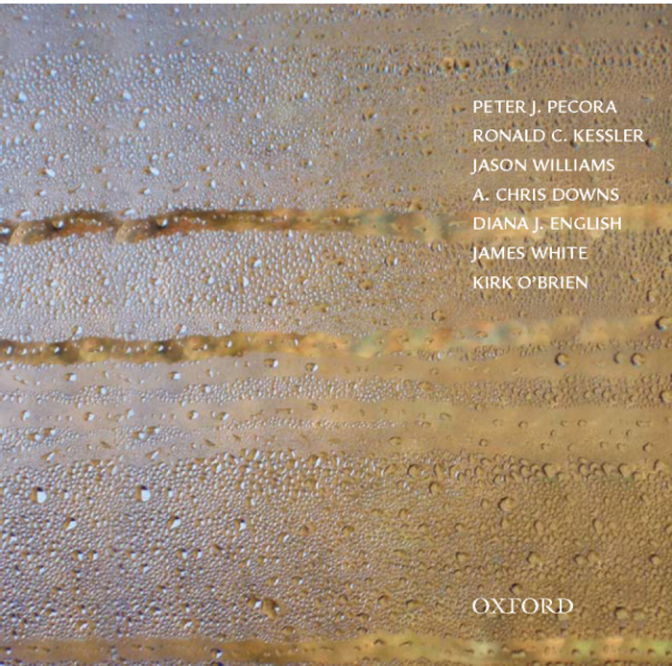
What Works in Foster Care?

KEY COMPONENTS OF SUCCESS FROM THE NORTHWEST FOSTER CARE ALUMNI STUDY



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Contents

PART I

INTRODUCTION

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Study Background, Rationale, and Participating Agencies

An interviewer reported interviewing a young woman who had been molested and raped from the age of two throughout her childhood. She was not removed from [her birth parent's] home until high school. She has spent her whole life climbing the ladders to overcome the backlash of her childhood. She is now employed at a drug and alcohol treatment center, has gotten her eating disorders at bay, and in her spare time makes bean bag couches. Then, life put another ladder in front of her: she now has multiple sclerosis. "We sat in her apartment while she walked me through her childhood pain. Soft saxophone jazz and giant cups of herb tea were an ironic calm to the storm of her life. In this humble interviewer's opinion, I met a remarkable woman this day."

This book focuses on how a group of young adults functioned years after leaving foster care. It also examines what made a difference in their lives. The research team investigated the role that quality services can play in helping children who spent time in foster care as adolescents become successful adults. The findings have much practical value for policymakers, administrators, line workers, and communities concerned about supporting children in foster care and young adults who have left foster care. More specifically, The Northwest Foster Care Alumni Study (Northwest Alumni Study) examined outcomes for adults who were placed in family foster care as children (here referred to as *alumni*). The investigation included adults who were between the ages of 20 and 33 during the interviewing period (September 2000 through January 2002), who had been placed in family foster care between 1988 and 1998, and who were served by one of three agencies: *(1)* Casey Family Programs; *(2)* the Oregon Department of Human Services, Division of Children, Adults, and Families; or *(3)* the Washington Department of Social and Health Services, Children's Administration, Division of Children and Family Services.

The primary research questions were:

1. How are maltreated youth who were placed in foster care faring as adults? To what extent are they different in their functioning from other adults?
2. Are there key factors or program components that are linked with better functioning in adulthood?

To answer these and other questions, case records were reviewed for 659 alumni. An attempt was made to track these alumni, and interviews were conducted with 479 alumni. Although the in-person interviews explored retrospectively some experiences while the alumnus or alumna was in care (e.g., educational services, therapeutic services, and therapeutic supports), they focused primarily on current adult outcomes including mental health, education, and employment and finances. Subsequent chapters, in addition to describing demographics, birth-family strengths and risk factors, agency membership, foster care experiences, and outcomes, present data explicating the relationship between foster care experiences and outcomes. These analyses will prove extremely useful for practitioners and policymakers as they work to improve services that will enhance the lives of youth in care.

