

Long-Term Foster Care in Washington:
Children's Status and Placement Decision-Making

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and
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June 2001

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Acknowledgements

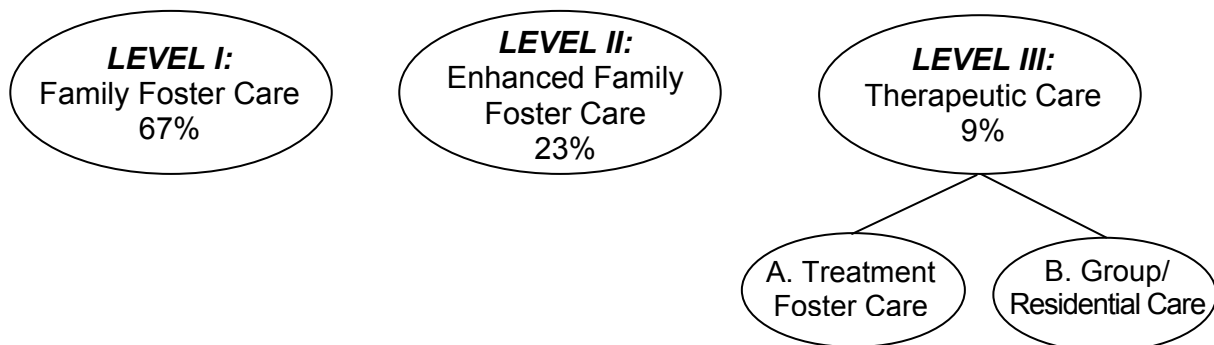
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EXECUTIVE SUMMARY

The 2000 Legislature directed the Washington State Institute for Public Policy (Institute) to compare placement decisions and funding methodologies for residential care services for children in long-term foster care and to examine the best practices in other states (EHB 2487). This report addresses placement decision-making and the state's funding methodologies. A separate report describes innovative practices in other states and reviews the literature on foster care;¹ some findings from that report are incorporated into this document.

Only a small percentage of children coming into contact with the child welfare system enter placement, and many children placed into care do not remain longer than a few months. In Washington, a high percentage (41 percent) of the approximately 7,000 children placed each year leave care within the first month, and close to half (48 percent) leave within the first three months of placement.²

In April 2000, 7,150 children in Washington State were in long-term foster care (90 days or more). The placements were divided into three levels:



This study was designed to answer the following research questions:

- As a group, how are Washington's children in long-term foster care functioning and behaving?
- Are these children placed in the right settings?
- Does the state have an adequate supply of placement options for its foster care population?

Through interviews and administrative data, we learned about the history and functioning of a representative sample of children at each level of care. Approximately two-thirds of the children were placed in Level I family foster care. The median payment for family foster care is \$344 per month, \$639 for enhanced family foster care, and \$3,417 for therapeutic care.

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

² Children's Administration, *Children Leaving Out-of-Home Placement* (Olympia, WA: Department of Social and Health Services, December 2000), CAMIS Report EMISLOSZ.

Study Findings

The Costs of Placement Failure

National research on foster care children and placement reveals, first and foremost, the connections between events and outcomes.³ In simple terms, these connections can be expressed as follows:

- Children in foster care longer than three months often enter this system with psychological injuries and vulnerabilities, as well as behavioral problems.
- Behavior problems can create difficulties in a child's placement and ultimately lead to multiple placements. Multiple placements are also associated with worse outcomes for children.
- Even for children with few impairments, being moved from setting to setting often increases their problems.

Given the harm associated with multiple placements, the clear ideal is connecting children with the most appropriate setting at the onset of their foster care experience, taking into account their psychological and physical needs.

Children's Problems and Needs as Rated by Their Caregivers

- The majority of 4- to 17-year-olds in foster care have difficulty getting along at home, at school, and in the community; many children have severe functional impairments.
- In family foster care, most children under 4 years old do not have developmental problems—motor, speech, social, emotional lags. However, most children from this age group who were placed in enhanced family foster care were described as having developmental problems.
- Most children in family foster care do not have problems relating to caregivers; however, most children in other care levels were identified as having signs of attachment difficulties.

Matching of Placement to Children's Problems and Needs

- A standardized assessment of children's problems revealed that, for the majority of children in foster care, their current placement level and supports received corresponded with the degree of their problems.
- A large majority of caregivers and caseworkers rated the placement as meeting key goals and as a good match for the child; this finding was true at all levels of care.
- Impairments reported for children placed in enhanced family foster care (Level II) and those in treatment foster care (Level III A) overlapped substantially. This overlap indicates that state policies guiding placement in these care levels is somewhat ambiguous.

³ For an examination of this research, see: Lee Doran and Lucy Berliner, *Placement Decisions for Children in Long-Term Foster Care: Innovative Practices and Literature Review* (Olympia, WA: Washington State Institute for Public Policy, February 2001), Document Number 01-02-3902.

- The children who appear at the greatest risk for placement failure are those in enhanced family foster care (Level II) and rated with severe impairments; they appear to need more services and/or supervision. Almost half (44 percent) of children in enhanced family foster care are in this category.
- Even though the majority of children in family foster care and enhanced family foster care were rated as moderately or severely impaired or as having clinically significant behavioral problems, most had *not* received any mental health or support services in the previous month.

Foster Parents

- A third of foster parents undertook the foster parent role because of an individual child, and 20 percent of caregivers are related to the children.
- Caring for foster children often interferes with normal family activities and frequently requires a constant level of supervision to prevent harm to others.

Placement Decisions

- Federal and state laws require that children be placed in the least restrictive, most family-like setting.
- Moving children from family foster care to a higher care level significantly increases placement costs; Level II care is almost twice as expensive, and Level III costs ten times as much. Placements at the higher levels are not always available when needed. Children often have repeated failures at a lower care level before they are placed in a higher level.
- Foster parents are not always fully informed about the children's history or problem behaviors.

Placement History

- The placement history of children in long-term foster care varies greatly. For children in family foster care, the median number of prior placements was 3, with a median duration of 1.2 years each. For the highest case level, therapeutic care, the medians of prior placements and duration were twice as high, with 6 prior placements and 3 years' duration. Almost a third of the children in therapeutic care had 10 or more placements.

Satisfaction With Children's Administration Caseworkers

- Caregivers at all levels of care were generally satisfied with the Children's Administration caseworkers.

Funding Methodologies

- The state redesigned its reimbursement system for foster care, and this new system went into effect in 2000. The payments are designed to reimburse foster families for their required effort and cost rather than the child's condition.
- The previous reimbursement rates for Level II care have been maintained to allow more time to determine appropriate levels.

I. BACKGROUND

Legislative Direction

The 2000 Legislature directed the Washington State Institute for Public Policy (Institute) to compare placement decisions and funding methodologies regarding residential care services for children in long-term foster care and to examine the best practices in other states (EHB 2487). A separate report describes innovative practices in other states and reviews the literature on foster care.⁴

This study examines 7,150 children in long-term care (over 90 days) during April 2000. Because we studied a “snapshot” of children, rather than following individual children over time, the study could not systematically examine the reasons children ended up in foster care nor efforts aimed at family reunification or adoption/guardianship.

The study relied on four data sources:

- Administrative data on foster children in long-term care (N=7,150)
- Structured interviews (N=280)
- Standardized behavior checklists regarding foster children (N=140)
- Focus groups with caregivers and caseworkers (N=3 groups)

Administrative data from the Department of Social and Health Services’ Case and Management Information System (CAMIS) and the Social Service Payment System (SSPS) allowed us to examine demographics, placement history, and cost.

In order to better understand child functioning and caregiver characteristics, we relied on structured interviews and standardized behavior checklists. To protect the privacy of the children and families, we followed informed consent procedures required for this project by the Department of Social and Health Services’ Human Subjects Review Board.⁵

The perspectives of those actively involved in the foster care system were solicited through focus groups with caseworkers, foster parents, and group/residential care providers. To ensure confidentiality, we received transcripts from the focus groups that did not identify participants by name.

⁴ Lee Doran and Lucy Berliner, *Placement Decisions for Children in Long-Term Foster Care: Innovative Practices and Literature Review* (Olympia, WA: Washington State Institute for Public Policy, February 2001), Document Number 01-02-3902.

⁵ See Appendix A for further information on the study methodology.

II. OVERVIEW: CHILDREN IN LONG-TERM, OUT-OF-HOME CARE

Slightly more than 7,000 Washington State children are in out-of-home placements that last longer than 90 days. About half the children placed in foster care in Washington return home within 90 days and are not the subject of this report.

How Is Out-of-Home Care Organized?

When children must be placed out of the home to ensure their safety, the Children’s Administration seeks placements in the least restrictive, most family-like setting, preferably with relatives.⁶ Relatives who care for children—often called kinship care—can apply to become licensed foster parents and receive foster care payments. If the relatives choose not to apply for this licensing, the child may be eligible for a financial grant through the Temporary Assistance for Needy Families (TANF) program.

Washington State has three principle care levels for children in long-term care. Levels II and III are used for children who require additional supports, services, or supervision.

Table 1
Out-of-Home Care in Washington State

CARE LEVEL		MEDIAN MONTHLY PAYMENT*
LEVEL I: FAMILY FOSTER CARE	Families receive a basic foster care rate. Children may or may not receive services from local mental health and social service agencies.	\$344
LEVEL II: ENHANCED FAMILY FOSTER CARE	Families receive higher payments for extra services, help in their home, and/or respite care.	\$639
LEVEL III: THERAPEUTIC CARE	This care level provides the highest level of supervision and services. Services are contracted with community agencies through Behavioral Rehabilitation Services (BRS). Two types of care exist: <ul style="list-style-type: none"> A. Treatment foster care: Specialized foster family homes providing enhanced services and supervision. B. Group home residential care with paid staff. 	\$3,417

*Cases of unlicensed kinship care (36 percent of family foster care) are excluded from these calculations because they are not eligible for foster care payments.

