Improvement Program's experience that often juvenile court judges are appointed to the bench and new clerks are hired with limited experience working with child dependency cases. In an effort to make training on processing child dependency cases more readily available, Virginia CIP developed its live training program, *Case Processing in Child Dependency Cases*, into two e-learning programs: *Foster Care Training Program for Judges* and *Foster Care Training Program for Clerks*. The following describes CIP's efforts to complete these e-learning courses.

Project Description - When new judges are appointed to the juvenile court bench, or when new staff persons are hired to work in the juvenile court clerk's office, they often have limited experience working in child dependency cases. This is problematic because they are not familiar with the time lines for processing these cases, nor are they familiar with the adjudicatory or dispositional requirements of these cases. Training is offered on the law, process and use of forms applicable to child dependency cases in the court as part of the annual Pre-Bench Orientation Program for new juvenile and domestic relations district court judges, and as part of the Juvenile and Domestic Relations District Court New Employee Basic Course. However, a judge or clerk may be in their position for several weeks to several months before any substantive training is received.

In an effort to make training on processing child dependency cases more readily available, CIP developed its live training program, *Case Processing in Child Dependency Cases*, into two e-learning courses: *Foster Care Training Program For Judges* and *Foster Care Training Program for Clerks*. Each course covers the following:

- The role of the judge, clerk's office, attorneys, guardians ad litem (GAL) and local department of social services in the child dependency case process.
- The timeliness of child dependency case hearings, including a review of Virginia's time line for abuse, neglect and foster care cases.
- The appropriate use and proper completion of child dependency court forms in accordance with the individual stages of the child dependency case process provided in the time line.

Additionally, a case scenario is used to assist participants in better understanding the child dependency case process.

Why E-Learning -

1. It is Available On Demand! E-learning programs are interactive online courses delivered by computer and viewed at the convenience and pace of the participant.
2. It Saves Time and Money. There is no travel required by the presenter or the participant.
3. It is Flexible. The participant may stop the course at any time. When he is ready to continue learning, he is able to start the course at the point at which he left off.
4. It Provides Participants the Opportunity to Learn. If there is a section of information that the participant wants to view more than once to maximize her understanding of the material, she may do so without the worry of interrupting the learning of classmates.

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Chairman DAVIS. And thank you very much for your good work in Virginia.

Ms. HOPPER. Thank you.

Chairman DAVIS. Ms. Wareing.

**STATEMENT OF TRACY WAREING, EXECUTIVE DIRECTOR,
AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION**

Ms. WAREING. Good morning, Chairman Davis and Members of the Subcommittee. I am Tracy Wareing, executive director of the American Public Human Services Association. And thank you so much for the opportunity to testify today regarding the promoting Safe and Stable Family and Child Welfare Service programs. And it is an honor to be sitting here with such a distinguished panel, as well.

The American Public Human Services Association is a non-profit organization whose membership includes the Nation's top govern-

ment human service executives from across each of the states, the District of Columbia, as well as hundreds of human service directors at the local—at the county level. We happen to also house nine affiliate organizations, including the National Association of Public Child Welfare Administrators, and I speak on their behalf today, as well. We are a bipartisan organization whose ideas and direction come from the open exchange and deliberation of the expertise of our members, two of which are on this panel, as well.

This morning I would like to address the importance of prevention of child maltreatment, and the support of front-end services for children and families at risk, and then share two recommendations with you for revisions, as you consider reauthorization.

As you know, Promoting Safe and Stable Families is one of the few Federal funding streams that supports services aimed at preventing children from coming into out-of-home care. In 2009, states reported PSSF funding as the single largest source of funding for preventative services, covering nearly 30 percent of children receiving preventative services, nationwide.

Over the past five years, states have successfully reduced the number of children in foster care by more than 20 percent, as you heard from Mr. Samuels. In that same time period, the national repeat maltreatment rate also declined. By promoting community-based family support, family preservation, reunification services, and adoption support, PSSF has played a critical role in helping states alleviate situations that might otherwise lead to children being placed in foster care, due to abuse or neglect, or staying in care too long.

We also appreciate the substance abuse and methamphetamine grants that were made available to states. These grants have been helping states to offer an array of services to address the specific needs of these families, and use a range of strategies to prevent and treat substance abuse. As you consider reauthorization of these programs, we want to acknowledge the importance of these to the states, and urge that you continue them.

However, I think, as we have heard today, the bulk of Federal funding for child welfare is directed toward out-of-home care, and it comes from a patchwork of funding streams, and it is not directed to prevention. The overall allocation of title IV–E funds, compared with title IV–B funds, is about \$10 of out-of-home care funding for each dollar of in-home funding. We urge this committee to address comprehensive child welfare finance reform, and recommend increasing support for preventative and supportive services in directing Federal resources toward the front end, to improve the outcomes of children and families.

While our members support the need for flexibility to deliver on an array of services that are responsive to the special needs of their community, they also understand the role of the Federal Government in ensuring Federal dollars are spent wisely and correctly, and that the outcomes we all desire are met. As our members continuously improve their internal processes, they have also worked to develop practical recommendations on streamlining Federal accountability measures under IV–B and IV–E, and have offered ideas to the Administration around that.

But the methodologies for monitoring and measuring must be related to the outcomes we all desire to see. To that end, as you consider reauthorization of Promoting Safe and Stable Families, we recommend: one, relaxation of what is sometimes referred to as the 20 percent rule, which essentially requires equitable spending across the four categories of PSSF funding. That spending restriction is too rigid.

Just to give you one example, California has shared with us that many of their smaller counties, some of which may perform no more than a few adoptions a month, struggle with utilizing the 20 percent spending requirement on the adoption promotion and support services. In those communities, the funds would be better directed to community-based family support and preservation.

Additionally, a colleague on the panel here mentioned the methodology for calculating monthly case worker visits of a child. Our members are deeply committed to the best practice of timely, effective, and regular case worker visits, and the role they place in ensuring safety and facilitating reunification and permanency. But the fact is, the current methodology is flawed. A case worker could, in fact, see a child 20 times a year, but if 1 month was missed, that case and those visits are not counted.

My written statement provides specific recommendations that our members believe will result in a much more accurate picture of the diligent efforts being made. And let me emphasize this is about methodology, not intent. Our members fully support the benchmarks set by the 2006 reauthorization.

With that, I thank you so much for the opportunity to be here. We urge reauthorization of Promoting Safe and Stable families and Child Welfare Services programs, and would welcome questions. Thank you.

[The prepared statement of Ms. Wareing follows:]



**US House of Representatives, Ways and Means Committee
Human Resources Subcommittee Testimony
Improving Programs Designed to Protect At-Risk Youth
June 16, 2011**

INTRODUCTION

Chairman Davis and Members of the Subcommittee, I am Tracy Wareing, executive director of the American Public Human Services Association (APHSA). Thank you for the opportunity to testify today.

APHSA is a nonprofit organization, established in 1930, which represents appointed state health and human service agency commissioners and their key state program administrators. Our membership includes the nation's top government human services executives from each of the states, the territories and the District of Columbia, as well as hundreds of human service directors at the county level. To serve such a constituency, we are a bipartisan organization, whose ideas and direction come from the open exchange and deliberation of our members. Our mission is to pursue excellence in health and human services by supporting our state and local agencies, informing policymakers such as this Committee, and working with our partners to drive innovative, integrated and efficient solutions in policy and practice.

APHSA houses nine affiliate organizations, whose members administer program-level operations and policies for each state. These include the National Association of Public Child Welfare Administrators and the Association of Administrators of the Interstate Compact on the Placement of Children. I speak on behalf of them as well.

APHSA understands the growing needs of our country's most vulnerable populations and are pleased to provide our shared national vision for the Promoting Safe and Stable Families (PSSF) and Child Welfare Services (CWS) programs. This morning, I would like to talk with you about three major issues: (1) the importance of prevention of child maltreatment and support of community-based services for children and families at risk or in crisis; (2) the accountability of public agencies to be good stewards of public funds and to manage performance, self-correct,

innovate and enhance their ability to achieve positive outcomes; and (3) specific examples of how state and local agencies are supporting children and families through the PSSF program. As Congress considers reauthorization of PSSF and the CWS, we hope what is paramount to the discussion is the need to effectively leverage federal dollars to prevent abuse and neglect as well as support the safe reduction of children in out-of-home placement.

PREVENTION

PSSF is one of the few federal funding streams that is targeted toward supporting prevention of out-of-home placement. The primary principles of PSSF are to prevent the unnecessary separation of children from their birth families, improve the quality of care and services for children and families in need and ensure permanency for children by either reunifying them with their families of origin or, when that is not possible, make arrangements for a permanent placement. Subpart 2 of Title IV-B was designed to support states in promoting community-based family support, family preservation, time-limited family reunification and adoption promotion and support. PSSF has played a critical role in helping states alleviate situations that might otherwise lead to children being placed in foster care due to abuse or neglect.

In 2006, states reported PSSF funding as the single largest source of funding for preventive services – covering nearly 30 percent of children receiving preventive services nationwide. Of the \$410 million appropriated in 2006 for the PSSF program an estimated 60 percent, or roughly \$250 million, went for preventive services such as family support and family preservation.

The overall allocation of Title IV-E funds compared with Title IV-B funds is about ten dollars of out-of-home care funding (entitlement) for each dollar of in-home funding (capped). While addressing comprehensive finance reform, we recommend increasing support for preventive and supportive services and directing federal resources toward front-end services to improve the outcomes of children and their families. These interventions continue to safely reduce out-of-home placements and lower incidences of abuse and neglect.

Today, there are more than 400,000 children in the United States that currently reside in some form of out-of-home placement. Although this number is still high, states have successfully reduced the number of children in foster care by more than 20 percent over the past five years. In that same time period, the national repeat maltreatment rate also declined. PSSF and the CWS programs have helped states achieve this success by making funds available to support prevention programs and safely exiting children from foster care to permanency. If these programs did not exist, the number of children in foster care would be significantly higher and child maltreatment rates would likely soar.

We also appreciate the substance abuse and methamphetamine grants made available to states. In these current economic times, we have seen a rising trend in the amount of families that come to the attention of the public child welfare system because of substance abuse issues. These grants have been helping states to offer an array of services to address the specific needs of these families and use a range of strategies to prevent and treat substance abuse in families. As Congress considers reauthorizing PSSF and CWS, we want to acknowledge the importance of these grants and urge Congress to continue these programs.

The Impact of PSSF

In FY 2009, states reported to the National Child Abuse and Neglect Data System that they provided prevention services to more than 3 million children. States have been using PSSF dollars to provide voluntary, preventive services to help families nurture their children at home. There are numerous ways to approach the delivery of services that prevent at-risk children and families from having contact with the public child welfare system. Two of the most notable initiatives serving the multiple needs of children and families are home visitation and differential response. Home visitation has been used by many states to connect families in need with nurses, early childhood professionals and well-trained paraprofessionals to educate them about healthy parenting. Research on the Nurse Family Partnership site in Elmira, NY found that children in nurse-visited homes had fewer admissions to the emergency room for injuries and ingestions than children who were not participating in these visits.

Differential response provides an alternative approach to respond to cases of alleged maltreatment rather than using the required standard procedure of most child protection agencies. To date, approximately 14 states have passed legislation allowing the use of differential or alternative response. Minnesota was one of the first states to implement this approach and evaluations of its model have shown a lower recurrence of abuse and neglect and a cost savings in the child welfare system. Measurements of short-term outcomes indicated a 28% increase in medical and dental care; an 83% increase in positive parenting; a 67% increase in family functioning; a 50% increase in child safety; and a 33% decrease in abuse and neglect factors.

Currently, these programs are being funded through a patchwork of federal funding streams and state and local dollars. Unfortunately, the bulk of federal funding for child welfare is directed toward out-of-home care and not for prevention; hence, there is an urgent need for comprehensive child welfare finance reform. PSSF has been a tremendous value to public child welfare programs. States have been able to leverage their prevention dollars to support prevention programs and finance the services that have been proven to keep kids out of the system. However, the problem still exists – we do not have the flexibility to use the majority of federal dollars to support prevention.

ACCOUNTABILITY

While our members support the need for flexibility to deliver an array of services that are responsive to presenting needs, they also understand the role of the federal government in ensuring federal dollars are spent wisely and correctly, and that outcomes are met. The policies Congress and the administration have set in the last two decades focusing on increased accountability have moved state and local agencies to develop internal processes to set benchmarks, enhance performance, and measure progress toward improved outcomes.

While our members continuously improve their internal processes, they have also worked with APHSA, NAPCWA, and other partners to develop practical recommendations on streamlining federal accountability measures under Title IV-B and IV-E and offering better ways to review, monitor and hold public child welfare systems accountable for their practices. Our recommendations to the Administration work to maximize federal, state and local resources, reduce redundancies and improve state and local decision-making based on accurate data.

State and local agencies' continuous improvement efforts highlight the need to allocate resources in a more strategic manner: based on data, state demographics, and progress toward meeting federal outcome mandates. The four categories of spending outlined in the PSSF (the 20% rule) are too rigid. As Congress considers reauthorization of PSSF, amendments should reflect state's ability to use funds to targeted areas for improvements, which may not equate to the same allocation across the four current service categories.

Providing services to ensure the safety and protection of children from abuse and neglect is child welfare's main responsibility, but not theirs alone. The continuum of care intersects agencies, programs, and oftentimes funding streams. The approach to a sound federal accountability system should reflect these same tenets; the intersection of sound methodologies to monitor and measure all programs across the continuum that are responsible for achieving better outcomes. This is our vision, shared by our members, and reflected in the safe reduction in out-of-home placements and the decrease in maltreatment and repeat maltreatment rates.

One accountability area we were asked to address is caseworker visits. APHSA members are committed to the best practice of timely and effective caseworker visits and agree they are important to ensuring safety and facilitating reunification and permanency. The states' performance in this area has continuously improved since 2006 (in some cases by over 200%) when The Child and Family Services Improvement Act of 2006 provided \$95 million in mandatory funding for states to strengthen and improve the frequency and quality of these visits. Texas used these funds to alleviate barriers associated with documentation of caseworker visits; for example, purchasing tablet technology and dictation tools. Resources were also used to

provide training for supervisors and management on the critical nature of contact, and to encourage ways to better engage families in safety decisions and permanency efforts. All of these efforts contributed to Texas' improved practice.

While the improvement in caseworker visits is important to note, our members are concerned that the current methodology for calculating the visits is problematic and creates a false impression about states' performance. The current methodology requires a child to be visited each and every month during the year. If the caseworker misses one month in the year due to legitimate unexpected circumstances (e.g. poor weather conditions, activities the child may be engaged in, or complications with the foster families' schedules), but sees that the child for the other 11 months, the entire case is disallowed and ultimately impacts the final results for the state.

If, however, the calculation is changed to be a cumulative measure where 90% of the time the child is in care the child is visited monthly, the picture would be quite different. For instance, Texas, using the ACF-approved sampling methodology, achieved a 50% increase in the level of improvement from 54% of children seen in face-to-face visits each and every month in FFY2007 to 81% in FFY2010. If there was a cumulative measure methodology, Texas would have been at 94% for FFY2010 and 93.7% so far in FFY2011 for all children. The change in calculation more realistically reflects the diligent efforts made by casework staff.

We recommend Congress change the current caseworker visit methodology as outlined above or by monitoring improvement in the CFSR process as we have recommended to the Administration.

HOW STATES HAVE USED PSSF DOLLARS FOR THE CONTINUUM OF CARE

Children and families face an array of challenges, including poverty, substandard housing, substance abuse, domestic violence and mental health issues. The current economic times have exacerbated these issues and have made child welfare services a critical resource in at-risk communities. These families are touched by many different agencies in addition to child welfare. Therefore, a full spectrum of services should be available before, during and after care to ensure the success of children and families and offer a continuum of care. I now want to showcase some of the great work being done across the country using Title IV-B PSSF funds.

In Washington, Early Family Support Services are provided to families where there is no finding of child abuse or neglect but the family was found to be in need of services. Nurse practitioners provide direct services to young mothers prior to any involvement in CPS. Over 800 families were served in the program in ways that prevented their children from entering foster care.

Minnesota's Family Group Decision Making (FGDM) continues to provide service planning and placement prevention strategies. It has been found to be effective in assessing the fundamental needs of children and families. In 2007, some 1,683 family group decision making conferences were held. A total of 863 FGDM conferences had the goal of reunification for the child and 820 conferences had the goal of family support/family preservation.

The evaluation of Chicago's Child-Parent Centers was part of a quasi-experimental evaluation that addressed maltreatment directly. The study found that children in the program, which provides care to children from disadvantaged neighborhoods during the two years before kindergarten, had only half as many court petitions related to maltreatment as did children in similar neighborhoods that did not have the program.

Georgia's PSSF Family Support Network showed improved maltreatment outcomes for at-risk families. In 2007, 90% of the at-risk families had no substantiated reports of maltreatment during or post service provision. The number of children with repeat incidents of abuse also decreased in Georgia:

- 3,405 families received PSSF Family Preservation services in FY 2007.
- 600 of those families had prior substantiated CPS case histories.
- 80% of those children remained safely in the home with no repeat incidence.

In Wisconsin, during 2007, over 33,717 children and 25,003 families received PSSF preservation, support, or reunification services from county agencies. Based on reports that compare actual outcomes with desired outcomes for the children and families served with this funding, counties typically met or exceeded their outcome goals.

Healthy Families New York (HFNY) is a community-based prevention program that seeks to improve the health and well-being of children at risk for abuse and neglect through the provision of intensive home visitation services. New York leveraged federal IV-B funds, state dollars, and philanthropic support to fund this initiative. HFNY mothers reported engaging in fewer incidents of very serious physical abuse, minor physical aggression, psychological aggression, and harsh parenting when their children were at Age 1. Compared with their counterparts in the control group, HFNY mothers reported committing only one-quarter as many acts of serious physical abuse against their children at Age 2, and first-time mothers under age 19 who were offered HFNY early in pregnancy were markedly less likely to report engaging in minor physical aggression (51% vs. 70%) and harsh parenting (41% vs. 62%).

CONCLUSION

We appreciate the Committee addressing the reauthorization of these vital programs and hearing the concerns of states. The congressional intent in creating these programs was due to the heightened concern of the large number of children in foster care and the need to make safety and permanence a priority. We share this concern and appreciate the leadership of the committee to gather input about what is working in states. To that end, we support the reauthorization of the PSSF and CWS programs and urge Congress to preserve federal dollars that support prevention and make the necessary amendments to the statute to effectively address the needs of our nation's most vulnerable children.

Lastly, I would be remised if I did not mention the House's proposal to defund the Social Services Block Grant (SSBG). Aside from PSSF, SSBG is the second-largest funding source supporting prevention services on national level. Roughly one-fifth of the \$1.7 billion in SSBG funding in FY2006 (or about \$340 million) was devoted to prevention. We urge Congress to maintain SSBG funds for states to continue their efforts to prevent children from coming into care in the first place, and to find alternative solutions for parents to safely parent and nurture their children in their own homes.

Thank you for the opportunity to testify. I am happy to answer any questions you may have.

Chairman DAVIS. Thank you.
Mr. Sciamanna.

**STATEMENT OF JOHN SCIAMANNA, DIRECTOR, POLICY AND
GOVERNMENT AFFAIRS, CHILD WELFARE, AMERICAN HU-
MANE ASSOCIATION**

Mr. SCIAMANNA. Thank you, Chairman Davis and Members of the Subcommittee.

Since 1877, the American Humane Association has been a national leader in developing cutting edge initiatives to prevent and respond to child abuse and neglect. Our work in research, family

group decision-making, differential response, and father engagement are a few examples of our efforts to strengthen families, children, and communities.

Let me talk briefly about some of the important services under PSSF. Reunification services. Once a child has been reunified, access to after-care is limited, since Title E funds provides for support only when a child is in foster care.

This week we co-hosted a briefing on Capitol Hill focusing on reunification. The compelling stories of the families who were there who were reunified with their children provided strong evidence that we could do so much more in this area. In 2009, 276,000 children left foster care and 51 percent were reunified with their parents, we feel we can do much more in this area.

One of our recommendations is that if we can't enact a comprehensive finance reform this year, then we should extend title IV-E entitlement funds to services for reunification, allowing dollars to address the only permanency option not currently funded under IV-E.

We also recommend that the current 15-month restriction under Promoting Safe and Stable Families be removed, since we would like the dollars to follow the children home into the family.

Adoption services. This subcommittee was key to enactment of the Fostering Connections to Success, and Increasing Adoptions Act. That started us towards a comprehensive reform of the finance system by eliminating the link to AFDC for adoption assistance.

We are increasing the number of adoptions annually, and have made great success in the last decade. But for a small percentage of these families, there is a need for post-adoption services, as Commissioner Samuels mentioned today. Recently a coalition led by Voice for Adoption held a Capitol Hill briefing, with one of the recommendations being that there be specific funding to address these post-adoption services, so that states can establish an infrastructure.

We recommend that the definition of adoption services under Promoting Safe and Stable Families be examined to see whether or not we could direct more dollars toward post-adoption services.

We also suggest that when Congress created the de-link, that they directed states to reinvest dollars, maintenance of effort into Child Welfare Services. Congress may want to look at directing those dollars, as some adoption groups have advocated, toward post-adoption services as a way to provide a steady source of funding.

Family support and family preservation are two very critical services. We certainly hope that they will continue to be categories in this area. There has been some consideration in the past about whether or not these categories should be collapsed. But we think that they, the four services, address four distinct families.

The big challenge for all of this funding is that in recent years, when this committee has increased mandatory funding, appropriators have sometimes used it as a rationale to decrease the discretionary piece of this program.

The need for substance abuse services. We would echo a lot of the comments that have been heard here today. There is growing evidence about the importance and the effectiveness of comprehen-

sive family treatment. We would suggest, however, that the specification toward methamphetamine be broadened, since there are a range of substance abuse issues and problems, depending on the locality and the part of the country, and grants should be based on the most effective strategies.

Workforce development you have also heard a great deal about. Case load visits are important. But, as you have heard, there are some problems with the data collection. We need to work on that. What we don't want is a system where we are just checking off visits. Instead, we will need to encourage quality visits. We have done a number of workforce studies for states to help them with that, to establish quality visits.

We think if the funding cannot be increased, we need to design a workforce strategy. Perhaps Congress should look at some sort of a race to the top that would allow some states to invest and—provide strategies that could develop a child welfare workforce development plan over several years.

Court improvement. I won't go into great detail here, because you have heard about the effectiveness of that. So we certainly hope that Congress will keep—and, if at all possible—increase funding.

We also want to emphasize that recently we released a report with several organizations about maltreated infants and toddlers. They are the biggest population coming into contact with the child welfare system. We think there needs to be greater focus on this population, not to the exclusion of other populations, but perhaps we can, in the oversight or in the IV-B-1 plan, outline what states are doing to address this vulnerable population.

Finally, in my closing comments, let me just say that if Congress cannot complete finance reform in this session, that they look at different ways to extend current funding in IV-E, whether it is to reunification services, or to doing some up-front services, such as differential response, an approach several of the states represented here today are implementing.

In closing, we appreciate the efforts of this subcommittee and others to pursue these matters in what has always been a bipartisan and bicameral way. As some of the Members of this committee have pointed out in the past, children in foster care and child protective services are, in fact, our responsibility. And we need to make sure that we are their good parents until they find permanent families.

[The prepared statement of Mr. Sciamanna follows:]

*** THIS TESTIMONY IS EMBARGOED ***
*** UNTIL THURSDAY, JUNE 16, 2011 AT 9:00 A.M. ***

American Humane Association™
The nation's voice for the protection of children & animals™

Testimony

American Humane Association

U.S. House Committee on Ways & Means

Subcommittee on Human Resources

*Improving Programs Designed to
Protect At-Risk Youth*

June 16, 2011

***** THIS TESTIMONY IS EMBARGOED *****
***** UNTIL THURSDAY, JUNE 16, 2011 AT 9:00 A.M. *****

Chairman Davis, Congressman Doggett and members of the Subcommittee, my name is John Sciamanna. I am the Director of Policy and Government Affairs, Child Welfare for the American Humane Association. I am pleased to submit this testimony to the Subcommittee on Human Resources on child welfare policy in general and more specifically on the reauthorization of Title IV-B part 1 and 2 of the Social Security Act.

Since 1877 the American Humane Association has been a national leader in developing programs, policies, training, research and evaluation, and cutting-edge initiatives to prevent and respond to child abuse and neglect. We work to strengthen families and communities and enhance child protection and child welfare systems at the state, county and local levels. Our work in research, Family Group Decision Making, Differential Response and father engagement are a few examples of efforts to strengthen families and improve the lives of some of our most vulnerable children.

THE REAUTHORIZATION OF TITLE IV-B PROGRAMS

Child Welfare Services and Promoting Safe and Stable Families are two important sources of child welfare funding that if used effectively can help address many of the causes of children being removed from their families and can remedy the causes that lead far too many children to be abused and neglected. Short of a comprehensive reform of child welfare financing built on entitlement funding, these two funds provide important support to policies and practices to address the prevention of child abuse and neglect, alternatives to removal and support for children and families who adopt, are providing kinship care or are reunified. This morning I will use my time to focus on potential improvements that can be made through Title IV-B.

Title IV-B of the Social Security Act was first established as part of the original law when it was enacted in 1935. Congress has authorized \$325 million annually and in FY 2011 Congress appropriated \$281 million. The appropriation has never reached \$325 million with the highest level peaking in 1994 when just under \$295 million was provided.

States must submit a five year "Child Welfare Services Plan" that is developed with the federal government. The plan requires several assurances and commitments and directs the states to outline how various parts of child welfare will be coordinated.

The Promoting Safe and Stable Families Program began as the Family Preservation and Support Services Program in 1993 and is an important federal source of funding for an array of support services for families and children. Within child welfare it is one of the few sources of targeted federal funds for services that may prevent child removal by strengthening families. After its creation in 1993 it was revised and reauthorized in 1997

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***** THIS TESTIMONY IS EMBARGOED ********** UNTIL THURSDAY, JUNE 16, 2011 AT 9:00 A.M. *****

under the Adoption and Safe Families Act (ASFA) and reauthorized in 2001 and 2006. At its inception in 1993 funds had to be used for family preservation and community-based family support services. The 1997 reauthorization added two additional categories of service: time-limited reunification and adoption promotion and support. Under program guidance to states, no less than 20% is to be allocated to each of the four categories of services.

Since the last reauthorization funding is divided between a total of \$345 million in mandatory funds and an additional \$200 million in discretionary funds. The authority for discretionary funding was a result of the 2001 reauthorization proposal by the George W Bush Administration. Since the additional discretionary funding was created Congress has never appropriated more than \$100 million in discretionary funding. In fact part of the challenge since discretionary authority was created in 2001 has been that appropriators have reduced funding in recent years, now at \$62 million.

Importantly, tribal governments receive three percent of the mandatory funds and three percent of whatever additional discretionary funds Congress approves. Tribes are also eligible for the substance abuse funding on a competitive basis.

The last reauthorization resulted in a reallocation of funding from other parts of federal child welfare programs, new funds were provided for grants to improve permanency outcomes for children affected by methamphetamines or other substance abuse and for strengthening the child welfare workforce.

Substance abuse funding starting at \$40 million in the first year now at \$20 million annually is awarded in methamphetamine/substance abuse treatment through competitive grants of up to \$1 million for a maximum of five years. The successful grants must be collaborative between the state child welfare agency and least one partner drawn from a list of 13 that includes state substance abuse agencies, community health and mental health providers, courts, non-profit agencies and tribal governments. In awarding the grant, the Department of Health and Human Services must place greater weight on those partnerships that address methamphetamine use.

The workforce funding is set at \$20 million and is awarded to all states but is conditioned on states collecting data and providing evidence that they are successfully conducting monthly visits to children in foster care. If states meet the standard, they are allocated a share of the \$20 million. Funding can be used for caseworker recruitment, retention training and technology use.

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KEY PROGRAMS UNDER PROMOTING SAFE AND STABLE FAMILIES (PSSF)

Services Provided

As noted, the vast majority of PSSF supports four categories of services: family preservation, family support, time-limited family reunification, and adoption support. During the 2006 reauthorization discussion there was some suggestion of combining all four categories of services because many of the services provided through these four programs could look very similar but while the services may be similar, the families are not. We would argue that the families served may be very different and the four categories help to assure all four families' needs are addressed.

Reunification Services

Under PSSF time-limited reunification services are intended to address the needs of children and families who are involved in the foster care system. Services are provided within 15 months of when the child entered foster care.

Successful family reunification may include some of the same services used to implement a successful family preservation approach: small caseloads, access to services including health, mental health and substance abuse treatment, counseling and sound best practice.

Support for reunification is limited. Only Promoting Safe and Stable Families allocates a portion of its funding for reunification. Other reunification services may have to be drawn from other programs or sources including some case management that may be drawn from the administrative costs under Title IV-E foster care. Once a child has been reunified with his or her family access to after care may be limited since Title IV-E funds provides for support only when a child is in foster care not after.

Earlier this week the American Humane Association worked with the American Bar Association's Center on Children and the Law to conduct a Capitol Hill briefing on reunification. We heard from family members on how their families were able to come back together. Their compelling testimony underscored the fact that some families can come back together with the proper support. The latest data available, from 2009, indicates that of the 276,000 children that exited foster care 51 percent or 140,000 were reunified with their parent or parents. Reunification is the case plan for a majority of children in foster care.¹ Results will vary from state to state from nearly 70 percent leaving for reunification in a few states to a low of nearly 30 percent in other states².

In recent years progress has been made. According to the 2004-2007 Outcomes Report issued by Health and Human Services³ examining the population of reunifications, the median percentage of reunifications amongst states for those that took place in less than 12 months time is 68 percent. There are challenges however. There are variations between

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states which may be driven by the particular characteristics of the foster care population or state child welfare policy. Additionally HHS data indicates that states were less successful in reunifying children with a diagnosed disability and states have had less success in reunifying children who had been in foster care for more than 24 months. We have limited information on why these conditions exist, what are the best strategies, and how to address possible barriers.⁴

Recommendation: *American Humane Association recommends that if we cannot enact a comprehensive finance reform, then we should examine strategies to extend Title IV-E entitlement funds to services for reunification, allow dollars to address the only permanency option not currently funded under Title IV-E (adoption and subsidized guardianships the other two). We also recommend that the current 15 month limit on the use of funds tied to when a child enters foster care be eliminated since it may allow very little ability to have funds follow the child home. Finally we would urge that further study and research be dedicated to examining effective reunification strategies, why states differ in their results and how we can better address the harder to serve population such as children in care longer than 24 months and children with disabilities.*

Adoption Services

Adoption services are services aimed at encouraging an increase in the adoption of children in foster care, these services can be used to help children and families prepare for adoption and address their post-adoptive needs. The nation has made significant progress in moving more children into adoptive homes. In 2009 more than 57,000 children had been adopted from foster care. At the same time we know that more than 114,000 children were waiting to be adopted.⁵ This Subcommittee was part of the key congressional leadership that oversaw the enactment of the Fostering Connections to Success and Increasing Adoptions Act (PL 110-351). That law importantly started us toward a more comprehensive finance system by eliminating the link between Adoption Assistance and the 1996 AFDC eligibility standard. As states realize a savings from this change Congress included a requirement or maintenance-of-effort, for states to reinvest any savings in state funds back into child welfare services.

Since 2002 the number of adoptions from foster care has exceeded more than 50,000 children each year and the number of children categorized as waiting to be adopted has decreased from more than 135,000 to the 114,000 listed for 2009.⁶ It is projected that more than 470,000 children will be in homes receiving adoption assistance in FY 2012.⁷ At the same time, for a small percentage of these families there will be a need for post adoption services. Most children will do very well but there are some instances where some children may have behavioral, learning, medical or emotional problems. These problems may be related to prior abuse and neglect. As the population of children adopted from foster care increases, there is a growing need to address post-adoption services. Such services may

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include respite care, support groups, crisis response, mental health services and training for professionals attempting to help these families.

Recently a coalition of adoption groups led by Voice for Adoption held a Capitol Hill briefing to highlight these challenges. Among the joint recommendations and statements by more than a half dozen organizations was a suggestion that a major reason for the current gap in post-adoption services is the lack of a dedicated and reliable source of federal funding. Further they urged policymakers to consider providing funding that is both flexible and sustainable, allowing states to rely on the funding in the future to enable longer-term investments in a post adoption services infrastructure.

Recommendation: *American Humane Association recommends that the definition of adoption services be refined to focus more funding on post-adoption services. We also suggest that Congress examine the maintenance-of-effort requirement under the adoption assistance delink enacted through the Fostering Connection Act. Guidance (ACYF-CB-PI-09-08) indicated that states have the flexibility to determine the methodology for calculating savings from this MOE and that the state does not have to provide a specific accounting of these funds. We propose a stronger documentation of this MOE and that this committee consider new language that would direct these savings from adoption assistance to be re-invested into post-adoption services.*

Family Support and Family Preservation

Family preservation services are designed to help children and families in crisis. These may be families in great crisis so caseloads are low and workers focus on a few families at a time. Programs may provide follow-up services and services to improve parenting skills. At times family preservation has had its critics but like any practice area, in at least this field, it is important to distinguish between best practices and practices that do not follow standards. A 2006 study by the Washington State Institute for Public Policy that reviewed rigorous evaluations of Intensive Family Preservation Service programs that adhere to the Homebuilders model significantly reduced out-of-home placements and subsequent abuse and neglect. The study indicated that such programs produce \$2.59 of benefits for each dollar of cost.⁸

Family support services include a broad spectrum of community-based activities that promote the safety and well-being of children and families. Intended to assist families not yet in crisis, these services include structured activities involving parents and children, respite care services for parents and caregivers, parenting skills training, and information and referral services. Programs may also include services outside the traditional scope of child welfare, such as health care, education, and employment.