This chapter begins by presenting data on the number of youth in care in the United States and how long they receive services. Next come a description of family foster care and a summary of the expectations of care. Then findings from foster care studies, research limitations, and the financial costs of providing care are presented. Conclusions about foster care are then drawn, followed by the rationale of the Northwest Alumni Study. The chapter concludes with a brief description of each chapter of this book. Quotes from alumni are included throughout the book to provide a first-person context; these were taken from interviewers' notes.

Foster Care by the Numbers

Placement of Children as a Consequence of Child Maltreatment

Every child has a right to a childhood experience that promotes healthy growth and development (United Nations, 1990). However, nearly 50,000 children come to the attention of child protective service agencies throughout the United States each week (U.S. Department of Health and Human Services, 2006). In 2007, approximately 5.8 million U.S. children were reported to child protective services as possible victims of abuse and neglect, with 794,000 confirmed victims (U.S. Department of Health and Human Services, 2009). When birth parents or other caregivers do not provide adequate protection and nurturance, city, county, or state governments intervene *in loco parentis* to care for the child (Wald, 1975).[1]

In 2006, an estimated 312,000 children received foster care services as a result of investigation for child abuse or neglect (U.S. Department of Health and Human Services, 2008c). About 783,000 children, or 1% of the nation's children, are served in foster care settings at some point during each year, including children who return home but reenter foster care (U.S. Department of Health and Human Services, 2008d). At any one time during the year, nearly 500,000 children are living in out-of-home care.

Though preventing the placement of children in foster care and minimizing their length of stay is a child welfare priority, many children will spend

a substantial amount of their childhood in foster care (U.S. Department of Health and Human Services, 2006). Nearly half of the children placed in foster care will remain there for a year or longer, with an average length of stay of two years. More specifically, of those children in foster care as of September 30, 2006, 58% had been there for 12 months or longer. Of those leaving care in fiscal year 2006, 49% had been in care for 11 months or less, but 16% had been there for three years or more. Over 26,000 older youth emancipate to adulthood from a foster care setting every year (U.S. Department of Health and Human Services, 2008c). While many children reunite with their birth parents or are adopted, some children remain in care until their 18th birthday, the time of emancipation.

In Oregon, one of the two states in the study, 6,199 children entered foster care in fiscal year 2006, with a total of 11,021 children in care on September 30, 2006. In Washington, the other state in the study, 7,004 children entered foster care in fiscal year 2006, with a total of 10,068 children in care on September 30, 2006 (U.S. Department of Health and Human Services, 2007b).

Duration of Stay in Foster Care

As discussed below, a primary goal of foster care is achieving a permanent living situation for the child. Despite the efforts of family-based service placement prevention programs (e.g., Walton, Sandau-Beckler, & Mannes, 2001), family reunification programs (e.g., Pine, Healy, & Maluccio, 2002; Walton, Fraser, Lewis, Pecora, & Walton, 1993), aggressive adoption and guardianship programs (Stein, 1998; Testa, 2002), and an emphasis by child welfare policymakers on shortening the length of placements,[2] many children will spend a substantial amount of their childhood in the foster care system (Wulczyn & Brunner, 2002) (See Figure 1.1). Nationwide, the median length of stay for children in care on September 30, 2006, was 15.5 months (U.S. Department of Health and Human Services, 2008b). In Oregon, the median length of stay for children in care in 2005 was 14.4 months (NDAS: http://ndas.cwla.org/data_stats). In Washington, the median length of stay for children in care in 2007 was 17.5 months (National Resource Center for Family-Centered Practice and Permanency Planning, 2008a, 2008b).

Foster Care: Goals, Objectives, and Key Outcomes

What Is Family Foster Care?