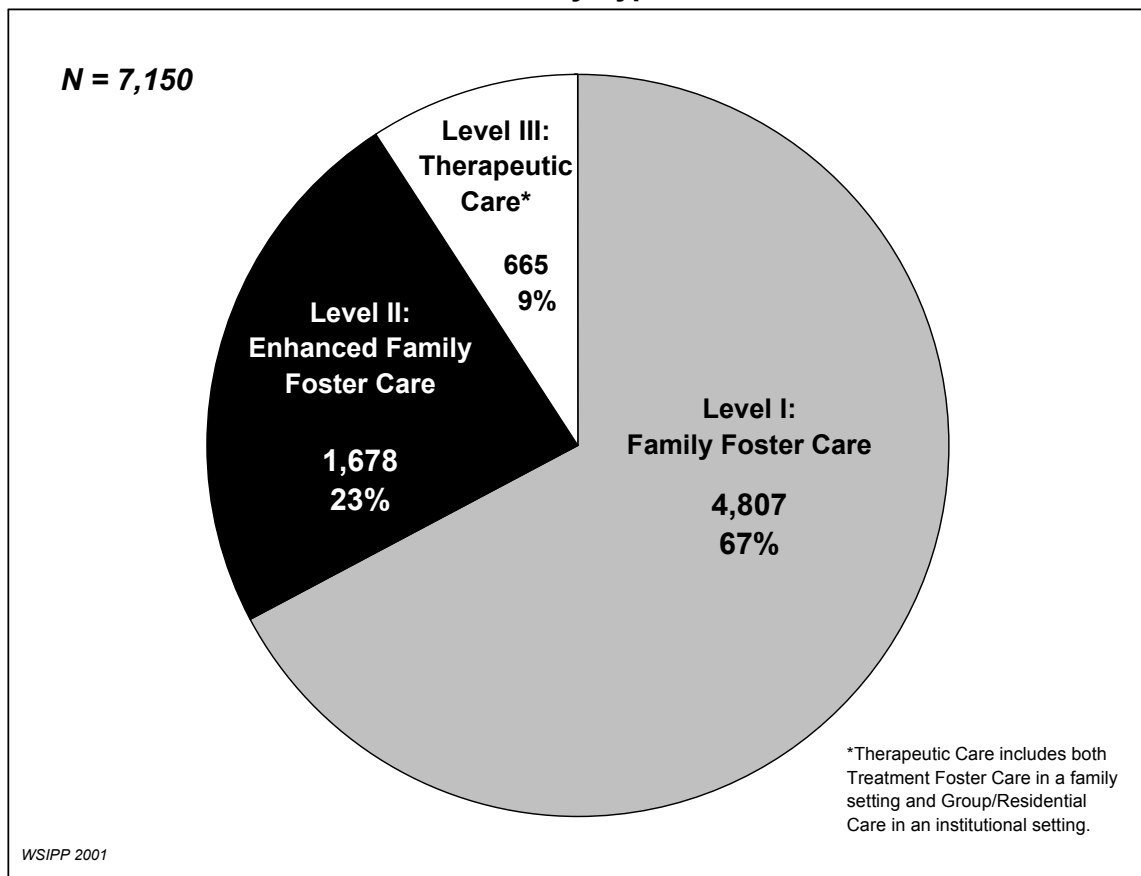
⁶ RCW 73.13.065. The state policy mirrors the federal policy contained in the federal Adoption Assistance and Child Welfare Act of 1980.

In the past, foster care was generally divided into two categories: family foster care and group care. Foster children in Washington who required high levels of supervision and intensive treatment were placed in residential group care facilities operated by paid staff. Starting in the 1990s, children needing additional supervision and services have been maintained in specialized foster homes where the foster parent(s) receive additional training, supervision, and support services. Therefore, the categories of care have expanded to include two additional care levels—enhanced family foster care (Level II) and treatment foster care (a version of Level III care).

When the data allow, this paper separately examines the two variations of therapeutic care (treatment foster care and group/residential care).

In April 2000, 7,150 children were in long-term care in Washington. The distribution by level of care is illustrated in Figure 1.

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



III. FOSTER CARE CHILDREN: IN-DEPTH ANALYSIS

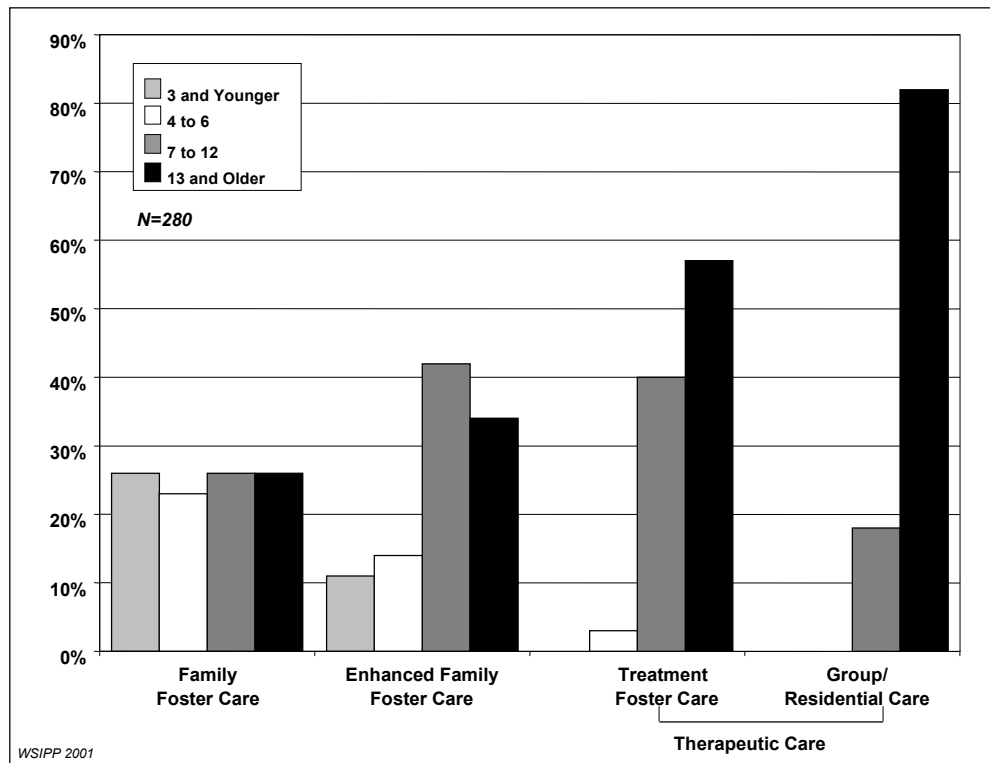
The information in this section was obtained from a random sample of 280 children in long-term care from the April 2000 snapshot. In order to capture information on all levels of care, cases from Levels II and III were over-sampled.

Caregivers who agreed to participate were interviewed by telephone; these caregivers included kin, foster parents, and agency staff working in residential facilities. All caregivers were also asked to complete a written checklist regarding the child; 126 completed and returned this instrument. The interviews⁷ covered a range of topics related to the children, their placement, and the caregivers' perceptions. Caseworkers for children in the sample were also interviewed.

Demographic Characteristics: All Children

Child characteristics by care level are shown in Figures 2, 3, and 4. In higher levels of care, greater proportions of the children are *older* and *male*. Racial differences are not significant across the care categories.

Figure 2
Child Demographics – Age



⁷ Interview questionnaires are available from the Washington State Institute for Public Policy.

Figure 3
Child Demographics – Gender

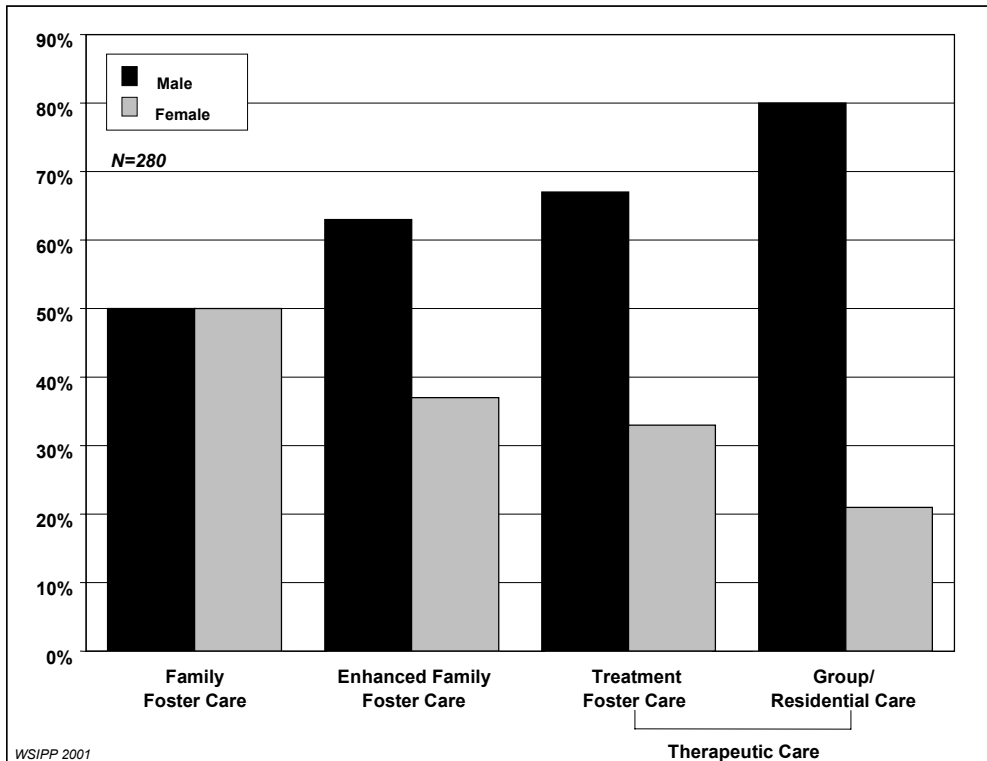
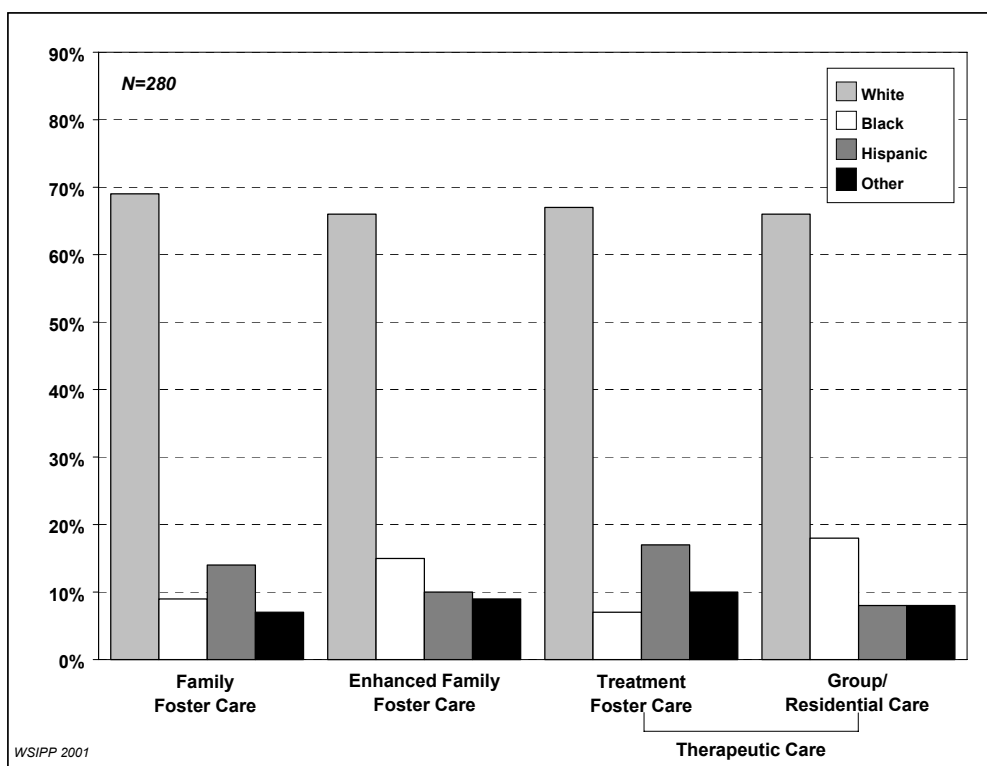