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Recommendation: *American Humane Association recommends that these two service categories continue as they are currently written. The great challenge for these two funding sources and in fact all four services described here is that congressional appropriators have looked at past increases (even in areas such as the courts and substance abuse treatment) in Promoting Safe and Stable Families reauthorizations as an excuse to make reductions on the discretionary side. It is absolutely critical that, unless there is a more comprehensive reform of the financing structure, we add to funding for prevention and interventions services as outlined here.*

The Need For Substance Abuse Services

A 2009 study of the New York City child welfare population by Children's Right, "A Long Way Home" found that "the most common allegations and other concerns identified when children entered foster care were inadequate guardianship/lack of supervision (57%), parental drug/alcohol misuse (54%), parental mental illness (27%), inadequate food/clothing/shelter (25%), physical abuse (21%)⁹..." Other surveys that have looked at the child welfare system across the states from social services, family courts, foster and adoptive agencies have indicated that at least 70 percent of cases involve a substance abusing parent.¹⁰ In the last reauthorization Congress inserted new mandatory funds directed at substance abuse with a specific emphasis on methamphetamine. The funds were generated when new restrictions were placed on state placement decisions and the use of Title IV-E administrative funds.

While it is important to recognize the significant impact methamphetamine can have on some families in some parts of the country we can't lose sight of the fact that substance abuse of any kind can have serious consequences. As Rebecca Project has documented, "Crack-cocaine continues to be the drug of choice for many low-income and vulnerable families. Parental addiction to alcohol, heroin, and prescription drugs continues to tear apart the lives and relationships between parents and their children. It is estimated that 8.3 million children in the United States live with at least one parent who abuses alcohol or who is in need of treatment for illicit drug use."¹¹

While we are still evaluating the outcomes for some of the substance abuse grants issued under the last PSSF reauthorization we are realizing results for comprehensive family treatment programs. Evaluations by the Substance Abuse and Mental Health Services Administration (SAMHSA) in regard to this approach document not just greater recovery and success but results that show greater reunifications and stability for children. One evaluation indicated that 88 percent of the children who were treated in the programs with their mothers remained stabilized and living with their mothers 6 months after discharge.¹²

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Recommendation: *American Humane Association recommends that greater funding be invested into these substance abuse grants and that these grants emphasize the use of family-based treatment. We urge the Subcommittee to invest more funding in this area. We also recommend that the specific emphasis on methamphetamine be removed since such a preference could have the unintended consequence of favoring one community or population over another. Funding should be awarded on the basis of need and the strongest proposals and programs.*

Workforce Development Caseworker Visits

Experienced child welfare workers are essential to ensuring abused and neglected children and their families are getting the support they need during times of crises. Yet, according to a 2001 study by the American Public Human Services Association (APHSA), 43 states reported an average annual worker turnover rate of 22% and a vacancy rate of 7%.¹³

A stable and fully staffed workforce is critical to successful outcomes in child welfare. Congress created a mandate for states to maintain monthly caseworker visits. It is equally critical that these visits be quality visits. One of American Humane Association's initiatives involved a Washington State Children's Administration Workload Study on how social workers spend their time in required activities.¹⁴

This study estimated how much time each task would take if mandated results were achieved. For example workers are expected to meet with their child-clients for at least one hour each month. That is the amount of time thought to be necessary for a worker to assess the child's condition and progress. When the actual time per case spent on face to face visits with children was calculated, the mean time spent was lower. This led the researchers conducting the study to recommend greater efficiencies in other activities and increased staffing. Reductions in caseloads would permit workers to spend the requisite amount of time meeting with children. States have had difficulty meeting the caseworker visit standard. In addition we are concerned that in light of state budget cutbacks, we could see a regression in whatever progress has been realized in workloads and staffing .

Recommendation: *Funding for workforce development should be maintained as well as the caseworker visit standards. If funding cannot be increased beyond the current \$20 million then funds should be converted into a type of "race to the top" competitive grant that would be awarded to a few states with the most comprehensive long term strategy to improve their child welfare workforce.*

Court Improvement

Court improvement funding is critical to an effective child welfare system. Generally funding from the various child welfare funding streams does not flow to the courts yet courts are an obvious and critical partner to any successful reforms.

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Some important initiatives have been developed in recent years that seek to better coordinate state child welfare systems and the state and local courts. Zero to Three has instituted a groundbreaking program, *Safe Babies, Strong Families, and Healthy Communities*, operating in ten diverse sites. The principle strategy of the Safe Babies program is the Safe Babies Court Team, which combines judicial muscle with child development expertise and community partnerships so that babies and toddlers are given life-changing help. By working together, multidisciplinary teams are implementing comprehensive research-based approaches to promote better long-term developmental outcomes for maltreated infants and toddlers. Training for judges has been a critical component for this and other programs.

Recommendation: *American Humane Association recommends that court improvement funding be increased so that successful models can be effectively extended in all fifty states.*

Child Welfare Services

Title IV-B part 1 is an important source of flexible child welfare funds but it also sets out a series of requirements for states to follow. It outlines priorities for all fifty states in establishing a coordinated child welfare system.

Recently, the American Humane Association joined with Zero to Three, the Child Welfare League of American, the Children's Defense Fund and Center for the Study of Social Policy to issue a report on infants and toddlers, "*A Call to Action on Behalf of Maltreated Infants and Toddlers*."¹⁵

Infants and toddlers are the age group most vulnerable to maltreatment and its aftermath. Every year, almost 200,000 children come into contact with the child welfare system. And 76,862 are removed from their parents' care.¹⁶ They constitute more than one quarter of all children who are abused or neglected.¹⁷ Of the estimated 1,740 children who died from abuse and neglect in 2008, more than three quarters (79.8%) were 3 years old or younger.¹⁸

Infants and toddlers are the largest single group of children entering foster care. Of the children who entered foster care during fiscal year 2009, 31% were less than 3 years old. Once they have been removed from their homes and placed in foster care, infants who enter care at less than 3 months old are in foster care 50% longer than older children and are much more likely to be adopted than reunified.¹⁹

Neuroscientific research on early brain development indicates that young children warranting the greatest concern are those growing up in environments, starting before birth, that expose them to abuse and neglect. It is during the first years of life when the brain undergoes its most dramatic development and children acquire the abilities to think, speak, learn, and reason. Early experiences, both positive and negative, have a decisive effect on

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how the brain is wired.²⁰ In fact, early and sustained exposure to risk factors such as child abuse and neglect can influence the physical architecture of the developing brain, preventing infants and toddlers from fully developing the neural pathways and connections that facilitate later learning.

Maltreatment alters the brain's architecture.²¹ These changes in the brain give rise to several psychological difficulties—cognitive delays, poor self-regulation, and difficulty in paying attention.²² Maltreated infants and toddlers may also struggle with poor self-esteem, behavior control, attachment formation and may have difficulty showing empathy, controlling their behavior in social situations, and initiating social interaction.

To fully address the needs of this very vulnerable child population we need to increase our focus of attention and practice at every level. This is not at the exclusion of another population but to recognize the critical child development needs of these infants and toddlers.

Recommendation: *American Humane Association recommends that Congress direct states to include in their Title IV-B state plan how they are addressing the needs of infants and toddlers that come in contact with the child welfare system.*

THE NEED FOR CHILD WELFARE FINANCE REFORM

It is important that as Congress reauthorizes these two programs and acts to possibly extend waiver authority, it not be viewed as a way to delay more significant reforms.

We recognize that these are challenging budget times. If a comprehensive reform cannot be enacted as one measure or bill then we suggest interim steps be taken to reform current financing. We propose these steps be done in a way that maintains the IV-E entitlement.

One area may be to examine ways to extend services for reunification through Title IV-E. Congress should also look at the possibility of freezing the current Title IV-E income eligibility to stop further erosion of federal funding for IV-E foster care and kinship care. Additionally we should look for ways to allow greater use of IV-E funding for innovation and front-end services such as differential response and Family Group Decision Making.

American Humane Association also believes that tribal governments or consortia of tribal governments need to share in any reforms or additional funding that may become available.

American Humane Association believes that research and evaluation are critical as we continue to make progress within the child welfare field. At times it may be possible to have random control trials as has been the case in some of the differential response sites such as Minnesota and Ohio. In other circumstances other evaluation designs may be included

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along with a strong comparison group model. It is critical to understand the link between practice and results, especially as it affects child well-being and families. At the same time this should not inhibit innovation or new approaches but instead become a tool to understand ways to improve how we are help this country's most vulnerable children.

In closing we appreciate the efforts of this Subcommittee and others to pursue these matters in a bipartisan and bicameral way. As some members of this committee have pointed out in the past, children in foster care and protective services are in fact our responsibility. Through no fault of their own these children have us as their parents. It is in every citizen's interest that we make a commitment to give every child a real family where he or she will thrive to become the leaders of our future.

FOOTNOTES:

- ¹ U.S. Department of Health and Human Services, Administration for Children and Families, The AFCARS Report: Preliminary FY 2009 Estimates as of July 2010 (17). Retrieved June 13, 2011 from http://www.aclfhhs.gov/programs/ch-stats_research/afcars/na-report17.htm.
- ² The Annie E. Casey Foundation. (2009). Kids Count Data Center. Retrieved June 1, 2011 from http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind_6277.
- ³ U.S. Department of Health and Human Services, Administration for Children and Families, Child Welfare Outcomes, 2004-2007. Retrieved June 13, 2011 from <http://www.aclfhhs.gov/programs/ch-stats/cv04-07/cv04-07.pdf>.
- ⁴ *Ibid.*
- ⁵ U.S. Department of Health and Human Services, Administration for Children and Families, The AFCARS Report: Preliminary FY 2009 Estimates as of July 2010 (17). Retrieved June 13, 2011 from http://www.aclfhhs.gov/programs/ch-stats_research/afcars/na-report17.htm.
- ⁶ *Ibid.*
- ⁷ U.S. Department of Health and Human Services, Budget Briefing Fiscal Year 2012, U.S. Department of Health and Human Services, 2011, <http://www.hhs.gov>.
- ⁸ Washington State Institute for Public Policy, (2006). *Intensive Family Preservation Program: Fidelity Influences Effectiveness—Revised*. Olympia: Author.
- ⁹ Children's Rights. *The Long Way Home: A Study of Children Stranded in New York Cities Foster Care*. (2010). Retrieved November 24, 2010 from http://www.childrensrightrights.org/vp-content/uploads/2009/11/2009-11-02_long_way_home_full_report_final.pdf.
- ¹⁰ National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up: the Impact of Substance Abuse on state budgets*. New York, New York: The National Center on Addiction and Substance Abuse, 1998.
- ¹¹ The Rebecca Project for Human Rights. *Memorandum: Cost Benefit Analysis of Family Treatment*. Washington D.C. The Rebecca Project for Human Rights.
- ¹² Center for Substance Abuse Treatment. *Residential Women and Children/Pregnant and post-Partum Women Fact Sheets*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
- ¹³ Gary Cychers. *Report from the Child Welfare Workforce Survey: State and County Data and Findings*, 2001. American Public Human Services Association. Available at <http://www.aphsa.org/policy/doc/cwswsurvey.pdf>.
- ¹⁴ Walter R. McDonald & Associates, Inc. (2007). Washington State Children's Administration Workload Study, 8.11.
- ¹⁵ American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, Children's Defense Fund, ZERO TO THREE: *A Call to Action on Behalf of Malnourished Infants and Toddlers*, 2011. Washington DC. Available online: <http://www.zerotothree.org-child-development/health-nutrition/childscalltoaction.pdf>.
- ¹⁶ *Ibid.*
- ¹⁷ *Ibid.*
- ¹⁸ *Ibid.*
- ¹⁹ *Ibid.*
- ²⁰ National Research Council and Institute of Medicine, From Neurons to Neighborhoods: The Science of Early Childhood Development. Jack Shankoff and Deborah A. Phillips, eds. Washington, DC: National Academy Press, 2000.
- ²¹ Jack Shankoff, 2007. Interviewed in *Helping Babies From the Bench: Using the Science of Early Childhood Development in Court*. Washington, DC: ZERO TO THREE.
- ²² Brenda Jones Harden, Infants in the Child Welfare System. *A Developmental Framework for Policy and Practice*. Washington, DC: ZERO TO THREE Press, 2007.

Chairman DAVIS. Thank you very much.
Mr. Yager.

STATEMENT OF STEVE YAGER, DEPUTY DIRECTOR, CHILDREN'S SERVICES ADMINISTRATION, MICHIGAN DEPARTMENT OF HUMAN SERVICES

Mr. YAGER. Good morning, Chairman Davis and Members of the Committee. Thank you for inviting me today to testify on child welfare reauthorization, specifically the Child Welfare Services program and the Promoting Safe and Stable Families.

Today I want to hit three areas, as my colleagues have covered a couple of other areas. I want to touch on case worker visits, data infrastructure, and audits.

Case worker visit funding is essential, and it has had positive impact on the children in Michigan. Michigan has seen a rate of case worker visits improved dramatically through the use of funding. Our base line in 2007 showed 14 percent of case workers actually achieving monthly visits with each child. In 2010 that rate increased to more than 70 percent.

We continue to aggressively pursue training for public and private case workers, courts, in foster and resource families, so not only will our rate of visitation improve to 90 percent by the end of fiscal year 2011, but also our quality will improve.

Reauthorization and extension of the case worker visit funding will support our initiatives to continue improvement in the rate and the quality of home visits. I would concur with our colleagues regarding the method of determining compliance for that. It is a concern that I would share with them.

As for substance abuse services, Michigan sees this as a continued need, as has already been stated, and we strongly support reauthorization of that funding.

Data-driven decision-making. Michigan's data-driven decision-making initiative began out of necessity. Our goal has been to provide central administration and local office management and staff with the reports necessary to increase positive outcomes for the children and families served in children's protective services, foster care, adoption, licensing, and juvenile justice programs. Our philosophy is to provide the field with data reports so they have the knowledge needed to manage the workforce proactively, and focus on key areas of practice that have been shown to increase child safety permanence and well-being.

In addition, the data reports provide central administration executives with the ability to review county performance, and the same areas of practice across the board.

Now, for a minute I would like to speak a little bit about audited processes. Michigan recommends that all Federal processes be streamlined and linked, so the frequent intrusions and required corrective action plans resulting from the myriad reporting and review requirements are eliminated.

For a state like ours that is also operating under Federal court consent decree, writing the reports, measuring data in subtle but different manners for each process and then participating in Federal reviews, program enhancement activities, leaves us with little time to work on implementing meaningful change.

From 2008 to 2010, Michigan underwent a title IV-E review, child and family services review, statewide assessment and on-site review, the CFSR program improvement plan, the title IV-E departmental appeals board litigation, the children's rights lawsuit, and SACWIS on-site review, and other reviews of the public assistance side of the department. We do not object to oversight, but to the increasingly seemingly constant nature of that oversight.

Michigan wants strong accountability in the operation of child welfare programs, but these divergent reviews and monitoring processes are too numerous to be value added, particularly to the staff responsible to providing services to families.

Michigan recommends that current Federal review and planning processes for the child family services review and the child family

services plan be blended into integrated and coordinated state planning processes. The proposal proffered by the American Public Human Services Association and the National Association of Public Child Welfare Administrators establishes both the manner in which this could occur, and the rationale for coordination. The proposal recommends a modified CFSR target of no more than three key practice areas. The state would be held accountable for its efforts to achieve sustainable improvement in those targeted areas.

Assessment data and continuous quality improvement activities form the basis of these activities. The proposal would employ qualitative data from the state's case review system, giving the review a real-time value, instead of the historical data profiles employed in the current CFSR process.

Under a coordinated plan, the states could more readily adapt to changes in funding, legislative focus, program operation, and external influences, essentially becoming more nimble in response to these changes. Currently, the two-year PIP period is counterintuitive to how child welfare really operates. Renegotiation is required for these modifications.

With respect to the commonality of data, we agree that national data standards need to be established. However, the child family services review data profile and measurement processes confuse external stakeholders, case workers, other agency partners, and the consumer community, including the legislature and press. This confusion often unjustly contributes to public disdain for our work, and impacts staff morale.

States should have more control over their individual processes. Michigan recommends using longitudinal data to assess our performance. This data modeling has a higher degree of reliability and we are able to move more quickly to assess the impact of changes in our policies and processes.

Another key component is—

Chairman DAVIS. If you could, sum up quickly, Mr. Yager.

Mr. YAGER. We need an external review process, and we have that in Michigan. Blending the external with our internal processes will improve the review system.

We believe the children's bureau, through technical assistance, can enable us to develop a more effective state-based system and would satisfy Federal review.

Thank you for your time today. I appreciate this opportunity. I want to encourage you to reauthorize the Safe and Stable Families.

[The prepared statement of Mr. Yager follows:]

**Child Welfare Services and Promoting Safe and Stable Families Reauthorization
June 16, 2011**

Michigan Department of Human Services
Children's Services Administration
Steve Yager, Director

Good morning Mr. Chairman and members of the committee. My name is Steve Yager and I am Deputy Director of Children's Services at the Michigan Department of Human Services.

Thank you for inviting me to testify today on child welfare reauthorization, specifically the Child Welfare Services program and the Promoting Safe and Stable Families program.

Caseworker Visit Funding

Michigan has seen our rate of caseworker visits improve dramatically through the use of the funding. Our baseline in 2007 showed 14% of caseworkers achieving a monthly visit with each child. In 2010, that rate increased to more than 70%. We continue to aggressively pursue training for our public and private caseworkers, courts and foster and resource families so not only will our rate of visitation improve to 90% by the end of fiscal 2011, but also our quality will improve. Additionally, we are heavily investing in mobile technologies to assist our caseworkers while in the field. The reauthorization and extension of the caseworker visit funding will support our initiatives to continue improvement in the rate and quality of home visits, which we believe has greatly improved child safety and has promoted placement stability.

While Michigan has not been required to pay a penalty for failure to achieve our stated goals, we would argue that assessing a penalty is counterproductive to achieving the goals of enhanced visitation. Michigan is not alone in the fiscal crisis that many states are facing. We acknowledge the penalty structure is considerably less than that applied to the Child and Family Services Review Program Improvement process. Any penalty in these trying fiscal times, however, takes a very real toll in the services we are able to provide to the children and families in the foster care system.

Michigan would like to see the additional IV-B (2) funds dedicated for improving the rate and quality of caseworker visits extended under the Promoting Safe and Stable Families reauthorization.

Substance Abuse Services for Caregivers

Michigan sees this as a continued area of need. There are several models available; however Michigan has not had the resources to develop anything on a statewide basis. Family drug courts and recovery coaches have proven effective. Michigan would advocate for additional funding for family drug courts and specialized Department of Human Services workers to coordinate/monitor the cases that are in drug courts.

Coordination of Medical Care for Foster Youth

Michigan's use of Foster Care Transitional Medicaid (FCTMA) has improved from 33.8% to 65.4% in the last 18 months. This Medicaid program is not intended for every youth exiting foster care, with some youth acting as parents and therefore receiving Medicaid under a different program. A total of 86.3% of youth exiting Michigan foster care were enrolled in a Medicaid program at the end of April 2011.

Data Driven Decision Making

Michigan's data driven decision making initiative began out of necessity. Our goal has been to provide central administration and local office management and staff with the reports necessary to increase positive outcomes for the children and families served in child protective services, foster care, licensing, adoption and juvenile justice programs. The philosophy is to provide the field with data reports so they have the knowledge needed to manage the workforce and focus on the key areas of practice that have been shown to increase child safety, permanency and well-being. In addition, the data reports provide central administration executives with the ability to view county performance in the same areas of practice in a summary and graph format. The reports have consistent formatting and allow a quick comparison of performance at each reporting level within the county and statewide to ascertain the consistency of standards.

Key areas of practice across programs were identified as:

- Visitation Standards: reports that outline the required visits with children and families and whether they are being completed.
- Case Service Plans: reports that indicate timeliness of case service plan completion and review of service plans by supervisors.
- Placement and Permanency: reports that indicate foster care placement stability, length of time to reunification and adoption, length of time for licensure and timeliness of foster care placement home studies.
- Medical Standards: reports that outline the required medical and dental care for children in foster care and whether they are being completed.
- Data Quality and Timeliness: reports that pinpoint data entry errors, delays or performance issues.

To ensure usability of the reports, case management staff are currently conducting user acceptance testing as the reports are developed and prior to their release to a production environment. Reports are accessed in InfoView software that allows multiple users, configurable time frames and other specific criteria for the reports. Once implemented, baseline performance of counties and the state can be determined and goals will be set to improve performance over time. Michigan expects full implementation of the initiative this fall.

Audit Processes

Michigan recommends that all federal processes be streamlined and linked so the frequent intrusions and required corrective action plans resulting from the myriad reporting and review requirements are eliminated. For a state like ours, that is also operating under federal court consent decree, writing the reports measuring data in subtle but different manners for each process and then participating in federal reviews and program enhancement activities leaves us with little time to work on implementing meaningful change.

From 2008 to 2010, Michigan underwent a Title IV-E Review, the Child and Family Services Review (CFSR) statewide assessment and onsite review, the CFSR Program Improvement Plan, the Title IV-E Departmental Appeals Board litigation, the Children's Rights lawsuit, a SACWIS onsite review and other federal reviews on the public assistance operations of the department. We do not object to oversight but to the seemingly constant nature of that oversight. Michigan wants strong accountability in the operation of child welfare programs, but these divergent reviews and monitoring processes are too numerous to be value added, particularly to the staff responsible for providing services to families. In an effort to ensure Michigan's compliance with the numerous requirements associated with federal review processes, we created a Federal Compliance Division within the Department of Human Services' Children's Services Administration. This division is responsible for state plan maintenance and ongoing activities associated with the multiple federal audit processes.

Michigan recommends the current federal review and planning processes for the Child and Family Services Review and Child and Family Services Plan (CFSP) be blended into an integrated state planning process. The proposal proffered by the American Public Human Services Association and the National Association of Public Child Welfare Administrators establishes both the manner in which this could occur and the rationale for coordination.

The proposal recommends a modified CFSR target of no more than three key practice areas. A state would be held accountable for its efforts to achieve sustainable improvement in those targeted areas. Assessment, data and continuous quality improvement activities form the basis of these activities. This proposal would employ qualitative data from the state's case review system, giving the review a "real time" value instead of the historical AFCARS and NCANDS data profiles employed in the current CFSR process.

Another argument for implementation of the coordinated process is the proposal for ongoing technical assistance by the Children's Bureau. The role of this technical assistance is identified as being consultative and instructive as states modify their processes. By comparison, the current CFSR is focused on identifying weaknesses and the dictating process-driven correction through the Program Improvement Plan (PIP). While the PIP includes many activities occurring over the two years of implementation, it often becomes a plan for the Children's Bureau, not for the state.

Under the coordinated plan, states could more readily adapt to changes in funding, legislative focus, program operation and external influences, essentially becoming more nimble in response

to these changes. Currently, the two-year PIP period is counterintuitive to how child welfare really operates and renegotiation is required for any modifications.

Combining the CFSR and the CFSP processes would allow for continuous implementation of the plans and continuous monitoring of goal achievement. For Michigan, the ability to establish a five-year plan that we self-monitor through data and reporting would aid us in adapting to the ever-changing face of child welfare service delivery. The current Child and Family Services Review process prescribes rather than evaluates. By refining the federal processes, states could be more creative and experimental in service delivery and have the support to evaluate child outcomes and related processes.

With respect to commonality of data, we agree that national data standards need to be established. However, the Child and Family Services Review data profile and measurement processes confuse external stakeholders, caseworkers, other agency partners, and the consumer community, including the legislature and the press. That no state has achieved every CFSR outcome is not reported to the public. Instead, the public hears that their state child welfare system failed the federal review. Child welfare systems receive unjustified bad press when the process itself is flawed. The process unjustly contributes to public disdain for our work.

The states should have more control over their individual processes. Michigan recommends using longitudinal data to assess our performance, rather than comparing our performance to other states. While the CFSR attempts to measure performance across multiple years and among 50 states, longitudinal data lends to constant monitoring and assessment more easily than the national standards. Using case and county specific data is critical to improve our system. Longitudinal data modeling has a higher degree of reliability and we are able to more quickly assess the impact of changes to the policies and processes we implement.

Another key component in any redesign is an external review process that augments internal quality assurance efforts. In Michigan, the State Court Administrative Office operates the Foster Care Review Board program that targets key components found in permanency outcomes. The annual report of this program regularly pinpoints the department's operational weaknesses in assuring safety, permanency and well-being. The process is much like the CFSR; highly-qualified staff and well-trained citizen volunteers review individual cases and interview families, children, foster parents and stakeholders to identify areas of concern. Because they are external to the department, they have no institutional bias and are able to provide recommendations for improvement. This external review is critical to development of our quality assurance system.

Blending the external review processes with state quality assurance systems and using longitudinal data is an ideal way to manage programs, identify barriers, enhance improvement and manage for results. We believe the Children's Bureau, through technical assistance, can enable states to develop a more effective state-based system that could suffice as a federal review process.

Chairman DAVIS. Thank you. Foster care is a shared system between the Federal Government and the states. I would like to start with Ms. Wareing. Given the 20 percent decline in the foster care caseload in the last 5 years, are states spending less, in terms of state dollars, on foster care and related programs?

Ms. WAREING. Well, I actually don't—Mr. Chairman, I think that they are spending less on foster care. I think that they have tried to redirect some of their dollars to in-home services, because there is not the Federal support at that level. So, trying to work on things where you are promoting children being safe, but before they come into the child welfare system, and that requires a large

amount of state funding in order to do that because there are limited—only, really, the title IV–B funds are available to support those types of programs.

Chairman DAVIS. I noted a suggestion in your statement, as well as by others on the panel today, that there should be more flexibility in how Federal foster care and other funds are spent, including for services. Are states leading by example and devoting any state foster care dollars no longer needed specifically for foster care to services to prevent foster care, placements, and otherwise assist families?

Ms. WAREING. From my experience—and I would certainly welcome colleagues who are closer to the ground—but yes, I think that is where states have tried to put their resources into programs that allow children to either not come into care or get home quickly. But that—you know, that has required a very concerted effort, and it does require resources around those prevention programs in order to make that happen.

Chairman DAVIS. Ms. Wilson, would you like to comment, from a Kentucky perspective?

Ms. WILSON. From a Kentucky perspective, we are actually spending as much or more money on foster care, the difference being that the total expenditure base may not be rising more, but the Federal support is declining. So we are spending more state dollars.

We are taking, though, both Safe and Stable Families dollars and any other state-appropriated monies that we can redirect into preventative services. We wholeheartedly would like to see the number of children in foster care reduced by a greater proportion than what it is.

Chairman DAVIS. Thank you. I would like to open a question up for the panel overall, just in my limited time. Earlier in the hearing we heard Mr. Samuels's ideas about streamlining. He talked about oversight streamlining, limiting measures of performance, the way the annual audits were approached. I would like to open it up for the panel on your thoughts on the proposal, on his ideas.

Ms. WAREING. Mr. Chairman?

Chairman DAVIS. And then we will go to Mr. Yager next.

Ms. WAREING. Thank you. I would echo—first I would say that, on behalf of the American Public Human Services Association, we would acknowledge that Mr. Samuels and his staff have been very open to participation from the states. They have asked and reached out directly to state administrators and deeper to—for ideas about how to streamline the process.

Our recommendations—and we have formal recommendations that we would be happy to share with this committee—would really bring together what are, in effect right now, planning, and then a review process, and then a monitoring process, and then a come back in and monitor again, into one seamless review process that would exist under the CFSR.

Chairman DAVIS. Thank you. Mr. Yager?

Mr. YAGER. I would support what Mr. Samuels had said. I think that's a great approach.

I think there needs to be a fundamental shift away from multiple on-site reviews, often looking at the same cases at different points

in time, to looking at the state's quality assurance system, encouraging a robust state quality assurance system that possibly could be certified by the Federal Government. They could then go into information out of the state's own system, as opposed to duplicating reviews across multiple counties.

Chairman DAVIS. Mr. Sciamanna?

Mr. SCIAMANNA. Yes, and we would agree that there is a need to do some reform for some oversight.

One that especially is based more on outcomes for children—actually, this committee was, I think, instrumental in the Fostering Connections, in that you started to look at some of those outcomes in other areas, in terms of health planning, in terms of educational outcomes.

And so, being able to kind of track that, and obviously also what is done at the front end, I think would be important—what we would like to see is a partnership more between the states and the Federal Government, so that that oversight and plan improvements can be jointly developed and implemented.

Chairman DAVIS. I appreciate that. One of the things that we have started to work on in this subcommittee with an earlier piece of legislation—hope to see follow through every one of the entitlement reauthorizations—is data standardization and data integration that would allow us to bring the Federal Government into the 21st century, and move away from the old Cobalt-based programs of the 1960s and 1970s, make it more like the private sector, in terms of both data accuracy, but significantly reduce improper payments and, frankly, pushing redundant measurement programs out on you from the different agencies, so we can drill down and get that data, and hopefully have a more proactive partnership.

With that, I would like to recognize the gentleman from Minnesota, Mr. Paulsen, for five minutes.

Mr. PAULSEN. Thank you, Mr. Chairman. I will just ask a question of Ms. Wareing. You mentioned—at the end of your testimony you talked about one-fifth of the SSBG funding, about 340 million of it, was devoted to prevention. I just noticed at the end of your testimony. Can you provide some additional background on that program, just for the record?

I guess I am kind of interested in knowing what states spend that \$340 million specifically on that you said is devoted to prevention. Like what type of prevention services, with at least some description of what those services do, or what they are.

Ms. WAREING. Mr. Chairman and Congressman Paulsen, let me try to broad-brush, and if there are more specific information that we could detail you, provide for you with how states specifically spend that money, we are happy to do that research.

But SSBG funding is the second-largest funding source for prevention activities, next to Promoting Safe and Stable Families for states. And they are able to leverage those dollars and really direct them to community-based services that are really designed much more on the prevention side of supporting families and—in the hopes that we are able to keep children safe and families well.

And so, they could be things like some of the same kind of things that you might see in Promoting Safe and Stable Families. It could be community supports, it could be home visitation. It could be

neighborhood parenting types of classes, and those types of things. You know, many of them, I think, are evidence-based—some of the questions that Congresswoman Black had talked about, in terms of ensuring that sort of—that the dollars are actually going to programs that work.

But I would also say there are very few programs that have the kind of flexibility where you can leverage other dollars. And that is really what SSBG provides. It allows funds that may not be sufficient for a particular community to really be—to give you that extra push that you really need.

Mr. PAULSEN. Is there a way to identify, like, how many families or people are actually served by this spending on prevention services, to get down to that type of data? Can you drive down to that?

Ms. WAREING. Mr. Paulsen, I don't know, off the top of my head, but I would certainly be willing to look at that.

Mr. PAULSEN. Or even what the average amount, for instance, per family or per person is, you know, allocated or is a part of that, just to—that would be helpful data, I think, as we are kind of looking at the—sort of the prioritization or the benefits of some of these programs, because you did note that in the testimony.

Ms. WAREING. Yes, absolutely. And it is incredibly helpful funding. I would say it is designed to be flexible funding. And so I am not sure, off the top of my head, how precise they can go to the dollars spent per family, but we will certainly look at that for you.

Mr. PAULSEN. Please, Mr.—

Mr. SCIAMANNA. Just in regard to the social services block grant, there has been a series of surveys of states conducted by Child Trends most recently, and Urban Institute every two years, asking states what they spend on child welfare services. And SSBG has pretty consistently been around—I think it's 20 percent of the Federal funding that states invest.

It varies by the 50 states. It will be about 300 million in the child protective services, nationally, but may also supplement what states do in terms of foster care, adoption assistance and support, and for youth. So there is a range of services that it does provide. But it has been a very critical component of the child welfare funding system.

Mr. PAULSEN. Thank you, Mr. Chairman. I yield back.

Chairman DAVIS. Thank you. The chair recognizes Mr. Reed for five minutes.

Mr. REED. Thank you, Mr. Chairman. I am hearing kind of a consistent theme here from the panel and from testimony that is coming across. Essentially, what I am hearing is that we need less auditing, more streamline reporting requirements to the Federal level.

But I would note that when I read the testimony I see some successes. I see 27 percent less kids in foster care, I see 20 percent over the last 5 years kids in foster care. So, does it not beg the question—I would be interested in the panel's response to—we have to be doing something right. And that has—we heard Mr. Samuels's testimony as to previously the requirement on the states was to give us a plan, and now it is give us a plan and then give us an accounting of how you spent the money.

So, my gut tells me that that change in philosophy of accountability, it seems to be—being implemented in this area. It seems to be working. So, is there any disagreement with that philosophy from anyone on the panel?

[No response.]

Mr. REED. Okay. So when we recommend less auditing, less accountability, if you would, from the states to the Federal Government, how do we maintain the successes by removing that accountability provision? Mr. Sciamanna?

Mr. SCIAMANNA. I guess it is not less accountability, but refining it. I think the child family service reviews were an important act by Congress in 1994. And I think even some of the states will say—they may have problems with what the current process is, but it did engage a number of stakeholders. So I think the question is more about a refinement of that process, and what is the most efficient way to oversee the states.

So, I think that is more of the debate, because certainly a number of advocacy groups and states will have different ideas, but we do need to have that oversight, because we should be doing a lot more for a lot of these families.

Mr. REED. Okay. Mr. Yager?

Mr. YAGER. And certainly we would agree with that. The accountability is important. That is not something that we want to shy away from. What we would suggest is that—is how they hold states accountable is what makes a difference.

If they come in and do multiple reviews, looking at same sets of cases, requiring a lot of our staff to focus a lot of time, and then write independent corrective action plans for each of those reviews, versus looking at the state's own data system and encouraging a robust data system that can be relied upon to prevent them from coming in at multiple points, they could rely on our data, supplement that with some coordinated efforts on site, and then produce their reports—

Mr. REED. Well, that is good to hear. So no one is really objecting to the accountability.

Mr. YAGER. No, sir.

Mr. REED. It is just a matter of getting the information streamlined.

Mr. YAGER. Yes, sir.

Mr. REED. And I am interested—and there is a lot of testimony in here—about prevention, preventative action. And that, in my gut, makes sense.

I note the court improvement program, Ms. Hopper. You indicated that the court improvement program contributed to the success in Virginia. Can you tell me exactly concrete examples of what programs, what preventative measures you took to accomplish that?

Ms. HOPPER. Well, the courts, of course, don't deliver programs. But they monitor the cases as they come in. And I think one of the critical components in the work that has been done in Virginia is the collaboration across all of the child serving agencies.

One of the mantras in Virginia is that it is not just social services that is responsible for these children; they are the community's children. And you need to bring together the schools, mental health

agency, the health department with Medicaid. All of those agencies need to be at the table in supporting local departments of social services who hold custody of children in foster care, and are held—frankly, all of them need to be held accountable for delivering whatever the support is that the child and the family need to get them out of foster care, or get them to some other permanent placement.