We believe that communities should be willing to invest as much to keep a family together as they would pay for placing a child. Despite this approach, many children are served by foster care, and many stay for an extended period of time. But what exactly constitutes family foster care? When a child's safety in the home is not guaranteed or the parents are unable to care for the child,

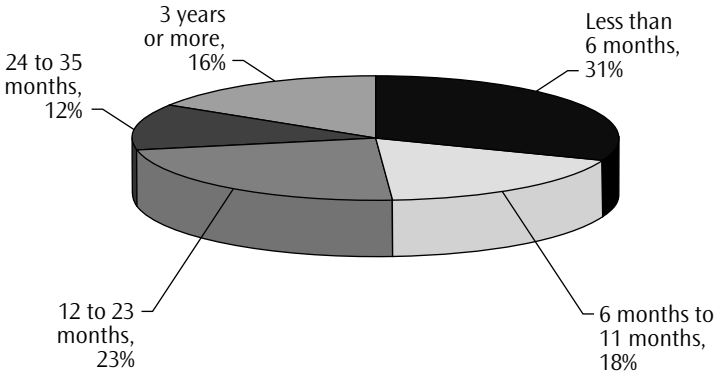

Figure 1.1. Duration of Stay for Children Exiting Foster Care During Federal Fiscal Year 2006 (Note that entry cohort statistics are more accurate.)

alternate systems of care come into play. The term *foster care* is generally used to encompass not only family foster care, but also placement of children and youth in group homes and residential settings—a topic covered later in this chapter. Family foster care, which is the focus of this chapter, has been defined as

> . . . the provision of planned, time-limited, substitute family care for children who cannot be adequately maintained at home, and the simultaneous provision of social services to these children and their families to help resolve the problems that led to the need for placement.
>
> (Blumenthal, 1983, p. 296)

The above definition reflects various principles that are well accepted in the field of child welfare, as exemplified by the "CWLA Standards of Excellence for Family Foster Care" (Child Welfare League of America, 1995), although not fully realized in policy or practice. First, family foster care is conceptualized as a comprehensive family support service, and the family is regarded as the focus of attention. Second, family foster care is carefully planned to be short term and to provide access to time-limited services and opportunities that can help families to become rehabilitated and children to grow up and develop into healthy adults. In some cases, however, longer-term services may be needed by families. And the sense of urgency to move children into a more permanent living situation has increased over the past 20 years.

The major functions of family foster care include emergency protection, crisis intervention, assessment and case planning, reunification, preparation for adoption, and preparation for independent living. To implement such functions, diverse forms of foster care are required, including emergency

foster care, kinship foster care, placement with unrelated foster families, treatment foster care, foster care for medically fragile children, shared family foster care, and small-family group home care. Also, long-term family foster care is an option for a small number of youth for whom family reunification, kinship care, or adoption are not viable permanency planning options.

In addition, there are indications that family foster care is responding to the substantial behavioral health needs of the children in care and becoming more treatment oriented. Specialized family foster care programs—particularly treatment foster care—for children and youth with special needs in such areas as emotional disturbance, behavioral problems, and educational underachievement are gaining significant use (e.g., Chamberlain, 2003).

Family foster care is sometimes provided as a multifaceted service, including specialized or therapeutic services for some children, temporary placements for children in "emergency" homes, and supports to relatives raising children through kinship care (Maluccio, Pine, & Tracy, 2002). (While there is little descriptive data on services to children in foster care, our experience is that much foster care is delivered without significant services for children other than basic health care and referral to mental health agencies for treatment.) In this book, *foster care* refers to both family and nonfamily types of out-of-home care, including shelter care, group homes, and residential treatment centers.

Current Goals, Objectives, and Key Outcomes of Foster Care

Although some of the current system goals, objectives, and key outcomes were not outlined explicitly during the time youth were in care during this study, similar principles were in place as the alumni had to have been in foster care as an adolescent between the years of 1988–1998 but they actually could have been in care as early as 1970 or in some form of transition services in 1999. This section places foster care in Oregon and Washington in the political context in which it functioned during the period of the study. Because foster care practice and programs have been governed by an intricate set of policies and laws at the federal, state, and local levels (Curtis, Grady, & Kendall, 1999; Lindsey & Schwartz, 2004; Pew Commission on Children in Foster Care, 2004), evaluation of such a piecemeal system has been extremely challenging.[3]

Historically, child welfare reviews focused on case record documentation (process) rather than on the capacity of state or local child welfare service agencies to create positive outcomes for children and families. Since March 25, 2002, the federal government has changed its approach to assessing state child welfare programs with the introduction of child and family services reviews. These reviews examine the outcomes of services provided to children and families served by state child welfare agencies. These outcomes

fall into three categories—safety, permanence, and well-being—which are described below:

Child Safety

- Preventing further child maltreatment by birth family members and others while the child is placed in foster care

Child Permanence

- Achieving a more permanent living situation for the child through reunification; adoption by relatives, foster parents, or nonrelatives; guardianship; or other methods
- Minimizing movement of the child from one home to another and from one school to another

Child and Family Well-Being

- Restoring and strengthening birth family functioning
- Maintaining family, school, and other connections
- Stabilizing or improving the child's emotional, social, and cognitive functioning
- Enabling positive ethnic identification
- Addressing physical health and mental health care (U.S. Department of Health and Human Services, 2003a)[4]

These three domains encompass what might be termed *immediate concerns* and are necessary considerations regardless of the length of stay in foster care. Other concerns surface as the length of stay for a youth increases. Duration of care can be triaged into the following groups:

1. *Group A:* Roughly one-third of the child and family situations are resolved quickly and permanently through reunification, adoption, or some other means.
2. *Group B:* About 18% of the children stay in foster care for six months to one year (U.S. Department of Health and Human Services, 2008b). Although more complicated, these situations usually are resolved with the same sorts of permanent placements described for Group A.
3. *Group C:* The remaining situations (about half of all situations) last for more than one year. Some of these youth are eventually placed in a permanent home. Unlike the cases in Groups A and B, a significant proportion of these cases are closed when the child reaches the age of majority (emancipation) rather than through a permanent placement. Also included in this group are those cases in which reunification was attempted unsuccessfully and an ensuing second or third foster care placement took place. These youth, who did not achieve a stable home, represent the failure of prompt or successful permanency planning.

All participants in the Northwest Alumni Study were Group C situations. In addition to the immediate concerns of child safety, child permanence, and child and family well-being, youth experiencing longer durations of care have additional outcomes with which agencies providing care must be concerned, including emotional, physical, and cognitive development. Specifically, the

following outcomes are considered important for youth in long-term care (American Academy of Pediatrics Committee on Early Childhood Adoption and Dependent Care [AAP], 2000; Berrick, Needell, Barth, & Jonson-Reid, 1998; Casey Family Programs, 2001, 2003a; Wulczyn, Barth, Yuan, Harden, & Landsverk, 2005):

- Reduction in the emotional trauma of child maltreatment
- Healthy physical development through regular checkups and adequate medical, dental, and vision care
- Avoidance of teen pregnancy
- Life-skills development
- High school graduation
- Healthy socialization
- Healthy adult relationships

Why Should Society Care About Foster Care Outcomes?

Why should society care about how youth formerly in care function as adults? And why should evaluation research be conducted to assess outcomes? First, a significant number of children and families are affected by child maltreatment and, consequently, are served in foster care every year. Second, existing research has found that outcomes are good in some areas and poor in others. Third, there are many gaps in the research on the effects of foster care and what factors are associated with positive outcomes. Finally, the financial costs of foster care are substantial, with over $20 billion spent every year. The next sections discuss each of these reasons in more detail.

Large Numbers of Children and Families Are Served in Foster Care

The number of children remaining in foster care at the end of the federal fiscal year has risen substantially since 1980. As described previously, in 2007 about 783,000 children (including re-placements) were served during that fiscal year, with 496,000 children remaining in care at the end of that federal measurement cycle—September 30, 2007 (U.S. Department of Health and Human Services, 2008d). The increase in placement rates over time and the lack of more substantial decreases may be due to cuts in preventive services, frequent agency leader turnover, dramatic increases in crack/cocaine and methamphetamine abuse, reduction in public housing and an increase in homelessness, continuing unemployment in many geographical areas and in some ethnic communities, and other factors. Studies have indicated that foster care *reentry* (Wulczyn, 1991), weak reunification efforts (Wulczyn, 2004), and parent substance abuse and mental health disorders (Besharov & Hanson, 1994; Marsh & Cao, 2005) have also contributed to the rise in foster care numbers. In fact, various studies have estimated that between 50% and 80% of parents involved with child welfare agencies are having

difficulty with substance abuse (Bruni & Gillespie, 1999; Child Welfare League of America, 1998). Community-based prevention initiatives need to be strengthened.