Figure 4
Child Demographics – Race



Placement History: All Children in Care

Placement history varies greatly by the children's level of care. The median number of placements for children in therapeutic care was twice that for children in family foster care. Most children enter higher care levels only after failed placements in family foster care.

Table 2
Placement History (N=280)

	LEVEL I: FAMILY FOSTER CARE	LEVEL II: ENHANCED FAMILY FOSTER CARE	LEVEL III: THERAPEUTIC CARE	
			TREATMENT FOSTER CARE	GROUP/ RESIDENTIAL CARE
NUMBER OF PLACEMENTS*				
MEAN	3.3	3.8	7.4	6.6
MEDIAN	3.0	3.0	6.0	6.0
RANGE	1–22	1–11	1–19	1–19
PERCENT 10+	3%	2%	27%	26%
LENGTH OF STAY* (YEARS)				
MEAN	2.0	2.9	3.6	4.3
MEDIAN	1.2	2.2	2.7	3.9
RANGE (YEARS)	0.25–11.8	0.28–12.0	0.31–14.2	0.25–13.0

* Statistically significant difference between groups.

Children 4 to 17 Years Old

A separate child development instrument was used to assess children under age 4, and results for these children are reported later. This section first covers results for older children.

Caregiver Reported Problems for Children 4 to 17 Years Old

Caregivers were asked whether children in their care had problems in particular areas. A standardized parent questionnaire was used to identify the topics. Table 3 shows that the percentage of children with reported problems usually increased by the care level. However, even in family foster care, a substantial majority was identified with behavioral or emotional problems. In addition, learning problems and attention deficit were noted in more than one third of children in family foster care. Very few children in family foster care were identified as having the severe psychiatric illnesses of schizophrenia or autism.

Across all groups, caregivers reported fairly high levels of concern that children suffered from problems possibly connected to their mothers' use of alcohol or drugs.

Table 3
Child Problems (N=280)

DOES YOUR CHILD HAVE . . .	FAMILY FOSTER CARE	ENHANCED FAMILY FOSTER CARE	THERAPEUTIC CARE	
		TREATMENT FOSTER CARE	GROUP/ RESIDENTIAL CARE	
	PERCENT AGREE	PERCENT AGREE	PERCENT AGREE	PERCENT AGREE
BEHAVIORAL OR EMOTIONAL PROBLEMS*	71	87	90	98
LEARNING PROBLEMS*	44	71	74	62
ATTENTION DEFICIT*	35	53	50	60
SLOW LEARNER*	37	60	47	44
PROBLEMS RESULTING FROM MATERNAL DRUG/ALCOHOL USE	29	49	50	37
MENTAL RETARDATION/ DEVELOPMENTAL DELAY*	16	38	20	21
SPEECH OR LANGUAGE PROBLEMS	18	26	7	15
SENSORY PROBLEMS	21	21	20	8
HEALTH PROBLEMS OR IS MEDICALLY FRAGILE*	24	19	30	5
PHYSICAL DISABILITY, ORTHOPEDIC, OR NEUROLOGICAL PROBLEMS*	7	24	21	5
SCHIZOPHRENIA	1	6	7	5
AUTISM	1	2	3	3

* Statistically significant difference between groups.

School Services

Among school-aged children, a significant percentage received special services in school during the previous three months. Receipt of such services often means children spend all or part of the day out of regular classrooms. A third of the children in family foster care, more than half in enhanced family foster care and treatment foster care, and three quarters in group/residential care were reported to have received these services.

Functioning for Children 4 to 17 Years Old

Children's functioning is often measured by examining several areas of their lives. Children with functional impairment have difficulties getting along with others and meeting age-appropriate expectations. A standardized measure was used to assess these factors—the Child and Adolescent Functional Adolescent Scale (CAFAS). This instrument measures

degrees of impairment at home, at school, in the community, and in relationships with others as well as covering moods, thinking, and substance abuse for children aged 4 to 17.

The CAFAS instrument⁸ relies on specific behaviors as reported by the caregiver. It has been found to reliably classify children into four groups by the treatment and placement needs:⁹

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

Examples of behaviors for each category are covered in Table 4.

Table 4
Examples of Children’s Impairment Measured by CAFAS¹⁰

LABEL	BEHAVIOR
MILD	<ul style="list-style-type: none"> • Occasionally disobeys school rules • Frequently fails to comply with reasonable rules and expectations • Frequently engages in behaviors that are frustrating or annoying • Single incidents of vandalism/shoplifting • Poor judgment/impulsive behavior difficulties in peer interactions • Often anxious, fearful, or sad, very self critical, low self-esteem, feelings of worthlessness
MODERATE	<ul style="list-style-type: none"> • Suspended from school due to behavior • Persistently disruptive and needing specialized program at school • Failing at least half of classes • Persistent failure to comply with reasonable household rules • Repeatedly plays with fire such that damage could result • Inappropriate sexual behavior • Frequent displays of anger toward others • Frequently mean to animals • Involved with gangs • Behavior typically inappropriate
SEVERE	<ul style="list-style-type: none"> • Expelled from school • Failing almost all classes • Harmed or made serious threat to hurt another • Behavior and activities must be constantly monitored to ensure safety of others • Deliberate and severe damage to property outside the home • Attempted or completed sexual assault • Behavior consistently bizarre or extremely odd • Depression associated with academic incapacitation or suicidality

⁸ K. Hodges (1997) CAFAS Functional Assessment Systems, 2140 Old Earhart Road, Ann Arbor, MI.

⁹ Ibid.

¹⁰ Ibid.

Table 5 shows the children’s degree of impairment was generally found to correspond with the care level. For the children in family foster care, 31 percent showed severe impairment, while 64 percent of children in group/residential care received this classification. *More than three quarters of children in each level of care have at least a mild impairment, and even in family foster care, almost half the children were rated as having moderate or severe impairment.*

Table 5
Relationship Between Children’s Functional Impairment and Placement* (N=243)**

IMPAIRMENT (CHILDREN 4 YEARS AND OLDER)	LEVEL I: FAMILY FOSTER CARE		LEVEL II: ENHANCED FAMILY FOSTER CARE		LEVEL III: THERAPEUTIC CARE			
					TREATMENT FOSTER CARE		GROUP/ RESIDENTIAL CARE	
	N	PERCENT	N	PERCENT	N	PERCENT	N	PERCENT
NONE/MINIMAL	19	23	8	9	1	3	3	8
MILD	23	28	22	24	7	23	4	10
MODERATE	15	18	21	23	5	17	7	18
SEVERE	26	31	40	44	17	57	25	64
TOTAL	83	100	91	100	30	100	39	100

* Statistically significant difference between groups.

** Some respondents chose not to answer these questions.

The CAFAS is composed of subscales that measure where children have difficulties. Table 6 illustrates that more children had difficulty at home and in school with smaller percentages of children showing severe impairment in the community.

Problems in the community area generally refer to breaking the law or getting in trouble in community settings. As might be expected, older children are more likely to have impairment in the community.

The subscales measuring functional impairment in moods (emotional distress), behavior toward others, and thinking (unusual or disorganized thoughts) also tended to correspond to the level of care, although severe thinking impairment rates are substantially lower than those for moods and behavior.

Table 6
Child Role Performance and Impairments

FUNCTIONING DOMAIN	LEVEL I: FAMILY FOSTER CARE	LEVEL II: ENHANCED FAMILY FOSTER CARE	LEVEL III: THERAPEUTIC CARE	
			TREATMENT FOSTER CARE	GROUP/ RESIDENTIAL CARE
	PERCENT SEVERE	PERCENT SEVERE	PERCENT SEVERE	PERCENT SEVERE
ROLE PERFORMANCE*				
SCHOOL/WORK	45	60	67	67
HOME	46	66	67	87
COMMUNITY	11	18	30	41
FUNCTIONING*				
MOODS	27	39	47	49
BEHAVIOR TOWARD OTHERS	28	33	40	51
THINKING	8	21	27	18

* Statistically significant difference between groups.

Two additional subscales measure self-harm and substance abuse. Overall, relatively few children were significantly impaired in these areas. However, 23 percent of children in group/residential care were rated as having severe impairment in self-harming behaviors such as threatening suicide, making a suicide attempt, or engaging in deliberately self-harming behavior. Substance abuse problems were most often noted in older children.

Behavior Problems for Children 4 to 17 Years Old

A subset of caregivers (N=126) completed the Child Behavior Checklist,¹¹ a widely used standardized checklist for children ages 4 to 17 years old. The caregivers who completed these questionnaires were compared with those who chose not to do so in order to determine if the responses could be viewed as validly representing the study group. The two groups were similar in terms of gender, age, ethnicity, kinship status, and level of care.

The checklist measures a range of problems as reported by caregivers and yields a standard score that indicates whether the child's problems fall in the clinical range. The *clinical range* is defined as exhibiting a level of problems that is reported in a very small subset of the population—only 2 percent of same age and gender children. The checklist produces three scores:

- An *internalizing* score (e.g., depression, anxiety);
- An *externalizing* score (e.g., aggression, disobedience); and
- A *total problem* score.