So, to some degree, prevention occurs when you are able to engage all of those agencies right at the beginning of the entry of the family into care. And one of the things that the courts in Virginia have done—and I think is also a hallmark of other court improvement programs across the country—is that the court is sort of a disinterested party, has the ability to provide the leadership to pull them all together and say, “Yes, I may make the final decision, as the judge, but I need to know that you all are all at the table supporting the family, and ultimately the agency, if they have—if the court has to put the child in care in resolving these problems.”

So, that kind of collaboration, which is supported by the child and family services review—but it has got to be more than a federally-directed effort. It has really got to be a locally-supported effort to be effective.

Mr. REED. I know my time has expired. I appreciate the testimony, Ms. Wareing. And I did note in your testimony there was a study of the nurse initiative out of Elmira, New York, which is in my district. I will be reaching out to them to find out how that program is continuing to work. So I appreciate that.

Thank you, Mr. Chairman, I yield back.

Chairman DAVIS. Thank you. Mr. McDermott?

Mr. MCDERMOTT. Thank you, Mr. Chairman. I received some information from a project in the State of Washington. So I want to put mine into the record. The Pierce County Alliance got a regional partnership grant from HHS to administer a promoting safe and family services programs like the one we are discussing this morning. It is called the Amphetamine Family Services Partnership. And it really is another example—and I think all of these, it would be nice if we could get them all—and I ask unanimous consent to put in the record a letter from Dr. Terry Schmidt-Wayland along with the evaluation of the program in the State of Washington.

Chairman DAVIS. Without objection.

[The information follows:]

June 16, 2011

Committee on Ways and Means
 Rayburn House Office Building
 Room B-318
 Washington, D.C. 20515

Re: Programs Designed to Protect At-Risk Youth

Dear Congressman McDermott:

I am writing as the Executive Director of the Pierce County Alliance (PCA) which is a large criminal justice/treatment organization in Washington State, to express adamant support for the continued funding of Children and Family Futures/Health and Human Services. We provide a Methamphetamine Family Services partnership which works with the co-occurrence of child maltreatment and substance use disorders which demands urgency, and the highest standards of practice from everyone charged with assuring child safety and promoting family well-being. After just recently completing a highly successful Regional Partnership Grant administered by Children and Family Futures, I am compelled to speak out about retaining funding for this incredibly valuable national resource.

Since the inception of the Pierce County Family Drug Court in 2001, we have worked together with community partners to establish a treatment court which has combined the County Superior Court system with the Juvenile Superior Court system. The two court systems work in partnership to handle the juvenile dependency cases under the auspices of the Adult Superior Court. In 2007 we were awarded a three-year grant through the Department of Health and Human Services to increase and enhance our Family Drug Court and to strengthen partnerships with the Pierce County Superior Court, the Washington State Attorney General's Office, the Pierce County Department of Assigned Counsel, The Division of Child and Family Services, the Pierce County Guardian ad litem/CASA office, and a local community action program called "Safe Streets".

The staff at Children and Family Futures provided dynamic and committed leadership to all of the programs participating in the Regional Partnership Grant process. The end result was a true confirmation that timely and permanent reunification of families is possible when using shared cross-system values and guiding principles. Again, Children and Family Futures was an instrumental factor to help build collaborative policies and practices in Pierce County. In this county alone, using this enhanced treatment court model we have turned the numbers around for child dependency. Pierce County had the highest rate of parental rights terminations for drug

Drug and Alcohol Assessment and Treatment - Adolescent Services - Family Counseling - Chemical Detection Services

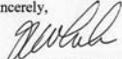
A private, non-profit organization serving the special needs of Pierce County

involved parents with up to 90% of cases ending in termination. Currently it is just the opposite and we actually see almost 85% of these referrals consistently result in permanent reunification. I have enclosed a copy of the Executive Summary that is a condensed version of the externally contracted research results of our Regional Partnership Grant.

The desire and potential to change individual lives and create responsible public policies does exist and is clearly seen in the workings of Children and Family Futures. This program has fostered dramatic progress with intervention to the cycle of addiction and resulting child abuse/neglect. The idea of discontinuing funding for this essential element of progress is not acceptable. As our community continues to look for ways to build crucially needed support for the drug addicted and co-occurring parents seeking to recover their sobriety and ability to effectively parent their children, we strongly endorse the continued funding for Children and Family Futures.

I would be happy to affirm the above or speak to committee members upon request.

Sincerely,



TERREE SCHMIDT-WHELAN, Ph.D.
Executive Director

Enclosure

More Families Reunited Using Holistic Approach to Treatment and Support of Methamphetamine Addicted Parents



Purpose

This report summarizes an evaluation of a drug treatment program in Pierce County, Washington, that was developed to support the Pierce County Family Drug Court. It focuses on the treatment of parents, who are dependent on methamphetamine and/or other drugs, with the aim of bringing them into recovery and helping them regain their capacity to provide safe and nurturing environments for their dependent children.

The intended outcomes of the program are parental recovery from substance dependency and the reunification of the family, or permanent placement of the dependent children when the parent fails to achieve recovery or decides not to seek permanent custody. The Pierce County Alliance (PCA), a local treatment provider, formed a regional partnership with the Washington State Department of Children and Family Services (DCFS) and other community providers in order to enhance support services for the families involved and improve results.

Based on an analysis of data collected since 2002 and the assessment of program changes initiated in 2007, the evaluation found that **the program is very effective in both rendering successful treatment outcomes and in preparing parents for successful reunification with their children.** In measuring the effectiveness of program improvements, the evaluation showed mixed results, that is, little difference from the comparison group overall, but significant increases in successful treatment and reunification over pre-2002 cohorts.

In addition to learning from the quantitative analysis presented, we also gained insights and suggestions from interviews with system partners. The quotes that appear throughout this document are results from this qualitative assessment.

Program Results

Success in the program can be seen at various stages. Among the most important milestones are these:

- Continuity in treatment (6 & 12 mo.)
- Sobriety (numbers of positive UAs after starting treatment)
- Treatment completion & graduation from Drug Court
- Positive, permanent child placement
- Reunification with parent
- Adoption with voluntary release of parental rights

The program has been successful in all of these measures.

For a copy of the complete evaluation report, please contact Pierce County Alliance or Geo Education & Research.

Table 1: Child Outcomes

Outcome	Comparison Group	Experimental Group	Both Groups
Reunited	82.6%	81.1%	82.7%
Adopted	12.1%	11.1%	11.8%
In custody of relative	5.3%	6.7%	5.7%
Turned 18		1.1%	0.3%

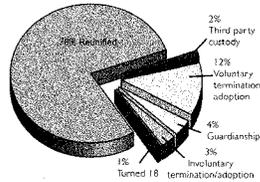
Program Overview

The methamphetamine epidemic that has swept the nation over the last two decades has put huge demands on the criminal justice system, public welfare resources, law enforcement, treatment, and environmental and public health services. The availability of the drug, its attractiveness to many users, and the fact that it is highly addictive, combine to present ever-greater demands on the available treatment services. In 2007, the number of treatment admissions for methamphetamine as the primary drug of abuse more than doubled nationally, rising to 7.5% of treatment admissions compared to 3.3% ten years prior.

Notwithstanding the increased numbers of users, the nature of the drug itself presents additional challenges to treatment providers because the mood altering and psychotic impacts tend to be more acute than with other popular drugs such as cocaine or heroin. Methamphetamine represses one's appetite, causing most users to ignore their basic nutritional needs, resulting in problems with physical health in addition to the mental health issues that impact at least 50% of those admitted for substance abuse treatment.

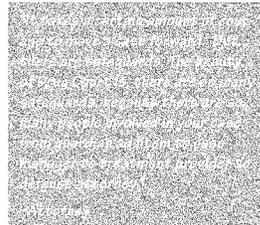


Table 2: Child Outcomes in Experimental Group



When caregivers of young children become dependent on methamphetamine, the children often come into harm's way due to domestic violence, child abuse and neglect. The impacts of this on the family have created even greater demands on community and governmental supports systems, particularly those charged with assuming the custody of drug-endangered children on behalf of the state. These cases eventually come before county family courts, charged with either restoring or denying parental custody rights and determining the ultimate disposition of the dependent child. This takes the form of reunification of the family or an alternative permanent placement (e.g., adoption by a relative; placement in foster care).

Since its inception in 1972, the Pierce County Alliance (PCA), a private, non-profit treatment service provider, has specialized in drug and alcohol treatment for offender populations. In recent years, the agency helped pioneer the implementation of drug treatment courts in Washington State. In 2001, PCA worked with the Washington State Department of Children and Family Services (DCFS), the Pierce County Superior Court, the State Attorney General, and other principals, to form a Family Treatment Court. That same year PCA helped initiate the Washington Methamphetamine Initiative. One of the component program efforts focused on treatment specifically designed to address the impact of methamphetamine on families. PCA developed the Methamphetamine Family Services (MFS) program to provide treatment and other parental support services to parents whose child custody rights were at risk, due at least in part, to their drug use.



Under a Regional Partnership Grant from the U.S. Department of Health & Human Services, the partners expanded program collaboration and enhanced service delivery with innovative, evidence-based approaches. They implemented other system changes to improve parenting skills and to extend crucial supportive services throughout the treatment and post-treatment processes. This entailed an intensive case management approach, which addressed all of the family needs through an extended continuum of care and involved family allies and the local community in post-treatment support.

The ultimate aim of the program is to return healthy families to healthy communities and improve the likelihood that families continue new and supportive habits. The goal is for parents to remain free of drug use and for children have the opportunity to grow and develop in a healthy environment.

Program Services

The program is based on a standard intensive outpatient model of chemical dependency treatment, which takes a client through three phases of group and individual therapy sessions that are progressively less intense. It takes at least 12 months, depending on the individual patient's progress. Throughout the treatment regimen, patients are monitored for sobriety and abstinence through random urinalysis and breath analyses.

Methamphetamine-dependent persons tend to progress rapidly in their disease of addiction, which presents a more challenging population for the treatment provider. PCA estimates this population requires two- to two-and-a-half times the amount of treatment time and effort than those dependent on cocaine, alcohol or other drugs. Additionally, most of these patients require a diverse set of services to address nutritional and medical needs, mental health problems, and often other disabilities that complicate the treatment process and denigrate their ability to maintain a functional and safe household for their children.

In addition to addressing the collateral issues of the parents, the enhanced program also focuses on efforts to support the long-term viability of the family by providing parenting skills training, addressing the children's nutritional and health needs, and providing counseling for those that had suffered abuse of any kind. It also incorporates the means for re-integrating the family into the community where they can benefit from a broader support system.

Table 3: Adult Success Rates by Group

Group	Percentage
Comparison	59.6%
Experimental	46.7%
Both Groups	57.7%

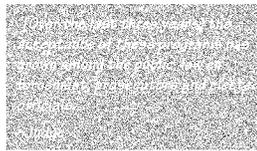
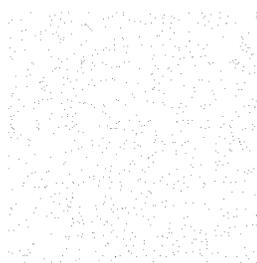
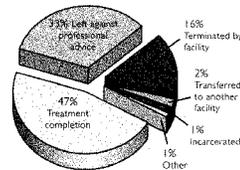


Table 4: Adult Treatment Outcomes



Conclusions

1) Is Meth Family Services an effective treatment program?

Yes. Compared to other, similar programs, MFS is as effective. We reached this conclusion by comparing the completion rate, which was about 50%, to other meth treatment facilities for which data were available.

Yes. The reunification rate for children is 80.0%, with another 10.8% of children being adopted after their parents voluntarily relinquish their parental rights. This places the overall success rate over 90%.

2) Is it successful at preparing parents for reunification with their children?

2) Is it successful at preparing parents for reunification with their children?

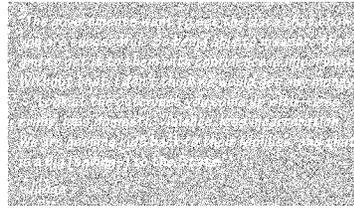
Yes. A client who successfully completes the MFS program is more likely to be reunified with at least one child than a client who does not complete the program. This conclusion is based on differences in child reunification rates between individuals who successfully completed treatment and those who failed treatment.

3) Has MFS improved its effectiveness since initiating program changes under this grant?

Some evidence for yes and no. The data reveal that MFS has maintained, but not improved, its success rate since the changes. This conclusion is based on the overall success rates between the comparison group and the experimental group. The data show that when implemented at its best (i.e., with the best case management and improved collaboration among system partners), the program success rate is much higher.

Recommendations

- ❑ Continue collaboration process and seek wider and deeper commitments from system partners and funders.
- ❑ Add partners who are effective in after-care service delivery and who monitor needs, services and outcomes.
- ❑ Add services that can help parents cope with the variety of challenges they face to remain sober and to improve their parenting skills.
- ❑ Provide high quality, ongoing case management services to all clients, throughout and following treatment and program participation. Use Drug Court graduates as mentors.
- ❑ Provide consistent funding for the courts, program and services (e.g., treatment, visitation, housing, after-care).
- ❑ Create a larger facility in order to bring the people who work on these cases together, to make the process more efficient.
- ❑ Continue collaborative efforts to assess results using the online database developed in this project.
- ❑ Continuously evaluate what is working and what is not working. Set goals and review them at least once a quarter.
- ❑ Keep funders informed of the program's progress and effectiveness, identifying for them and for new partners, the resources, processes and procedures that are essential for success.
- ❑ Maintain strong leadership from judges and program administrators.



Research conducted and report prepared by:

 **Geo Education & Research** Bill Lee, Ph.D., President
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206.364.6660 or 206.914.6563

Chairman DAVIS. I think there are a number of very good practices that are out there, and the question is whether we have enough money to go further.

I would say both to Mr. Reed and Ms. Black that the visiting nurse business was in the Accountable Care Act. Some of us put this in as a part of the whole of the revamp of the health care act.

I would say also, Mr. Chairman, one thing that I wish we had up here—we have got these wonderful people who run these programs, but I think this audience is filled with people who have actually experienced it.

I happen to know one of them sitting here was taken out of her home when she was 12 years old, when her mother was sent to prison, and her mother was sent to prison and 8 kids were taken into the system. They—when she came out of prison, she was de-

ported, although she had a green card. She was deported, leaving eight kids here, in the United States. So this young woman went through six or seven homes, and then aged out, and managed to get herself through college at the University of—or Washington State University, and is an intern in my office.

I would like to hear from you, those of you who are state directors, particularly. What are the problems of the interaction of the legal system of taking the parent away and locking them up, and leaving the kid in a set of foster homes?

Because one of the issues that we had here on this sheet of paper which I sent around to everybody, which is how much money we are spending, you look down here, “Mentoring children of prisoners.” There is nothing.

And I would like to hear from you what the problems are that you see in that particular genre of case, where you have taken the kid away and put the parent into prison. You said you had lots of it in Kentucky. Here is your opening.

Ms. WILSON. Thank you. I think one of the greatest concerns we have is, particularly with young children, breaking that bond between a parent and a child, and how we facilitate trying to do visits between children with their parents, when parents are incarcerated. That is certainly something that we struggle with.

The other issue, then too, is—

Mr. MCDERMOTT. Is that because the distance to the state prison, or is it the reluctance of the foster parent to take the child, or—

Ms. WILSON. It is a combination of factors. It is distance. It is just the sheer logistics of getting children their prescribed times for visits.

One of the avenues that we have taken to try to work with this is we have an organization called Prevent Child Abuse Kentucky that actually goes into one or two of our Federal prisons and conducts classes with parents to prepare them for changes in their children. Because the other problem that we see is that when parents are released, their children are not the children they were when they left. And to help that parent be educated about effective parenting, but also about stages in development of children, so that when they are reunited they are better prepared to deal with the challenges before them that their children will bring.

Mr. MCDERMOTT. What do you find in Virginia and Michigan?

Ms. HOPPER. With regard to incarcerated parents and their children? I was just sitting here thinking one of—the only authority in Virginia in the district courts for bringing prisoner—we’re talking district courts, where these cases are handled—for bringing prisoners to court, as opposed to circuit courts, is actually in the juvenile court with parents who are incarcerated, and are before the court in child dependency cases. And our legislature gave us that authority.

And so, we actually encourage the courts to bring parents to court when they are having foster care review hearings or permanency planning hearings about their children.

But the reality of it is, Congressman, that if you are going to take a child to a prison to visit their parents, the visitor situation is often not very good. It can be very stressful for a child. It can

be tough to be in that kind of an environment. You need training for the people who take them, to help them make judgements about what happened to the child while they were there, and when they come back. And often these parents are there for a very long time.

Chairman DAVIS. Thank you. The gentleman's time has expired. I would echo your sentiments, having been a prison volunteer for eight-and-a-half years in the Kentucky Corrections cabinet. That is a fairly traumatic experience for a child, especially if they have got some history that they are carrying in there.

The chair recognizes Mr. Berg for 5 minutes.

Mr. BERG. Thank you. One of the most difficult things, I think, in this whole process is the unintended consequences, where you sit around and you—it is probably no more evident than what you are dealing with, trying to figure out the best way to help these kids, and yet at the end of the day, the practicality of it, it sometimes has the opposite effect.

And so, I just kind of wanted to expand on this. You know, I have—you know, the President has reduced the funding in half for this prison program. Is anyone familiar with—you know, I have heard it said that actually it is kind of detrimental to some of these children, because you are establishing a short-term relationship, and then you are kind of pulling that away. Is there anyone on the panel familiar with that, and could explain that position, if you will?

Mr. SCIAMANNA. I think—yes, what I read on one of the mentoring programs—at least the HHS justification—was that their evidence seemed to be that a lot of these mentorships were ending within six months, and I think a significant percentage within three months. And the concern is that, when that happens, then you reinforce the sense of abandonment.

So, I think it is—at least in one of the programs they talked about better focusing some of the funding. So I—you know, I don't know. You would have to ask the department exactly the details in this program. But I think that is one of the concerns that sometimes exists in some of these efforts.

Mr. BERG. And from my perspective, I just really believe that unless you measure things you can't manage them. And too often we are putting money and putting new programs, and they just continue on without anyone really saying, "Hey, wait a minute," you know, "that king doesn't have any clothes on," or, "It's not working, and how can we"—which kind of bring up my other passion, and that is really people at the state level, you know, giving them the flexibility to know what works and what doesn't work, and allowing them to make those changes.

And so, I guess, Ms. Wareing, we talked a little bit about, I guess what—I would like to ask you about the waivers, and you know, how you see that as a—I think you support that, but explain how you see that working. And we did pass a bill here at the end of May to encourage the waivers, and I was wondering if your organization was supportive of that, and maybe you can explain how that will help.

Ms. WAREING. Sure. We are absolutely supportive of the expansion, essentially, of what had been the title IV-E waivers, as I think other folks have mentioned here, as my colleague at the end

of the table, Mr. Yager, mentioned, the—you know, the ability to use the IV-E dollars in a way that is beyond the just bringing kids into foster care. It is really the idea of what child welfare finance reform, in a more comprehensive way, is driving at.

It allows states to meet the goals we have said they need to meet, and be accountable to those goals, but fit it to what their community needs are, and communities are different, and states are different. And, you know, the ability to do that and take—in a very difficult fiscal time for all of us, be able to be flexible with those dollars and use them as smartly as possible, we fully support that.

We also fully support examining child welfare finance as a whole. But a huge step would be to expand the ability of the waivers to reach many more states for an extended period of time.

Mr. BERG. I will yield back. Thank you.

Chairman DAVIS. I thank the gentleman. And now the chair recognizes Ms. Black from Tennessee.

Mrs. BLACK. Thank you, Mr. Chair. And I want to follow up on the questioning that Congressman Berg just completed, and that is the sharing of the information, the good information, because you all have—those of you at the state level, you have very good stories about what has worked in your state. And certainly that is something that should be shared with others.

At the same time, Ms. Wareing, I appreciate the fact that each community, each state, may be different in its own complexion, and why it is so important to give that flexibility and allow something to incubate at a state that may really be very successful.

I would like to hear from each of you, whether you are at the state level or an organizational level, how that information that may be a good piece from some place else that is doing a good job—how do you get that information? How is that shared?

And we will start with you, Ms. Wilson. I mean, I like a number of the things that are in your testimony, and I am going to be calling the people that I know back at our state, and talking to them a little bit about that. But how would you both share what you have done successfully, and then also hear what other people are doing?

Ms. WILSON. Certainly. And I know some of the people in your state, and we would be happy to talk with them.

We have two avenues, actually, of both receiving and giving information. One of those is, both through HHS, through ACF, and through organizations like APHSA, they are invaluable when we have the opportunity to share, either via conference calls, to share at conferences, make presentations about specific programs. And so, in return, we both provide that information and we get that information.

I think all of us—a common theme that has been expressed this morning—I think if you were to look at each of the 50 states individually, what you would find is that one of the things that the CFRs did above all else was really push states to be succinct in their data collection, to target that data, and then to use that data. And I think that is the key, is using the data to inform the practices.

So, we look to our national organizations to help us get the word out. We look to those organizations also to make states aware of practices, promising practices, as well as we do ACF, and to share that information among the states.

Mrs. BLACK. Thank you. Ms. Hopper.

Ms. HOPPER. The court improvement programs, of course, are significantly focused on court processes and relationships with communities.

And the National Council of Juvenile and Family Court Judges, through their permanency planning for children department, is a terrific resource for us. And they cultivate judges across the country with particular expertise—many of them come from your states—that are available to us to use in our states to call on as resources.

The National Center for State Courts is also a terrific resource.

And then, the national resource centers that are funded through HHS, the Center on Legal and Judicial Issues and the Child Protection Center are two that we are currently using on training on child safety.

So, the national resource technical assistance that is available probably—I look at it a little bit differently than the executive branch does, but they help to pull together best practices, and people who are really on the cutting edge of these issues. And we rely on them heavily to know what is going on across the country.

Mrs. BLACK. Do you think other states are relying on them, as well?

Ms. HOPPER. Oh, yes, ma'am. I do believe they are.

Mrs. BLACK. Okay. Great, great. Ms. Wareing?

Ms. WAREING. I would just add—and Pat so eloquently talked about the way that the associations really play a role. But, you know, there is a lot of people in this room, many people, who come to work every day thinking about the ways in which we can better serve, have better, healthier lives for our children and families.

And part of what I think has happened in recent years that is remarkable in a way that has allowed really good things to happen—and if we didn't say this, I think other people on the panel would agree—Promoting Safe and Stable Families, and including some of the things that happened in the last reauthorization were very helpful. So, you know, that, I think, is an important thing to leave the panel with.

But there is a real shared governance and leadership that exists across national organizations, at all levels of state and local government. And those are the—the more we can make that a dynamic relationship, as opposed to a linear relationship, that is the way that things get shared.

Mrs. BLACK. Thank you.

Mr. SCIAMANNA. Yes. Actually, I hope American Humane Association is part of the solution. We do have a research department, based in our Denver office, and we either partner with states or localities, as they implement these practices. Or we do research around specific programs or practices, differential response.

Something that actually the state of Tennessee is implementing, it is the way you design your child protective services system. But there was extensive work, and it is ongoing work, in terms of the

state of Minnesota and their progress, where they have had control groups findings on the results of differential response, how it has really helped families.

So, in our case, what we have done is we have gone into states like Ohio and now New York, and we help them implement it on a county-by-county basis. But it is research-based, and it is similar to what we are also doing, in terms of the fatherhood outreach, through fathers with children in child welfare. There is a research component.

Mr. YAGER. I would quickly add that the ACF hosts conferences, and those conferences are very available to us. They are often funded for us, and we are able to go and share information. But I would also add that there is child welfare list serves where we can get on in real time and talk with our colleagues across the country and share information back and forth about what works and what doesn't work.

Mrs. BLACK. Thank you very much.

Chairman DAVIS. I thank the gentlewoman, and I want to personally thank each of our witnesses who have come in today, taken the time to—some come from far away, knowing you have got a day job waiting for you that is accumulating demands while you are here with us.

We look forward to working with you closely in the future. Any additional input that you would like to have, certainly we are very open to that and want to craft the most efficient and proactive re-authorization possible.

And if Members have additional questions, they will submit them to you in writing. What we would ask is that you submit your answers also the committee, just so we can insert them in the official record, so everyone will have access.

And thank you all again. And, with that, the committee stands adjourned.

[Whereupon, at 11:12 a.m., the subcommittee was adjourned.]

[Submissions for the Record follow:]

Adoptions Together

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Title of Hearing: Improving Programs Designed to Protect At-Risk Youth

Date: June 29 2011

On behalf of Adoptions Together, I would like to thank the Subcommittee for giving our organization the opportunity to present testimony about the importance of post permanency services for at-risk children and youth.

Organizational Background

Adoptions Together is committed to building healthy permanent families by providing the highest quality child placement services and lifelong therapeutic support to children and their families. Adoptions Together provides family reunification services as well as services designed to meet the needs of children in foster, kinship, guardian and adoptive families. Adoptions Together also advocates for systemic change and continuous improvement in the child welfare system.

Adoptions Together employs a racially and culturally diverse staff of 40 people and maintains contractual relationships with over 50 licensed clinical social workers and professional counselors who provide therapy, assessment and training services. The Board of Directors is a diverse group of individuals who advise the agency as community leaders in business, health care, nonprofit management, development, and financial management. Volunteers and interns support the agency on a regular basis.

Adoptions Together has offices and key projects in Maryland, Washington DC and Virginia. Projects in each area are designed to reflect each community served with



the highest outcomes possible. Many of these programs have been built based on best practices from programs across the country that are achieving strong results.

The Importance of Post Adoption Services

Post-permanency services are a critical feature of child welfare practice as public agencies work diligently to place children with special challenges in permanent families. Children who have experienced trauma and are unable to be raised in their birth families are at risk for developmental challenges as they mature. The children needing the most intensive post-permanency services are usually older with a history of child abuse/neglect, multiple foster home placements, learning disabilities, and/or medical issues. Families who provide guardianship and adoption for children need a range of services to keep themselves strong, healthy, and flexible. Post-permanency services are designed to provide this range of services which include: information and referral; preparation of the child for guardianship or adoption; crisis counseling; individual and systemic advocacy; individual, group, and family counseling; support groups for children, adolescents, and adults; respite care; and training for professionals as well as parents.

Post Permanency Family Center

Towards this end, the government of the District of Columbia (through the DC Child and Family Services Administration) contracted with Adoptions Together in 2007 to establish the Post Permanency Family Center (PPFC). Now in its fourth year, PPFC has a deep understanding of the community, the population, and the services that best serve children and families brought together through resources of the government in DC—services that keep families strong.

Current PPFC services include therapy and case management, training, community outreach, crisis intervention, therapy groups, and respite. Additionally, the staff of PPFC (100% residents of the District of Columbia) are frequently called upon to serve arising needs in the community and provide expertise on key matters affecting families in the District of Columbia. PPFC is also a center for future



leadership through PPFC's strong history of partnered with student interns and researchers from key academic institutions in the region, and a community gathering place.

Adoptions Together values this partnership with CFSA as a representation of the heart of our mission: *"Adoptions Together builds healthy lifelong family connections for every child and advocates for continuous improvement of systems that promote the well being of children."*

Therapy and Case Management

The goal of the therapy and case management services at PPFC is to provide a holistic approach to therapeutic needs that are tailored to each child and family we serve. These services included the following:

- Peer support/mentoring
- Case Management
- Crisis counseling, and 24 hour hotline for crisis intervention
- Phone coaching
- Short term issue-related counseling, and Therapy and management of severe disorders (i.e. mental illness, medication, and severe attachment disorder)

At intake, each child and family is assessed for their individual needs and presented with the full milieu of treatment options available. A treatment plan is tailored for each family to address the presenting challenges. Resources from the surrounding community that can support this healing process are also presented. If the family of origin remained active in the child(ren) life, they are encouraged to play a role in the therapeutic process.

In 2010, PPFC responded to 290 inquiry calls. 1,063 in-center therapy sessions were held (1351 total hours) and 135 in-home therapy sessions were held.

Some examples of participant comments in this area

- A parent who attends therapy and parent trainings at the PPFC wrote in an email, "Because of your help, I don't respond so harshly...to my daughter



(when she acts out.) We just talk about what caused it and how to handle the situation the next time. I am also giving more hugs. Thanks again.”

- Parent who had completed intake stated (during a brief follow up phone call): “Thank you again for taking the time to meet with me. After our meeting it was the first time I had felt hopeful in a long time...and what you said to me really helped give me permission to take some very important steps [in figuring out a visitation plan for her son and his biological family]”.

Training

The goal of training services at PPFC is to train professionals (including CFSA staff and other community leaders and staff), and parents in support of the community and families we serve. Forty three parents and fourteen professional trainings were given in 2010 and three hundred fifty-four people attended those trainings. The 2010 trainings offered at PPFC were as follows:

<u>Parent Trainings</u>	<u>Professional Trainings</u>
Trauma and Sexual Behavior in Adolescents & Youth	Youth & Porn Addiction
Discipline vs Punishment	The Process & Impact of Disruption
ADHD Basics	Emotional & Regulatory Healing
Attachment 101 & 102	Attachment Training Series for Caseworkers (4 sessions)
“What Triggers You?”	Attachment Training (@ Latin American Youth Center)



“Working with Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth & Parents”



Working with the LGBTQ Community (PPFC Staff)

The Ins and Outs of Guardianship

Joy, Loss & Trauma

The Impact & Process of Disruption

Trauma and Sexualized Behavior

Roll with the Punches

Self Care for Professionals

Love & Logic Series

Ethics in Child Welfare (@ ATTACH Conference)

Youth & Porn Addiction

Addressing the needs of LGBTQ Youth

Birth Parents & the Triad

The Impact of Process of Disruption

Adoption Law

Sexualized Behavior and Trauma

Managing & Understanding the Triad

Learning about Youth Villages (for PPFC)

Psychotropic Youth

Understanding the IEP

Relax, Refuel, & Rejuvenate

Over three hundred professionals, parents and children attended training programs at PPFC during 2010. The evaluations from the 2010 parent and professional trainings are overwhelmingly positive.



- One participant wrote, "This workshop was exactly what I needed, it was professional and had so much information, I was really glad to find this!"

Therapy groups

The goals of the therapy groups hosted at PPFC are to provide peer support and strategies for successful parenting in a group setting. This form of treatment aids in socialization, relationship building, and allows flexibility in working with key sub groups within the adoption and guardianship community. Ninety-six people attended multiple sessions of group therapy during 2010.

Therapy groups active at PPFC during 2010 included:

- Open Teen Group
- Open LGTBQ Parent Group
- Clinical Rap Group
- Strengthening Family Coping Resources (SFCR) Group
- Coming of Age for Girls
- Respite Groups

The Zanvyl and Isabelle Krieger Fund awarded Adoptions Together support for PPFC and wider staff to be trained in an evidenced-based model for a family support group called Strengthening Family Coping Resources (SFCR). The clinical team was trained in the model and led the first group session. It was a great success, with each family attending group every week, for ten weeks, without missing one session! The SFCR group is an evidence based support group designed for families at risk of developing Post-traumatic Stress Disorder was a huge success and ran from April 28 to June 30. One client recently stated "I would have been in jail by now if I didn't come here to talk."

Respite

The goal of the therapeutic respite program (*A Place to Go & Grow*) at PPFC is to provide families with a chance to have a break from the pressures of family life (which are often exacerbated) when children have a history of trauma, neglect or abuse. PPFC families were able to attend respite one Saturday each month.



In 2010, thirty six children were able to utilize this program. PPFC was also the recipient of a \$5,000 mini-grant from Adopt-Us-Kids to support our respite program.

Key examples of participant comments in this area

- A parent whose child participates in the monthly respite program, *A Place to Go and Grow* told the respite coordinator, "I really appreciate that my daughter can now talk about her feelings and thoughts about adoption and growing up." Her daughter chimed in and said, "I like respite because I know I can go there and feel comfortable expressing myself."
- Parent who had just brought her daughter to respite for the first time stated: "Kim and her team are so good, were so on point and are just doing a really great job. My daughter loved it and already found a little group of friends to hang out with."

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Child Welfare League of America



Testimony of
Child Welfare League of America

**U.S. House Committee on Ways and Means
Subcommittee on Human Resources**

Hearing on
Improving Programs Designed to Protect At-Risk Youth
June 16, 2011

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The Child Welfare League of America (CWLA) is a ninety year-old non-profit organization representing hundreds of state and local child welfare organizations including both public and private, and faith-based agencies. CWLA members are located in all fifty states and provide a range of child welfare services from prevention to placement services including adoptions, foster care, kinship placements, and services provided in residential settings. CWLA envisions a nation in which all children and youth are safe, nurtured in their families and communities, and grow up to be productive citizens. To achieve this CWLA leads and engages the nation to advance policies, best practices, and collaborative strategies that result in positive outcomes for vulnerable children, youth and families. On behalf of our member agencies, CWLA offers the following comments and principles in regard to the reauthorization of Title IV-B of the Social Security Act (IV-B).

CWLA appreciates the subcommittee's attention to and consideration of this critical legislation. The array of child and family services funded by IV-B prevents maltreatment and enables alternatives to child removal for struggling families. For children who cannot continuously safely remain with their families of origin, the funds support permanency solutions through reunification, adoption, and kinship. Furthermore, the statute includes fundamental protections for children and service provision to address their needs and the needs of their families. In these ways, IV-B is instrumental in keeping all children safely thriving in permanent, loving families.