Foster Care Outcomes Are Mixed

How is the child welfare field doing in terms of achieving key outcomes for children served in foster care? Results are mixed and, as will be documented in Chapter 2, in some areas, such as postsecondary educational achievement and employment earnings, the results are unacceptably poor. The evidence from some recent studies has indicated that some children who received foster care services were at greater risk of being arrested or incarcerated, of having lower high school graduation rates, of experiencing lower employment rates, of suffering from depression more frequently, and of being overrepresented among the homeless when compared to the general population (Buehler, Orme, Post, & Patterson, 2000; English, Widom, & Brandford, 2002; Pecora et al., 2003a; Widom, 1989a) or when compared (in some cases) to children from families with similar income or other demographic characteristics but who experienced no foster care placement (see, e.g., Minty, 1999; Pecora & Wiggins, 2009).

In contrast, other studies have found that certain alumni outcomes were reasonably positive: Youth in care exhibited improvements in physical health, emotional adjustment, school performance, and behavioral functioning (Berrick et al., 1998; Biehal & Wade, 1996; Coulling, 2000; Goerge, Wulczyn, & Fanshel, 1994). Due to the mixed results of foster care studies, additional research is necessary to identify more clearly areas of success and areas requiring attention.

Methodological Limitations of Research on the Effectiveness of Foster Care

Concrete information explaining why some studies demonstrate successful outcomes and others do not is lacking. Possible explanations include different levels of rigor in study methodology and the fact that some services work better for some children than others. Ultimately, broad conclusions about foster care outcomes from existing studies cannot be made because of the following methodological issues (some exceptions noted):

1. Comparison groups, matched on variables such as family background, preplacement child adversity, age, ethnicity, and gender were not used. Further, data have not been statistically adjusted for variables such as these.
2. Few quasi-experimental or experimental studies exist. Control groups permit valid comparisons to the general population of children or to subgroups of children with similar family or child characteristics who have not been placed (Barth, 1990; Holdaway & Ray, 1992; Jacobson & Cockerum, 1976; Jones & Moses, 1984; Rice & McFadden, 1988).
3. General population or other benchmarks were not used to place findings in context.

4. Sample sizes were too small to support meaningful conclusions.
5. The field has overrelied on cross-sectional ("snapshot") or exit data instead of longitudinal cohort data (Courtney, Needell, & Wulczyn, 2004a). Exceptions include the National Survey of Child and Adolescent Well-being (NSCAW) and LONGSCAN, a longitudinal study of child maltreatment (Blome, 1994; Kohl, Gibbons, & Green, 2005; Runyan et al., 1998b; Starr & Wolfe, 1991; Usher, Randolph, & Gogan, 1999).
6. Few studies have collected detailed service data that permit analyses of services related to outcomes.
7. Important functional measures of child or adult well-being such as mental health diagnoses, employment, parenting as adults, and community service were not used.
8. Most follow-up studies collected incomplete educational achievement data because they did not follow alumni long enough to capture high school completion with a graduate equivalency degree (GED) or college completion when the individuals were in their mid- to late 20s.
9. A common set of standardized diagnostic measures that assess behavior, educational functioning, satisfaction, self-esteem, and other central dependent variables were used infrequently. Thus, comparisons to other populations are limited.
10. Youth in care, caregivers, alumni, and front-line staff were not often involved in study design and data interpretation, which would have helped ensure that researchers gathered meaningful information in respectful ways.
11. For new or underexplored problem areas, few qualitative studies were completed that would help the field better understand the program model, the dynamics of treatment, consumer perceptions of service, and what is working for whom and why.