¹¹ T. M. Achenbach (1991) CBCL, University of Vermont. Prospect St., Burlington, VT.

Table 7 illustrates that the percentage of children in clinical ranges increases as the level of care intensifies. A substantial percentage of children in family foster care are reported to have clinically significant scores. These scores reveal the challenges faced by these children and their caregivers.

Table 7
Child Behavior Checklist¹² (N=126)

BEHAVIORAL PROBLEMS	LEVEL I: FAMILY FOSTER CARE	LEVEL II: ENHANCED FAMILY FOSTER CARE	LEVEL III: THERAPEUTIC CARE	
			TREATMENT FOSTER CARE	GROUP/RESIDENTIAL CARE
	PERCENT CLINICAL	PERCENT CLINICAL	PERCENT CLINICAL	PERCENT CLINICAL
INTERNALIZING	33	44	56	55
EXTERNALIZING*	47	71	81	72
TOTAL PROBLEMS*	51	78	81	82

* Statistically significant difference between family foster care and the other groups.

Children Younger Than Four

Children under 4 years were assessed for developmental concerns. A different screening tool for this age group was used—the Parents’ Evaluation of Developmental States (PEDS). Caregivers were asked whether they had concerns about the child in a variety of key developmental areas. The PEDS was chosen because research has found that caregiver ratings on this measure correspond with the results from in-depth examinations of children’s developmental status.¹³

All children in this age group were either in family foster care (Level I) or enhanced family foster care (Level II). Table 8 shows that for the 39 respondents, significant differences emerged regarding children’s developmental problems in comparing these two levels of care.

Overall, the large majority of young children in family foster care were rated as *not* having developmental problems (categorized as “Global/Cognitive” in the table) or in the specific areas, whereas 86 percent of children in enhanced family foster care received this rating. Differences between the groups were most pronounced for language and articulation (e.g., understanding what the caregiver says), motor skills, behavior, and social development.

¹² F. P. Glascoe (1998) Ellensworth & Vandermeer Press Ltd., PO Box 68164, Nashville, TN 37206.

¹³ Ibid.

Table 8
Developmental Status for Children Under 4 Years Old (N=39)**

DO YOU HAVE ANY CONCERNS ABOUT . . .	LEVEL I: FAMILY FOSTER CARE (N=28**)		LEVEL II: ENHANCED FAMILY FOSTER CARE (N=11**)	
	N	PERCENT AGREE	N	PERCENT AGREE
GLOBAL/COGNITIVE*	4	18	6	86
LANGUAGE & ARTICULATION*	4	15	5	46
RECEPTIVE LANGUAGE*	4	15	2	18
FINE MOTOR*	2	7	3	27
GROSS MOTOR*	2	7	4	36
BEHAVIOR*	5	19	9	82
SOCIAL-EMOTIONAL*	2	7	6	55
SELF-HELP	3	11	2	18
SCHOOL*	2	8	2	22
OTHER*	7	26	5	46

* Statistically significant difference between groups.

** Some respondents chose not to answer certain questions.

In addition, 30 percent of children under age 4 were reported to have chronic medical problems.

Measuring Attachment: All Children

“Attachment” is a psychological concept that references children’s capacity to form and maintain relationships with others. Children who have been maltreated or rejected by parents are more likely to display difficulties in interpersonal relationships with caregivers. Research on attachment commonly separates children into two groups: the securely attached and the insecurely attached. Children who are securely attached generally have positive interactions with caregivers. In contrast, insecurely attached children may display interaction patterns with caregivers, such as being anxious and clingy, distant and aloof, manipulative and superficial, or inappropriately angry or fearful. In this research, the caregivers rated the children as either securely or insecurely attached according to their overall style of interaction.

Table 9 illustrates that attachment status varied by level of care. A majority of children in family foster care is considered to be securely attached, whereas the majority in the more intensive levels of care is perceived to be insecurely attached. Not surprisingly, caregiver ratings of insecure attachment and children’s functioning problems are highly correlated in this study. When children have more psychological and behavioral problems, the relationship with caregivers is more stressed.

Table 9
Attachment Status*

DEGREE OF ATTACHMENT	LEVEL I: FAMILY FOSTER CARE	LEVEL II: ENHANCED FAMILY FOSTER CARE	LEVEL III: THERAPEUTIC CARE	
			TREATMENT CARE	GROUP/ RESIDENTIAL CARE
	PERCENT	PERCENT	PERCENT	PERCENT
SECURE	62	41	45	37
INSECURE	38	59	55	63

* Statistically significant difference between family foster care and other groups.

IV. THE CAREGIVERS

The caregivers supplied information about their life situations, their reasons for becoming foster parents, and how this role influenced their family life. The 224 respondents¹⁴ were mostly female, Caucasian, and of moderate to low income.

Table 10
Caregiver Demographics (N=224)

CAREGIVER DEMOGRAPHICS	LEVEL I: FAMILY FOSTER CARE		LEVEL II: ENHANCED FAMILY FOSTER CARE		LEVEL III: TREATMENT FOSTER CARE	
	N	PERCENT	N	PERCENT	N	PERCENT
GENDER						
MALE	13	13	12	13	1	4
FEMALE	87	87	83	87	25	96
INCOME						
LESS THAN \$20,000	14	15	13	15	5	21
\$20,000–\$39,000	33	34	33	38	8	33
\$40,000–\$59,000	26	27	26	30	9	38
\$60,000–\$79,000	15	16	9	10	2	8
\$80,000 OR MORE	8	8	7	8	0	0
RACE/ETHNICITY						
AMERICAN INDIAN	5	5	9	10	2	8
ASIAN/PACIFIC ISLANDER	1	1	0	0	1	4
BLACK	5	5	4	4	1	4
HISPANIC	6	6	2	2	3	12
WHITE	80	80	75	81	17	65
OTHER	3	3	3	3	2	8
GEOGRAPHIC AREA						
RURAL	27	28	28	31	10	39
SMALL TOWN	23	24	29	32	8	31
SUBURBAN	34	35	21	23	5	19
URBAN AREA	12	13	13	17	3	12

Responses of 50 percent or over are in bold.

Some respondents chose not to answer certain questions.

Percentages may not sum to 100 due to rounding.

In family foster care, a single foster child was the norm, whereas caregivers providing enhanced family foster care and treatment foster care had a median of two foster children. Twenty-seven percent of all foster parents also had an adoptive child residing in the home.

Caregivers had been foster parents for an average of six years (median of three). Sixty-four percent had been caring for children for five or fewer years.

¹⁴ Facility staff were excluded.

Why They Became Foster Parents

Overall, more than a third of caregivers became foster parents to care for a specific child, about half for the child in this study and half for another child.

The proportions varied by the care level. More than a fourth of the family foster care parents became involved for the particular child in the study, whereas only one (4 percent) of the treatment foster parents became involved for this reason.

Kinship Care

Twenty-one percent of the respondents are related to the children in their care; half of these kinship providers are licensed as foster parents. Relatives are ten times more likely to have become foster parents for the specific child in the study (60 percent) compared with unrelated foster parents (6 percent).

Children in kinship care are significantly younger than children who are unrelated to the caregivers; they are also significantly less likely to be severely functionally impaired. Kinship providers did not differ from other foster parents by their race, gender, or age.

Many relatives decide to become foster parents because of the needs of a particular child. Once they have become foster parents, some kin go on to become alternative caregivers for other children.

Role Identification

Caregivers reported that they take their role very seriously. More than half consider themselves to be professional foster parents; this identification was found in all care levels. Table 11 shows the differences among respondents based on the level of care.

Table 11
Caregiver Roles

CAREGIVERS	LEVEL I: FAMILY FOSTER CARE	LEVEL II: ENHANCED FAMILY FOSTER CARE	LEVEL III: TREATMENT FOSTER CARE
	PERCENT AGREE	PERCENT AGREE	PERCENT AGREE
FOSTER CARE ONLY OCCUPATION	26	48	50
WORK OUTSIDE OF HOME	57	51	46
SPECIALIZE IN CARE FOR CHILDREN WITH EXCEPTIONAL NEEDS	39	56	79
CONSIDER SELF PROFESSIONAL FOSTER PARENT	51	77	87

Responses of 50 percent or over are in bold.

In this sample, 18 percent of foster parents reported that they hired staff to help provide care (excluding group/residential providers). This finding, however, varied significantly by type of care; only 13 percent of family foster care and treatment foster care parents hired staff, while 25 percent of enhanced family foster care hired staff.

Children’s Influence on Family Life

Across all levels of care, many foster parents report the child as needing close supervision at all times. The percentages vary by the care setting: family foster care (34 percent), enhanced family foster care (70 percent), and treatment foster care (65 percent).

For enhanced family foster care (Level II) and treatment foster care (Level III) providers, 20 to 25 percent report that the child’s problems interfered all or much of the time with normal family activities such as going out or doing fun family activities, having quality time, and getting along with their other children.

Some disruptive behaviors are reported with high frequencies by Level II and III caregivers. Almost half the Level II caregivers reported that the foster child damaged property in the home on purpose, and 40 percent reported the child threatened to harm other children. Higher rates of most disruptive behaviors were reported in Level II homes compared with Level III.

Table 12
Percentage of Caregivers Reporting
Disruptive Behavior by Foster Children

	LEVEL II: ENHANCED FAMILY FOSTER CARE	LEVEL III: TREATMENT FOSTER CARE
HARMED ADULTS IN HOME	19	15
HARMED OTHER CHILDREN	30	15
THREATENED TO HARM ADULTS	16	27
THREATENED TO HARM OTHER CHILDREN	40	36
DAMAGED PROPERTY IN HOME ON PURPOSE	47	26

Counseling and Other Services

Foster parents were asked about mental health counseling for the children and the delivery of other support services. Table 13 indicates that the recent history of counseling or other support service use (within the last month) significantly differed by the level of care.

Table 13
**Hours of Support Services Within Last Month
 Reported for Foster Children**

HOURS OF . . .	LEVEL I: FAMILY FOSTER CARE		LEVEL II: ENHANCED FAMILY FOSTER CARE		LEVEL III: TREATMENT FOSTER CARE	
	N	PERCENT	N	PERCENT	N	PERCENT
MENTAL HEALTH SERVICES						
NONE	65	60	50	51	5	17
1 TO 4	30	28	26	26	13	45
5+	13	12	23	23	11	38
SUPPORT SERVICES						
NONE	80	76	61	62	6	21
1 TO 4	10	10	10	10	6	21
5+	15	14	27	28	17	59

Responses of 50 percent or over are in bold.
 Some respondents chose not to answer.