Child Welfare Services (CWS)

Child Welfare Services, Part I of IV-B, provides flexible funds for states to develop and continuously improve services to protect and promote child welfare, prevent maltreatment, enable permanency within a family, and maintain a quality workforce to carry out these critical services. It is designed as a federal-state-local partnership. There are limitations on the use of funding to ensure it is not duplicating foster care, education, health, or child care services. In practice, states use most CWS formula funding for child protection, to prevent or remedy maltreatment through activities like investigations or casework. A substantial portion of the funding is also directed towards the federally emphasized service approach in Part II of IV-B: family support, crisis intervention, reunification, and adoption support. *CWLA supports this federal, state, and local partnership.*

CWS Requirements

States must incorporate specific protections and services for children in order to receive funds, and this includes operating information systems to readily review child cases and assess progress towards permanency goals. These requirements apply regardless of eligibility for Title IV-E foster care funds, which cover less than half of children removed from their homes. Service development requirements include strategies for caseworker visits and health oversight of children in foster care, foster and adoptive parent recruitment, treatment of special populations like abandoned infants, and ongoing service and staff improvement. CWS must also be coordinated with services provided through

the Social Services Block Grant (SSBG), Temporary Assistance to Needy Families (TANF), Medicaid, and IV-E and IV-B, Part II of the Social Security Act. *CWLA supports these protections for all children and the systemic requirements that leverage efforts to prevent and address maltreatment.*

Disproportionality remains a significant challenge in child welfare. The child welfare field recognizes that youth of some racial and ethnic backgrounds experience disparate impacts because of the experiences in the child welfare system. African American and American Indian children, for example, are overrepresented in out-of-home care compared to their representation in the general population, while Hispanic overrepresentation can be variable. Children of color are more likely to be screened in at various stages of CPS decision making: reporting, investigation, substantiation, and placement in foster care. They are more likely to remain in child welfare for longer periods of time and less likely to be reunited with their birth parents.¹ *CWLA would like to see a new requirement for data collection and research regarding the causes and effective approaches for reducing disproportionality in child welfare.*

In partnership with ZERO TO THREE and other advocacy organizations, CWLA is working to promote policies that support the positive development of infants and toddlers known to the child welfare system. Infants and toddlers are the age group with the highest rates of maltreatment, accounting for more than one quarter of all children with substantiated cases of abuse or neglect.² They account for almost a third of all children placed in foster care.³ The child maltreatment they experience and subsequent responses from the child welfare system occur during a time when their brains are developing at life-altering rates. The toll extracted can resonate throughout their lives in the form of deficits in IQ scores, language ability, and school delay as well as physical health difficulties.⁴ *For these reasons, CWLA believes state plans should identify how systems are addressing the developmental needs of infants and toddlers who come in contact with the child welfare system. In particular, the health oversight plan should include steps for detecting and addressing developmental delays. Because infants and toddlers who have experienced abuse or neglect have a very high rate of developmental delays, they need medical homes and periodic screening by physicians as well as Part C of the Individuals with Disabilities Education Act early intervention services.*

Furthermore, CWLA would also like to see a new requirement for data collection and research that allow us to discern the experiences of infants and toddlers in the child welfare system. Often infants and toddlers are not included as a distinct category in data collection. Similarly, more research is needed on their experiences and what approaches work best in their case.

The use of kinship and guardianship are growing trends in child welfare due in part to the provisions in the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351, hereafter the Fostering Connections Act) which for the first time established reimbursement under Title IV-E for guardianship assistance payments, at state option. *CWLA believes states should be encouraged to provide kinship and guardianship. State plans under CWS should include steps the state will take to provide and expand this*

support. As with disproportionality and infants and toddlers, CWLA would like to see a new requirement for data collection and research that allow us to examine outcomes and effectiveness for kinship/guardianship. Kinship research would also connect to the disproportionality research since minority children are overrepresented in kinship families. To this end, there should be systemic evaluations of the experiences of families of color in kinship settings and promising practices to address disproportionality.

Of the 276,000 children that exited foster care in 2009, 29,471 reached the age of majority and become adults without a permanent family.⁵ Children who age out of the system are far too often inadequately prepared for adult lives. They are disproportionately represented among high school drop outs, the homeless and the unemployed. The Fostering Connections Act took a significant step forward in allowing states to extend care to age 21. All states should extend care up to age 21 for those youth who remain in care and who need continuing support. Permanency planning and relationship connections should continue at the same time the youth are offered assistance to emancipate with the skills and resources needed to live independently. Because of the particular vulnerability of this population, CWLA believes CWS state plans should identify the independent living preparation services that will be provided to all youth who are in foster care at any time after their 14th birthday regardless of their placement.

Attention to the unique needs of tribal populations has been strong in recent years, particularly with the passage of the Fostering Connections Act, granting tribes the option to administer IV-E programs. Studies show that culturally competent care results in better outcomes for children and families involved in the child welfare system.⁶ In partnership with the National Indian Child Welfare Association, CWLA believes state plans should promote tribal-state cooperation and coordination, and data collection requirements should be expanded, with tribal consultation, to better track outcomes data on American Indian and Native children. In so doing, consultation from both tribes and states should inform the revision of state plan requirements as they relate to the Indian Child Welfare Act (ICWA).

Promoting Safe and Stable Families (PSSF)

Part II of IV-B funds four vital services that address four different types of families in need: those in need of basic support services that can strengthen the family and keep them whole, families being reunified, families we are trying to preserve or maintain, and adoptive families in need of support. CWLA supports these categories and the way they emphasize different families' needs. These categories should continue to be the target for PSSF in a reauthorization bill.

Family Support Services (FSS) are targeted to families with difficulties and concerns related to the proper functioning of the family and care of the children. The focus of FSS is on prevention. The services address the need to improve the well-being of a child, family functioning, and the parent's ability to provide for the family, before they are in crisis. In order to reach families in need of assistance, family support programs work with outside community organizations such as schools, Head Start programs, and child welfare

agencies. The aim is to provide temporary relief to families by teaching them how to better nurture their children. Involvement in these services is voluntary. Types of services include parent education, child care relief, and self-help groups.

Family Preservation Services (FPS) are comprehensive, short-term, intensive services for families delivered primarily in the home and designed to prevent the unnecessary out-of-home placement of children or to promote family reunification. The services are intended to protect a child in a home where allegations of child abuse or neglect have occurred, prevent subsequent abuse or neglect, prevent placement of a child, or reduce the stay for a child in out-of-home care. Families in need of family preservation services are usually referred by public welfare agencies. Services are provided within 24 hours of referral and the family's involvement is voluntary. These services provide a holistic response to families on a 24-hour basis, including services such as family therapy, budgeting, nutrition, and parenting skills.

Reunification is the first permanency option states consider for children entering care. Yet, in many ways, it is the most challenging option to achieve in a plan-based, permanent way. We know that 49% percent or 202,065 children in care on September 30, 2009 had a case plan goal of reunification with their parents or other principal caretaker. At the same time 140,000 children, or 51 percent of those children who left care in 2009, were returned to their parent's or caretaker's home.⁷ Successful permanency through reunification requires many things, including skilled workers, readily available supportive and treatment resources, clear expectations and service plans, and excellent collaboration across involved agencies. Reunification also requires worker skills, the need for accessible and culturally appropriate support and treatment services for families with children and the critical need for after care or post-permanency services to ensure that safety and permanency are maintained following reunification.

The range of preservation and reunification services should specify mental health and substance abuse services for parents. Children of all ages, and in particular infants and toddlers who have been traumatized by maltreatment may need mental health services, including assessment of the parent-child relationship; parenting education programs that are effective in working with maltreating parents; frequent (as often as daily) parent-child contact if the child has been removed from the home accompanied by support for productive visits; and child-parent psychotherapy.

Adoption support is an important need as the numbers of adoptions continue to increase. Of the 423,773 children in foster care on the last day of 2009, approximately 114,556 were waiting to be adopted and 69,947 were free for adoption (parental rights had been terminated).⁸ Children adopted from foster care often experience emotional, psychological and developmental consequences as a result of their maltreatment. In navigating these challenges, adoptive families are strengthened when they have access to pre- and post- adoption services. For example, support groups, case management, respite care and mental health services. *In partnership with Voices for Adoption, CWLA sees room for improvement in the systemic structure of adoption promotion and post permanency support. To this end, Congressional direction could clarify MOE guidance*

(ACYF-CB-PI-09-08) and require states to document savings under the adoption assistance de-link in the Fostering Connections Act. As the federal government pays for adoption assistance payments that states previously covered, states should be required to reinvest those savings in the adoption infrastructure to ensure successful permanency for adoptive families.

PSSF Requirements

Receipt of PSSF funds requires states to create a five year Child and Family Services plan, including goals and measures for achieving the plan. In addition, they must annually submit a progress report and a final review in the fifth year. Within this reporting, states must describe the services they will provide within each of the four categories. *CWLA supports these requirements as an effective way to address accountability within this flexible funding stream. In order to ensure appropriate attention is being paid to all families in need, CWLA believes states would strengthen service provision by documenting both adoption promotion and adoption support, separately. This way, better attention can be paid to the needs of both finding adoptive homes for appropriate children and supporting this form of permanency when it is achieved. An explanation and areas for improvement should be required in instances where no funding is spent in either area.*

The Court Improvement Program (CIP)

CIP includes grants for assessing and improving the handling of maltreatment cases, judicial workforce training, and data grants to improve the timeliness of court decisions. Courts are an integral component of the child welfare system, because they provide crucial case decisions like judicial findings of maltreatment and approval of permanency changes for children. The gravity of decisions must account for the perspectives of those affected and court staff must be well-informed about social work practice including interventions, child development, human behavior, and the consequences of trauma. This is one of the few places in child welfare law where funding is provided for the courts. *We support the Court Improvement Program and believe it should be expanded to fund successful models in every state. Furthermore, we support the administration's proposals to incorporate strategies for faster adoption after the termination of parental rights, concurrent planning, youth participation in hearings, court workforce training on trauma, and the incorporation of tribal courts. Tribal CIP should be available to tribes who administer either Title IV-B or Title IV-E because of legal requirements like judicial determinations that necessitate fully operational dependency court systems.*

Regional Partnership Grants to Improve Outcomes for Children Affected by Parental Substance Abuse

These grants are competitive grants to established collaborations serving children at risk for or victims of maltreatment due to parental substance abuse. Estimates suggest that between 50% and 80% of child welfare cases involve a parent with a substance abuse problem.⁹ Further, data show that children of parents with substance abuse disorders are

nearly three times more likely to be abused and more than four times more likely to be neglected than children of parents who do not abuse substances.¹⁰ *CWLA supports the grants, but propose the language reflect the variety of problems associated with local differences in the types of substances abused, and the occurrences of polysubstance abuse. Grant funding should include broader terminology without emphasis on any particular substance. Furthermore, we agree with Representative Denny Rehberg (R-MT) in emphasizing support for family-based substance abuse treatment.*

Grants to Improve Monthly Caseworker Visits

Funds reserved for caseworker visits are intended to target “retention, recruitment, training, and ability to access the benefits of technology.” Requirements to develop standards and reporting on frequency and quality of the visits are also included to reach the goal of 90% of children in foster care being visited monthly by next fiscal year, 2012.

Effective child welfare services are based on accurate differential assessments and require knowledge of human behavior, the factors underlying child maltreatment, and the way in which both risks and protective factors interact to produce an overall picture of a family’s needs. In the child welfare field visitation is not an isolated service or stand-alone intervention. Rather it is an integral part of a larger case planning process. To reach this visitation goal with an attention to quality, we need a comprehensive strategy to strengthen the child welfare workforce. We would not want a system of care where too few workers with very high caseloads are simply meeting an outcome measure of numbers. Rather each state should engage in activities designed to improved the quality of worker visits and be assisted in implementing a long term workforce strategy that sets goals around reduced workforce turnover, higher education levels, adequate caseloads, initial and on-going training, adequate supervision and the proper partnerships with educational institutions and other partners in workforce development.

CWLA supports the maintenance of targeted funds to improve workforce development, including the standards for caseworker visits. Furthermore, we support Representative Karen Bass’s (D-CA) call for improved attention to the workforce through legislative proposals similar to the Child Welfare Workforce Improvement Act, previously proposed in the 110th Congress (S. 2837). Studies or demonstration projects on the workforce should include particular attention to increasing knowledge of trauma and its consequences for children, as well as secondary trauma’s affect on the worker; and it should include knowledge of childhood development, particularly brain development and the impact of various child welfare policies and practices on promoting positive development.

Mentoring Children of Prisoners

A parent’s incarceration can cause traumatic separation, permanency instability, and feelings of stigma in a child. This can result in behavior and development disruptions that present as poor academic performance, juvenile delinquency, and substance abuse. This special population deserves attention to ensure their resiliency.¹¹ Mentoring for this

population is an effective way to engage at-risk children and youth, provide connections to caring adults, and perhaps most importantly, build relations among family members during and after incarceration. Mentoring studies show strong evidence in enhancing resiliency by improving academic performance and reducing delinquency and substance use, in addition to promoting self-esteem, social skills, and knowledge of education and career opportunities.¹²

Mentoring Children of Prisoners is a competitive grant program to community-based, public or private entities serving young people with incarcerated parents. It was created as a designated funding stream within PSSF in 2001. Since 2005 and until 2011 it was funded at \$50 million and enabled over 100,000 child and mentor matches. There were no FY2011 appropriations for this program, ending the funding for over 200 mentoring programs. *CWLA recommends reauthorization of this program and a reinstatement of funds in the appropriations process.*

CWS and PSSF Funding

We recommend reauthorization for a minimum of 5 years and at least continued funding levels. Since 2006, CWS has been authorized at \$325 million and in FY2011 funded at \$281 million. In FY2011, PSSF was authorized at \$365 in mandatory funds and \$200 million in discretionary funds. With an appropriation of \$63 million in discretionary funds approved in FY2011 it was funded at \$428 million. It should be recognized that our commitment to preventing abuse and neglect could be strengthened. Representative Karen Bass's testimony on this subject rightly pointed to the need for greater investment in prevention strategies like differential response, upfront assessments, and early interventions. *There is a need for better targeted funding with a focus on those programs which link to improved outcomes and evidence of what works. For example, evidence-based and evidence-informed PSSF demonstration grants could be awarded to programs which are innovative and show progress in reducing undesirable outcomes. CWLA supports the expansion of IV-B in this way, in addition to the continuation of mandatory funds and full appropriation at at least 2011 authorized levels.*

These dollars work in tandem with Medicaid and SSBG funding. In the absence of increased funding, it must be recognized that IV-B funding loses leverage if those other programs are cut or compromised. *CWLA strongly believes that Medicaid and SSBG must be preserved for IV-B to remain effective.* Another way to leverage funds would be to incorporate the administration's incentive fund proposal into reauthorization. In absence of comprehensive finance reform and increasing prevention and intervention services, this is a way to continue to progress. *CWLA supports the administration's proposal to provide \$250 million in incentive funds for states to earn after showing effective outcomes.*

Fostering Connections Act

The recently enacted Fostering Connections Act has resulted in significant steps forward in improving the child welfare system. Many states and tribes are expanding and improving services. Many children and families coming in contact with the child welfare

system are experiencing these improvements. One area that needs improvement however is in education stability. *The legislation needs to be adjusted to ensure stability is addressed with each placement of the child rather than just the first placement.* In addition, the success of the adoption incentive is considerable. *CWLA recommends a similar incentive be established for achieving permanence for children. Building off the success of the existing incentive for adoptions of children from child welfare there should be a similar incentive to states to encourage permanence achieved through reunification and kinship/guardianship.*

White House Conference on Children and Youth

Finally, CWLA feels that the reestablishment of a White House Conference on Children and Youth, similar to the Aging Conference, would be an important tool to help communities and states deal with many of these challenges from creating effective prevention strategies to understanding what is needed in comprehensive finance reform. Ultimately the federal government can provide vital support and leadership—but we will truly improve outcomes for this nation’s most vulnerable children and families only if these new laws and programs are carried out down to the casework level. This is CWLA’s mission and we believe, our collective responsibility.

¹ Hill, R.B. (2011). "Gaps in research and public policy." In D.K. Green, K. Belanger, R.G. McRoy, and L. Bullard, *Challenging Racial Disproportionality in Child Welfare: Research, Policy, and Practice*. (pp.101-108). Washington, DC:CWLA Press.

² Children’s Bureau. (2010). *Child maltreatment 2009*. Washington, DC: U.S. Department of Health and Human Services(HHS). Available online at

<http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf#page=4>.

³ Children’s Bureau. (2010). *The AFCARS report. Preliminary FY 2009 estimates*. Washington, DC: U.S. Department of Health and Human Services. Available online at

http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.htm.

⁴ Harden, B.J. (2007). *Infants in the child welfare system: A Developmental framework for policy and practice*. Washington, DC: ZERO TO THREE; Wuczyn, F., Ernst, M., and Fishier, P. (2011). "Who are the infants in out-of-home care? An epidemiological and developmental snapshot." *Chapin Hall Issue Brief*. Chicago, IL: Chapin Hall at the University of Chicago. Available online at

<http://www.chapinhall.org/research/brief/race-and-child-welfare>.

⁵ *The AFCARS report (2010)*.

⁶ Red horse, J.G., Martinez, C., & Day, P. (2001). *Family preservation: A case study of Indian tribal policy*. Seattle, WA: Casey Family Programs.

⁷ *The AFCARS report (2010)*.

⁸ *Ibid.*

⁹ Osterling, K., & Austin, M. J. (2008). "Substance abuse interventions for parents involved in the child welfare system: Evidence and implications." *Journal of Evidence-Based Social Work*, 5(1/2), 157-189. doi:10.1300/J394v05n01-07.

¹⁰ United States Department of Health and Human Services, Administration for Children and Families, Office on Child Abuse and Neglect. (2009). *Protecting children in families affected by substance use disorders*. Washington, DC: Child Welfare Information Gateway. Available online at

www.childwelfare.gov/pubs/usermanuals/substanceuse/substanceuse.pdf

¹¹ Maier, K. (2006). "Children of incarcerated parents." *Journal of Children and Poverty* 12(1); Wright, L. and Seymour, C.B. *Working with children and families separated by incarceration*. Washington, DC: CWLA Press.

¹² MENTOR (2011). *Research and Studies*. Washington, DC: MENTOR. Available online at http://www.mentoring.org/news_and_research/research_and_studies/.

Conference of Chief Justices, Conferences of State Court Administrators

***THE CONFERENCE OF CHIEF JUSTICES
THE CONFERENCE OF STATE COURT ADMINISTRATORS***

WRITTEN TESTIMONY

by

Hon. Wallace B. Jefferson
Chief Justice
Supreme Court of Texas
President of the Conference of Chief Justices

Ms. Lilia G. Judson
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On

Improving Programs Designed to Protect At-Risk Youth

Submitted to the

**SUBCOMMITTEE ON HUMAN RESOURCES OF THE
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES**

Subcommittee Hearing
Thursday, June 16, 2011
B-318 Rayburn House Office Building

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Introduction

Mr. Chairman and Members of the Subcommittee, our statement is submitted on behalf of the Conference of Chief Justices and the Conference of State Court Administrators (Conferences). We thank you for the opportunity to provide you with information for the record on the reauthorization of the Promoting Safe and Stable Families (PSSF) Program.

The membership of the Conferences consists of the highest judicial officers and the state court administrators in each of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, and the Northern Mariana Islands and the Territories of American Samoa, Guam and the Virgin Islands. The National Center for State Courts (NCSC) serves as the Secretariat for the two Conferences and provides supportive services to state court leaders including original research, consulting services, publications, and national education programs.

The points that we want to make in this testimony are:

- The Conferences commend Congress for its efforts to improve the protections available to at-risk youth through the enactment of the Safe Families Act (ASFA), the Promoting Safe and Stable Families (PSSF) Program, and the Fostering Connections for Success and Adoption Incentives Act (FCSAIA).
- It is our belief that the state court systems and judges are key to effective implementation of the requirements and policies of these Acts.
- ASFA significantly increased the monitoring and oversight responsibilities of the State courts for child protection cases, but did not provide the state court systems with additional resources to assist them in meeting the new demands.
- Subsequently, Congress authorized three Court Improvement Programs (CIPs) grant programs.
 - The “basic” CIP grant allows State courts to assess and improve the handling of child abuse and neglect cases.
 - The “training” CIP grant provides training for judges, legal personnel, and attorneys handling child welfare cases.
 - The “data” CIP grant allows State courts to increase accountability and improve the timeliness of court decisions on child welfare cases through the

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collection and analysis of data and the exchange of data with the State child welfare agencies.

- Specifically, we are requesting that funding for the three CIPs, which are set asides within PSSF, also be maintained in the reauthorization legislation.

Support for the Reauthorization of the Court Improvement Programs

The Conferences have established child welfare reform and the effective implementation of the Acts as one of their highest priorities.

In 1993, Congress created the CIP “basic” grant program to assist state courts in improving their handling of child abuse and neglect cases. Unlike most federal grant programs, Congress explicitly recognized the effect of a federal mandate on the State court systems and provided for the funds to go directly to the highest court in each State, instead of being funneled through a state executive agency. Congress authorized \$10 million annually for three years for judicial improvement efforts. Congress required that each state use their CIP funds in the first year to conduct an assessment, identify problems in processing child abuse and neglect cases, and develop strategies for addressing those identified problems. In subsequent years, CIP funds could be used to implement the identified system improvements. Based on the success of these initial efforts, Congress has subsequently extended CIP funding. State courts have used subsequent funds for periodic reassessments and implementation of further improvements.

In 2005, Congress established the CIP “training” grant and CIP “data” grant. The two newer CIP grants were authorized in partial response to the May 2004 recommendations of the Pew Commission on Children in Foster Care. The Commission’s recommendations included a call for (1) the adoption of court performance measures by every dependency court to ensure that the courts can track and analyze their caseloads, increase accountability for improved outcomes for children, and inform decisions about the allocation of court resources and (2) better training for judges, attorneys and volunteer advocates.

State Participation

The CIP programs are voluntary programs. It speaks well for the programs that all fifty states and the District of Columbia are currently participating in the CIP grant programs. A wide variety of strategies for improvements have been implemented. The following is a very small sampling of some of the innovations prompted by CIP funds.

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In **Kentucky**, CIP funds have facilitated a data exchange between the court system's Children's Automated Tracking System (CATS) and the state agency's data tracking system, The Worker Information System (TWIST). CIP funds have also supported enhancements to CATS, including (1) tracking important court dates, including adjudications, dispositions, and permanency reviews and (2) tracking names and addresses of parties. Future updates will include (1) tracking CIP-related training, (2) tracking and notifying interested parties, (3) researching a CATS interface with the statewide tracking system for the Kentucky Court of Justice (KyCourts), and (4) automating updates and notification to all parties involved in review processes.

The **Louisiana** Court Improvement Project designed the Connections for Permanency demonstration project to find family or kin for dependent youth and to engage them in the child's life in a meaningful way. The target populations are youth aging out of foster care, in residential care, or with a case goal of Another Planned Permanent Living Arrangement (APPLA). A primary purpose of the demonstration project was the development of a family finding methodology that could be successfully replicated across the state.

CIP funds in **Minnesota** have been used to enhance judicial decision making through the provision of the *Judges Juvenile Court Benchbook*, model orders, and practice guides. Court staff developed and continue to update the *Judges Juvenile Court Benchbook*. Updates have included chapters about immigration, child development, and adoption issues. These updates and new chapters were posted in 2010. CIP Training Grant funds were used to pay for the costs of consultants to help draft the new chapters. Funds have also been used to enhance practice of child protection system stakeholders through the development of practice manuals and protocols designed to assist the counties to improve practice. Topics include overall practice related to child protection, truancy protocols, and intensive family court guides. In an effort to create an overarching guide for issues regarding safety, permanency, and well-being, CIP staff members also prepared the Child Safety, Permanency, and Well-Being Checklist.

New York has used some of its CIP funds to actively work with Tribal groups. Some specific initiatives include (1) the addition of St. Regis/Mohawk Tribal Court to the Enhanced Interdisciplinary Practices Initiative, (2) collaboration between the Eighth Judicial District and the Cattaraugus and Allegany Peacemaker Courts of the Seneca Nation of Indians, (3) collaboration between the Niagara County Family Court and Chiefs and Clan Mothers of the Tuscarora Nation to discuss their decision-making processes, facilitate communication, and provide culturally competent training, (4) collaboration between the Genesee County Family Court and the Tonawanda Seneca Band of Indians that resulted in an informal protocol for native children at risk of out-of-home placement, and (5) the NYS Federal State Tribal Courts Forum, whose purpose "is

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to share information about the different justice systems [NYS and Tribal] in order to minimize and prevent conflict” and work with the training workgroup from the Forum to address issues concerning children in the child welfare system and state courts.

CIP funds have supported the **Texas** Foster Youth Justice Project, which provides legal advice, assistance, guidance, and representation in enforcing foster youth rights. Funds have been used for (1) legal resources via the Internet, (2) direct legal representation, (3) training to legal aid staff attorneys, (4) pro se legal resources, (5) attorney resources, (6) outreach by traveling and making presentations, and (7) a statewide telephone hotline for foster youth and alumni. Other accomplishments include (1) preparation and printing brochures and posters for the project; (2) adding and maintaining resources on the TFYJP website at www.texasfosteryouth.org; (3) creation of a judicial checklist for youth aging out of foster care that was mailed to over 130 contacts; (4) distribution of 3,500 copies of *A Guide to Those Aging Out of Foster Care in Texas*; (5) publication of the booklet *Sealing Juvenile Court Records in Texas*; (6) development of Internet materials about the right of foster youth to attend court hearings, *Attending Court Hearings: Rights of Foster Youth to Attend Court Hearings Legal Memorandum* and *Directing Attorneys ad Litem to Advocate to Attend Court Hearings*; and (7) conducting twelve “Know Your Rights” presentations around the state and at the State Bar Annual Poverty Law Conference.

In **Washington**, some CIP funds were used to implement a pilot program, in which youth who are 12 years and older, and who are the subject of a dependency proceeding, shall have the right to (1) receive notice of the dependency proceedings and hearings that involve them, (2) be present at such hearings, and (3) be heard personally. The youth may also request an in-chambers interview with the judicial officer to express his or her wishes about issues before the court. The sites selected were Benton-Franklin, King, Spokane, and Thurston Counties.

As the aforementioned examples indicate, State courts have met the challenge of Congress. They completed comprehensive assessments of how they handled child abuse and neglect cases. They identified not only the problems, but also developed and implemented innovative solutions for improving court processes and procedures. Children across the country have benefited from this funding, as courts have been able to improve and expedite the processing of child welfare cases with the goals of placing children in permanent and safe homes and improved outcomes for children.

In reality, the amount of CIP funds each state receives is not large. States, however, have combined the CIP funds with state and local dollars to make sweeping changes in the way they handle child abuse and neglect cases. The initiatives described in this testimony provide a very small sampling of how states have been able to leverage the CIP funds. The availability of CIP funds has stimulated a synergy among judicial, executive,

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and private resources that has resulted in broad changes in how state courts handle child abuse and neglect cases. The process, however, is not over. The CIP funds continue to be a critical factor in improving the outcomes for these children.

The Court Role in Child Welfare Proceedings

Our interest in this issue grows out of our longstanding involvement with federal efforts to protect children at risk of abuse and neglect. The enactment of the Adoption Assistance and Child Welfare Act of 1980 (P. L. 96-272) vested a unique and critical responsibility with the courts to oversee the protection of children in child abuse and neglect situations. For the first time, the 1980 Act required courts to review and evaluate state welfare agencies' actions. Further, courts were required to make judicial determinations that the state agencies had made "reasonable efforts" to prevent the removal of children from their homes, to reunify children with their families after a foster care placement, and to provide permanent homes for children who cannot be reunited with their families. Congress also required courts to hold dispositional hearings no later than eighteen months after a child's original placement and hold a hearing every twelve months thereafter to review progress on the permanency plan. States in which the reasonable efforts findings were not made and properly documented and in which the time frames for hearings were not met could be sanctioned with the loss of federal funding. In addition to the requirements in the Acts that govern the state child welfare systems, the federal Child and Family Service Reviews (CFSRs), which are conducted by the Administration for Children and Families of the U. S. Department of Health and Human Services every five years, include a review and evaluation of state court efforts and compliance.

Congress concluded that the promises of the 1980 Act were not realized and the passage of ASFA, PSSF, and FCSAIA holds new promises for children who are vulnerable to abuse and neglect. The CFSR serves as a tool to assist states to assess their compliance with federal and state law and to develop corrective action plans where their performance falls short. Congress needs to recognize and provide federal support for the needs of the institutions critical to effective implementation of the Acts and to assist the states in undertaking corrective action to improve their child welfare systems.

Impact of Federal Requirements on the Courts

The effect of the federal requirements on courts has been to increase the workload of the courts because of the added judicial determinations and longer hearings needed to resolve the complex issues required by the Acts. The following represents the highlights of some of the requirements and their impact on the courts.

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- Judges are required to make the child's health and safety the primary standard for determining a state's reasonable efforts to keep the child in the home or reunify the child and the parents.
- Judges are required to make judicial determinations of when reasonable efforts to prevent removal and reunify the family are not required because of egregious circumstances.
- Judges are required to make the difficult decisions pertaining to the termination of parental rights in cases where a child has been in foster care for fifteen consecutive or fifteen of the twenty-two most recent months. In the cases where an exception to the fifteen-month rule is requested, judges must determine whether the compelling reasons are sufficient not to file the petition.
- Judges are required to conduct hearings on the permanency plans that have been developed by state child protection agencies no later than twelve months after a child enters care, six months earlier than had been required in the past.
- Judges are required to ensure that the procedural rights of foster parents, pre-adoptive parents, and relative caretakers are protected and that they are notified of hearings and have the opportunity to be heard at all hearings.
- Judges are required to review the placement of a foster child every twelve months and to determine when the child will be returned to his or her parents or placed for adoption or with a relative or with a legal guardian.

ASFA also strengthened the courts' oversight authority in reviewing the work of the child protection agency staff. The combined result of the ASFA changes is more complex and significantly longer court hearings.

Further, FCSAIA required state agencies to ensure notice of a child's removal is provided to a much broader group of relatives and interested persons and to deepen engagement practices. Also, agencies are required to develop education stability plans, health care plans, and transition plans for each youth in foster care. State courts provide oversight to ensure that these notice requirements and engagement efforts are adequate and that permanency and transition plans are developed in a timely manner. Courts are also charged with overseeing the implementation of each permanency and transition plan and that the agencies comply with and make progress in the implementation of the plans. State courts also have a critical role in the approval of guardianships and in ensuring that the child welfare agencies are making on-going efforts to locate the relatives of children

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in foster care, place siblings together while in foster care, and facilitate contact between children in foster care and their family members.

We support implementation of the Acts. Our concern is with ensuring that courts have the resources necessary to implement the Acts. We believe that the policies and procedures required by these Acts are necessary to ensure better outcomes for children. We share your belief that the health and safety of our children should be given the highest priority when deciding the difficult issues pertaining to the termination of parental rights and the removal of children from their homes and families.

Recommendation of the Conferences

We encourage you to reauthorize the three CIP programs. State courts have effectively leveraged these dollars to make systemic improvements to court processes and procedures. These improvements have positively impacted the outcomes for children who are in need of protection and in state custody. Our work, however, is not completed. The CIP funds are critical to continued improvement and the effective implementation of the Acts.

Thank you for giving the Conferences an opportunity to be heard on this important issue.

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Cook Inlet Tribal Council

Written Statement Submitted for the Record by
Gloria O'Neill, President & CEO,
Cook Inlet Tribal Council, Anchorage, Alaska
to the House Ways & Means Committee
Subcommittee on Human Resources
Hearing on Improving Programs Designed to Protect at Risk Youth
Held on June 16, 2011
Submitted on June 30, 2011

The Cook Inlet Tribal Council submits this statement for the record for the Hearing on Improving Programs Designed to Protect At-Risk Youth held by the United States House of Representatives Ways and Means Subcommittee on Human Resources on June 16, 2011.

Cook Inlet Tribal Council (CITC) is an Alaska Native tribal organization, with tribal authority delegated through Cook Inlet Region, Inc., organized through the Alaska Native Claims Settlement Act and recognized under Section 4(b) of the Indian Self-Determination and Education Assistance Act (PL93-638, 25 U.S.C. 450b).

CITC is the primary provider of educational, workforce development, and social services for Native people in Anchorage. Our mission can be summarized in three words: People. Partnership. Potential. For nearly three decades, CITC has been building human capacity by partnering with individuals to help them achieve personal goals that result in lasting, positive change for themselves, their families, and their communities. Each year, CITC serves more than 10,000 individuals and their families through more than 50 programs.

We understand that various stakeholders are providing testimony regarding the reauthorization of Title IV-B, a program that we rely on significantly. Title IV-B, Subpart I funds have enabled CITC and the eight regional Cook Inlet Tribes to establish an ICWA Advisory Council to guide joint efforts in prevention and reunification across the region—a significant accomplishment given the independent relationships among tribes in this area. Title IV-B, Subpart II funds help CITC to maintain its information infrastructure to support the continuum of services available to participants seeking CITC services. We are committed to continuously improving our infrastructure and as a result of this funding have implemented a 'results-based accountability' process to identify meaningful outcomes to collect and measure. The funds have allowed CITC to provide reunification support to an annual average of thirty families engaged in supervised visitation services. In the most recent fiscal year, 70% of children assisted achieved a permanent and preferred placement. CITC's Child Welfare and TANF collaboration project 'Agency Without Walls,' funded by Title IV-B Subpart II, has enabled CITC to de-silo and integrate our services within the organization to maximize impact for our participants.

Our greatest sustainable resource is the potential of our children. The development and stewardship of this resource is by far our greatest responsibility, our greatest opportunity, and the single most important ingredient to a secure economic future for Our People. Their protection and care is of utmost importance to us. Our children will be our leaders and our caretakers. For this reason, we would like share our priorities as they relate to the reauthorization of Title IV-B.

Tribes and Tribal organizations face significant challenges when it comes to child welfare and limited resources are available to resolve those challenges. Although Title IV-B program funding levels are not sufficient to meet all of our needs, Title IV-B is an invaluable resource to Tribes and Tribal organizations.

Tribal and Tribal organizations' access to programs such as Title IV-B is an important representation of the federal trust responsibility. Access to this funding helps to ensure that our children receive care from those who know their needs best and are most equipped to respond to them—Tribal communities.

In order for CITC to continue to successfully serve Our People's unique needs, we recommend that Title IV-B, Subparts 1 and 2 be reauthorized and that tribal access to Title IV-B funding be increased. In addition, we'd like to recommend some changes.

First, we strongly urge the subcommittee to protect Title IV-B, Subpart 2 funds for the Regional Partnerships to Improve Outcomes for Children Affected by Parental Substance Abuse Grant as is. This funding supports grantees addressing meth and substance abuse issues. There are six current tribal grantees, of which CITC is one. These programs not only help the children and families of these Tribes, but have also provided models from which tribes (and states) nationwide can learn from, and are the only grants available that allow Tribes and Tribal organizations to address this important nexus between child welfare and substance abuse. The Regional Partnership funding has enabled CITC to develop more effective partnerships with the Alaska State Office of Children's Services and the Native Village of Eklutna for the purpose of integrating tribal, child welfare and recovery services to prevent unnecessary foster care placement. These improved partnerships have reenergized the effort to share data and determine critical future data elements across tribal, state, and service lines to better understand the impact of interventions.

Second, we strongly support increasing the tribal set-aside for Title IV-B, Subpart from 1% to 3%. Under Title IV-B, Subpart 1 about two-thirds of the 565 eligible tribal governments receive less than \$10,000 per fiscal year. At least half of the Tribes receive amounts under \$5,000 per fiscal year. The bare minimum needed to establish a child abuse and neglect prevention program in any tribal community is approximately \$80,000.

Third, CITC is not in a position to take advantage of a Tribal Court Improvement Program (CIP) as we do not have Tribal courts. However, we strongly support previous recommendations made by NICWA and other organizations that tribes be made eligible for CIP funding, and urge the Subcommittee to give the recommendations every consideration. Tribes administering IV-B and/or IV-E should be made eligible for CIP funding under Title IV-B, Subpart 2. CIP funding supports dependency courts and is not currently available to tribes. This funding would help tribes to integrate their courts and child welfare programs.

In addition, Title IV-B state plan requirements should be amended to enable improved tracking of outcomes data on AI/AN children, including the promotion of tribal-state cooperation and coordination, and expanded data collection requirements, with tribal consultation. Recently, the

American Public Human Services Administration (APHS) also recommended that additional information be collected by the Statewide Automated Child Welfare Information Systems (SACWIS) so as to better define specific measures to evaluate how AI/AN children are doing in the child welfare system and ways to improve outcomes. States and tribes need data to identify specific problems and determine and implement the appropriate interventions/solutions.

Finally while it is vitally important to reauthorize Title IV-B programs, we urge the subcommittee to do so as a part of a larger child welfare financing reform effort. It's time to make prevention a priority and Tribes and Tribal organizations need to be at the table when it happens. Currently, very few federal child welfare programs fund prevention work. Federal programs should address the issues that bring children into foster care, not solely post-removal issues.

In closing, we thank the Subcommittee Members and staff for their continued attention to the unique needs of our children. We ask that as you consider reauthorization of Title IV-B, you remember how critical this funding is to Tribal organizations and the families and children that we serve.

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Dave Thomas Foundation for Adoption



DAVE THOMAS
FOUNDATION
FOR ADOPTION®

Finding Forever Families for Children in Foster Care

Testimony of

RITA L. SORONEN
PRESIDENT & CEO
DAVE THOMAS FOUNDATION FOR ADOPTION

Submitted to the

COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HUMAN RESOURCES
U.S. HOUSE OF REPRESENTATIVES

For the hearing on

Improving Programs Designed to Protect At-Risk Youth

June 16, 2011

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There is no more important work in this country than assuring the safety and well-being of our most vulnerable citizens – children who, through no fault of their own, are in the child welfare system waiting for a permanent family. Thank you to the members of the Subcommittee for their commitment to reviewing and assessing existing policy and practice on behalf of these children, with a vigilant eye on providing the most effective evidence-based services on their behalf. The Stephanie Tubbs Jones Child Welfare program and the Promoting Safe and Stable Families program provide critical Federal funding through the Social Security Act for children who need and deserve our very best efforts.

For nearly twenty years, the Dave Thomas Foundation for Adoption has shared the Subcommittee's quest to elevate and dramatically improve the services we provide to abused, neglected, dependent and abandoned children for whom the government has assumed temporary, but frequently long-term responsibility. Created in 1992 by Dave Thomas, who was adopted, the Dave Thomas Foundation for Adoption works to dramatically increase the number of adoptions of waiting children from the United States foster care system, while providing information, resources and educational materials to potential adoptive parents, individuals and organizations, at no cost to the user. Additionally, as a national non-profit public charity, we provide grants to public and private organizations in all 50 states and the District of Columbia to results-based agencies that aggressively and measurably move children out of foster care and into adoptive homes.

Although we are encouraged by an increasing national awareness about the needs of foster care youth¹ (and in particular about children waiting to be adopted), a decline in children entering care and greater numbers of children being adopted from foster care², we are gravely concerned about older youth waiting to be adopted. For the past decade, the number of older children adopted from foster care has remained unchanged. Additionally, most recent reporting noted 29,000 of the nearly 115,000 children waiting to be adopted from foster care were on the track for aging out of the system without a permanent family.³ The unfortunate outcomes for children

¹ Harris Interactive, *National Adoption Attitudes Survey*, commissioned by the Dave Thomas Foundation for Adoption, 2007.

² U.S. Department of Health and Human Services, Administration for Children and Families, *The AFCARS Report: Preliminary FY 2009 Estimates as of July 2010* (17).

³ *Ibid.*

aging out of care are well-documented, and include significantly higher percentages than the general population of being undereducated, unemployed or underemployed, homeless, becoming teen or young parents, and an increased likelihood for arrest. These numbers have not declined and in fact are trending higher.

Since these youth have typically spent the longest periods of time in care, the core issues of the abuse or neglect which they have experienced are exacerbated by frequent moves while in care, potential separation from siblings, multiple school or educational placements and frequent turnover of social worker or other system contacts in their lives. The children most at risk of aging out and moving into society without the safety net of a family and a home, the youth who suffer the consequences of the government's broken promise of a family, are the children for whom the Dave Thomas Foundation for Adoption has dedicated its energy, expertise and resources.

Strategies for recruiting and matching adoptive families for these children have a history of anecdotal rather than evidence-based development. Cataloging children online or through the media is common practice and supported by federal funding, but there is scant evidence to suggest it is an effective method for effectively recruiting appropriate families for America's longest waiting children with individualized and often clinical needs.

In response, the Dave Thomas Foundation for Adoption has dedicated significant resources to develop, implement and grow a national model of child-focused recruitment (Wendy's Wonderful Kids⁴) combined with long-term rigorous experimental evaluation of the model. The program has grown from six pilot sites in 2004 to now 122 fully funded sites in all 50 states, the District of Columbia and 4 provinces in Canada. Of the 122 individual sites, 20 underwent a randomized control trial; although the full evaluation will not be released until October 2011, preliminary results show that the children in the experimental group were significantly more likely to be adopted with the greatest positive impact on older children. The national evaluation of Wendy's Wonderful Kids is the first ever randomized control trial of an adoption recruitment effort that has demonstrated success and is supporting one of the nation's largest databases of

⁴ Child-Focused Recruitment Model, see attachment, p.6

information on the more than 7,000 children served to date. Of these children, nearly 3,000 have had a finalized adoption or are in their pre-adoptive placement simply waiting for the final adoption court hearing and another 3,500 have had potential families identified. Of the children successfully served, 45 percent are age twelve or older, 27 percent have experienced six or more placements, 50 percent have been in the system more than four years, 10 percent have been in care for more than 10 years, and 21 percent had a failed or disrupted adoption prior to this program.

As the Subcommittee looks to reauthorize these important programs, it is imperative to assure that evidence-based practices define how we serve America's at-risk and vulnerable children waiting to be adopted. Scarce resources must be used most effectively and, given the national success of the Dave Thomas Foundation for Adoption model recruitment program, we would ask the Subcommittee to consider:

1. Retain the 20 percent set-aside for adoption with a focus on older child adoption. In support of this, it is critical that the Department of Health and Human Services provide technical assistance to states on evidence-based practice for adoption.
2. Reauthorize the Court Improvement Program with specific attention to adoption, including more aggressive use of concurrent planning as required in the Adoption and Safe Families Act; amending the statute to support court strategies to shorten the time between termination of parental rights and adoption; and to support evidence-based practices from the personnel who come before the court on behalf of the youth waiting to be adopted.
3. Aggressively assess the current \$20 million set-aside for caseworker visits. States are making significant progress on visits and the Child and Family Services Reviews support this effort. To put this scale of funding in perspective, an expenditure of \$20 million for model recruitment for older youth, based on the history of the Foundation's evidence-based program, would assure the adoptions of thousands of older youth previously at risk of aging out of the system without a family. Redirecting this significant source of

funding toward older child adoption based on a platform of success can turn the tide of a decade of older youth lingering in care and aging out.

Finally, we are grateful for the Subcommittee members' commitment to understanding, addressing and elevating the national work for children who have suffered not only abuse and neglect but the grief and loss of family that they must also endure. Dave Thomas reminded us daily that "these children are not someone else's responsibility; they are our responsibility." Thank you for understanding that the promise of a family for 115,000 children is the responsibility of each of us charged with their care, and for your continued efforts to improve programs to protect vulnerable and at-risk youth.

⁴ ATTACHMENT - WENDY'S WONDERFUL KIDS CHILD-FOCUSED RECRUITMENT MODEL

In 2004, the Dave Thomas Foundation for Adoption created *Wendy's Wonderful Kids* in response to the national crisis of children lingering in foster care without a permanent family. Through the *Wendy's Wonderful Kids* program, the Dave Thomas Foundation for Adoption is currently funding 122 adoption recruiters across the nation whose work focuses exclusively on finding permanent adoptive homes for children waiting in foster care.

Child-Focused Recruitment Strategy

Effective, aggressive and accountable recruitment activities are critical to the success of *Wendy's Wonderful Kids*. Recruiters carry caseloads of 15-20 of America's longest waiting children and work toward ambitious adoption and child match goals. Rather than casting a broad net of general awareness and recruitment campaigns or defaulting to internet photo listings, media profiles of children or public photography displays, *Wendy's Wonderful Kids* recruiters are expected to be agents of change in the lives of the children for whom they are recruiting and employ an intensive and exhaustive evidence-based child-focused recruitment strategy.

The child-focused recruitment strategy is based on a specific aggressive recruitment plan tailored for the individual child based on their unique circumstances, challenges, desires and needs and includes, but is not limited to, the following key components:

Relationship with Child: Recruiters meet with the child regularly to develop trust and openness. This relationship is essential to building an effective recruitment plan.

Case Record Review: Recruiters conduct an in-depth review of the existing case file. An exhaustive case record review includes identification of all significant people in the child's life past and present, including potential adoptive parents.

Network Building: Recruiters meet with significant adults identified in the case record review and maintain regular and ongoing contact. Regular contact with individuals close to and knowledgeable about the child facilitates effective recruitment and matching.

Child Assessment and Recruitment Plan: Recruiters determine the child's strengths, challenges, desires, preparedness for adoption and whether the child has needs that should be addressed before moving forward with the adoption process. Based on the file review, interviews with significant adults, assessment of and input from the child, recruiters develop a comprehensive recruitment plan. The plan for each child is customized and defined by the child's needs.

Diligent Search: Recruiters conduct a diligent search of potential adoptive families and identified connections to additional resources and pursue aggressive follow-up with contacts identified, with the knowledge and approval of the child's caseworker.

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Ways and Means Human Resources Subcommittee
Improving Programs Designed to Protect At-Risk Youth*

Thank you for the opportunity to share our concerns as well as our encouragement to continue providing post-adoption services to children and families who have worked alongside the government to establish a safe and permanent home for our nation's foster children. Embrace Waiting Children Inc. (Embrace) is a non-profit organization founded at Rhea's Mill Baptist Church in the North Texas area. We currently serve families by hosting support groups, respite programs and equipping other churches across the country to reclaim the care of the fatherless.

As well as supporting families throughout the foster care and adoption process, my wife and I are adoptive parents of 4. Our oldest is 18, adopted two years ago, after spending 9 years in foster care and enduring two disrupted adoptive placements. He came to our home with many emotional and behavioral barriers, and we were unable to find adoption competent professionals to assist him in the healing and attachment process. As parents we were able to lean on the relationships we had with other families in our support groups and take advantage of the local churches who cared for us, but for the most part, the post-adopt services that were available to our son needed to be more substantial.

We are aware that you are considering two programs, The Promoting Safe and Stable Families program and the Stephanie Tubbs Jones Child Welfare program, and seeing the limited impact they have had in our sons life, we strongly encourage you to not only maintain these funding streams but to better direct where those funds go. We are in desperate need of adoption competent therapists, psychiatrists and counselors. It is not enough for us to make funds available, we must provide direction for their use and see that needs are being met. Without these funds, one of our most vulnerable populations becomes a future burden instead of a future hope. Thank you for your consideration and work regarding our nation's foster children. I trust your ongoing efforts will be productive as we work with one another to care for these children and families.

Sincerely,

Bruce Kendrick
Director of Outreach
Foster & Adoptive Parent



Evan B. Donaldson Adoption Institute

EVAN B. DONALDSON

adoption 

Testimony of:

**Adam Pertman, Executive Director
and
Susan Livingston Smith, Program Director
Evan B. Donaldson Adoption Institute**

Submitted to the
**U.S. House of Representatives Committee on Ways and Means
Subcommittee on Human Resources**

For the hearing on:
**Improving Programs Designed to Protect At-Risk Youth
June 16, 2011**

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We would like to thank Chairman Davis, Congressman Doggett and members of the Subcommittee for holding this hearing on the reauthorization of Title IV-B child welfare programs. We are also grateful for the opportunity to present written testimony on the funding of these vitally important services to a very vulnerable population of children – those who have experienced abuse or neglect or are at risk of maltreatment.

We are Adam Pertman, Executive Director, and Susan Livingston Smith, Program Director, of the Evan B. Donaldson Adoption Institute, an independent and nonpartisan research, policy and education organization that was created for one principal reason: to provide accurate, knowledge-based information for practitioners, policymakers, journalists and others so that we, as a society, can shape better laws, policies and practices to improve the lives of everyone touched by adoption, especially children.

Our testimony relates specifically to the reauthorization of Title IV-B, subpart 2, the Promoting Safe and Stable Families Program, which includes the requirement that at least 20 percent of these funds be allocated to the category of services defined as “adoption promotion and support.” Our testimony is based on extensive research that the Institute has conducted on the needs of children and families after adoption – in particular those families adopting children from foster care – as well as on the over 20 years of research on post-adoption services for child welfare adoptive families that Program Director Susan Smith has conducted.¹

The Donaldson Adoption Institute has partnered with a number of other child welfare and adoption organizations across the country to ensure that adoption encompasses not only the placement of children into families, but also includes post-adoption services that enable these families to succeed in raising their children to healthy adulthood.

For many years, the federal government has aggressively promoted the adoption of children from foster care who cannot return home. It has done so largely through legislation such as the Adoption and Safe Families Act of 1997 and, most recently, through reauthorization and improvement of the Adoption Incentive Program in the Fostering Connections to Success and Increasing Adoptions Act of 2008.

These legal and policy changes have succeeded in increasing adoptions from the child welfare system from approximately 15,000 in 1988 to 57,456 in FY2009; in all, approximately three-quarters of a million children have been adopted from foster care over the past 15 years. It is important to note that each adoption from foster care brings a net savings of \$143,000 to state and federal governments (Barth, Lee, Wildfire, & Guo, 2006).

The Need for Post-Adoption Services

Many children come to their families with elevated risks for future developmental issues because of adverse prenatal and early-life experiences; inadequate nurturing; prenatal exposure to drugs and alcohol; physical and sexual abuse; and multiple placements in care, among other reasons. As Commissioner Bryan Samuels testified to this subcommittee,

¹ The Institute’s 2010 report, “Keeping the Promise: The Critical Need for Post-Adoption Services to Enable Children and Families to Succeed,” can be accessed at: http://www.adoptioninstitute.org/research/2010_10_promises.php

experiences of abuse and neglect have left a "traumatic fingerprint" on the development of these children.

Many adoptive parents are not prepared to understand or successfully navigate these challenges. Studies show that about 45 percent of these children fall in the "clinical range" on standardized measures of behavior problems many years after their adoptions, and some have very severe behavior problems that lead their parents to seek help repeatedly, often with little success (Rosenthal & Groze, 1994; Howard & Smith, 2003; Vandivere, Malm, & Radel, 2009).

The failed efforts of many families to get effective help have led to the development of specialized post-adoption services in many states. The primary types of services include: education and training, support groups, information and referral, respite, and clinical services. Adoptive families' service needs range along a continuum, with many more families needing less-intensive services such as education and support and only a small minority of families needing high-end services such as respite or residential care.

In an overwhelming majority of cases, adoption is genuinely beneficial and permanent; however, for the minority of adopted children with high-end needs, intense and ongoing difficulties can result in children being returned to care. When adoptions do fail, the economic and social costs to our country are considerable, and the toll on the children and families involved is even greater. Furthermore, for every adoption that doesn't work out, there are others – though it must be stressed still a minority – in which the families struggle every day to address the serious problems their children experienced *before* they were adopted.

The cost of compounding these problems is extremely high for children, families, and society. Some adoptive placements disrupt before they are finalized (10-15%), and children return to foster care, resulting in higher governmental costs. Some children are returned to foster care or residential treatment after adoption, and sometimes parents legally dissolve their adoptions.² Both failed adoptions and adoptions in which children have severe issues that are not being adequately addressed have a clear impact on society, but they also take a huge human toll on the affected children and families.

Raising a child with chronic behavioral problems typically results in high levels of parenting and family stress and can weaken the marital relationship, which in turn threatens family stability and the adoptive relationship. One parent served through an adoption preservation program described her experience as follows:

We were lost, sinking, destroying our family rapidly before these services. We spent thousands upon thousands of dollars, not counting the time involved in seeking help. This was the only place we could find help, information, relief ... an understanding of how these troubled kids work and how to try and cope ... and to still love them. It's so hard to put into words the devastating effects on the family ... the destruction, the financial drain, the breakdown of the marriage and physical health.

² A recent study using FY2005 AFCARS national data identified 3,166 children exiting care that year who were adopted prior to their most recent entry into care. Of those in the latter category, the adoptions of 1,241 children (39%) were classified as legally dissolved, while most (59%) of the remaining children leaving care were reunified with their adoptive parents (Festinger & Maza, 2009).

Recommendation

The Evan B. Donaldson Adoption Institute recommends that a dedicated funding stream for post-adoption services be created by redefining the service category of "adoption promotion and support" in Title IV-B, subpart 2, to become "adoption and post-adoption services;" and by requiring that a portion of these funds be expended on post-adoption services. We also concur with the recommendation of the American Humane Association that this committee consider new language that would direct savings from the adoption assistance delink in the Fostering Connections Act to be reinvested into post-adoption services.

According to available evidence, states currently spend all or most of the funds designated for adoption promotion and support on activities related to achieving adoptions for children in care. A report from the National Conference of State Legislatures (Christian, 2002), citing a 2002 review by James Bell and Associates, reported that 1 percent of total child welfare spending from federal and state sources went to "adoption promotion and support." States most commonly reported spent these funds on adoptive parent recruitment and training, home studies, and worker training – i.e., all activities focused on adoption promotion.

Our nation has made considerable progress in finding adoptive homes for children who have suffered from maltreatment (though we need to continue making progress, particularly for older youth in care). Now we need to shift the paradigm so that our priority moves from focusing almost solely on achieving permanency to also assuring that adoptive parents receive the services that will allow them to raise their sons and daughters to healthy adulthood. The federal government must take the lead in making a commitment to the development of post-adoption services. Guaranteeing this commitment in law and through a dedicated funding stream is the most effective way to serve and preserve families across our country, today and into the future.

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Submitted to the

US House of Representatives Committee on Ways and Means
Subcommittee on Human Resources

For the hearing on:

Improving Programs Design to Protect At-Risk Youth
June 16, 2011

Chairman Davis and Members of the Subcommittee, I am Brenda Lawrence, executive director of Family Design Resources, Inc. (FDR). Thank you for the opportunity to offer information to bolster understanding of the critical need for federal funding to strengthen post-adoption services and supports to families and children.

Family Design Resources is a private, non-profit social service consulting agency that provides program management, technical assistance and training for Pennsylvania's Statewide Adoption and Permanency Network (SWAN). FDR, in partnership with Diakon Lutheran Social Ministries and under the authority of Pennsylvania's Department of Public Welfare, Office of Children Youth and Families, administers the broad-based programs of the network, including comprehensive post-adoption services. A step-by-step approach puts our state's families in touch with the services they need to ensure permanency and prevent re-entry to the child welfare system.

Families can initiate the process by calling our SWAN Helpline. The information and referral specialists explain the services, assist the family in choosing an agency to work with and then submit the referral for service. This leads directly into the assessment of that family's needs. An assessor visits the home, talks with the entire family to build on family strengths and recommends possible services. In the words of one family served, "We were at the end of our rope! Having the caseworker come to our home helped us to see the light at the end of the tunnel. Help had finally arrived."

Referrals are made for one or any combination of three services—case advocacy, respite and support group. Each provides relief in distinct ways by connecting families to case advocates, other families and respite caregivers. A case advocate, for example, helps the family learn about and access services in the community, provides support and expertise. One family shared with our Helpline staff, "Our caseworker was helpful, caring and non-judgmental. She was the first person who really believed us about the behaviors our son was exhibiting. She was our guide towards resources that could help support our entire family."

The support group service is designed to support families by fostering relationships with other families in similar circumstances, forming a community of support and mentoring, and providing information and educational materials. One family expressed the help they received in this way: "Finding support from other families who are going through the same struggles is what keeps me going. It means I am not alone."

Respite services support the family by developing resources that help alleviate the pressures of parenting special needs children. A respite provider offers a safe environment for the child while the family takes a short break by going out for the night or enjoying a weekend away. Respite is flexible and can occur inside or outside the home. Our services also allow for a family to choose their respite providers, providing a higher level of assurance to the family. SWAN has served families for whom respite was a lifeline to hope. According to one family, "I was ready to return my child to CYS. The situation had become desperate for our entire family. Respite gives us the much needed refreshment to rejuvenate, regroup and continue to strengthen our family."

At the time we designed the initial post-permanency programs for Pennsylvania's families in 2002, support groups were meeting but were not funded, and respite and case advocacy services were not available. The limited research available at the time and a gap analysis that we performed to understand the overall needs of our state's families helped to lay a strong foundation for the design of a comprehensive program. Current research continues to support the need for flexible, tailored post-adoption services in the areas of case advocacy, respite and support groups.

As evidenced by the testimonials I've shared today, post-adoption support can change fear, anxiety, frustration, despair, hardship and burnout to hope, trust, confidence, preservation, adaptability, cohesion and most importantly, permanence. And isn't that what we're all really aiming for?

Thank you for the opportunity for me to share the positive experiences of Family Design Resources and the families we serve. I would be happy to answer any questions you may have about Pennsylvania's approach to post-adoption support.



Zero to Three, National Center for Infants, Toddlers, and Families

**STATEMENT FOR THE RECORD OF
 MATHEW E. MELMED, EXECUTIVE DIRECTOR
 ZERO TO THREE: NATIONAL CENTER FOR INFANTS, TODDLERS, AND
 FAMILIES**

**SUBMITTED TO THE SUBCOMMITTEE ON HUMAN RESOURCES
 HOUSE COMMITTEE ON WAYS AND MEANS**

**HEARING ON IMPROVING PROGRAMS DESIGNED TO PROTECT AT-RISK
 YOUTH
 June 16, 2011**

Mr. Chairman and Members of the Subcommittee:

I am pleased to submit the following written testimony to the Subcommittee on Human Resources on behalf of ZERO TO THREE, National Center for Infants, Toddlers, and Families. My name is Matthew Melmed, and I am the Executive Director of ZERO TO THREE, a national non-profit organization that has worked to advance the healthy development of America's infants and toddlers for over 30 years. I would like to start by thanking the Subcommittee for holding this hearing examining how to improve the care of the very vulnerable children overseen by the child welfare system. Today, I want to urge your attention to, and your action on behalf of, a subset of that group who truly are the most vulnerable members of our society: infants and toddlers who have experienced abuse or neglect.

Every seven minutes in America, an infant or toddler is removed from parental care and placed with another adult, often a stranger. These babies are only a portion of the very young children who are found to be abused or neglected. These distressing events happen at a time in a child's life when the brain is developing seemingly at light speed as the child acquires the abilities to think, speak, learn, and reason. A baby's brain is forming 700 new neural connections *every second*. Early experiences, both positive *and* negative, have a decisive effect on how the brain is wired. So it should not be surprising that early and sustained exposure to adverse experiences such as abuse and neglect can literally alter the brain's architecture, giving rise to difficulties that include cognitive delays, poor self-regulation, difficulty paying attention, poor self-esteem, and difficulty forming attachments. While no child in the child welfare system has a story that is less than compelling, infants and toddlers are at risk for carrying that story around for the rest of their lives ingrained in the very architecture of their brains.

Recently, ZERO TO THREE joined with other national children's organizations, American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, and Children's Defense Fund, to issue a *Call to Action on Behalf of Maltreated Infants and*

*Toddlers.*¹ This document lays out the case for ensuring that every baby who comes to the attention of child welfare receives care oriented to supporting positive development at every step. It provides a checklist of the elements of such a developmental approach. These elements or action steps can be used by federal and state policymakers to build these elements into policy initiatives, such as the reauthorization of Title IV-B of the Social Security Act, as well as child welfare practice at the state and local level.

My remarks are taken from the *Call to Action* and seek to make the case to the Subcommittee for a special focus on babies, not to the exclusion of other children, but as a population with special and unique needs that warrant decisive action that can improve their lives. I also will discuss a promising model, the Safe Babies Court Teams, which implements a developmental approach through local juvenile and family courts. Finally, I will outline recommendations for the reauthorization based on the checklist in the *Call to Action*.

Infants and Toddlers Are a Significant Proportion of the Child Welfare Population

Very young children have the highest rates of maltreatment, with the rate for infants (20.6 per 1,000 infants) far outstripping other age groups. In 2009, 187,428 infants and toddlers had substantiated cases of abuse or neglect.² Sometimes their vulnerability has tragic consequences: of the 1,676 children who died from abuse or neglect in 2009, almost three out of four (79.8%) were younger than age three and close to half (46.2%) were infants.³

Infants and toddlers comprise almost a third of children who are placed in foster care each year (31% in 2009). More than half (16%) were infants.⁴ Once in care, they tend to stay longer, with infants who come into care younger than 3 months staying the longest. These newborns are less likely to leave care with their biological parents (only 28% are reunified compared with 43% adopted) than older infants (42% reunified and 26% adopted).⁵ Almost a third of infants who are reunified will return to foster care.⁶

The Developing Brain is Harmed by Abuse and Neglect

Neuroscientific research on early brain development indicates that young children warranting the greatest concern are those growing up in environments, starting before birth, that expose them to abuse and neglect. Such early and sustained exposure to risk factors like child abuse and neglect can influence the physical architecture of the developing brain, preventing infants and toddlers from fully developing the neural pathways and connections that facilitate later learning. In short, maltreatment alters the brain's architecture.⁷ These changes in the brain give rise to several psychological difficulties—cognitive delays, poor self-regulation, and difficulty in paying attention.⁸ Maltreated infants and toddlers may also struggle with poor self-esteem, behavior control, attachment formation and may have difficulty showing empathy, controlling their behavior in social situations, and initiating social interaction.

Clearly, infants and toddlers in the child welfare system face developmental challenges. Approximately one third of infants and toddlers investigated by child welfare services have been determined to have a developmental delay.⁹ Data from the National Survey of Child and Adolescent Well-Being (NSCAW) indicate that 35% of children from birth to age 3 years

involved in child welfare investigations were in need of early intervention services. However, only a small percent (12.7%) of these children were receiving the Individualized Family Service Plans to which they were entitled under federal law.¹⁰

I want to especially mention the effects on babies of maternal substance abuse and particularly alcohol use during pregnancy. This topic is particularly important given the IV-B targeted grants for children affected by methamphetamine or other substance abuse that give priority to programs focusing on methamphetamine use. Alcohol use often co-occurs with other substance abuse during pregnancy and can occur on its own as well. One estimate is that 70 percent of children in foster care were prenatally exposed.¹¹ While there is much publicity surrounding illegal drug use during pregnancy, alcohol causes the most serious neurobehavioral effects in the developing fetus as well as long term behavioral, cognitive and other deficits. Fetal Alcohol Spectrum Disorders are the invisible problem that not only affects many babies in the child welfare system, but may also have gone undiagnosed in many of their parents, contributing to difficulties in carrying out effective case plans.

Early Relationships are Key

The damage resulting from maltreatment becomes more comprehensible when we understand that relationships with caregivers are the context in which early development occurs. These first relationships that a child forms with adults have the strongest influence on social and emotional development.¹² Infants and toddlers rely on their closest caregivers for security and comfort. Those who are able to develop secure relationships are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments.¹³

Not surprisingly, researchers have found that approximately 82% of maltreated infants show disturbances in their attachment to their caregivers.¹⁴ These disruptions place them at great risk. And when young children are formally separated from their caregivers, challenges to maintain and rebuild relationships may be compromised. Young children who do not form an attachment with at least one trusted adult suffer, and their development can deteriorate rapidly, resulting in delays in cognition and learning, relationship dysfunction, and difficulty expressing emotions. Young children with unhealthy attachments are also at much greater risk for delinquency, substance abuse, and depression later in life.

Infants and Toddlers in Foster Care are at Particular Risk

Infants and toddlers placed in foster care are at particular risk. The care they receive following removal from their parents, if not properly attuned to its effect on their development, can compound the developmental harm from maltreatment. Psychologist Brenda Jones Harden describes foster care placement for babies as "major surgery without an anesthetic."¹⁵ Separation from parents, sometimes sudden and usually traumatic, coupled with the difficult experiences that may have precipitated out-of-home placement, can leave infants and toddlers dramatically impaired in their emotional, social, physical, and cognitive development.¹⁶ Negative foster care experiences may extend and compound developmental impairments¹⁷ which research indicates can affect each domain of developmental functioning.¹⁸

Two major problems for infants and toddlers in foster care are the lack of ongoing parent-child contact and the multiple moves that some children experience. Maintaining or healing attachments with parents are critical for young children but can be difficult while the child is in placement. Visitation for infants and toddlers should be as frequent as possible (e.g. daily or multiple times per week) and be conducted in home-like locations that are familiar to the child.¹⁹ Typical child welfare policy dictates once weekly visits between parents and children. An overarching principle of infant mental health intervention is that relationships (e.g. between parent and child as well as family and interventionist) are the conduit for change in the young children and families served.²⁰

Multiple moves while in foster care are a particular concern for infants and toddlers. When a baby faces a change in placement, fragile new relationships with foster parents are severed, reinforcing feelings of abandonment and distrust. Even very young babies grieve when their relationships are disrupted and this sadness adversely affects their development. These multiple moves place children at an increased risk for poor outcomes with regard to social-emotional health and the ability to develop secure healthy attachments.²¹ A developmentally appropriate policy strives to make the first placement the last placement, at least until reunification with parents may occur.

Babies Carry the Effects of Maltreatment Throughout Their Lives

The toll extracted by maltreatment and the often-inadequate response of the child welfare system to address impairments can resonate throughout a child's life. NSCAW data indicate that half of maltreated infants exhibit some form of cognitive delay. They are more likely to have deficits in IQ scores, language ability, and school performance than other children who have not been maltreated.²² Maltreated infants and toddlers are also more likely to have physical health difficulties—greater neonatal problems, higher rates of failure to thrive, and dental disease.

Disproportionate exposure to early trauma and other developmental risk factors can result in a variety of mental health disorders. Physical abuse impairs a young child's social adjustment, including elevated levels of aggression that are apparent even in toddlers. Long-term negative outcomes include school failure, juvenile delinquency, substance abuse, and the continuation of the cycle of maltreatment into future generations. Too often, foster children become parents themselves too soon and have little experience with loving, nurturing relationships to guide their own parenting. The cycle must be broken.

Hope Through Action: A Unique Window of Opportunity

Research confirms that the early years present an unparalleled window of opportunity to effectively intervene with at-risk children.²³ To be effective, interventions must begin early and be designed with the characteristics and experiences of these infants, toddlers, and families in mind.²⁴ Intervening in the early years can lead to significant cost savings over time through reductions in child abuse and neglect, criminal behavior, welfare dependence, and substance abuse. If services are not provided until a child is 6, 7, or 8 years of age, the most critical opportunity for prevention and intervention is missed.²⁵ A study of the cumulative costs of special education from birth to age 18 years found that intervening at birth resulted in lower costs

over the course of childhood than services started later in life (approximately \$37,000 when services were begun in infancy, 28% to 30% lower than when begun after the age of 6).²⁶

Given this early window of opportunity, there are a number of ways that policymakers and practitioners can intervene to improve outcomes for infants and toddlers. Child welfare practices must be focused on child safety and also structured to promote healthy development and the formation of a secure attachment. A reorientation of thinking is needed to reform approaches to infants and toddlers who come to the attention of the child welfare system at such a developmentally critical time.

An Agenda for Addressing the Developmental Needs of Infants and Toddlers

To help policymakers and child welfare administrators build a more developmentally responsive system, the *Call to Action* lays out guiding principles for promoting infant and toddler development and the protective factors that help families mitigate the trauma of maltreatment and provide a nurturing environment for young children. They include:

- *Every child welfare decision and service should have a goal of enhancing the well-being of infants, toddlers, and their families to set them on a more promising developmental path.* Reorienting a child welfare system toward a developmental approach requires commitment from policymakers as well as the inclusion of specific knowledge of the science of early child development in the training for child welfare, social service, early childhood, and legal workforces.
- *Stable caring relationships are essential for healthy development.* Child welfare policies and practices should make supporting responsive, secure bonds between the youngest children and their parents and caregivers a central goal. This means maintaining and supporting parent-child contact; minimizing multiple placements; limiting the use of congregate care to situations where parents and their young children can be cared for together; and promoting timely permanence.
- *Early intervention can prevent consequences of early adversity.* Developmentally appropriate screening and assessments must become routine, followed by intervening early with necessary services. We should not forget the needs of the parents, who often are themselves victims of childhood trauma. Infant and early childhood mental health specialists can help address the relationship between baby and parent and baby and foster parent. Child-parent therapy may be essential. Special efforts are needed to get this help to infants and toddlers when they first come to the attention of the child welfare system.
- *Families and communities must be key partners in efforts to ensure the well-being of every child.* The child welfare system cannot do it alone. Child welfare policies must facilitate coordination among agencies to provide comprehensive assistance for at-risk families. For at-risk families with young children, help in building strong friendships and community connections that reduce isolation can provide an especially valuable network of support.

- *Child welfare administration at the federal, state, and local levels must focus on infants, toddlers, and their families in such functions as the delivery of services, data collection, research, and attention to special populations.* It is critical that we know more about what is occurring with the youngest children in the child welfare system and what works best in addressing their needs. We must acknowledge and respond to their needs in program administration, research, data collection, and analysis, as well as the provision of ongoing services.