A substantial majority of children in family foster care did not receive services. The more surprising finding was the low receipt of services by children in enhanced family foster care. Children in this care category are supposedly differentiated from those in basic care because of higher service and supervision needs, yet most had not received mental health or other support services.

V. DECISION-MAKING ON PLACEMENTS

The Children’s Administration has identified several characteristics as important when making placement decisions regarding foster children.¹⁵ Caseworkers, foster parents, and agency employees were asked to rate how well these criteria were met for the particular child in the sample.

A substantial majority of caregivers reported that the current placement met the child’s needs on a variety of measures (see Table 14).

Table 14
Placement Appropriateness as Viewed by Caregivers (N=204)

MEASURES	LEVEL III: FAMILY FOSTER CARE	LEVEL III: ENHANCED FAMILY FOSTER CARE	LEVEL III: THERAPEUTIC CARE	
			TREATMENT FOSTER CARE	GROUP/ RESIDENTIAL CARE
	PERCENT AGREE	PERCENT AGREE	PERCENT AGREE	PERCENT AGREE
MAINTAINS CHILD RELATIONSHIPS	78	77	72	72
KEEPS CHILD CONNECTED WITH CULTURAL HERITAGE	82	86	79	82
PROVIDES PERMANENCY	83	76	72	34
PROTECTS CHILD FROM HARM	99	100	100	97
MEETS CHILD’S MEDICAL NEEDS	98	94	96	97
MEETS CHILD’S MENTAL HEALTH NEEDS	88	84	93	92
ACCESS TO SCHOOL SETTING AND SERVICES	95	98	93	88
PREPARATION FOR INDEPENDENT LIVING	91	88	90	87
PLACEMENT AND SERVICE PLAN WORK WELL FOR CHILD	95	94	86	85
SETTING PROVIDES A GOOD MATCH WITH CHILD’S NEEDS	94	95	90	80

¹⁵ Department of Social and Health Services, Children’s Administration Practices and Procedure Guide.

Satisfaction With the Children's Administration Caseworkers

Caregivers were asked to rate their satisfaction with the Children's Administration caseworkers and services for foster parents. The questions focused on whether the caregivers believed they received sufficient training, whether their input was heard, and whether they expected responsiveness from the caseworker if they needed help.

The responses were totaled to create an overall measure of satisfaction. Scores ranged from 1 to 5, with 1 reflecting strong agreement that the Children's Administration was helpful. For all levels of care, caregivers were very positive about the Children's Administration caseworkers with scores ranging from 1.6 to 2.0.

When potential respondents were initially notified about this study, some called the researchers and expressed concern that any criticisms of the Children's Administration could be passed on to caseworkers and potentially harm their relationship with the caseworker and/or the child. Despite assurances of confidentiality, some caregivers chose not to participate because of this concern. It is not possible to know whether some respondents were influenced by similar concerns.

Placement Matching to Child Needs

When foster placements fail, it is usually because children have behavioral problems that become unmanageable for foster parents. This failure may occur because children and families are not receiving the appropriate services or because the child's problems require a more comprehensive, therapeutic environment than is possible in a regular family home.

Children in long-term care vary in the degree of their problems, functional impairment, and attachment difficulties, with more problems consistently reported for children in higher levels of care. Differences in problem severity, as might be expected, are most pronounced when comparing children in family foster care with those in group/residential care.

One group of children—those in enhanced family foster care (Level II)—appeared the most mismatched. Although 44 percent were rated as having severe impairments that likely need intensive treatment, many had not recently received counseling or support services. The fact that a fourth of the foster parents have hired staff suggests that the children's behavior could not be managed in a regular family environment. In contrast, although a somewhat higher percentage of children in treatment foster care were rated as having severe impairment, 80 percent were receiving counseling and support services, and half as many of their foster parents hired staff.

Children in enhanced family foster care with severe impairment were more likely to be rated by caretakers as having problems with attention deficit, low intelligence, mental retardation, learning problems, being medically fragile, having a disability, and being insecurely attached. Ninety percent of children with more than four of these characteristics were rated as severely impaired by the foster parent. Homes where the children were rated as having a severe impairment were also more likely to have hired staff.

Enhanced family foster care does not appear to be an adequate placement for children with severe impairments.

Caseworker Perceptions of Placement Appropriateness

On a subset of cases (N=204), caseworkers also answered questions about the extent to which the placement met criteria established by the Children's Administration regarding appropriate placement considerations. The questions were identical to those asked of caregivers and produced similar results.

Caseworkers strongly agreed that the placement met the child's needs for safety, permanency, cultural and family connections, and health. Over 95 percent agreed that the setting and service plan worked well for the children.

VI. PERSPECTIVES FROM FOCUS GROUPS

Most children in long-term foster care carry at least some emotional or behavioral consequences of maltreatment and their parents' inability to resolve conditions that led to placement. As this study has revealed, many of these children have significant developmental, emotional, and behavioral problems and have impaired functioning at home, at school, in the community, or in relationships with others.

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

Foster parents have varying capacities to handle the range of children needing placements. When the child's problems are extreme, a family-like home setting may not provide enough structure and support. In these cases, a therapeutic setting providing round-the-clock supervision and treatment-oriented care is often necessary. This level of care is best provided in treatment foster homes or in residential facilities.

To learn more about the placement decision-making process in Washington State, focus groups were conducted. The groups included caseworkers (3 participants), foster parents (5 participants), and group/residential care providers (18 participants).

Caseworkers

Caseworkers indicated that a variety of factors influenced their decisions about the placement of children. There was general agreement that selecting a placement for a particular child is often not the result of identifying a family or setting that is especially well suited to meet that child's individual needs:

...once the decision has been made to place the child, the matching has to do with whether there is a foster parent available, whether that foster parent is willing to take that child, and whether the child can remain in their community so that visitation can occur so there's the least disruption to the child. I'm afraid that what we do more than anything else is resource driven.

Because there are rarely more placement options than children needing placement, caseworkers make pragmatic decisions based on "Is there an available bed for this age child?"

Respondents made a distinction between the decisions about placement into more intensive settings, such as group or residential care. Caseworkers appear to be quite autonomous in seeking an available space in a foster home, while decisions for residential care ordinarily involve extensive consultation. Group care coordinators and teams of

caseworkers and supervisors were mentioned as necessary participants. Placements into a group/residential care facility generally result after children have failed in family foster care.

Caseworkers were well aware of the extraordinary expectations placed on foster parents. Families are asked to take in children who often have problems resulting from abusive and neglectful experiences. They are expected to provide a loving and safe environment while at the same time tolerating children's difficulties in interpersonal relationships. Foster parents also must be willing to limit their emotional investment in these children so reunification efforts with biological families can be pursued. As one participant said:

I can't imagine doing what these foster parents do. You would have to pay me twenty thousand dollars a month...so to me the money is not even an issue. To me the hard part is what they are asked to do.

Participants recognized that foster parents might, unfortunately, at times get short shrift from caseworkers. Sometimes it is because a child's situation demands immediate resolution. In other cases, it is due to the priorities and legal requirements that dictate what caseworkers must do:

I sometimes wonder if we withhold information from foster parents that they initially should have in the decision-making process of whether or not they should accept a child. We just kind of skirt or minimize the behaviors, and then they are full blown in the foster home.

Foster families and their needs, although appreciated, are by law and policy secondary to the state's mandate to find temporary homes for children while attempting to restore children to birth families or kin:

Because, to tell the truth, our primary client is the child and its birth family. The foster parents, although they are certainly an integral part of what we do—we couldn't do they job without them—take a second seat to the primary needs of the child and the family.

Caseworkers mentioned the unrealistic assumption that altruistic motives are sufficient for foster families:

...the notion that loving a child would be enough, you know, providing a safe home for them, it's not enough any more.

They noted that many children come with problems that might have even begun to develop in-utero. Specific mention was made about children from drug- or alcohol-affected families, children who have criminal behavior, or children who are psychotic. The courts and other systems expect the Department of Social and Health Services to produce living environments that not only meet the children's needs but also afford protection from harm to other children and to the community. Children coming into care now are thought to have far more complex problems than in the past.

Caseworkers were well aware that they are not always able to provide the desirable support and assistance to foster families:

...there is very little understanding of what the demands are on the social worker in terms of training, in terms of court work, in terms of other responsibilities for other children on their caseloads. And so that impacts their availability to respond to the foster parents as quickly as they would like to.

In terms of policies that exacerbate instability of placements, caseworkers mentioned the fact that higher payments or more intensive settings are often time-limited and these limits can undermine efforts to retain foster parents or keep children in the level of care that they need. While there may be incentives initially for foster families who agree to care for severely troubled children, they are removed as soon as the children improve. More intensive settings, such as therapeutic foster homes or residential care, are by design limited to certain lengths of stay.

They'll go from setting to setting because [the settings] are time-limited.

Caseworkers also mentioned that, in many cases, the available services to support children and foster parents are not as helpful as they might be. In particular, outpatient mental health care that is delivered in a clinic is not seen as especially useful for many of the children:

And the mental health system has to go out into the field into these homes, into the settings where the behaviors are occurring and do the interventions and provide support.

The idea of assessment centers, preferably home-like or cottage-type environments, was mentioned as a possible improvement. Under this scheme, children could receive assessments in a single place rather than being sent to individual providers who each offer a limited perspective. If a comprehensive picture of the child's needs was available, it might lead to improved matching and stability.

Foster Parents

The foster parents who participated were recruited from the Foster Parents Association of Washington State (FPAWS) and were very experienced and knowledgeable. Many had clearly been providing foster care for years, some had adopted children from foster care, and one was a foster parent recruiter. These participants had a sophisticated understanding of the applicable federal and state laws, rate structures, and the pressures faced by caseworkers. They gave many examples of cases that reflected a broad range of foster care situations, from infants recently entering the system to very troubled teenagers who had many previous placements.

Participants reported that placement decision-making is very often driven by the availability of a home that will take the child:

Our experience is they call around and whoever has an empty bed, they are going to place that child with us, if we agree to it. A lot of times, they are

looking for a bed space, so they give it to you, and they are going to tell you what you need to hear so you will take the kid.