A Developmental Approach in Practice: Safe Babies Court Teams

While the checklist for a developmental approach in the *Call to Action* may seem both sweeping and daunting for child welfare systems to implement, I want to highlight a model developed at ZERO TO THREE that has successfully applied developmental principles to foster care cases involving infants and toddlers. Within the Safe Babies, Strong Families, Healthy Communities project, Safe Babies Court Teams are combining judicial leadership with the science of early childhood development and community partnerships to produce systems change at the local level in 10 communities around the country. Each Court Team, led by a juvenile and family court judge, is representative of all the decision-makers, services and resources which can support abused and neglected babies in the community. Individual team members learn how to apply evidence-based whole-child decision-making to improve healthy developmental outcomes one baby at a time. Collectively, the whole team creates systemic changes that build community capacity to improve outcomes for all babies and toddlers in the child welfare system. In short, Court Teams transform the way communities approach the needs of marginalized babies and toddlers to lay a healthy foundation for their educational and social success.

The Court Teams approach leads to better decision making, as monthly meetings keep cases involving these rapidly developing children moving forward, and ensures “front-loading” services, so that families’ needs are assessed from the beginning and a plan for services developed. The community team ensures access to needed family and child-specific services, including universal screening for developmental delays (under Part C of IDEA and the Child Abuse Prevention and Treatment Act), primary care pediatric medical care, emphasis on working jointly with the parent and child to create a healthy relationship, bringing the foster parents into the circle of adults working with the maltreating parents to serve as mentors and post-permanency resources, frequent opportunities for parents and children to spend time together in home-like settings under the supervision of adults who help the children and parents enjoy their time together. There is a focus on kinship care, increasing involvement of fathers, and concurrent planning. Expediting permanency is a major goal.

Judges leading these teams see the approach as transforming how they do their work. An independent evaluation found the Court Teams were meeting 97% of identified service needs, achieving timely permanency in 95% of closed cases, minimizing placements while in out-of-home care, and achieving positive safety outcomes.²⁷ The Teams have increased parent-child visits needed for healthy attachments as well as relative/kinship placements. Most exciting, I am able to share with you the results of a recent study using the data from the original evaluation. When compared with a nationally representative comparison group (n=511), the children served

by the Court Teams in Des Moines, IA; Hattiesburg, MS, New Orleans, LA, and Fort Bend County, TX (n=298) reached permanency two to three times faster. This differential was true when the two samples were compared by types of exit (e.g. reunification, adoption, kinship custodianship). *Children served by the Court Teams exited the foster care system approximately one year earlier than children in the comparison group.*²⁸

The Court Teams projects were the model for legislation introduced in the previous two Congresses by Representatives Rosa DeLauro and Ileana Ros-Lehtinen (The Safe Babies Act of 2009, H.R.3474) and expected to be reintroduced in this Congress.

Incorporating a Focus on Infants and Toddlers in Title IV-B Reauthorization

The reauthorization of the child welfare programs included in Title IV-B of the Social Security Act offers a promising starting point for infusing both a special focus on infants and toddlers and the adoption of a developmental approach into child welfare policy. The *Call to Action* is intended to be a guide to building a system that embodies such a developmental orientation. The following recommendations provide a cross-walk from the elements of that system to the policies in the federal statute.

- (1) *Require states to describe in their Title IV-B state plans how they are addressing the developmental needs of infants and toddlers who come in contact with the child welfare system.* A state plan requirement would ensure that states begin to think about infants and toddlers as a distinct population with unique needs and to better target resources to meet those needs.
- (2) *Require an emphasis on detecting and addressing developmental delays and including services in case plans for infants and toddlers.* Because infants and toddlers who have experienced abuse or neglect have a very high rate of developmental delays, they need medical homes and periodic screening by physicians as well as Part C of the Individuals with Disabilities Education Act early intervention services. Currently there is a requirement that all infants and toddlers with substantiated cases of abuse and neglect be referred for screening, but even when children are not initially found eligible for early intervention services, they need continued monitoring and screening.
- (3) *Promote the availability of a continuum of mental health services for parents and young children that support social and emotional wellbeing.* Infants and toddlers who have been traumatized by maltreatment may need mental health services. These include assessment of the parent-child relationship; parenting education programs that are effective in working with maltreating parents; frequent (as often as daily) parent-child contact if the child has been removed from the home accompanied by support for productive visits; and child-parent psychotherapy specifically for families with very young children. Such provisions could be applicable within the range of family services defined in Sec. 431(a).
- (4) *Promote training of stakeholders (including child welfare workers, judges and other court-related personnel, and community providers) on early childhood development, particularly brain development, and the impact of various child welfare policies and practices on promoting positive development.* Judges are the first to admit that legal education does not include child development, much less the science specifically relating to brain development in the first three years of life. Child welfare workers and service

- providers also may not have the specialized knowledge they need to ensure the practices and services for young children are designed to promote optimal development.
- (5) *Require data collection and research that allow us to discern the experiences of infants and toddlers in the child welfare system.* Often infants and toddlers are not included as a distinct category in data collection. Similarly, more research is needed on their experiences and what approaches work best in their cases.
 - (6) *Eliminate the focus on methamphetamine use in the targeted grants for children affected by substance abuse and ensure that alcohol use, as well as the developmental needs of the children, are addressed.* We support approaches to the problems facing families in the child welfare system that involve community collaboration and consider the range of needs of both parents and children beyond the substance abuse. The use of alcohol on its own or in conjunction with other substances contributes to neurobehavioral effects in babies and may even contribute to the cycle of child welfare involvement in some families. We urge attention to this problem.
 - (7) *Increase funds for court improvement to bring the approach of the Safe Babies Court Teams to communities across the country.* The Court Teams approach may be thought of as “child welfare reform from the ground up.” It is changing the lives of maltreated babies and their families as well as changing systems in communities. The latest evidence shows it is helping babies find permanent homes much faster. We urge the Subcommittee to consider making this approach available to more courts and communities as an avenue to ensuring a developmental approach to caring for infants and toddlers in the child welfare system.

Take Action for a Better Future for Abused and Neglected Babies

In conclusion, I appreciate the opportunity to provide input to the Subcommittee as it begins to consider the reauthorization of Title IV-B. Maltreated infants and toddlers should not be twice neglected--once by their caregivers and again by a child welfare system and a society that fail to do everything they can to ensure the development of vulnerable young children does not suffer because of their circumstances. The numbers describing the prevalence of infants and toddlers in the child welfare system certainly call for attention. But even more compelling is the developmental disaster that lies in wait for babies who are maltreated and lack that one person in life who is crazy about them and who will envelop them in positive, nurturing experiences. The good news is that, just as maltreatment can resonate throughout a child's life, so can solid, nurturing early intervention that puts his or her development on a positive path. We *can* make a difference in these children's lives *if* we act now to ensure that what we know from the science of early childhood development guides what we do for these very vulnerable babies.

¹ The complete report is available at <http://www.zerotothree.org/public-policy/federal-policy/childwelfareweb.pdf>.

² U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2010). *Child Maltreatment 2009*. Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can.

³ U.S. Department of Health and Human Services, Administration for Children and Families. Child Maltreatment 2008. U.S. Department of Health and Human Services, 2010. www.acf.hhs.gov.

- ⁴ U.S. Department of Health and Human Services, Administration for Children and Families. The AFCARS Report: Preliminary FY 2009 Estimates as of July 2010 (17). Retrieved August 10, 2010 from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.htm.
- ⁵ Fred Wulezyn, Lijun Chen, Linda Collins, and Michelle Ernst. "The Foster Care Baby Boom Revisited: What do the Numbers Tell Us?" *ZERO TO THREE Journal*, 31 no.3: 4-10.
- ⁶ *Ibid*
- ⁷ Jack Shonkoff, 2007. Interviewed in *Helping Babies From the Bench: Using the Science of Early Childhood Development in Court*. Washington, DC: ZERO TO THREE.
- ⁸ Brenda Jones Harden, Infants in the Child Welfare System. *A Developmental Framework for Policy and Practice*. Washington, DC: ZERO TO THREE Press, 2007.
- ⁹ Cecilia Casanueva, Theodore Cross and Heather Ringeisen, *Developmental Needs and Individualized Family Service Plans Among Infants and Toddlers in the Child Welfare System*. 2008. Downloaded August 18 at <http://ems.sagepub.com/cgi/content/abstract/13/3/245>.
- ¹⁰ *Ibid*.
- ¹¹ Katrine Herrick, Lucy Hudson, and Larry Burd. "The Elephant in the Cradle: Fetal Alcohol Spectrum Disorders." *ZERO TO THREE Journal*, 31 no. 3: 44-50.
- ¹² National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Jack Shonkoff and Deborah A. Phillips, eds. Washington, DC: National Academy Press, 2000.
- ¹³ *Ibid*.
- ¹⁴ *Ibid*.
- ¹⁵ Brenda Jones Harden, Comments at Congressional Baby Caucus Briefing on "America's Most Vulnerable: Infants and Toddlers in the Child Welfare System," May 23, 2011.
- ¹⁶ Alicia Lieberman and Patricia Van Horn, "Assessment and Treatment of Young Children Exposed to Traumatic Events." In J. Osofsky, ed., *Young Children and Trauma: Intervention and Treatment*, New York: The Guilford Press, 2007.
- ¹⁷ National Research Council, *From Neurons to Neighborhoods*.
- ¹⁸ Brenda Jones Harden, Infants in the Child Welfare System. *A Developmental Framework for Policy and Practice*. Washington, DC: ZERO TO THREE Press, 2007.
- ¹⁹ Brenda Jones Harden, Infants in the Child Welfare System. *A Developmental Framework for Policy and Practice*. Washington, DC: ZERO TO THREE Press, 2007.
- ²⁰ *Ibid*.
- ²¹ Yvon Gauthier, Gilles Fortin, and Gloria Jeliu, "Clinical Application of Attachment Theory in Permanency Planning for Children in Foster Care: the Importance of Continuity of Care." *Infant Mental Health Journal* 25, no. 4 (2004): 379-397.
- ²² *Ibid*.
- ²³ National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Jack Shonkoff and Deborah A. Phillips, eds. Washington, DC: National Academy Press, 2000.
- ²⁴ Brenda Jones Harden, Infants in the Child Welfare System. *A Developmental Framework for Policy and Practice*. Washington, DC: ZERO TO THREE Press, 2007.
- ²⁵ Infant Mental Health Project, Center for Prevention and Early Intervention Policy, Florida State University, Tallahassee.
- ²⁶ M.E. Wood, "Costs of Intervention Programs." In C. Garland et al., eds., *Early Intervention for Children with Special Needs and Their Families: Findings and Recommendations*. Westar Series Paper No. 11, Seattle: University of Washington, 1981.
- ²⁷ Hafford, C., McDonnell, C., Kass, L., DeSantis, J., & Dong, T. (2009). *Evaluation of the Court Teams for Maltreated Infants and Toddlers: Final Report*. Submitted to the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice by James Bell Associates, Arlington, VA.
- ²⁸ K.L. McCombs, *Fostering a Permanent Home: A Mixed Methods Evaluation of the ZERO TO THREE Court Teams for Maltreated Infants and Toddlers Initiative: Effect on Time to Permanency*. Chapel Hill, NC: University of North Carolina at Chapel Hill, 2011.

Generations United

**Written Testimony of Donna M. Butts
Executive Director, Generations United
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**To the Subcommittee on Human Resources
Ways and Means Committee
U.S. House of Representatives**

June 30, 2010

As an organization dedicated to improving the lives of children, youth, and older adults through intergenerational strategies, Generations United is pleased to have this opportunity to submit testimony about the Stephanie Tubbs Jones Child Welfare Services and Promoting Safe and Stable Families Programs (PSSF) to the Subcommittee on Human Resources of the Committee on Ways and Means. Generations United urges the committee to sustain and strengthen supports for children raised in “grandfamilies,” families headed by grandparents or other relative caregivers (also known as kinship families).

Generations United is the national membership organization that works to improve the lives of children, youth and older adults through intergenerational collaboration, public policies and programs for the enduring benefit of all. Founded in 1986 by the National Council on Aging, Child Welfare League of America, AARP, and Children’s Defense Fund, Generations United has served as a resource to policymakers and the public about the economic, social and personal imperatives of intergenerational collaboration since 1986. One of GU’s core initiatives is its National Center on Grandfamilies.

BACKGROUND ON GRANDFAMILIES

According to estimates from the American Community Survey more than 6.7 million children across the country are living in households headed by grandparents or other relatives.ⁱ The foster care system serves approximately 102,000 of these children.ⁱⁱ In fact, children raised in grandfamilies represent almost one-fourth of the children in foster care. For grandfamilies in foster care, the state generally has legal custody and caseworkers and judges can assist with access to services, such as school enrollment and the receipt of medical care.

However, the vast majority grandparents and other relatives raising children do not have a legal relationship with the children they care for – such as adoption, legal custody, or guardianship. Without the help of caseworkers and judges to ease the process, it is often very challenging for these grandfamilies to access many of the same services and resources. Furthermore children in these families are known to face additional hardships because their caregivers are more likely to be single, older, of poorer health, have more mental health programs and of lower economic status than traditional foster parents.ⁱⁱⁱ

Even in the face of these challenges these grandparents and other relatives step in to provide an invaluable safety net for children whose parents are unable to care for them for a variety of reasons including: military deployment, incarceration, mental or physical illness, death, and poverty. By doing so, “grandfamilies” keep families together in times of need and save taxpayers

an estimated least \$6.5 billion a year by preventing children from entering the foster care system.^{iv} In addition, research shows that children who remain in relative homes have better outcomes those living with non-relatives.^v

Despite the important role that millions of grandparents and other relatives play in caring for children outside of the formal foster care system, the vast majority of available supportive policies and services are targeted at supporting only those kinship families where the caregivers are licensed foster parents or otherwise involved with the formal child welfare system. The following recommendations address how The Promoting Safe and Stable Families Program can reduce barriers for these grandfamilies not involved with the formal system to allow the caregivers to access services and resources necessary to provide for the children for whom they care.

RECOMMENDATIONS

Identify, Evaluate, and Promote Evidence-Based Programs Serving Grandfamilies, or Kinship Families.

Research shows that children placed with relatives fare better than children placed with non-related foster families. Children in relative foster care placements as compared to those in non-relative foster care are: safe if not safer; more stable; more likely to remain with siblings; and more likely to stay connected to community and culture.^{vi}

While research on outcomes for children living in homes with relatives outside of the formal foster care system is limited, initial studies suggest these children have better outcomes than children in foster care.^{vii} Yet supportive programs and services are often critical to ensure children thrive. Support is needed to identify, evaluate and promote evidence-based practices in programs serving grandfamilies who are not connected to the formal foster care system. This could be accomplished through providing additional support for a national resource center to collaborate with other national nonprofits and leaders in the field of kinship care/grandfamilies to accomplish the following:

- Identify promising programs serving grandfamilies
- Conduct comprehensive evaluations of these promising programs to transform them into evidence based programs
- Collect and synthesize research on grandfamilies

When evidence-based models are identified, policymakers should invest in them and promote ways to encourage the field to take them to scale.

Provide Incentives for States to Provide Services and Support to Grandfamilies by Leveraging Current Resources And Promoting Interagency Collaboration

Generations United recommends that the Promoting Safe and Stable Families program provide incentives for states to use funds already available to grandfamilies. In periods of scarce resources, federal programs can better serve children and families by leveraging limited

resources across agencies. Policies that support grandfamilies have a unique opportunity to promote collaborations across funding streams and administrative agencies serving younger and older people. The National Family Caregiver Support Program (NFCSP), which is a part of the Older Americans Act and is administered by the Administration on Aging, allows up to 10 percent of its funds to be utilized for services and supports for grandfamilies in which the caregiver is 55 or older. Promoting Safe and Stable Families (PSSF) could encourage the full use of this funding by including language which provides incentives through guarantees of supplemental PSSF funds dedicated to serving grandfamilies thereby multiplying the NFCIP funds used to support the families.

The National Family Caregiver Support Program (NFCSP) provides funds to states to serve family caregivers in five categories of services: information to caregivers about available resources; assistance to caregivers in gaining access to the services; individual counseling, organization of support groups, and caregiver training; respite care; and supplemental services on a limited basis. States have the option to use up to ten percent of these funds to serve children and caregivers in families where grandparents or other relatives are raising children. While some states use the full allowable 10 percent of funds to serve these families. Others use only a small portion or none of the allowable amount of funds to serve these families. As a result child welfare agencies are left with fewer collaborative resources to better serve children and families at risk.

The National Family Caregiver Support program also limits the use of their funds to grandfamilies with caregivers ages 55 and over. Area Agencies on Aging report frequent requests from families with caregivers under the age of 55 seeking supports. Unless they have other funds without age restrictions, they are unable to serve these families. Blending NFCSP and PSSF funds would eliminate the age barrier.

Generations United recommends that the PSSF Program incentivize states to increase their NFCSP investments in programs that serve children in the care of grandparents or other relatives. Specifically PSSF should designate a portion of funds which would be dedicated to support grandfamilies in states that elect to use the full 10 percent of NFCSP dollars to serve grandfamilies. This approach would leverage resources from both the aging and children's communities, serving a population of mutual interest while resulting in a win-win for children and caregivers.

To further identify areas of potential synergy, an interagency planning team should be established to make recommendations to Congress on opportunities for further collaboration and leveraging of resources across agencies serving children, youth and caregivers.

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¹ U.S. Census Bureau, American Community Survey, 2005-2009, Table B09006.

² U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, the AFCARS Report Preliminary FY 2009 Estimates as of July 2010. Accessed April 14, 2011 at http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report17.htm

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⁴ This figure was calculated based on the federal share of the 2000 average monthly foster care maintenance payment, which was estimated at \$545 in the Green Book committee on Ways and Means, U.S. House of Representatives. Half the children are used for our calculation due to a conservatives estimate that the other half already receive some type of governmental financial assistance, such as a Temporary Assistance for Needy Families child-only grant. Consequently the cost of one million children entering the system would represent all new financial outlays for taxpayers.

⁵ David M. Rubin et al., *Impact of Kinship Care on Behavioral Well-being for Children in Out-of-Home Care*, 162 *ARCHIVES FOR PEDIATRIC & ADOLESCENT MED.* 6 (June 2, 2008) available at <http://archpedi.ama-assn.org/cgi/content/full/162/6/550> ; Generations United (2007) *Time for Reform: Support Relatives in Providing Foster Care and Permanent Families for Children*.

⁶ Generations United (2007) *Time for Reform: Support Relatives in Providing Foster Care and Permanent Families for Children*.

⁷ Rubin David M. Rubin et al., *Impact of Kinship Care on Behavioral Well-being for Children in Out-of-Home Care*, 162 *ARCHIVES FOR PEDIATRIC & ADOLESCENT MED.* 6 (June 2, 2008) available at <http://archpedi.ama-assn.org/cgi/content/full/162/6/550>.

National Association of Social Workers



**Written Testimony of
Elizabeth J. Clark, PhD, ACSW, MPH, Executive Director
National Association of Social Workers**

**For the
Subcommittee on Human Resources,
Committee on Ways and Means
U. S. House of Representatives
Washington, DC**

June 30, 2011

Hearing on "Improving Programs Designed to Protect At-Risk Youth"

Chairman Davis and other distinguished members of the Subcommittee on Human Resources, Committee on Ways and Means, we thank you for considering our statement as you prepare to reauthorize the Promoting Safe and Stable Families Program and the Stephanie Tubbs Jones Child Welfare Services Program.

The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world, with 145,000 members. NASW works to enhance the professional growth and development of its members, to create and maintain standards for the profession, and to advance sound social policies.

Social work is the largest social service profession in the United States. Social workers help people function better in their environments, improve their relationships with others, and solve personal and family problems through individual, social, and psychological support. The most commonly reported practice areas of licensed social worker members are mental health (37%), child welfare/family (13%) and health (13%). Social workers also work with older adults, adolescents, and with other populations in various settings.

Overview

The social work profession has a long tradition of involvement with the child welfare system and welcomes the opportunity to participate in the process of reauthorizing the Promoting Safe and Stable Families Program (PSSF) and the Stephanie Tubbs Jones Child Welfare Services Program. These programs are essential funding sources for an array of services for families with children. According to the federal report, Child Maltreatment 2009, an estimated 3.3 million referrals of possible child abuse and neglect were made to state and child protective service (CPS) agencies in the United States in 2009, of which 61.5% were accepted for investigation, resulting in 702,000 children

found to be victims of abuse and neglect. These programs are also a critical component for reaching the goals of the Adoption and Safe Families Act (ASFA) that aims to build capacity in states and communities so that services are available for children and families.

Background on the Stephanie Tubbs Jones Child Welfare Services Program

The goals of the Stephanie Tubbs Jones Child Welfare Services Program, as articulated recently by Bryan Samuels, Commissioner, Administration for Children and Families, in his testimony before your Committee on June 16, 2011, are: "(1) protecting and promoting the welfare of children; (2) preventing the neglect, abuse or exploitation of children; (3) supporting at-risk families that allow children, where appropriate, to remain safely with their families or return to their families in a timely manner; (4) promoting safety, permanence, and well-being of children in foster care; and (5) providing training, professional development, and support to ensure a well qualified child welfare workforce. Services are available without regard to income and funds are distributed to states through formula grants. The FY 2011 funding level is \$281,181,000.

Background on the Promoting Safe and Stable Families Program

The PSSF program was created in 1993 and originally named the Family Preservation and Support Services Program. At that time, all funding was guaranteed or mandatory. When PSSF was reauthorized in 1997 it was and renamed the Promoting Safe and Stable Families Program, with a mix of mandatory and discretionary funding. According to the Administration for Children and Families, the primary goals of this program are to "prevent the unnecessary separation of children from their families, improve the quality of care and services to children and their families, and ensure permanency for children by reuniting them with their parents, placing them with an adoptive family or in another permanent living arrangement." States and eligible tribes are to spend most of the funding for four service categories: family support, family preservation, time-limited reunification and adoption promotion and support.

Funding is divided between a total of \$345 million in mandatory funds and an additional \$200 million in discretionary funds. Since the additional discretionary funding was created, Congress has never appropriated more than \$100 million in discretionary dollars. In fact, part of the challenge since discretionary authority was created has been that appropriators have reduced funding in recent years, now at \$62 million.

In addition to formula grants to states and tribes, some of the funds are set aside for evaluation, research, training and technical assistance projects (\$6 million in mandatory funding or 3% of discretionary) and \$40 million in state mandatory funds to improve the quality and quantity of caseworker visits with children in foster care and parental substance abuse programs. NASW advocated for this additional funding source for many years and while we applaud Congress for recognizing this child welfare workforce challenge, additional resources and supports are needed in this area. In addition, NASW fought tirelessly to secure the passage of the PSSF legislation into law in 1993 and its subsequent reauthorization.

NASW Recommendations to Improve the Child Welfare System

It has been widely documented that the child welfare system is over-burdened, understaffed and under-trained and that children are left too long before securing a safe and permanent home. Child welfare positions are particularly demanding and stressful, often involving unreasonable workloads and low pay in comparison to jobs in other sectors that require comparable amounts of education and responsibility. Consequently, it becomes difficult to attract and retain the most qualified employees — those with professional training and experience. We hope to work with Congress to identify solutions to these complex problems and we offer the following recommendations:

Improve Education and Training Opportunities for Frontline Workers

The public has high expectations for the child welfare system, as it should. Every day, these agencies make life and death decisions for children and families with complex needs, striving to meet extensive legal mandates. We know that proper staff training is a critical component of this system¹. A number of studies have documented the critical connections between training, competency, and quality services.

The connection of workforce quality to family outcomes was further documented in a March 2003 report, one of the earliest ones of its type, which states, "A stable and highly skilled child welfare workforce is necessary to effectively provide child welfare services that meet federal goals. [However,] large caseloads and worker turnover delay the timeliness of investigation and limit the frequency of worker visits with children, hampering agencies' attainment of some key federal safety and permanency outcomes".² The issue of high caseloads will be addressed later in this document.

A later study also found a link between agency performance and workforce capacity³. The average annual staff turnover rate of 12 California county child welfare agencies was used to rank them into low (8%), moderate (13%), and high (23%) turnover groups. Families served by counties with low turnover had significantly lower maltreatment recurrence rates and were more likely to have approved current case plans and up to-date child medical exams. In addition, a study of private foster care agencies in Milwaukee found that high case manager turnover for a family (e.g., multiple workers serving the family's case within the last two years) increased the time required to achieve permanency for children⁴.

It has been shown that a well prepared staff is more likely to remain in the field of child welfare, thus reducing worker turnover and increasing continuity of services with the family.⁵ Some social workers are able to take advantage of federal assistance through the Title IV-E and Title IV-B programs of the Social Security Act. These funds are used to upgrade the skills and qualifications of child welfare workers through their participation in training programs specifically focused on child welfare practice. While these programs serve a useful purpose and must be preserved, we know that these two programs alone cannot support the entire field of child welfare workers.

A national study entitled "Assuring the Sufficiency of a Frontline Workforce: A National Study of Licensed Social Workers,"⁶ shines a bright light on issues related to workforce retention. The study warns of an impending shortage of social workers that threatens future services for all Americans, especially the most vulnerable among us, children and older adults. Key findings include:

- The supply of licensed social workers is insufficient to meet the needs of organizations serving children and families;
- Workload expansion plus fewer resources impedes social worker retention; and
- Agencies struggle to fill social work vacancies.

Recommendation: Congress should provide the 3.3% in discretionary funds to allow for research, training, and evaluation of services in the child welfare system. Also, greater investments are needed to provide child welfare workers with professional development preparation and ongoing training opportunities, particularly in the area of cultural competence. We believe that valuable employment incentives, including pay increases, benefits, student loan forgiveness, and promotional opportunities are essential for the development of a highly skilled human services workforce.

Establish a National Caseload Size

Child and family service administrators constantly strive to attain an optimal mix of financial and human resources and appropriate case load sizes for their workers. This process is complicated by a constrained economy in which many human service agencies are facing state and federal budget cuts, prompting agencies to make difficult choices that may result in increased caseloads and workloads for front-line and supervisory staff⁷.

The Child Welfare League of America recommends a caseload ratio of 12 to 15 children per caseworker, and the Council on Accreditation recommends that caseloads not exceed 18 children per caseworker. However, a national survey found that caseloads for individual child welfare social workers range from 10 to 110, with workers handling on average 24 to 31 children, each double the recommended number⁸. As was noted, high caseloads lead to increased worker turnover and reduced service capacity.

Recommendation: We ask Congress to consider ways to establish a national caseload size. Federal policy incentives that encourage states and counties to improve their human services workforce by building a comprehensive and integrated continuum of services, fostering innovation in program design, and developing consistent leadership, are desperately needed. Federal statutes, policies, and funding streams can help make important and lasting improvements in the ability of social workers to meet the needs of the consumer.

Conclusion

Social workers are an integral part of the child welfare system as is the Promoting Safe and Stable Families Program and the Stephanie Tubbs Jones Child Welfare Services Program. For the system to be improved, adequate funding and supports for the program need to be made, and the program must be fully funded to its authorized level of \$505 million. Also, social workers who care for children and families must receive adequate salaries, appropriate training, and manageable caseloads if the system is to be truly reformed. We look forward to partnering with you on this important legislative initiative.

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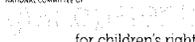
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National Committee of Grandparents for Children's Rights


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NATIONAL COMMITTEE OF

 for children's rights
 ATTENDANCE, EDUCATION & THOUGHT LEADERSHIP
 FOR CHILDREN AND KINSHIP FAMILIES

SUBMISSION OF THE NATIONAL COMMITTEE OF GRANDPARENTS FOR CHILDREN'S RIGHTS AND THE EMPIRE JUSTICE CENTER FOR THE JUNE 16, 2011 WAYS AND MEANS HEARING RECORD ON IMPROVING PROGRAMS DESIGNED TO PROTECT AT RISK YOUTH

PRIVATE KINSHIP CARE: AN UNDERUTILIZED CHILD WELFARE RESOURCE

The reauthorization of the Promoting Safe and Stable Families Act ("PSSFA") presents an opportunity to provide critical support to a vulnerable population of children and caregivers in private kinship care (grandparents and relatives caring for children, *i.e.*, extended families). Children live with grandparents and other relatives for the same reasons that children enter foster care: parental abuse, neglect, substance abuse, mental illness, abandonment, as well as for other reasons such as military deployment, incarceration illness, and temporary relocations.¹ These circumstances cause many kinship children to face special challenges, including higher rates of developmental disabilities,² emotional problems,³ physical and learning disabilities,⁴ bereavement issues, attachment disorders and parental alienation.⁵

Kinship care is not only this nation's most valuable resource for children whose parents cannot successfully parent; it is also a less expensive and more effective resource for children than traditional foster care. Kinship care falls into the statutorily required categories of family support services and family preservation services, and thus should be eligible for PSSFA funds. In recognition of the important role of kinship care in preserving families, we make the following recommendations: (1) a portion of PSSFA funds should be set aside for research on temporary and voluntary placements with kin; (2) a cost benefit analysis of kinship programs; (3) kinship program evaluations; and (4) supportive services to kinship families. These actions would ensure greater utilization of our kinship resources and provide more effective care of children that is significantly less costly than foster care.

This discussion reviews the importance of private ("informal") kinship care, notes its benefits for children at risk, and concludes that dedicated federal funding for research, evaluation, and support services is critical to the survival of this cost effective resource.

DEFINITION AND SCOPE OF KINSHIP CARE

Kinship care refers to full-time, non-parental care of children by grandparents, relatives, and sometimes family friends, without the assistance of parents. While the phrase kinship care is occasionally used as shorthand for kinship foster care, it applies both to public and private care. In an attempt to identify the distinction, the 2000 report to Congress on kinship care used the term "public kinship care" to refer to kinship foster (formal) care and "private kinship care" to refer to non-foster (informal) care.⁶

STATISTICS ON KINSHIP

- Total Number of Kinship Caregivers is estimated to exceed 2.6 million
 - 61% of Kinship Caregivers are Grandparents
 - 29% of Kinship Caregivers are Other Relatives
 - 10% of Caregivers are Non-Relatives
- 4.6 million Children Live with Grandparents
- 1.9 million Children Live with Other Relatives

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FACTS ABOUT KINSHIP

- The United States has two child welfare systems: foster care and private kinship care. The number of children in private kinship care is at least ten times larger than those in all foster care placements (combined kinship and non-relative foster care).⁸
- Children who live with grandparents and other relatives achieve more permanency, better well-being, and better outcomes than children in foster care.⁹
- Children who live with grandparents and other relatives have significant special challenges, including psychological and emotional trauma, similar to children in foster care.¹⁰
- Private kinship support services provide case management, respite, assistance in accessing public benefits, legal information, advocacy, and other supports, that enable children to stay out of foster care.
- In 2010, New York State spent 1.37 billion dollars on foster care. Until the FY2011-12 budget, New York State spent approximately \$3 million on private kinship care for the Office of Children and Family Services Kinship Program (statewide Kinship Navigator and 21 regional programs). The FY2011-12 budget cuts Kinship program funding to under \$1 million. Most states spend less on private kinship services.¹¹
- In New York State, at an average cost of \$54,060 per child for all foster care placements, or using the more conservative estimate of \$21,535 per child for regular non-specialized foster care, if only 55 children enter all foster placements (at a rate of \$54,060), or if 140 children enter regular foster care (at a rate of \$21,535), the cost equals the funding of \$3 million for the entire NYS OCFS Kinship Program. See Appendix I.¹²

CHILDREN BENEFIT - BETTER OUTCOMES

Private kinship care is the natural ally of foster care. Both are family focused and both are dedicated to the well-being of children. Yet, most importantly, children do better with kin and private kinship care is less expensive than foster care.

There are numerous studies showing children raised by family members live in safer and more stable homes than children in the care of non-relatives. An article in *Families in Society: the Journal of Contemporary Social Services* emphasizes this fact:

After controlling for demographic and placement characteristics, children in kinship care had significantly fewer placements than did children in foster care, and they were less likely to still be in care, have a new allegation of institutional abuse or neglect, be involved with the juvenile justice system, and achieve reunification. These findings call for a greater commitment by child welfare professionals, policy makers, and researchers to make kinship care a viable out-of-home placement option for children and families.¹³

A June 2008 study, published in the "Archives of Pediatric and Adolescence Medicine," conclusively shows that children have better outcomes with relatives than in stranger foster homes.¹⁴ This study has bolstered policy arguments supportive of private and public kinship care and contributed significantly to the passage of the federal "Fostering Connections Act."¹⁵

SPECIAL CHALLENGES

Kinship caregivers confront special challenges. The average age of a kinship caregiver is 56, with a significant number in their sixties or older. They are disproportionately poor, with 20% at or near the poverty level. Many caregivers are on fixed retirement incomes. Caregivers experience enormous stresses, related to caring for the very young or for teenagers, their relations with parents, custodial issues, and problems accessing services, and navigating various systems. They may be suddenly confronted with the need to leave the workforce in order to care for children. The children's parents frequently remain involved either directly or peripherally with the children, although not in the role of daily provider. Elderly caregivers may be dealing with their own health issues.

Grandparents and other relative caregivers face barriers related to benefits, services, and custodial rights. Private kinship caregivers face challenges enrolling children in school, getting medical care for children, obtaining standing in custodial procedures, accessing legal services, obtaining necessary documents and benefits. Kinship families have very few specialized services, and can face barriers when seeking general services that are readily available to parental families.

FEDERAL AND STATE LAWS REMAIN FOCUSED ON KINSHIP FOSTER CARE

Over the last fifteen years, beginning with the Adoption and Safe Families Act,¹⁶ child welfare policies have increasingly recognized that kin are the one large scale resource for children at risk. Yet, like other federal child welfare enactments, the recent "Fostering Connections to Success and Increasing Adoptions Act"¹⁷ is almost entirely on the importance of kinship foster care placements.¹⁸

CHILD WELFARE AGENCIES "DIVERT" CHILDREN IN PRIVATE KINSHIP FAMILIES

Many children who are living with kin in private kinship care were "diverted" from foster care, by placing them with relatives via "temporary" or "voluntary" placements.

I. VOLUNTARY PLACEMENTS

Voluntary placements occur when kin step up to care for children and they do not become foster parents. According to the Adoption Foster Care and Reporting System (“AFCARS”) for fiscal year 2008, “more than 125,000 U.S. children live in out-of-home kinship care.” These placements are referred to as “voluntary placements.” A recent survey profiled a sampling of 8,961 children in voluntary placements or foster care (using the National Survey of Child and Adolescent Well-Being (“NSCAW”)¹⁹ showed that children in voluntary placements received significantly less oversight, services, and financial assistance.

Another study reports on the uneven use of kinship foster care from state to state and the uneven opportunity for kin to become foster parents, and concludes that the lack of supervision may also contribute to recidivism and disruptive intrusions by parents, as well as to unjustified financial hardships.²⁰ Its author Rob Geen states:

. . . [C]hildren [in] voluntary kinship care placements . . . may effectively be excluded from public agency supervision, from the specialized health and mental health and school-related services that might be available through foster care, and their parents are denied the services they may need in order to effectively reunify with their children. At the same time, voluntary kinship care placements may benefit children and caregivers by preventing the stigma and intrusion of child welfare system and juvenile court involvement. Not a single study to date has examined voluntary kinship care placements in depth.²¹

In New York State, diversion tactics are common practice in some upstate counties. While there are no absolute clear statistics for the number of children involved, the Office of Children and Family Services (“OCFS”) estimates that over 2,400 children were placed using voluntary “direct” custody pursuant to Article Ten neglect proceedings.²² Diversion refers to New York State’s Family Court Act (“FCA”) §1017 where courts can order a child to be placed in foster care or in the “direct custody” of a relative pursuant to a neglect proceeding.²³

II. TEMPORARY PLACEMENTS

In addition to voluntary placements, “temporary” placements typically occur when child protective services (“CPS”) is called upon to investigate and then attempts to find a “temporary” placement in order to avoid an Article Ten proceeding. For example, a worker is concerned that the mother is on drugs and decides to locate a family member and ask them to assume “temporary” care. When these situations occur, parents are asked if there is a relative who can care for the children, a call is then made, often by CPS or some professional familiar with the children’s circumstances, and the relative is asked to take the children into their care. No removal proceeding is initiated.

There is no official statistical data on temporary placements, although anecdotal evidence from a recent national summit on kinship care indicates that the practice is common in most states.²⁴ In a sampling of children drawn from the New York State Kinship Navigator’s Efforts to Outcomes (ETO) database, 3,351 children entered 21 regional kinship programs from Buffalo to Long Island. Of those children, 1,843 had past or current involvement with child protective services; of which 343 were placed in the custody of kin pursuant to neglect proceeding (commonly called voluntary placements) and 76 were placed with kin who were foster parents. The remaining 1,424 (42%) were placed “temporarily.”²⁵

III. PRIVATE CUSTODY & GUARDIANSHIP PROCEEDINGS

Private custody orders are another alternative placement strategy, when initiated pursuant to neglect proceedings. Private custody and guardianship proceedings are often initiated when kin decide not to seek foster care or they might not qualify, or they may never be told that they can become foster parents, or they may not have any contact with child welfare agencies and seek custody independently. They will then seek custody or guardianship in a private "third party" action, where they either have the consent of the parents or must prove unfitness, abandonment, or some other extraordinary circumstance that diminishes the protections afforded parents. For these kin, legal representation is practically non-existent.

NEED FOR RESEARCH AND FEDERAL OVERSIGHT

There is a need for study and research regarding the use of kin in voluntary and temporary placements. Data is needed on the number of these placements, the length of stay with the caretaker relative, barriers faced to stability, and the supports needed to help these families thrive. Importantly, study will most likely confirm that the number of voluntary and temporary placements far exceeds the number of children placed in kinship foster care. If this is proven, then there is a very strong argument for a federal focus on these practices. Moreover, while voluntary placements usually continue reunification efforts, they do not provide supportive services, and the need for supportive services parallels the needs of all private kinship placements, including temporary placements. In sum, examination of these practices should add emphasis to the need for uniform policies and federal supports for the entire private child welfare system (private kinship care).

State by state data on the number of private custody or guardianship proceedings involving non-parents and the actual number of kinship families who have courts orders of placement are critical to serving these families effectively.

FEDERAL AND STATE POLICIES ARE NOT COST EFFECTIVE

The fact that informal kinship care provides children with better outcomes²⁶ than foster care is a compelling justification for targeting resources to support kinship families. With the use of these dollars for kinship services, more caregivers will be able to provide informal kinship care, which will result in substantial savings because fewer children will enter the more expensive foster care system.²⁷

In New York, the average cost for one child in foster care is \$49,570. This is determined by taking all foster care costs, which include the cost for children in institutional foster care, administrative costs and supportive services, divided by the number of children in foster care. A more conservative estimate of \$15,045 per child, is derived by taking the average cost of a basic foster care grant for a child placed with a foster parent plus administrative costs.²⁸ The cost of informal kinship care (including a TANF funded child only grant)²⁹ is only \$6,490 per child, a significant savings.

CRITICAL SUPPORTS FOR PRIVATE KINSHIP FAMILIES

While there are many benefits for children who live with kin, these children and their families have a greater likelihood of "socioeconomic risks" such as living in a household that is below the federal poverty level; with a caregiver without a high school degree; living with a caregiver without a spouse; or living in a house with four or more children.

In New York State, nearly all children in informal kinship arrangements are eligible to receive a child-only payment through Temporary Assistance for Needy Families (TANF). However, children in formal kinship care were roughly three times as likely to receive financial support as children in informal kinship care in 1999 (70% vs. 25%) and in 2002 (69% vs. 22%). An important priority for organizations providing kinship services is to assist private kinship caregivers in obtaining child-only assistance.

Lack of access to financial support for private kinship care continues to be a major obstacle to care, despite the fact that modest increases in financial support benefit children and caregivers. One study has shown that an increase in the amount of monthly income equivalent to the average TANF child-only grant is associated with a 7% greater likelihood that kinship youth will graduate from high school.³⁰ High school graduation is associated with greater likelihood of future employment and higher lifetime earnings.³¹ In addition, adequate levels of financial and material resources are associated with lower levels of caregiver stress, which is associated with healthier family and child functioning.³²

PROGRAM SUPPORTS

Many of New York's Kinship Programs are national models. For instance, Presbyterian Senior Services in the Bronx operates a grandparent apartment building that is a nationally known model for such projects; Cornell Cooperative Extension publishes the award winning series, "Parenting a Second Time Around;" and Catholic Family Center's Kinship Care Resource Network ("KCRN") won the 2008 Catholic Charities USA National Family Strengthening Award. Such programs are representative of programs across the nation that provides effective supports. Yet, there is no federal funding for these programs. Despite their successes, New York's budget crisis is resulting in the elimination of those programs, and federal funds are critical for this work to continue.

RECOMMENDATIONS ACYF SHOULD:

1. **Evaluate the effectiveness of supportive services for private kinship families.** Across the country hundreds of programs support kinship families. Many of these programs are administered via state child welfare agencies, using state or federal dollars. Yet there is no model of best practices nor of cost effectiveness. ACYF should specifically have targeted funds to research outcomes for kinship families and the cost benefits of supportive services.
2. **Research the use of voluntary and temporary placements.** These placements may significantly exceed the number of kinship foster care placements. ACYS should specifically have targeted funds to identify the scope of these practices, examine their effectiveness, and establish uniform policies regarding assessment and placements.
3. **Set aside a percentage of the family preservation and supportive services funding for services to private kinship families.** Dependent upon results of research on supportive services outcomes and cost benefits, services to private kinship families, including voluntary, temporary, and private placements, should be funded pursuant to PSSFA's supportive and preservation funding.

Appendix I. Summary of Cost Benefit Calculations- New York State Kinship Programs

Fiscal Year 2011-12 Savings

If the New York State Office of Children and Family Services (OCFS) Kinship Programs are not funded:

- If **60** children enter all foster placements, the cost will equal the entire \$3 million for full funding of the OCFS Kinship Program.
- If **200** children entering regular foster care, the cost will equal the entire \$3 million for full funding of the OCFS Kinship Program;
- Without these programs, an estimated 475 children will leave informal kinship care and enter foster care during FY2011-12. At an increased cost between \$23,545,750 (foster care placements minus informal cost) or \$7,146,375 (regular foster parent care minus informal cost).
- **Average Cost of (Formal) Kinship Foster Care** Annual overall costs of foster care = **\$1,376,000,000** (OCFS foster care budget). Number of children in all foster care placements = 24,541).
- Average cost of all foster care placements (institutional, special and exception needs foster parents, etc, plus administrative costs); = **\$56,060** per year
- Average cost of one child placed in regular foster care (basic foster parent payment plus administrative cost) = **\$21,535 per year.**

Average Cost of Informal Kinship Care

Annual cost of one child in a OCFS kinship program (\$140,000 per program, over 300 children served per year per program) = **\$466**. Annual average cost of public assistance per child (OTDA payment plus administrative costs) = **\$6,024**.

- Total cost per child of informal kinship care = **\$6,490**.¹

Average Difference in Cost

- Difference between average cost of children in all formal foster care placements (\$54,060) and the cost for children in informal kinship care (\$6,490 – including a public assistance grant) = **\$49,570**.
- Difference for a child placed in regular foster care with a foster parent = **\$14,595**.

¹ Not all informal kinship families receive these grants. However, for simplicity the calculation assumes that they do.

NOTES

¹ Cheryl Smithgall, et al., *Caring for their Children's Children: Assessing the Mental Health Needs and Service Experiences of Grandparent Caregiver Families*, CHAPLIN HALL SUMMARY SHEET 103 (May 2006).

² Jennifer M. Kinney, et al., *Grandparent Caregivers to Children with Developmental Disabilities* in WORKING WITH CUSTODIAL GRANDPARENTS (Bert Hayslip Jr. & Julie Hicks Patrick, eds. 2002).

³ Smithgall, *supra* note 1.

⁴ A study conducted in 1994 found that 70 percent of grandparents reported caring for a child with one or more medical, psychological or behavioral problems. See D. Lai & S. Yuan, *Grandparenting in Cuyahoga County: A Report of Survey Findings*, CUYAHOGA COUNTY COMMUNITY OFFICE OF AGING (2004).

⁵ "Over a quarter of the caregivers (27.5%) indicated that the child had a disability." James P. Gleeson et al., *Individual and Social Protective Factors for Children in Informal Kinship Care*, JANE ADDAMS COLLEGE OF SOCIAL WORK, UNIVERSITY OF ILLINOIS AT CHICAGO (Feb. 26, 2008).

⁶ U.S. Dep't Health & Hum. Services et al., *Report to the Congress on Kinship Foster Care* (June 2000), available at <http://aspe.hhs.gov/hsp/kinr/2e00/full.pdf>.

⁷ See American Community Survey, *Grandparents*, (2005-09), available at http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2009_5YR_G00_S1002&-ds_name=ACS_2009_5YR_G00_ (asserting that close to 4.6 million children live with grandparents (6.3% of all children in the United States)); See also Pew Research Center, *6% More Children Raised by Grandparent During Recession*, <http://pewresearch.org/databank/dailynumber/?NumberID=1093> (last updated June 27, 2011) (indicating that an estimated 1 in 10 children in the U.S. live with a grandparent); See also Mark F. Testa et al., *Pursuing Permanence for Children in Foster Care: Issues and Options for Establishing a Federal Guardianship Assistance Program in New York State* (June 2010), available at <http://ocfs.ny.gov/main/reports/Pursuing%20Permanence%20for%20Children%20in%20Foster%20Care%20June%202010.pdf> (In New York, approximately 6,400 foster children are residing in the homes of grandparents, aunts, uncles, and other relatives on any given day).

⁸ AFCARS, 2010; U.S. Census Bureau 2006-2008

⁹ See Justine G. Nelson et al., *Kinship Care and "Child-Only" Welfare Grants: Low Participation Despite Potential Benefits*, 13 J. FAM. SOC. WORK 3 (2010).

¹⁰ Smithgall, *supra* note 1.

¹¹ New York State Kinship Coalition, *Kinship Care in New York: Keeping Families Together* (March 2011), app. J available at http://www.nysnavigator.org/documents/AARP_KincareKeepingFamilies10.pdf.

¹² See attached Appendix I.

¹³ Marc A. Winokur et al., *Matched Comparison of Children in Kinship Care and Foster Care on Child Welfare Outcomes*, 89 J. OF CONTEMP. SOCIAL SERV. 3 (2008).

¹⁴ David M. Rubin et al., *Impact of Kinship Care on Behavioral Well-being for Children in Out-of-Home Care*, 162 ARCHIVES FOR PEDIATRIC & ADOLESCENT MED. 6 (June 2, 2008) available at <http://archpedi.ama-assn.org/cgi/content/full/162/6/550> (The NSCAW survey from October 1999 to March 2004 of children entering out-of-home care after a maltreatment report concluded that children placed into kinship care had fewer behavioral problems 3 years after placement than those placed into foster care).

¹⁵ *Id.*

¹⁶ Adoption and Safe Families Act of 1997, 42 U.S.C. §1305 (2010).

¹⁷ Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. 110-351, 122 Stat. 3949 (2008).

¹⁸ *Id.*

¹⁹ Christina Sakai, et al. *Health Outcomes and Family Services in Kinship Care: Analysis of a National Sample of Children in the Child Welfare System*, 165 ARCHIVES OF PEDIATRICS & ADOLESCENT MED. 2 (2011).

²⁰ *Id.*

²¹ Robert Geen, *Kinship Foster Care: An Ongoing, Yet Largely Uniform Debate in KINSHIP CARE: MAKING THE MOST OF A VALUABLE RESOURCE*, (Robert Geen ed., Uniform Institute 2003).

²² New York State Office of Children and Family Services Connections database, April 2009.

²³ See Sobie, McKinney Practice Commentary, Family Court Act §1028-a (2009) (discussing local district tactics to avert foster care placements).

²⁴ In March 2011, the Child Welfare League of America and the National Committee of Grandparents for Children's Rights sponsored a national summit on private kinship care. The Summit's findings closely parallel the recommendations herein.

²⁵ New York State Kinship Coalition, *Kinship Care in New York: Keeping Families Together* (March 2011), available at http://www.nysnavigator.org/documents/AARP_KincareKeepingFamilies10.pdf.

²⁶ Rubin, *supra* note 17. Demonstrating for the first time on a nationally representative sample of children from the NSCAW that children in kinship care are not only more likely to attain early stability in out-of-home care than children in general foster care, but are also less likely to have behavioral problems than children in foster care three years later. See New York State Kinship Coalition, *Kinship Care in New York Report*, at app. B (2008). All three NYS kinship summit reports provide examples of program supports that increase the well-being and stability of kinship families. See *AARP New York State Kinship Summit Reports*, CATHOLIC FAMILY CENTER, (2005, 2008, 2011), available at <http://www.nysnavigator.org/pubsforpros/aarpsummit.php>.

²⁷ The cost savings include administrative costs. However, actual administrative costs will depend upon staff case loads, re-assignment, and other administrative factors or the use of a contracting agency. While it is fair to say that the total direct and indirect costs for one child average over \$50,000 - for a child who leaves informal kinship care and is placed in foster care, the real cost savings are the amount that transfers to foster parents plus whatever real administrative savings would actually be incurred. Real administrative costs may only occur when a sizable increase in cases results in a case worker being hired or when payments to an outside contracting agency are made.

²⁸ New York's 2011 Kincare Summit report provides that the average cost of all foster care placements in one year is equivalent to \$56,060, whereas the total cost per child of informal kinship care is \$6,490, including a public assistance grant which not all informal kinship families receive. Thus the difference between the average cost of children in all formal foster care placements and the cost for children in informal kinship care is a savings of \$49,570. NYS Kincare Coalition, *Kinship Care in New York: Keeping Families Together*, at apps. H & I (2011), available at www.nysnavigator.org.

²⁹ Not all informal kinship families receive grants. However, for simplicity the calculation assumes that they do.

³⁰ See Nelson *supra* note 9; See also Hwa-Ok Park, *Grandmothers Raising Grandchildren: Family Well-Being and Economic Assistance* 24 FOCUS 19, 19-27 (2005).

³¹ See Nelson *supra* note 9.

³² James P. Gleeson et al., *Individual and Social Protective Factors for Children in Informal Kinship Care*, JANE ADDAMS COLLEGE OF SOCIAL WORK, UNIVERSITY OF ILLINOIS AT CHICAGO (Feb. 26, 2008).

³³ In March 2011, the Child Welfare League of America and the National Committee of Grandparents for Children's Rights sponsored a national summit on private kinship care. The Summit's findings closely parallel the recommendations herein.

Hearing on Improving Programs Designed to Protect At-Risk Youth

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National Family Preservation Network



NATIONAL FAMILY PRESERVATION NETWORK

Developing Strong Families by Supporting Preservation, Reunification, and Fatherhood Initiatives

June 23, 2011

The following is a statement in support of PSSF reauthorization, specifically with regard to the allocation for family preservation funding which includes Intensive Family Preservation Services (IFPS).

What are the Benefits of IFPS?

Better Outcomes for Children

Because IFPS prevents unnecessary out-of-home placement, it's important to first look at what happens when children are removed from their family:

- Children in foster care spend an average of more than two years away from their homes.
- A child is twice as likely to die from abuse in foster care than in his own home.
- Maltreated children placed out-of-home exhibit significant behavior problems in comparison to maltreated children who remain in their homes.
- Maltreated children removed from their homes later experience higher delinquency rates, teen birth rates, and lower earnings than children who remain in their homes.
- Children placed in foster care have 2–3 times higher arrest, conviction, and imprisonment rates as adults than maltreated children who remain in their own homes.
- Post-Traumatic Stress Disorder strikes one in four foster youth after leaving foster care. That is double the PTSD rates of veterans returning from Iraq and over 6 times the rate among the general U.S. population.
- In studies that spanned four states, one out of every three youth who aged out of foster care struggled with mental health problems such as major depression, substance abuse, social phobia and anxiety. Almost one quarter of such youth in Texas had a history of suicide attempts.
- Former foster youth are at high risk for a range of other health problems including generally compromised health, substance abuse, sexual risk-taking behaviors, physical and sexual abuse and malnourishment.

With appropriate targeting, IFPS diverts 80–90+ percent of children from out-of-home placement, but it is estimated that states provide IFPS to fewer than 1 in 10 children placed in foster care. Extensive media coverage of deaths of abused and neglected children may result in child welfare caseworkers removing more children from their homes. In turn, caseloads increase, workers are overloaded, and the tragic consequence is more child deaths. Only about half of the children in foster care return home each year. Approximately 50,000 children are adopted each year but at least twice that many are waiting for adoptive homes. Some of these children will grow up in foster care. No state has been able to effectively address child abuse and neglect by focusing primarily on out-of-home placement and adoption. States with effective child welfare systems focus on reducing the number of children entering out-of-home care. IFPS is strategically positioned to assist in this effort and would have far greater impact if every state were to establish or strengthen and expand these services.

Safety

In over three decades of IFPS nationwide with thousands of families served, there has been less than a handful of child deaths that can be directly linked to IFPS, either during or after the intervention. Recent research indicates that safety is the strongest area when families are assessed following an IFPS intervention.

To what can this strong safety record of IFPS be attributed?

- The safety of the child is the highest priority.
- IFPS therapists respond immediately to family crises. Workers generally see families within 24 hours of referral.
- IFPS therapists meet with families in the home which allows for a more thorough assessment and opportunities for effective intervention.
- IFPS therapists see families frequently, sometimes for hours at a time in order to provide a quick response to emergencies and to teach skills during a crisis when families are most willing to learn new behaviors. Workers are available 24/7 and carry only a few cases at a time in order to be readily available.
- Prior to terminating the intervention, IFPS therapists connect families with other community services to reinforce gains. Families are not abandoned at the end of the IFPS intervention.
- Therapist training, supervision, and ongoing monitoring and quality assurance provide additional measures to ensure the safety of families.

Improvement in Family Functioning

The North Carolina Family Assessment Scale is an assessment tool used in conjunction with IFPS services. The tool measures family functioning at intake and at case closure. Research indicates that most families show improved functioning in all areas that the tool measures: environment, parental capabilities, family interactions, safety, and child well-being. Only 6–9% of families deteriorate in functioning following an IFPS intervention. With those families, the assessment at case closure may result in out-of-home placement for the child. Although placement is not prevented, the safety of the child is ensured, and that is the top priority.

Cost Savings

Far more federal, state, and local funds are spent on out-of-home care and services than are spent on in-home services. For example, Child Trends reports that states spent at least \$4 billion in federal Title IV-E funds on foster care in FY 2006. In contrast, states spent \$363 million in Title IV-B funds (Subpart 2—Promoting Safe and Stable Families) on family preservation and support

as well as time limited reunification and adoption promotion. While there are other sources of funding for both foster care and in-home services, the overall ratio is about ten dollars of out-of-home care funding (entitlement) for each dollar of in-home funding (capped).

The financial incentive to increase funding for IFPS is that for each child who receives in-home services and safely remains at home rather than entering out-of-home placement, there can be substantial savings. The Washington State Institute for Public Policy (WSIPP) found that Intensive Family Preservation Services programs adhering to the HOMEBUILDERS® model are very cost-effective. WSIPP calculated \$2.54 of benefits for each dollar of cost due to reduced out-of-home placements and lowered incidence of abuse and neglect.



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North American Council on Adoptable Children

Testimony of:

Joe Kroll
Executive Director
North American Council on Adoptable Children

Submitted to the
U.S. House of Representatives Committee on Ways and Means
Subcommittee on Human Resources

For the hearing on:
Improving Programs Designed to Protect At-Risk Youth
June 16, 2011

North American Council on Adoptable Children
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For 37 years, the North American Council on Adoptable Children (NACAC) has supported adoptive families and advocated for permanent families for foster children. States have made dramatic progress in increasing adoptions from foster care in the last decade (to 57,000 in FY 2009). Since 2000 more than 500,000 children have been adopted from foster care. Support for these children and the families who adopt them is one of NACAC's primary concerns.

Efforts to achieve permanence for a child should not stop when an adoption finalizes. Families very often need support to ensure their adoptions are safe, stable, and lifelong.

The Need for Post-Adoption Services

Children adopted from foster care bring with them their histories and their experiences of loss, trauma, abuse and neglect. In too many cases, they bring brain damage from prenatal alcohol or drug exposure and a family history of mental illness. Many foster children waiting for adoption—and children already adopted from foster care—have special physical, mental health, and developmental needs. Studies show that these children are at heightened risk of moderate to severe health problems, learning disabilities, developmental delays, physical impairments, and mental health difficulties.

These issues always have an impact on the family—along a continuum that can run from challenging to disabling. Each child and her family must have access to adoption-competent resources and support services that can serve to keep the child safe and stable in her home. In fact, many families report that inappropriate or untrained providers can cause more harm than good to their children and families.

NACAC recently conducted a nationwide survey to assess what support services are most effective, what is available, and where the gaps are. The results of the survey show that:

- Many children had significant difficulties in school (89.6 percent) or the community (53.5 percent).
- When asked what would help, 73 percent of parents indicated that a greater understanding of adoption issues—by school personnel and community members—would reduce the challenges their children face.
- Overwhelmingly, parents and providers agree that raising children adopted from foster care requires supports and resources that are specifically designed to address the experiences the children bring to the adoptive family.
- Appropriate services are often beyond the reach of the average adoptive family, and parents identified the following barriers to receiving needed support:
 - Inability to find needed services (43%)
 - Providers who don't understand adoption issues (39%)
 - Services that cost too much (33%)

- Providers who don't accept Medicaid (30%)¹

Unfortunately, in extreme cases, when the needs of a child adopted from foster care cannot be met at home, he is at risk of reentering foster care and/or entering a residential or psychiatric program where the costs can run as high as \$100,000 per year.

What is the role of government in adoptive families' lives? According to the Adoption and Safe Families Act, the government's mandate is to ensure the safety, well-being, and permanence of each child entering foster care. Placing children into adoptive families who do not have the ability to access appropriate services for those children flies in the face of this mandate and its implications. It is not the intent or the spirit of the law, and often leaves children without safety, well-being, or permanence.

Funding Recommendations Related to Post-Adoption Support

It is time for the federal government to ensure a steady, substantial funding stream directed at post-adoption services. By targeting existing child welfare funding streams—Title IV-B2, Adoption Incentives, and the Fostering Connections Act's maintenance of effort funds—to post-adoption services, the government can ensure its promise to foster children is kept without spending any additional resources.

Currently, states can apply these funds with great discretion to a variety of health and human service efforts. Even those jurisdictions that use these monies for adoption often pour the largest percentage into recruiting new adoptive families, while ignoring the needs of the families they have already created.

We are not seeking new government funds, but rather a designation that a significant portion of funds already being drawn down be applied to support the families that step forward to love, protect, and parent children who have been in foster care.

NACAC's specific recommendations are:

- Title IV-B Subpart 2 of the Social Security Act, The Promoting Safe and Stable Families (PSSF) Act provides state welfare agencies with funding for four categories of services: family preservation, family support, time-limited reunification, and adoption promotion and support. HHS regulations require states to spend at least 20 percent in each of the categories. Emilie Stoltzfus's report *Child Welfare: Funding for Child and Family Services Authorized Under Title IV-B of the Social Security Act* (June 2011) reports that 10 states budgeted or spent less than 20 percent in adoption promotion and support in 2007 or 2010. There is no suggestion in this report that HHS is monitoring state implementation or requiring states to follow HHS policy.

¹ North American Council on Adoptable Children Survey of Post-Adoption Needs, 2010-2011

We ask Congress to require HHS to enforce its regulation that states spend 20 percent on adoption promotion and support. We also request that as you reauthorize PSSF that you clarify the post-adoption services that can be covered including support groups, training for parents and children, parent-to-parent peer support, warm lines, case management, educational advocacy and support, respite care, crisis intervention, and mental health and other therapeutic services.

- Another funding stream that should be utilized to support the 500,000 former foster children who have been adopted in the past 10 years is the maintenance of effort (MoE) provision of the Fostering Connections to Success and Increasing Adoptions Act (Public Law 110-351). As more adopted children become eligible for Title IV-E adoption assistance, states are required to reinvest the resulting savings in child welfare services. Unfortunately Program Instruction ACYF-CB-PI-10-11 issued July 9, 2010 gave state agencies the flexibility to calculate the savings, provided no guidance on the use of the MoE funds, and failed to require an accounting of these funds.

NACAC asks Congress to mandate that states reinvest 20 percent of these MoE funds in post-adoption services. While states value flexibility in the use of federal funds, a case can be made to commit a small percentage to the very children whose adoption created these savings in the first place.

- The Adoption Incentives program can also be used to supplement post-adoption services. Congress should fully fund the program and require states to spend the funds on post-adoption support. For adoptions finalized in 2009, states received just 87 percent of what they should have been awarded for increasing the adoptions for children from foster care, particularly those with special need and older youth. Adoption incentive should also be spent to support the newly created families. Because these funds vary year to year, however, states should not be expected to rely solely on adoption incentives for critical, ongoing post-adoption services.

The benefits of adoption for children in foster care have been well documented. Post-adoption supports clearly play a critical role in the adoption of children with special needs—making it possible for them to be adopted by loving families who have the resources necessary to support them. These services are a vital support to families raising children with often serious behavioral, emotional, or physical disabilities. With support programs, families are able to remain committed and effective parents as they raise their children who have special needs. As a result, these children achieve the safety, well-being, and permanency that the government has sought for them.



**Northwest Adoption Exchange and Oregon
Post Adoption Resources Center**

Attached please find Testimony for:

Kelly DeLany,
Director of the Northwest Adoption Exchange and
Kendra Morris-Jacobson,
Director of Oregon Programs - Oregon Post Adoption Resource Center

Both programs of:
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Submitted to:
The U.S. House of Representatives Committee on Ways and Means,
Subcommittee on Human Resources

Regarding the Hearing:
Improving Programs Designed to Protect At-Risk Youth
June 16, 2011

*"Life day to day has become tougher. We have had a little respite
this past year thanks to your support...today, I feel more ready
to live with him tomorrow."*

~The Caldwell-Krabe Family, regarding help for their adoptive son from the
Oregon Post Adoption Resource Center,
La Pine, Oregon – December, 2010

Dear Honorable members of the Subcommittee, we thank you for your time and interest in the topic of post adoption services for families adopting from foster care.

We, Kelly DeLany, Director of the Northwest Adoption Exchange and Kendra Morris-Jacobson, Director of Oregon Programs – Oregon Post Adoption Resource Center, both programs of Northwest Resource Associates, would like to present the following testimony regarding the importance of the continued availability of federal funding for the Promoting Safe and Stable Families (PSSF) and the Stephanie Tubbs Jones Child Welfare programs.

Supporting families who step forward to adopt our nation's most vulnerable children – foster children who cannot live with birth parents due to neglect, abuse or parental substance use – is a pressing social and fiscal necessity. Finalizing the placements of foster children into loving adoptive homes with families or relatives who can care for them safely is not only critical for children, but saves each State hundreds of thousands of dollars each year.

We offer this testimony based on the perspective and experience of our State's post adoption services program, the Oregon Post Adoption Resource Center (ORPARC). ORPARC's ability to serve children and families is made possible by federal funding through PSSF, Title IV-B Subpart 2 of the Social Security Act.

The story of ORPARC, described below, demonstrates how even a small amount of federal funding at the State level can create a successful and far-reaching impact.

A national award-winning program, ORPARC is one of the best, proactive investments that Oregon makes in children and families. As Oregon adoption worker Cathy Tuma states, *"What is the cost of a disrupted adoption?... I can't think of any resource as valuable or cost-effective as ORPARC."*

ORPARC's 12-year-old program helps families to maintain adoptions of special needs foster children through free, culturally competent and evidenced-based post adoption services. The clients that ORPARC serves include the growing population of grandparents and kinship or guardianship families raising adoptive grandchildren and/or other adoptive relatives.

One of the first of its kind in the United States, ORPARC was created in response to the increasing number of adoptions stimulated by the Adoption and Safe Families Act. ORPARC has since served as an exemplary program for many other States. ORPARC received the 2006 National Adoption Excellence Award from the Federal Children's Bureau, and is one of only eight organizations nationwide listed by the North American Council of Adoptable Children (NACAC) and the Child Welfare Information Gateway as a model post adoption services program.

Utilizing just five staff, ORPARC presently serves over 9,000 adoptive and assisted guardianship families parenting approximately 11,896 children under the age of 18. Since the State of Oregon finalizes the additional adoptions or guardianships of more than 1,000 state children each year, ORPARC's client base is continually growing.

As an example of how even a small program like this can be effective, on an annual basis, ORPARC delivers 25-35 statewide trainings; fields almost 2,000 calls for parenting consultation, crisis intervention or service referrals; sends out over 1,500 library materials; and assists 55 statewide adoptive family support groups. ORPARC's strategic community connections and support services help families and state workers find, network, and connect with existing resources in their communities.

An impactful and lean program, *ORPARC's preventative services help adopted children to stay adopted*, avoiding costly returns to state care. Each adoption from foster care brings a net savings of \$143,000 to state and federal governments¹. Given that the cost of residential treatment in Oregon can reach \$150,000/year per child², if ORPARC helps just "one child" to stay adopted the savings more than justify an investment in this vital program.

Many of our nation's foster children have complex needs that require extra parenting commitment. Within the last five years alone, ORPARC has helped a minimum of 77 families in crisis to preserve their adoptions of high needs foster children. When families facing an adoption disruption crisis can turn to a program like ORPARC, it relieves the burden on already strained State budgets and workforces. In Oregon, it is estimated to cost \$26,605 per child per year to be raised in *basic* foster care³. If just five children disrupt from adoption and return to care, the cost of their care for one single year nearly surpasses the State's annual funding for ORPARC (\$135,072)!

¹ Barth, R., Lee, C., Wildfire, J., & Guo, S. (2006). *A comparison of the governmental costs of long-term foster care and adoption*. Social service review, 80(1).

² Clackamas Behavioral Health Division. (2011, March 8). [Email communication].

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Numerous States, including Oregon, are facing budget shortfalls. Over the last two biennia, the ORPARC program, itself, has been in jeopardy from State budget cuts. In fact, starting July 1, 2011, ORPARC will receive a reduction in State funding that will impact the scope and breadth of its services.

Many States face similar scenarios to Oregon, making the ORPARC story nationally relevant. We would like to emphasize how crucial it is to ensure that federal support through PSSF remains stable, both so that children can live safely and permanently with families, and so that States can make efficient use of our nation's resources. We not only urge Congress to reauthorize this legislation, but we encourage you to significantly strengthen the language regarding State implementation of post adoption services. *Post adoption services help States to make smart, targeted investments of their limited dollars.*

We thank you for the careful consideration and deliberation that you, as Subcommittee members, are giving these issues. If we can be a resource for the Subcommittee, please don't hesitate to contact us at 503-241-0799.

For the families themselves, a reliable post adoption services program such as ORPARC is a lifeline. In closing, we leave you with these thoughts from an Oregon family:

"From social services I adopted two children with a lot of problems from prenatal drug and alcohol and other early abuse, and ORPARC has been a ray of sunshine in what has, at times, been a very difficult road. When I first contacted ORPARC I cried when they did not ask my income or where or when my kids were adopted....all they asked is what they could do to help. ...it is a huge relief to just have someone want to help... Thanks for your support of this service..."

~The Raven Family, Halfway, Oregon - March, 2011



NYS Citizens' Coalition for Children



NYS Citizens' Coalition for Children

Testimony of:
Sarah Gerstenzang
Executive Director
NYS Citizens' Coalition for Children

Submitted to the:
United States House of Representatives' Committee on Ways and Means
Subcommittee on Human Resources

For the hearing on:
Improving Programs Designed to Protect At-Risk Youth
June 28th, 2011

I would like to thank the Subcommittee for the opportunity to submit testimony in considering improvements in the reauthorization of two federal child welfare programs. I write to you as the Executive Director of the New York State Citizens' Coalition for Children (NYSCCC), a statewide nonprofit that provides information, support and advocacy for foster and adoptive families, and as a foster/adoptive parent. My testimony will focus on the need for federal funding for post adoption services. First, I would like to strongly endorse the testimony of Nicole Dobbins, Executive Director of Voice for Adoption. NYSCCC shares the views expressed in her testimony. Second, I would like to share excerpts from three emails that I have received from families (I have removed identifying information):

1. *I have two granddaughters that were adopted a few years ago and there are some serious family issues occurring. Is there any support in New York State that can assist me in helping them?*
 2. *I have been to many of your May conferences in Albany and have 3 adopted through foster care and live in [country redacted]. My oldest daughter who is 14 is starting to use drugs, alcohol and is very sexually active. It's a long story and the same as many you have heard before. We are considering possibly sending her to a therapeutic boarding school such as [school redacted]. I am wondering if you can steer me in the direction of any financial aid programs for this type of therapy. My husband and I earn over 100,000 annually on paper, but barely make our bills because of expenses.*
 3. *I hope you can help me. My 13 year old daughter just punched me in the chest in the midst of an argument. This brought to a head ongoing problems we have been having. She is adopted and clearly does not wish to continue living with me, her adoptive mother. I am out of work and cannot leave her alone in the apartment. I have taken away her apartment key since finding a 15 year old boy half naked hiding in her closet.*
- I can no longer keep her safe nor make her happy. She is clearly angry and resentful. She longs for her other family that gave her up in [country redacted]. I am unemployed and it is becoming more and*

more difficult to just get through the day. We almost went to the police yesterday. Can you please give me some direction? I've tried social workers, psychiatrists (she was diagnosed with depression and oppositional defiant disorder), pills, etc. and nothing seems to work. Can you please help?