Foster parents concurred that there are insufficient foster homes to match children to specific home settings. One consequence is that caseworkers either do not know or do not communicate all of the pertinent information about a child before the placement. There were many comments about receiving children and only later learning crucial information about their history or about problems that might interfere with placement stability. One parent described a seven-month-old child who was a “screamer” and had already been in three homes; another reported receiving a child with sexual behavioral problems despite having made clear that this behavior was not acceptable given the presence of other children in the home. The message was not that they were unwilling to take these children in all cases, but rather that being informed would help make the placement successful:

We got a call...and, instead of getting our feet wet, we got dumped in at the end of the flow. Pretty much the child ended up blowing out of our home. Whereas, had we known the problems ahead of time, we could have headed those off at the road and been able to deal with those. We adopted a child with an attachment disorder that we probably wouldn't have adopted if we knew now what we knew then, and we were just told she needs lots of love and care. And well, for the first two years we struggled with that, and now it's—now it's been at least twice, maybe three times as difficult working with therapists and stuff, not only to repair the damage she had when she came to us, but repair what's happened the last two years because we didn't know what we were doing. We weren't prepared for a child like that.

If a greater supply of foster parents were available, and caseworkers knew the foster parents well, a very different approach could be taken:

The caseworker is going to be able to be picky. They aren't going to call and say, Hey have you got a bed open. I need it. Instead they are going to call you and say, I was wanting to talk to you about a child. I have a couple of resources, but would this child fit in your home?

Under these circumstances, foster parents would feel as though their opinion counted and that they were a part of a team.

The foster parents agreed about the importance of being involved in case planning and decision-making. They were frustrated by restrictions on the information they could be given, especially about the birth parents, but recognized that there were laws prohibiting dissemination of certain information. On the other hand, they found it very helpful to meet with caseworkers, counselors, and guardians-ad-litem to determine a child's needs and to set up a plan. They also observed that they often had specialized information about the children and their functioning.

The supply and retention, I think, would be a lot easier if the team work were there.

They described the many expectations that go with being a foster parent, such as:

It requires so much of parents' attention during the day. You have to be available for the principal to call, the counselor to call, the teacher to call and be able to go to the school at a moments notice.

As one foster parent noted:

I have had to cut back on my hours. I had a perfect work record until I became a foster parent.

In addition, children may arrive at a foster home with virtually no possessions, and only a token amount of money is available for clothing or supplies for the child. The state expects foster parents to acquire necessities and wait a month for reimbursement. The foster parents described how expenses can add up:

We draw on our reserves, and those reserves never get replaced because by the time that little check comes around, it's always spent because of the extra laundering cost because they wet the bed or they wet their clothes or they damaged their clothing or they damaged your walls or your doors...these fees never catch up. So you cut down on the little extra things on the budget that you were planning. Like maybe that dinner out with your husband to talk about the family. Or maybe that roller skating trip that would be really great for the kids, but that's going to take an extra twenty, twenty-five bucks, and I better get Johnny the mattress cover he needs for his bed.

They would like to give these children the toys or clothes that not only would help them make a smoother transition in the foster home, but allow them to experience a more normal childhood. The foster parents spoke to the reimbursement structure. They described having to be aggressive advocates under the previous cost rate system to get the level of support they felt was necessary.

You know, it just makes you feel bad because most of us aren't in it for the money. We are in it to help children. And so, why should we have to scrape and scrounge and beg and plead... I was looking at taking care of this child for the rest of her life, you know, why turn around and dicker over fifty dollars. Seriously, it's really low pay. You have got to do this totally out of the heart or else you are a fool for doing it.

They were skeptical of the new rate structure because it is based only on the time necessary to care for the child. Because it is based on children having problems that require extra time and effort, the ordinary needs of families can be missed:

We work twenty-four seven, and we need a break once in a while, not because they are being a bad kid or something is going haywire. Frankly, if X and I want to get off by ourselves, I take a day off work because we can put the kids in day care and so we go to lunch. We don't go out at night. Well, we go out at night, but we take seven [people]. If I want to go out for bingo or something, if I use a respite caregiver, it comes off my one day a

month which means when I want to take my week's vacation, I don't have [that] day. There should be some kind of system also that allows you to be able to hire a respite caregiver for a couple of hours...that's just the kind of a normal thing that I would think any loving couple wants to do and spend time together themselves.

The legal requirements imposed on foster parents make it more difficult to maintain ordinary family life. For example, they may not use anyone as a babysitter who has not had a criminal background check or been approved as a respite care worker by the caseworker. This same restriction applies to allowing children to stay overnight with friends.

Foster parents also described the pressure associated with the expectations for what happens in their homes: "We are set at this super high standard." Even the most innocuous circumstances, such as a young child falling and scraping a knee, can produce anxiety about whether this incident will be perceived as their failure to provide proper supervision. They described feeling as though they needed to communicate every detail to the caseworker or risk possible investigation. Foster parents also described the discomfort of being investigated.

Participants discussed the key roles often played by biological parents. Children may be affected by their visits with biological parents, but foster parents are not permitted to have full information about the parents. They also commented that often the rationale why some children are returned home or kept in care was difficult to discern. They believed that many children were left for long periods in limbo, or procedures to terminate parental rights were repeatedly delayed or extended for what seemed like the flimsiest of evidence that the parent had improved. This situation inevitably has an impact on the children and on foster parents in terms of the expectation of stability and permanency and the degree of emotional commitment that foster children and foster parents can make with each other.

They need to follow through on terminations, and they need to let you know, especially when you are asking is the child going to be here for a while or...is there a chance it is going to go home. And not that you are going to treat that child any differently, but at the same time you can kind of not get your hopes up that this is one you are going to be able to have around for a long time.

Another complaint concerned foster parents' access to service resources for the child and the restrictions imposed by payment methods. In many cases, children can only receive services from agencies that take medical coupons. Foster parents believed that they are often forced to accept whatever is available even though they may not have had positive experiences with the agency or what is available is not appropriate.

Despite concerns about the way the system works, foster parents expressed a high level of commitment to caring for these children. There were observations that many caseworkers go the extra mile and make themselves available to foster parents, even off hours. They also described programs in various regions of the state that they considered exemplary. For example, in some areas there are support systems and mentors for foster parents, while in others a standard format is used to outline the rules and expectations or the background and interests of children before they arrive in a foster home. Programs that

emphasize foster parent involvement and provide support and guidance were really appreciated.

Group/Residential Services Providers

The participants, all representatives of private agencies contracting with the state, clarified that their organizations provide more than group or residential care. These agencies may also license and supervise foster homes and offer various support services. Children in their care, therefore, may be residing in a facility or in a home-like setting. These providers stressed the importance of distinguishing between foster homes that are part of a continuum of care overseen by private agencies from “state” foster homes.

With regard to the placement decision-making process, children are usually referred to group care by the Children’s Administration after having “blown” out of several state foster homes. Because state and federal laws mandate placement in the least restrictive environment, they noted that failure in a family home is usually required before a child is considered for a more intensive setting. An individualized assessment is typically not part of the process. However, participants noted that the actual placement determination is often driven by available resources:

I think it is sometimes simply where the bed is, not necessarily what’s best for the child or who can best provide the appropriate services. It goes back five years ago when they designed the system of care and said, there will be an assessment piece; the state says, yes, we do systematically categorize kids in terms of assessment levels...but there is no systematic approach to it. To me, it’s a supply and demand...

Participants remarked that there are significant regional differences in referral patterns. Sometimes this variation is caused by differences in community supports and services:

So, if you have a child in foster care in a rural area, there may not be a mental health center anywhere nearby to provide any in-home intervention or support for the kinds of issues that we are talking about, and so that child may go almost immediately to a restrictive level because of lack of resources.

In other cases, there are apparent differences in philosophical views about the value of group care:

Some regions aren’t fond of group care and don’t believe there’s much use for it, and some regions see a much greater use for it. There’s a difference in the way they choose to review and [make decisions on cases].

Some regions and offices are viewed as thoughtful and “planful,” while others operate in a crisis-driven mode: “I’ve got a kid; I’ve got to place them. You’re a group home, come get them.”

It was noted by participants that there is no systematic assessment process within the Children's Administration. Assessment information that is required by policy as part of a group home referral is often not sent with referral packets. They reported it is not uncommon for entire sections of the forms to be incomplete or for certain routine evaluations—for example, psycho-educational evaluations performed by schools for special education students—to be missing from the files. There is also often a long interval between the decision to refer a child and when the material is compiled and the child can be moved to the group care provider.

It will still take three months or more for all the information to get gathered together even though it's [a child] in the system already.

Participants noted that caseworkers frequently do not know the children well, are unfamiliar with their background, and have incomplete files to use as a resource in answering questions. It may take strong advocacy on the part of a desperate parent or foster parent to accelerate the process of getting required information so the child can be placed. One private agency representative stated that they are addressing this gap by having their own assessment process or by assigning staff to contact previous providers to track down the relevant information:

We have dramatically slowed down our intake process so that we can better assess whether or not a kid is appropriate for our program.

Participants indicated that most have sought and obtained national accreditation, which sets standards for service delivery, including what information should be considered in the intake process. They strongly endorsed accreditation as an excellent mechanism for quality improvement and standardization. In general, the participants saw themselves as striving to achieve a system of care that responds to the child in an individualized fashion based on nationally accepted standards.

I would say the majority of providers in this state have a national perspective, have built their own continuums. So basically, when a provider takes a kid on this level of care, they are anticipating discharging to some service that they either provide directly or have some connection to.

Intensive levels of care are typically transitional in that they are used to stabilize behaviors and reduce symptoms until children can be placed into family settings. Because of this policy, these placements can subject children to additional movements and changes in their home, school, and community environments.

The participants have attempted to create an alternative process where children who may initially need residential or facility-based care can be transitioned to less intensive settings within the same agency. In addition, they make every effort to locate and utilize community resources that can provide additional services.

Participants contrast this approach with the way they perceive that the Children's Administration often operates in its relationships with other groups or systems.

I sometimes think that if there was a philosophical change from the top down, and that change was to view providers and foster parents and community as respected resources and partners, a lot would be gained. I think there's a certain adversarial sort of thing now, and that's one of the reasons that you don't get maybe all the information that's needed on placement, and foster parents are not provided with all the things that are needed. They are saying we have to get this child placed and, you know, we will do what we have to do to get them placed. But it seems like it could be a more open and shared process.

One participant mentioned that sometimes caseworkers behaved as if the money for the higher care levels was taken from their own pockets, and another described an internal Children's Administration procedure for special review of high-cost cases. The participants reported increased strain in recent years between the Children's Administration and foster parents and private agencies.