Post adoption services are for families who have a child who was adopted – privately, internationally or from foster care. Most children who are adopted do very well. However, some children have emotional, behavioral, medical and/or educational problems as a result of the prior abuse and/or neglect they suffered. Problems can be short-term or on-going, and parents need help so that their children can live safely at home. Essential services include information and referral, support groups, respite, education and counseling by therapists with specialized training.

NYS has previously funded some post adoption services (13 programs in 20 counties) through TANF. But this funding ended in December 2010. Last year, 451 NYS adoptive parents and professionals responded to a NYSCCC survey assessing the needs of NYS adoptive families. Significant problems were noted by participants in accessing services, especially therapists who were knowledgeable about adoption and the impact of abuse and neglect on development. Many of the parents expressed that they felt abandoned at a time when they were desperate for help. It is a tragedy for the child, family and community when parents can't keep their children safely at home.

Post adoption services would save money **by increasing the numbers of children who are adopted¹, decreasing the numbers of children who enter or re-enter foster care² and decreasing the number of children who enter residential treatment³.** More information is available at nysccc.org/adoption/post-adoption-services/.

¹ The Bridges to Health program (B2H) is a very good example of how when services are provided to children and their families the rate of adoption from foster care to adoption increases. B2H ensures that children with significant medical and psychological needs receive services after an adoption. Data from B2H shows that by providing better supports, the percentage of children with a goal of adoption in NYS increased from 26% to 35.5%. If we provided supports to families adopting children with fewer challenges and assumed the same increase in the percentage of children with a goal of adoption (and the achievement of that goal), \$19,593,930 would be saved each year!

² Children are entering foster care (foster care, international & domestic private adoption) **after** being adopted because they could not be maintained in their families. The federal child welfare reporting system (AFCARS) now requires states to report on whether children in foster care were previously adopted. Although not all NYS counties have complied with this reporting requirement, for the less than one third of cases where the data was entered, 425 children now in foster care were previously adopted (personal communication with the NYS Office of Children and Family Services 4/27/2010).

³ One example is the Post Adoption Resource Center (PARC) at Parsons Child and Family Center in Albany serves six surrounding counties. Based on family reports and conservative estimates, 58 families had a child at risk of placement in 2009. However, only six of the children entered a residential treatment center. Post adoption services kept 52 children out of residential care at an annual savings of more \$4 million dollars for only 6 counties – and at a cost of only \$225,000 to operate PARC.

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Research on Vulnerable Families

**Testimony to the Human Resources Subcommittee of the House Ways and Means
Committee**

**By Marybeth J. Mattingly, Ph.D.
Director, Research on Vulnerable Families
The Carsey Institute**

June 29, 2011

Chairman Davis, Ranking Member Lloyd Doggett, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony on the needs of at-risk youth—in particular those who spend significant time in foster care.

My name is Beth Mattingly, and I am the director of research on vulnerable families at the Carsey Institute at the University of New Hampshire. The Carsey Institute has conducted extensive policy-relevant research on the differences between rural, suburban, and central city families and children in order to better understand trends in child poverty and the implications of different policies and social programs. Carsey recently analyzed data on 727 children in foster care for at least one year. This document summarizes the institute's findings and some of the federal policy recommendations that would affect the lives of children in long-term foster care.

Different Health Needs of Foster Kids

Emotional and Behavioral Problems

The measures taken by the Child and Family Services Improvement Act (CFSIA) of 2006 are critical. These measures reauthorized the Promoting Safe and Stable Families program to ensure that medical providers have regular contact with children in the child welfare system. Research shows that about 30 percent of children in foster care have emotional and behavioral problems, as compared to about 4 percent of children in the general population.¹ Children in foster care are sixteen times more likely to receive psychiatric diagnoses and eight times more likely than their peers to be prescribed psychotropic medications.² Our research shows that the prevalence of these problems increases with age among foster children. More than one in four 11- to 14-year-olds living in out-of-home care arrangements for an extended time experienced emotional problems, as compared to just 10 percent of 3- to 5-year-olds in similar situations.³ These problems may affect the likelihood of permanent placement for children as well; the same study showed that four years after being removed from the home, a higher share of children with emotional problems were living in foster care settings, rather than living with kin or adoptive parents.⁴ That so many children with emotional and behavioral problems remain in foster care highlights the need for comprehensive mental health services over time. In fact, the American Academy of Pediatrics and the Child Welfare League of America (CWLA) recommend that children and teens in foster care be screened early and often to assess for health problems.⁵

Need for Frequent Screenings

Based on recommendations from the American Academy of Pediatrics and the Child Welfare League of America, the funding provided by the CFSIA for monthly caseworker contact with children in out-of-home care is critical to their well-being. The above cited recommendations suggest that children undergo a “health screening visit within 72 hours of placement, a comprehensive health admission visit within 30 days of placement, [and a] follow-up health visit within 60 to 90 days of placement.”⁶ Further, these agencies recommend that newborns up to six months be seen monthly, infants up to 24 months be seen every three months, and children up to age 21 be seen every six months.

Our research indicates very high rates of emotional and behavioral problems among older children remaining in foster care. Legislation like the CFSIA, which frees caseworkers' time for frequent monitoring and provides funds for frequent medical provision, works positively toward the health care goals discussed above and may improve the well-being of those who remain in foster care.

Thank you for taking the time to explore these important issues in detail and for the opportunity to identify some of the implications of federal policy for vulnerable children and families.

¹Children's Bureau, Administration for Children and Families, "The Adoption and Foster Care Analysis and Reporting System (AFCARS) Report" (Washington, DC: U.S. Department of Health and Human Services, 2010).

²See N. J. Hochstadt et al., "The Medical and Psychosocial Needs of Children Entering Foster Care," *Child Abuse & Neglect*, vol. 1, no. 1 (1987): 53-62, and L. Leslie et al., "Addressing the Developmental and Mental Health Needs of Young Children in Foster Care," *Developmental and Behavioral Pediatrics*, vol. 26, no. 2, (2005): 140-151.

³Wendy A. Walsh and Marybeth J. Mattingly, "Long-Term Foster Care—Different Needs, Different Outcomes," *Issue Brief No. 31, Spring* (Durham, NH: Carsey Institute, 2011).

⁴*Ibid.*

⁵Healthy Foster Care America, "Health Care Standards: Fundamental Principles" (Elk Grove Village, IL: American Academy of Pediatrics, 2010).

⁶*Ibid.*



Sacred Authority**STATEMENT SUBMITTED FOR THE RECORD OF A HEARING**

“IMPROVING PROGRAMS DESIGNED TO PROTECT AT-RISK YOUTH”
HEARING, JUNE 16, 2011
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HUMAN RESOURCES

WRITTEN TESTIMONY OF:
LORNA HOGAN
ASSOCIATE DIRECTOR OF SACRED AUTHORITY
REBECCA PROJECT FOR HUMAN RIGHTS
WASHINGTON, DC

My name is Lorna Hogan and I am the mother of four children. I began self-medicating with marijuana and alcohol at the age of fourteen because it was the only way I knew how to cope with being physically and sexually abused. After awhile, this combination was no longer working and I needed something stronger to help me cope. I began using crack cocaine.

Crack cocaine would take me to horrible places I never imagined I would go. The once clean police record I had became stained with drug related crimes I committed to support my habit. My children were definitely affected by my drug use. I couldn't be a mother to them.

I couldn't stop using. I tried several single adult treatment programs but I was just detoxing. I was not getting help for the emotional pain I kept suppressed by using drugs. There were no services provided for me as a mother. There were no services for my children. There were no opportunities to heal as a family.

During this time, my family and I were receiving regular home visits by child welfare workers. These home visits did not help my family heal. Because there was nowhere we could go together, my fear of losing my children caused me to hide my struggle from the caseworker. We needed treatment.

In December, 2000, I was arrested on a drug related charge and my children were placed with Child Protective Services. When I went before the judge for sentencing, I begged him for treatment. The judge refused my request. I felt hopeless. I not only lost my children, I lost myself. I didn't know where my children were or what was happening to them. I felt I would never see them again.

In jail, I received no treatment. I was surrounded by women like myself—we were all mothers. We were all there, in jail, suffering from untreated addiction, but there were no treatment services in jail for us, there were no therapists that could help us address physical and sexual abuse, depression or trauma.

When I was released there were no referrals to aftercare treatment programs. I was released to the street at ten o'clock at night with four dollars in my pocket. I still didn't know where my children were. I went back to doing the only thing I knew, which was using drugs. I felt myself sinking back into a life of self-degradation.

Months later, by the grace of God, I finally found someone to listen to me: a child welfare worker who was assigned to my case. I disclosed that I had been using drugs for 26 years, and she referred me to an 18-month family treatment program. A family treatment program is where a mother can go with her children and the family as a whole unit receives help together.

In family treatment, I addressed the underlying reasons for my addiction. I identified the many ways that I self-medicated to numb my pain. I had a therapist to help me address the guilt and shame of being a mother who used drugs. I also had parenting classes that gave me insight into how to be a better mother.

As part of my treatment process my children and I were reunified and my children received therapeutic services so that they too could heal from the pain of my addiction, and their being separated from me.

Today I am a graduate of the family treatment program. I acknowledge ten years in recovery from substance abuse. My children and I have been reunified for nine years. They are succeeding academically in school and I am a PTA mom. We are a whole, strong and loving family today.

My story is not unique, there are many women across this country who share my journey from surviving violence, to addiction, to the criminal justice and child welfare systems; and it's because of family treatment programs and the comprehensive services that we received, we were able to heal and raise our families with dignity and health. Family treatment is the second chance our families need.

Thank you.

Stephanie Trevitz

Stephanie Trevitz, Ed.D., NBCT (National Board Certified Teacher)
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Hearing on Improving Programs Designed to Protect At-Risk Youth

June 23, 1999, twelve years ago, was a day that changed the course of history for my husband and me. Having received our foster parent license in the state of South Carolina, a call came to provide respite for a two year old child who was in the process of reunification with a biological father. The child's foster mother, her fourth caregiver in her short time on this earth, was out of town. We were to keep the child for a week -- until the foster mother's return.

A one week commitment continues now as a twelve year odyssey.

In spite of the fact that this child was in foster care and attended daycare five days per week, in less than three hours of being in our care, we discovered what would be diagnosed two days later as genital warts around the child's rectum. A forensic exam indicated anal penetration during the time spent with the father, and that the abuse had continued long term. Removed from the biological parents at eight months of age, the child had returned often for unsupervised visits apparently to be continually abused.

One week turned into three as the Department of Social Services began to investigate every possible perpetrator, from the father to the daycare to the foster mother. No perpetrator was identified until, three months later, we were still parenting this child.

Then it happened. One day, this beautiful, incredibly intelligent, yet haunted child said to me, "Mommy, tell my brother's daddy 'DON'T TOUCH MY BOTTOM NO MORE! TELL HIM NO! NO!'"

The biological brother came on visits with her father at the local DSS office.

Stunned, I braced myself and replied, "I promise it will *never* happen again."

We had no extra money and had no idea what to do, but we researched until we found who we believed to be the best attorney in our state. He'd never lost a case. We asked

him if we could hire him to represent the child along with the DSS attorney who was overworked and overwhelmed. At age five and a half, we finalized our adoption of this child.

This child's path toward healing was slow and painful and continues today. Between ages two and three and a half, the child had screaming fits where we had to hold the child like a baby but with caution so that we were not kicked, hit, or bitten. The child began slowly and the fits increased until they would last anywhere from 45 minutes to two hours and would occur up to four times per day. I left my job to be a stay at home mother. We sold our home and bought one we could afford on one salary.

Eventually, the child was able to make it through a half day of preschool with no problems.

Now, the child is 14 and two grade levels behind in school, but not for a lack of IQ or ability. Ghosts continue to haunt this child; bipolar disorder continues to send this child on a constant motion that is impossible to control. The child struggles with school socially, emotionally, and academically trying to balance the good weeks so that they overcome the bad, but the child continues to be haunted daily and nightly by the ghosts from her past. We have finally accepted that full healing will likely never come. Instead, we will manage the condition as best as possible. Afraid to be alone, we hope to get a therapeutic dog so that as an adult, there will be the opportunity for independence without the need to rely on others to survive.

When our first child was three, the phone rang. Our baby was a few days away from being one year old and was hospitalized for a horrible assault by the biological mother. One eye was swollen shut. Two were blackened, and there was a knot on the temporal lobe that stayed for a month. Most notable was the baby's size. He was 15 pounds at almost 12 months old.

The baby came home and within a week and a half had chubby cheeks and a huge smile. Three huge meals per day, larger than the meals that we as parents ate along with four bottles per day, and the baby had chubby cheeks within a week. I remember the very moment I was rocking the baby in the wee hours, feeding a bottle, looking the baby in the eyes and fell in love.

Three weeks after the baby came home, the Department of Social Services called again. His mother was pregnant, was due in three months, and they wanted the children to be together. So three days before Christmas, we brought home the second baby, a half brother, who was perfect in every way. In nineteen months, we had become the parents of three children: ages 2 days, 14 months, and 3 ½.

By the time our second baby was one, it was clear that some things for him were not progressing as they should. Wanting so badly to walk, he could only fall and fall flat on the face causing blackened eyes. I began to notice tremors in the hands when the baby was feeding himself. Language was not developing appropriately. I was devastated

because this second baby was supposed to be "normal". There had not been the experience of any abuse like the others. This second baby had rarely slept as an infant, but I had cared and loved this baby so much.

Seven neurologists later, we had the first of what would become many diagnoses for both of the babies. Currently, the older child is 11. He has autism, ADHD, and a neurological disorder that presents as Parkinsonism. The younger child is 10 with the same diagnoses. And both continue with diagnoses of reflux, bladder conditions, mood disorders, sleep disorders, and learning disabilities.

We were surprised with the information about an 11 year old child who was in a foster home in our neighborhood. His parents attended our church. They had a house full of girls and wanted to adopt a boy. After having this for nine months, they told us one Saturday that he was leaving on the upcoming Monday. Assuming he was going to be reunited with his family, we were stunned to find out that they had decided they wanted a "real boy," and they were not planning to adopt him in spite of the fact that they told him they were. As we found out later, on Monday morning during breakfast, they told him to turn his books in at school. His caseworker would be taking him somewhere else. On the Friday before, he had told his resource teacher that when he was adopted, he was going to be able to have someone sleep over with him.

God himself put this child on our hearts. We knew little about him, but the injustice alone was more than we could stand. I finally decided to pray and ask God for "a sign I could recognize" regarding whether or not we should call and request to adopt this child. I knew we had our hands full with three special needs children. The sign? Thirty seconds after I prayed, I passed a Wendy's marquis that read, "Change the life of a child forever."

This child is now 18. He has fetal alcohol syndrome, and he has struggled in school. Coming out of a self-contained classroom, he made up his mind that he wanted to earn a diploma. He is now the success story of his high school as he spent three quarters on the honor roll this year. He wants to work in the culinary arts field. He required plastic surgery on his ears to pin them down. He had to have growth hormones to reach his potential size and weight, and we had to induce puberty on him. However, we were his 13th placement and his final one. Chances were good he would not have ever been placed. He is a joy in our home.

With years gone by, being the parents of four special needs children, we were letting our foster parent license lapse. We had been parenting our first child for eight years. My husband had been laid off from a job, and I had gone back to teaching. The first day back after Christmas break was a teacher work day, and the children attended at camp at our church. They made individual "king's cakes" with plastic babies inside. I picked them up and they begged to take the "baby cakes" home with them. Jokingly, I told them we would do NOTHING to encourage any more babies to enter our house. But the four kids and the four "baby cakes" went into the car and home we went.

I sat the baby cakes down on the kitchen counter and went directly to check email. The phone rang within seconds. It was DSS and as usual, I was stunned by their news: our first child's full biological siblings were at the local police department. They would need foster care and adoption. They were six and eight.

Our girl is now 10 and is a Duke Tip Scholar, meaning she is in the top 5% of all fourth graders in the nation. She suffers from generalized anxiety disorder, and she often cannot get away from the memories that haunt her from living with her biological parents, going on drug buys, seeing horrible domestic violence, and dissociating to survive.

Our boy is 12 and has bipolar disorder like his older sister. We are unable to find any post adoption help for him, and he does things like urinating down the air vents in our home, lying constantly, and he's insanely jealous of the boys with autism and with the fact that their behavior program is different from his own. For the protection of everyone in our home, this child has slept on the floor of my and my husband's bedroom for four months now. We are afraid to put him upstairs with the other children. We would have to relinquish rights to be able to place him somewhere for help. And we believe that a child learns to live in a home by living in a home. Yet, we run into brick walls everywhere we go for help.

My point in the details is this: permanency is one answer for foster children, but it does not solve the numerous traumas the child faces on his or her way to reaching that permanency. When we first adopted, our state system was so supportive. Now that our children are getting older and their problems re mixing with academic and social issues, puberty, and the fatigue of my husband and myself, the services are falling away at a rate that is unprecedented. Now that they are reaching ages where we know they will be with us long into adulthood, we have no help. One child has been a client for two years of a state mental health program set up to serve foster children and to keep them in the home – the least restrictive environment, and she has had services for 10 weeks out of those two years.

The question I ask you is this: What would you do if you were me? What would you do if you walked in my shoes?

I implore you to continue to support post-adoptive services and to increase the availability of post adoptive services. Increasing adoptions without providing the support the children and the families need is not the answer. Again, permanency without provisions only creates a situation that is potentially cyclical with children being relinquished back to the foster care system in a situation and an age where they are unadoptable.

Thank you for your time to read my testimony.



The Adoption Exchange



Testimony of:

Kathy Searle

Lisa Tokpa

for

The Adoption Exchange, Inc.

14232 E. Evans Avenue

Aurora, CO 80014

Submitted to the

**U.S. House of Representatives Committee on Ways and Means
Subcommittee on Human Resources**

For the hearing on:

Improving Programs Designed to Protect At-Risk Youth

June 16, 2011

When a child is adopted by a family many people like to believe that the story is over, the child and the family will live happily ever after, just like in the fairy tales. However, children in the child welfare system often have suffered abuse and neglect, experienced the incomprehensible loss of the only family they knew and have experienced multiple moves from one foster home to another. For these children, the story has only begun. Often, adoptive families are the ones who listen to the stories of their children – how they were left alone, hungry, wondering if anyone would ever come back for them. These families are the ones who watch the rage spill over as they try to draw closer to their children. They are the ones who take the hits from the child even though they did not inflict the original pain. Adoptive families are the ones who lay awake at night wondering if the child they are raising will ever be successful, will ever be emotionally whole. Adoption is only the beginning of a long and painful healing journey.

Sympathy is frequently afforded to orphaned children, however, the ongoing needs of the families who open their hearts and homes to these children are often overlooked. There are some biological families who may say, “Well my children are pretty tough too, why do adoptive families need additional help and services?” It is only those families who do not know the devastating impact of trauma and overwhelming loss who say these things.

In a recent study by Wendy A. Walsh and Marybeth J. Mattingly, Long –Term Foster Care – Different Needs, Different Outcomes, many of the children who linger in foster care are those with emotional and behavioral issues. These issues make it difficult to reunify children with these challenges with their biological families. Twenty seven percent of children aged 11 – 18 in out-of-home care have clinical levels of emotional problems and 41 percent have clinical levels of behavioral problems. Children exhibiting no emotional problems are reunified with their biological families 31 percent of the time while only 19

percent of children with emotional problems are able to return home. Children who cannot be returned to their biological families are being placed for adoption.

If we expect children placed for adoption from foster care to be able to overcome the tremendous challenges that lay before them, then we must join together to help their families access necessary services that they would otherwise not be able to access. Many of these families call our organization each day, reaching out for help and support. Most of these families have adopted older children, hoping to give them a chance at a successful life. These families often do not learn the depth of their child(ren)'s wounds until after the adoption is finalized, when many of the supportive services from the government are no longer available to them. The wounds from their children's past are exhibited through behavior that is complex, and at times, extremely difficult and even dangerous for parents to deal with, many telling us they cannot go on for one more day.

These families need more than a listening ear, they need access to competent professionals who understand the dynamics involved when bringing a traumatized child in to a new family. They need respite care so that they can get much needed rest to continue to parent. They need ongoing training to help them solve the mysteries of their child's behavior, give them skills to help them parent effectively and help them understand and meet the special needs that their child might have. They need access to support groups with peers who understand the unique challenges that they face and give them encouragement to keep going, no matter what. They need funding for services and special equipment that Medicaid does not cover. We often hear families say of our post-adoption program's family funding component, "I'm not sure what we would do without this."

Through our experience, conducting post-adoption programs both in Colorado and Utah, we have learned the important link between recruitment of quality adoptive parents and post-adoption services. If families know that there are

post-adoption resources available to them, they are more likely to consider adopting. This is especially important in our attempt to recruit families for children who have severe physical, mental or emotional disabilities, requiring specialized services that are often too expensive for many families.

All too often we hear from adoptive families considering "dissolving" an adoption. These families are in crisis and are considering returning the child back to the care of the state. If this occurs, the child may "age out" of the system and continue the cycle of abuse with his/her own children. Well-prepared and well-supported adoptive families are the key to breaking this vicious cycle. When good parenting is modeled, these children develop new tools and capacities that will help them be successful parents themselves someday. To avoid "failed adoptions" and this devastating cycle, comprehensive post-adoption programs are vital.

Even before adoptions are finalized, families need to be connected to services and know that support is there when they need it. We have seen that the families who have supportive communities are more likely to persevere when the journey of adoption becomes difficult. The Adoption Exchange's Colorado Post-Adoption Resource Center has a "Prospective Parent Specialist" on staff, who helps families navigate through the process of adopting while connecting the families to important post-adoption resources and services, even before their adoption is finalized. We are encouraged to see an increasing number of families better equipped to handle the challenges that can come with adoption.

The Adoption Exchange is one of a handful of agencies that are stepping forward to meet the critical needs of adoptive families, before, during and after the adoptive placement. We have served over 2,850 adoptive families through our post-adoption programs in Colorado and Utah which include services such as classes, lending libraries, funding, referrals for support groups, respite care and adoption-competent mental health professionals. We believe that a holistic perspective on adoption, which includes post-adoption support, is the only way in which children will stay out of the foster care system and within loving families. Funding for these services is critical to the healing that can best occur in a family. We ask that you consider the lives of these children and their families and that you make the difficult choices with the limited funding available to help these families step forward to break the cycle of abuse and neglect.

For further information please contact Dixie van de Flier Davis, Executive Director, The Adoption Exchange: 303.755.4756, dixie@adoptex.org.

The National Mentoring Partnership

**Statement of Tonya T. Wiley
Vice President, External Relations
MENTOR: The National Mentoring Partnership**

**Testimony Submitted to the House Ways and Means Committee
Subcommittee on Human Resources**

Thank you for the opportunity to submit testimony into the Subcommittee record for the hearing on improving programs designed to protect at-risk youth. I specifically would like to focus my remarks upon the U.S. Department of Health and Human Services' Mentoring Children of Prisoners (MCP) program. MCP was most recently reauthorized in 2006 as an amendment to the Social Security Act, a law within the Ways and Means Committee's jurisdiction.

MENTOR: The National Mentoring Partnership (MENTOR) is the nation's lead champion for youth mentoring, with the goal of helping children by providing a public voice, developing and delivering resources to mentoring programs nationwide and promoting quality for mentoring through standards, cutting-edge research and state-of-the-art tools. We believe that, with the help and guidance of an adult mentor, each child can unlock his or her potential.

We further believe that MCP is an important federal program that simply provides competitive grants to establish local mentoring programs or grow existing programs so they are able to match mentors with young people with one or more incarcerated parents. At their best, MCP grants help ensure that children in need of a positive role model have access to quality mentoring relationships.

With regard to mentoring in general, research shows that youth who participate in mentoring relationships experience a multitude of positive benefits. Mentoring can help young people succeed in school, work and life. But, positive outcomes are possible only when they are engaged in **high-quality** mentoring. Research shows that mentoring programs following research-based best practices create mentor/mentee matches that last longer and are closer, which leads to stronger outcomes for mentored youth. Practices critical to high-quality mentoring include hiring and training staff in mentoring best practices; recruiting, screening and training volunteers; matching children with suitable mentors; providing oversight of mentoring relationships; and evaluating outcomes for mentored children.

Incarceration rates have increased substantially in the United States over the past several decades and, while, arguably, the most damage has already been done to the victims and communities at large, there is another distinct population of victims: the children of those offenders who are negatively affected by the incarceration of their parents. It is a group that, along with their families, has been described as more at-risk than any other subculture in this country.

Basic conclusions can be drawn as to how children experience the loss of a parent. While age may affect the extent of the trauma, children always experience the separation from a parent

for any significant length of time as a traumatic and important life event. This trauma pulls them away from their normal developmental path, and the trauma is exacerbated by situations with heightened levels of uncertainty. Children's responses to the separation will change over time, from short-term crisis responses at the time of arrest and immediate incarceration, to the long-term responses during any extended period of incarceration and re-entry. Research indicates that children feel the stigma of having a parent arrested and placed in prison within their peer group, their family members, teachers and even their neighborhoods.

However, the presence of certain factors, including social supports and a sense of hopefulness, can mediate the impact of parental incarceration on child development. Mentoring can be one of those positive factors and is a simple, yet powerful concept: a caring adult provides guidance, support and encouragement to help a young person achieve success in life. Mentors serve as role models, advocates, friends and advisors. Mentoring programs of all shapes and sizes across this country exist for one reason: to build strong, effective relationships between caring adults and young people who might not otherwise have positive adult role models in their lives. The Mentoring Children of Prisoner's Program offers children of prisoners a role model that may not be available otherwise. This role model can be the difference between a sense of hopefulness or hopelessness about the future and can offer the child a world of opportunity.

In conclusion, I respectfully request that this Committee continue to support the Mentoring Children of Prisoner's program. On behalf of the thousands of mentoring programs and millions of mentored children across the country, we strongly encourage you to continue this wise investment in our young people. MENTOR also stands ready to work with the Committee to improve MCP where necessary and serve as a resource in this regard.

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Voice for Adoption

Voice for Adoption
SPEAKING OUT FOR OUR NATION'S WAITING CHILDREN



Testimony of:
Nicole Dobbins
Executive Director
Voice for Adoption

Submitted to the
U.S. House of Representatives Committee on Ways and Means
Subcommittee on Human Resources

For the hearing on:
Improving Programs Designed to Protect At-Risk Youth
June 16, 2011

Voice for Adoption
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I would like to thank the Subcommittee for taking the time to hold a hearing on the reauthorization of two important child welfare programs that are currently in place to protect and serve our nation's children. I would also like to thank the committee for its interest in hearing perspectives for improvements to these programs from individuals who work on behalf of children and families.

This Subcommittee is tasked with an incredibly important and critical responsibility. Our national child welfare policies affect the everyday lives of children and families. The children who come to the attention of the child welfare system are at its mercy. Once a child welfare worker intervenes in a child's life their safety and well-being are our government's responsibility, both through policy and practice, to ensure that safety and permanence are a priority for that child. It is certain that this is a challenging task; balancing the interests of each of the key stakeholders, including the children, biological parents, relatives, and foster or adoptive parents, as the plan for safety and permanence are determined. The Promoting Safe and Stable Families program and the Stephanie Tubbs Jones Child Welfare program are vital vehicles to ensure that our nation's at-risk children get their needs met. These programs provide funding for valuable services that either allow children to be returned to their birth families or provide opportunities for children to find permanency, often through adoption, with other caring adults such as relatives or foster parents.

Voice for Adoption (VFA)¹ is a membership advocacy organization. We speak out for our nation's 115,000 waiting children in foster care. VFA members, who are spread across the country, recruit families to adopt special needs children and youth with special needs. Our members also provide vital support services both before and after adoption finalization to help adoptive families through the challenges they often face. We, like the members of this committee, are dedicated to finding permanent, loving families for every waiting child in foster care. We are also committed to ensuring that those children continue to have their needs met after they find their permanent families.

Over the years the federal government has invested in the promotion of adoption of children from foster care. Its most recent and significant dedication to adoption promotion came from the reauthorization and improvement of the Adoption Incentive Program through the Fostering Connections to Success and Increasing Adoptions Act of 2008. This committee championed the Fostering Connections legislation; the Adoption Incentive Program has in part led to the increased numbers of adoptions from foster care. The number of children adopted from foster care continues to rise; last year 57,000 children were adopted from foster care, up from 51,000 in 2005². We at Voice for

¹Voice for Adoption is a coalition whose Board is composed of Adopt America Network, Adoption Exchange Association, The Adoption Exchange Inc., Casey Family Services, Child Welfare League of America, Children Awaiting Parents, EMQ FamiliesFirst, Family Builders Network, Kinship Center, Latino Family Institute, New York Council on Adoptable Children, North American Council on Adoptable Children, Spaulding for Children-Michigan, and Three Rivers Adoption Council.

²U.S. Department of Health and Human Services, Administration for Children and Families, The AFCARS Report: Preliminary FY 2009 Estimates as of July 2010 (17). Retrieved June 15, 2011 from http://www.acf.hhs.gov/programs/childstats_research/index.htm#afcars

Adoption are encouraged by the increase in adoptions from foster care and our members thank Congress for investing in finding families for waiting children. As our system continues to strive for permanency through adoption we would like to shed light on the concern for post-adoption services. While many of the children in adoptive families fare well, some adopted children are in need of services post-finalization.

As you are aware, many of the children who are adopted from foster care have experienced emotional, psychological and developmental consequences from prior abuse and or neglect. Unfortunately these challenges follow them to their new homes and adoptive parents sometimes struggle to find support for the challenges their children are faced with. This is why Voice for Adoption and nearly 40 additional organizations came together this May to hold a Congressional briefing on this issue. We collectively created and endorsed a set of policy recommendations that we feel will begin to address the lack of post-adoption supports available to families. Among the list of recommendations are: the creation of a flexible and sustainable government funding source for post-adoption services, elimination of state policies that require parents to relinquish their rights to receive state mental health services¹, an increased number of adoption competent professionals², and support for research and evaluation of post-adoption service models.

The Promoting Safe and Stable Families (PSSF) legislation, under Title IV-B Subpart 2 of the Social Security Act, provides formula grants to child welfare agencies in four categories of services: family preservation, family support, time limited reunification and adoption promotion and support. As you work to reauthorize PSSF we hope you will consider strengthening the language to include a definition of pre and post-adoption services. Congress should acknowledge the essential role that these services play in providing the stability that children need after being adopted from foster care. Adoptive families need to be able to access a continuum of services, including support groups, case management, respite care and mental health services. Additionally, within this existing funding stream, post-adoption services are pitted against other important child welfare services like adoption promotion, forcing States to decide whether it is more important to recruit adoptive families or support them after they have adopted. Creating such a dilemma makes it harder for children to get their needs for both permanency and stability met. Furthermore, in their annual reports states are not required to differentiate the amount of funds spent on adoption promotion versus adoption support under this section, thus some states may not be providing any dollars on adoption support services. In fact some states submitted reports with zero spending in this category altogether and at least 10 states reported spending that did not come close to the twenty-percent allotment for adoption promotion and support³. Supplemental reporting in these states should be required to determine the reasons for unspent funding in the adoption category and areas for improvement should be identified.

¹ The Bazelon Center of Mental Health Law reports that 21 states have some type of relinquishment statute, requiring parents to relinquish custody to the state to access state funded mental health services.

² Adoptive families are outspoken about the unintentional harm caused by some professionals – mental health providers and others – when professionals do not understand the dynamics and impact of adoption and previous trauma on children’s overall development.

³ Congressional Research Service, Emilie Stoltzfus (June 2011), *Child Welfare: Funding for Child and Family Services Authorized Under Title IV-B of the Social Security Act*

In times of tight federal budgets we encourage Congress to examine an existing and justified source of funding that could be used to support post-adoption services. Congress acted to expand the federal adoption assistance eligibility, in the Fostering Connections to Success and Increasing Adoptions Act (Public Law 110-351). This eligibility is phased in over time until 2018 and states will continue to save money that would have been spent on state adoption assistance programs. Congress put a Maintenance of Effort (MoE) clause in the act to ensure freed-up state dollars would be re-invested into Title IV-B or IV-E programs. However, federal guidance issued indicated that agencies had the flexibility to determine savings and were not required to provide a specific accounting of these funds⁶. Adoptive families make a permanent commitment to their children, and VFA believes that Congress should make a commitment to providing ongoing support to help these families meet their children's needs. We encourage Congress to consider this option as a way to reinvest at-least-a portion of these funds – which are being generated from adoptions - into investing in sustaining adoptive families and ensuring their success. Adoption is a life-long experience, and children and families deserve support as the children move toward adulthood.

As you work to reauthorize and improve these programs I hope you will keep in mind the love, commitment, and sometimes solace adoptive families provide for their children, but more importantly, the time, patience and tenacity it takes to raise children with painful pasts. Adoptive families need our support as they care for our most precious children, raising them to be successful, productive individuals.

In closing we appreciate the proven dedication and unity of this Subcommittee, as your work on these issues remains a priority across party lines. We look forward to your continued efforts on behalf of waiting children in foster care, because a life without a family is detrimental for each waiting child and for our country.

⁶ U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Program Instruction ACYF-CB-PI-10-11, issued July 9, 2010. Retrieved June 20, 2011 from: http://www.acf.hhs.gov/programs/cb-laws_policies/policy/pi/2010/pi1011.htm#sectj