There was a perception that the Children's Administration is driven by concerns about liability as a result of recent civil verdicts against the Department of Social and Health Services. For example, participants remarked that many foster parents have complained that despite the very difficult-to-handle children they take in, they now worry more about being investigated by the Division of Licensed Resources:

The foster parents are feeling this thing with CPS coming in at the drop of a hat. They can ask for support, support, support for weeks, and they're not going to get it. But make one call to CPS, and they can have a worker at the house in three hours.

The participants advocated for an approach with foster parents that paralleled the agency's structure and decision-making in which, for example, foster parents are not only provided with immediate access to crisis response and support services (e.g., respite), but are also included in decision-making about the children and training opportunities along with professional staff.

Participants unanimously agreed that the major cause of the systemic problems is inadequate funding of the Children's Administration, which leads to high caseloads for caseworkers and insufficient compensation for foster parents and contractors. They expressed extreme frustration that despite many previous reports, testimony before the legislature, and well-established needs, the state has been unwilling to provide the level of funding necessary to care for these troubled children. Much of what is perceived to be problematic in placement decision-making and instability of care can be attributed to not paying what it costs to do the job right.

Participants discussed what they had experienced as a common scenario: a caseworker must place a difficult child but is anxious to avoid the expense of a group care setting. In these situations, the caseworker often starts by offering extra payments to a foster family to secure a bed, even though the family may not be equipped to care for the child. This often results in failed placements and exacerbates the children's problems, eventually leading to the necessity of group care.

Once children arrive in the more intensive settings, the pressure...is always to limit the length of care, not because children do not need it, but to conserve resources.

One consequence of this approach is that as soon as children stabilize, pressure builds to move the child to a less-expensive setting:

And just because a child's behavior is even stabilized for a month or two, what happens is a child will be taken out and put back into that home, and [the situation] will blow up, or [the child will be] put in another foster home and [that placement] will blow up, and they'll be back in the program. I think that's part of the whole placement decision-making process. It is not just a child coming in, but as changes are made, once a child is in the system, I think that sometimes we base it on money as opposed to the real needs of the child.

Even though children may be thriving for the first time, respondents reported that because of costs as well as philosophy, it is not viewed by the state as a long-term alternative. These forces create a disincentive for success. As one participant commented:

The business people on my board are absolutely crazy about—crazy at this system because they continually say, let me get this right. If you do real good work with this kid, you get less money? If you do really incredible work with them, their symptoms go down, their category goes down, and you are going to get less money for doing that?

The participants expressed frustration that the Children's Administration and the legislature do not appear to appreciate that the children who require a more intensive setting have very severe emotional and behavioral problems that will not be resolved by short-term, cheaper interventions. And ironically, the children's difficulties are partially caused by multiple failed placements, as well as their original maltreatment and parental rejection:

The reality of it is these people are scarred and damaged pretty severely, and they'll be struggling with this their entire life. They are not going to be able to get over it in 18 months in group care and be all better.

It seems particularly unfortunate to these agency representatives that children's conditions deteriorate as a consequence of state policies and practices, yet the state is unwilling to change its policies.

Despite their frustration that recommended changes are rarely acted on, the participants were clearly invested in doing what they could to improve the system and intended to continue pushing for reforms.

VII. FUNDING ISSUES

At the time this study originated, the Children’s Administration in DSHS had decided to redesign its rate structure for foster care and had selected a consultant for this purpose. The concerns that motivated this decision were identified as follows:

- **Accountability**—How to account for and monitor flexible funding.
- **Incentives**—Whether the system encourages the maintenance of the child in care rather than improved outcomes.
- **Market Demands**—Relationship between the supply of foster homes as a resource for the most difficult children and the amount that the families can receive.
- **Consistency Between and Among Regions**—whether the great discrepancy among regions in the use of these plans is warranted by the characteristics of the children.¹⁶

As of January 2001, the previous system of Basic Rate, Special Rate, and Exceptional Cost Plan payments was replaced by a four-tier payment system. The child’s social worker and foster parent jointly complete a Foster Care Assessment Form that takes account of the child’s needs and the foster parent(s) obligations to meet these needs. The rate schedule is as follows:

Table 15
**Monthly Rate Payment Schedule
 By Age of Child and Level of Care**

	AGE 0–5	AGE –11	AGE 12+
SCHEDULE 1	\$351.31	\$426.81	\$499.95
SCHEDULE 2	\$519.62	\$595.12	\$668.26
SCHEDULE 3	\$846.52	\$922.02	\$995.16
SCHEDULE 4	\$1,110.24	\$1,185.74	\$1,258.88

The assessment takes account of the average number of hours the foster parent needs to spend on the child in the following areas:

Care of Child

- Physical Needs
- Behavioral Needs

¹⁶ Hornby Zeller Associates, *Foster Care Rate Redesign: Final Report* (Prepared for the Casey Family Program and State of Washington Children’s Administration, June 30, 2000).

Participation in Child's Therapeutic Plan

- Physical Therapeutic Plan
- Emotional/Behavioral Therapeutic Plan

Education

- Individual Interaction
- Advocacy

Arranging, Scheduling, and Supervising Activities

- Medical/Dental Appointments
- Parental Visits/Other Activities

House Care

- Chronic Conditions
- Destructive Behavior
- Preparing Child for Transition

For each area, the numbers of hours or activities per week are measured. (See Appendix B for the Assessment Form.)

The rate structure allows an exception for “children with extraordinary needs.” These children have medical, emotional/behavioral issues that require extraordinary parenting and care duties and, in most instances, have exhausted all placement options. Reimbursement levels above the top tier are allowed; the reimbursement level equals the amount paid under the previous system. Special approval is needed for this rate. The Children’s Administration intends to review this decision after there is some experience with its operation.

The new rate structure was designed to be cost-neutral and was subject to pilot tests before implementation.

The new rate structure was phased in through June 30, 2001. Because this new system was in transition during the study, the researchers could not assess its operation or how it may influence placement decisions over time.

VIII. SUMMARY AND DISCUSSION

In Washington State, like most other states, placement decisions about long-term foster children are influenced by a combination of factors.

- *Federal and state legal mandates* set the context within which caseworkers must operate. The most influential legal factor is that children must be placed in the *least restrictive, most family-like environment*.
- A placement must be *available* and *willing to accept* the child.
- Costs are also a key factor. The state has forecast a \$267 million price tag for foster care in the 2001–03 biennium. The median monthly cost for licensed foster care costs ranges from \$344 per month (family foster care) to \$3,400 per month (group/residential care).

Two-thirds of foster care children in Washington State are placed in family foster homes—this is the traditional setting conjured up by the term “foster care.” The remaining third are in a variety of settings ranging from foster homes with additional services and staff to residential treatment facilities.

Policy Questions

This study was designed to answer the following research questions:

- As a group, how are Washington’s children in long-term foster care functioning and behaving?
- Are these children placed in the right settings?
- Does the state have an adequate supply of placement options for its foster care population?

This section will first cover these topics, then conclude with findings on related questions.

How Are the Children Doing?

The following picture emerged for children over 4 years old in long-term care:

- Most have emotional, behavioral, and learning problems, are functionally impaired in key areas of role performance, and have difficulties in relationships with caregivers.
- For a substantial portion, these problems are severe.

Given the circumstances that initiate a foster care placement, this picture is not surprising. Children in long-term term care are victims, or at high risk to become victims, of maltreatment. In addition, when children do not return home in less than 90 days, it is usually because their parents are unable or unwilling to correct the conditions that led to placement. The experiences of children who have moved from placement to placement have likely exacerbated their underlying problems.

Overall, the youngest children in care (those under age 4) were in better shape. Most were in family foster care, and proportionally few were rated with developmental delays.

Are Foster Children Placed in the Right Settings?

When caregivers—foster parents and private agency staff—were asked to rate a particular child’s placement, most rated the current setting as appropriate for the child. The respondents strongly endorsed the placement as a good match for the child, meeting goals of safety, permanency and stability, cultural and family needs, and health and mental health needs. Appropriately, group/residential care was not usually rated as meeting permanency needs.

Overall, the match between children and care level was quite good. Children who were in the best shape in psychosocial terms were in the most family-like, least costly setting. Children exhibiting the greatest problems and requiring the highest level of supervision were in the most intensive level of care.

One group of children—those in enhanced family foster care—appeared the most mismatched. Although 44 percent were rated as having severe impairments that likely need intensive treatment, many had not recently received counseling or support services. The fact that a fourth of the foster parents have hired staff suggests that the children’s behavior could not be managed in a regular family environment. In contrast, although a somewhat higher percentage of children in treatment foster care were rated as having severe impairment, 80 percent were receiving counseling and support services, and half as many of their foster parents hired staff.

We found substantial variation in the number and length of placements by care level. For children in family foster care, the median number of prior placements was 3. For those in the highest care level—therapeutic care—the median was twice as high. Almost a third of the children in therapeutic care had more than ten prior placements.

Children in family foster care had been in care a median of just over a year, whereas the median was 3 years for those in therapeutic care. The time range in each category was extremely broad, with 4 months as the lowest and 11 to 13 years as the highest. Focus group participants observed that children must fail in placements before being moved to a higher care level; their view is supported by this data.

Does Washington Have an Adequate Supply of Placement Options Given the Needs of the Foster Care Population?

The state does not appear to have an adequate supply of the third level of care—therapeutic care. A significant percentage of children in family foster care and enhanced family foster care are severely impaired. The high number of prior placements for some children in these care levels is further evidence that they are either not receiving appropriately intense services or are not placed in the right care level.

At the same time, the study indicates that some children are sufficiently stabilized to make the transition from therapeutic care to family foster care. Standardized instruments could help with these decisions. A child's improvement in a higher care setting can be evidence that the setting is appropriate; thus, care must be taken in deciding to alter the placement.

Where Are the Weakest Links in the System?

Child welfare professionals and policymakers share a broad consensus that when children must remain in foster care for extended periods, placement stability is a priority goal. At present, multiple failures in one setting are the most common "trigger" events that move a child to a higher level of care. As covered earlier, the median number of placements was twice as high for children in the highest level of care, and many more children in this group had numerous placements. The least restrictive, least expensive setting is an appropriate placement choice many times, but decision-making needs to place a higher emphasis on placement *stability*.

In reviewing the study findings on foster children in Washington, the group appearing at highest risk of placement failure are those placed in enhanced family foster care who display serious behavioral or functional problems. Many of these families report that they are not receiving services, and significantly more foster parents of children with these characteristics have hired staff to help with care-taking. Three explanations for this finding are possible:

- The children are not identified by caseworkers as needing more intensive services or levels of care.
- The available services are not viewed as beneficial to the child and/or family.
- Hiring staff is seen as a viable alternative to such services.

Given the serious problems reported about these children, a natural question is why they are not moved to the next care level. In this case, the next level would be treatment foster care (a version of therapeutic care). This setting is a specialized family home where the foster parents have agreed to provide high levels of supervision and a therapeutic living environment. The parents receive special training and immediate access to support, crisis response, and respite.

Because so many children in enhanced family foster care have significant problems, it may be unclear to caseworkers when treatment foster care is justified. Caseworkers may think of treatment foster care as a "step down" setting after children stabilize in a group/residential setting rather than viewing it as an alternative therapeutic setting.

Could Assessments Improve Decision-Making?

The 2000 Legislature directed the Children's Administration to implement a standardized, validated approach to screening children within the first 30 days of out-of-home placement.

Working with professionals from the community, the Children's Administration developed an assessment model called "KIDSCREEN." This process was modeled after the screening/assessment process developed for the Texas Human Resources Department. The assessment covers six topics, called "life domains":

- Child development
- Life events
- Family/social characteristics
- Child's educational needs
- Emotional/behavioral assessment of child

Four field offices are serving as pilot sites for this project: Seattle South, Bellingham, Olympia, and Omak. The sites are relying on common instruments to measure some life domains, as well as testing a couple of options for other domains.

As of February 2001, nearly 200 children had received initial screens.¹⁷ An evaluation of the assessment project is being conducted by the Office of Children's Administration Research, and an update is due to be released in July 2001.

Clearly, the "KIDSCREEN" has important applicability to placement decisions in foster care. This assessment could assist caseworkers in determining initial placement levels, as well as informing decisions when caregivers report that the child is experiencing significant problems.

The companion report to this paper by Doran and Berliner¹⁸ provides caution about experiences from other states that have attempted to incorporate assessments into decision-making. These states have encountered some significant barriers, including caseworker resistance. Successful implementation requires an investment on the state's part, both in identifying and evaluating a valid and workable instrument and in orchestrating and reinforcing the implementation in agency policy and supervision.

The High Cost of Failure

Although therapeutic foster homes and group/residential settings are more expensive than family foster care, substantial costs are also associated with placement failure. Placement failure takes a toll on children, even those who are functioning well. Children with multiple disrupted placements have been shown to develop more severe problems; these are more expensive to address and may or may not be ameliorated.

¹⁷ Office of Children's Administration Research, *Kidscreen Evaluation Report*, (Olympia, WA: Department of Social and Health Services Children's Administration, February 2001).

¹⁸ Lee Doran and Lucy Berliner, *Placement Decisions for Children in Long-Term Foster Care: Innovative Practices and Literature Review*, (Olympia, WA: Washington State Institute for Public Policy, February 2001).

In addition, foster parents who are asked to take on children without the necessary support services, or children whose problems outstrip the capacities of ordinary families, may abandon this role. It is expensive and difficult to recruit foster parents, and the costs increase when many foster parents decide to no longer participate and new families must be recruited. Finally, caseworkers expend substantial time when a placement is at imminent risk or fails. This situation creates a crisis that requires the caseworker's immediate and full attention. The stress of this decision-making environment also discourages thoughtful planning and full consideration of the child's therapeutic needs.

What Steps Could Increase the Likelihood of Placement Success?

The study suggests four directions:

1. Structured assessments can assist placement decisions.
2. Foster parents need to be fully informed about children's history and emotional/behavioral problems before a placement, particularly in situations where the placement goal is long-term stability.
3. Prior to all but temporary placements, foster parents need to be specifically informed regarding the expectations for their participation in treatment to alleviate children's behavioral problems.
4. For many children in long-term foster care, caregivers report severe impairments and yet indicate that relatively few of these children are receiving services intended to address and resolve behavioral and psychological issues. When children have significant problems in functioning, caseworkers should make affirmative efforts to ensure that mental health and support services are supplied. It is especially important to try to preserve a placement that is in jeopardy because of the deleterious effects of failure on children. These services might include mental health counseling, intensive family preservation services, respite, foster parent support groups, or mentoring for the children.

What Kind of Treatment Is Most Likely to Help Children?

Most people think of individual counseling sessions when they think about mental health treatment for a child in foster care. Unfortunately, this kind of treatment has been found to be ineffective for the behavioral problems that commonly cause the problems that threaten placements: problems of defiance, disobedience, aggression, anger outbursts, or inappropriate sexual behavior.¹⁹

Several specific interventions have been developed for children in foster care and proven effective in maintaining placements or reducing problems in foster children. Unfortunately, these programs are not commonly available in all areas of the state. To change this situation, the Regional Support Networks would need to give foster children a higher priority for service and contract for proven behavioral interventions.

¹⁹ J. R. Weisz, B. Weiss, S. S. Han, D. A. Granger, and T. Morton, "Effects of Psychotherapy With Children and Adolescents Revisited: A Meta-Analysis of Treatment Outcome Studies," *Psychological Bulletin* 117(1995): 450-468.

How Do Caregivers Rate Caseworkers?

Caregivers expressed satisfaction with their relationship with the Children's Administration. Although it is relatively common to hear complaints about the unavailability of caseworkers' support to foster parents and other caregivers, individual respondents rarely reported such problems in the structured interviews. In many cases, state caseworkers were rated as performing their jobs in a highly competent manner.

What Can Be Learned About Recruiting and Retaining Foster Families?

Clearly, foster parents in Washington are providing safe and loving homes to maltreated children. They welcome troubled children into their homes even though this situation places significant burdens on them. Many foster parents report that the children's problems interfere substantially with their work, ordinary family activities and relationships, and the care of other children. In addition, many foster children are violent and destructive and require constant supervision.

The study tells a story about foster parents that may be helpful in recruiting and maintaining foster parents:

- 35 percent become foster parents because of a particular child;
- 20 percent of caregivers are related to children;
- 27 percent of foster parents also have an adoptive child in the home; and
- Two-thirds have been foster parents for less than five years.

These results reinforce the state's policy to seek caregivers from a child's extended family or with adults who already have a connection to them. While most families do not remain foster parents long term, as a group, foster parents are more likely than most families to adopt a child. Future efforts at recruiting and retaining foster parents should also coincide with policies that promote placement stability. Initial placement decisions that correspond to the level of difficulties faced by a foster child and ongoing supports appropriate to the needs of the foster family are two steps that may improve the continuity of foster care placements and lead to positive outcomes for youth in foster care.

APPENDIX A: STUDY METHODOLOGY

Any study of human subjects must be conducted with sensitivity to privacy concerns as well as concerns about how the study could affect individuals. A study of children in foster care necessitates additional concerns because the state is acting both as their parent as well as the body asking for information. Thus, the research procedures were established with particular sensitivity to the population's vulnerability. The DSHS Human Research Review Section approved the study and established the procedures to be followed. The key provisions are summarized in this appendix.

Members of the research team at the Washington State Institute for Public Policy, Harborview Center for Sexual Assault and Traumatic Stress, and the Social and Economic Sciences Research Center signed Confidentiality Agreements.

Caseworkers, caregivers, the children in long-term care, and participants in the focus groups were considered subjects, and consent procedures were required for participation. Because children were not directly interviewed, caseworkers and caregivers were permitted to consent on their behalf. They were given opportunities to decline participation and were encouraged not to participate if there were any concerns that participation would negatively impact the foster child or the foster parent/foster child relationship. The Human Research Review Section approved the scripts (verbal contacts) and statements (written contacts) that were used.

Method

Total Sample of Children in Long-Term Foster Care

Data on children's demographic characteristics, legal/placement history, and cost of care were extracted from CAMIS and SSPS.

Research Procedures

Subjects

- Caregivers of children in long-term care (foster parents and group/residential staff) participated in a 45-minute interview and completed a standardized behavior checklist. They were paid \$20 for their time.
- Caseworkers of children participated in a 15-minute telephone interview.

Measures

Caregiver interviews gathered:

- Demographic information;
- Responses to questions from research instruments assessing functioning (4 to 7 year olds) or developmental concerns (children younger than 4 years old);
- Items describing attachment status;
- Ratings of placement appropriateness using Children’s Administration criteria;
- Satisfaction with the Children’s Administration caseworkers; and
- Characteristics/perceptions regarding foster parenting (foster parents only).

Caseworker interviews covered:

- Ratings of placement appropriateness using Children’s Administration criteria; and
- Perceptions of policy issues.

Focus Groups on Placement Decision-Making

Subjects

Caseworkers, foster parents, and group/residential agency representatives.

Procedure

Names of caseworkers who were experienced in placement decision-making, foster parents referred by the Foster Parents Association of Washington State (FPAWS), and administrative personnel (directors or their designees) from the primary group/residential care providers were forwarded to the SESRC. SESRC invited individuals to participate in separate focus groups that inquired about perceptions of placement decision-making.

Participants were invited to participate by letter and assured of confidentiality. Consent was given by responding to the invitation and attending the focus group. Participants were not identified in the transcripts.

Residential Services Time-Line

Human Research Review process begins.....	07/01/00
Final approval received	08/24/00
Confidentiality Agreement signed by all parties	08/29/00
Data set received from CA and stratified sample of subjects identified for interviews	09/00
Subject recruitment.....	10/01/00 – 01/15/01

Human Research Review Section Approved Process for Subject Recruitment

Process for obtaining consent for participation:

- Caseworker is contacted by telephone and after hearing a HRR Section-approved script gives permission for a letter to be sent from the Children’s Administration informing caregivers of the study.
- Letter is sent to caregiver from the Children’s Administration, and, if the caregiver does not call to decline further contact within 2 weeks, caregiver identifying information is forwarded to Harborview.
- Letter is sent from Harborview to caregiver explaining the study and requesting participation; if the caregiver does not call to decline further contact, the name and telephone number is sent to the SESRC.
- SESRC makes multiple (up to 18 callbacks) attempts to reach the caregiver, and, if the caregiver agrees, conducts a 45-minute telephone interview.

Minimum of 5 weeks from caseworker agreement:

Interviews conducted 01/17/01 – 03/02/01
Cleaned final data set received by Harborview Medical Center 03/09/01

APPENDIX B: FOSTER CARE RATE ASSESSMENT