The Financial Costs to Society Are Substantial

In addition to the large number of children served and the mixed outcomes they experience, society should also be concerned with foster care because of the financial costs of providing services. Foster care services represent a major societal investment. As with any investment, Americans have a right to know the economic return on that investment. From the moment that calls are screened by an agency charged with initiating an assessment of possible abuse or neglect, through removal and placement of children in substitute care, to pursuing permanency options (such as reunification or adoption), to emancipation, to the ultimate disposition of cases, the full range of child welfare services to children and families is covered through a multi-billion-dollar patchwork of federal, state, and local funding. For example, in state fiscal year 2006, $25.1 billion was spent, including $12.4 billion from federal funds, $10.6 billion from state sources, and $2.6 billion from local governments (DeVooght, Allen, & Geen, 2008).[5]

Other, more general costs to society have been estimated by various experts. For example, the *direct costs to society* due to hospitalization, chronic health problems, mental health care, child protective services, family

support, foster care, law enforcement, and the judicial system have been conservatively estimated at $24.3 billion (Fromm, 2001). This must be a conservative estimate, as federal, state, and local funding in state fiscal year 2006 was estimated at $25.7 billion alone (DeVooght, Allen, & Geen, 2008). The *indirect costs* in terms of special education, later mental health and physical health care, juvenile delinquency, lost productivity to society, and adult criminality were estimated at an additional $69.7 billion, for a total cost estimate of *$94.1 billion annually* (Fromm, 2001).

The costs for treatment and other services may not be surprising, given national data that establish a strong link between childhood adversity and later adult psychiatric disorders (Kessler, Davis, & Kendler, 1997). So, the overall social and fiscal significance of this program area is high. Children are traumatized, parents suffer, and agencies have been sued when their responsibilities for child safety, stability, and nurturing were not fulfilled. For example, thousands of individual lawsuits and over 25 child welfare–related class action lawsuits have been filed against states in the past 20 years based on maltreatment of children while in care, inadequate provision of mental health services, frequent placement moves, and other practice deficiencies that led to a child's injury or poor development. When these societal costs are added to those described above, the overall costs are extraordinarily high.

The Condition of Foster Care

Practice experiences; research findings[6] from landmark studies such as those of Fanshel and Shinn (1978), Maas and Engler (1959), and the National Survey of Child and Adolescent Well-Being (NSCAW) (U.S. Department of Health and Human Services, 2001b); a long history of research in other countries;[7] and more recent critiques of foster care have underscored a number of points concerning foster care in the United States.

First, despite its temporary intent, foster care has become a permanent status for many children entering the system. Further, until the mid-1980s, many children "drifted" in foster care, going from one placement to another, with little sense of stability or continuity in their living arrangements. Although more attention has been paid to permanency planning recently, the latest federal outcome data document that some children continue to experience too many placement changes.[8]

Second, family supports remain inadequate and unforgiving (Curtis & Denby, 2004). For example, because of time limits placed upon public assistance provided by Temporary Assistance for Needy Families (TANF; five-year limit) and parent rehabilitation before termination of parental rights imposed by the Adoption and Safe Families Act (ASFA), many families lack the resources and time needed to rehabilitate (U.S. Department of Health and Human Services, 2003a). Indeed, many children placed in foster care come from poor families that are barely managing to survive on limited income from public assistance programs (Lindsey, 2004).

Third, children of color are disproportionately represented in foster care in many communities, and they experience less positive outcomes. This is especially true of African American, Latino, and American Indian/Alaska Native children (Hill, 2001, 2007; U.S. Government Accountability Office, 2007). To date, the factors that drive disproportionate representation and outcomes are not fully understood and programs are only beginning to address the issue.

Fourth, as discussed above, data on the effectiveness of foster care are mixed. Improving a system of care with such mixed outcomes is a challenge because, until recently, the data haven't suggested where to target interventions. However, this study and others (Courtney et al., 2005a, 2007) suggest that addressing the mental health needs of youth in care may be the place to start. Further, underresearched areas remain. For example, there is some evidence that keeping siblings together has beneficial effects in terms of placement stability and other outcomes (Hegar, 2005; Leathers, 2005), but more data are needed.

Finally, common standards of care and performance targets are new to foster care. Built on the collection of common child demographics and general rates of child maltreatment, formal expectations of foster care now exist. For example, recent legislative action has focused on introducing key measures or outcome indicators that are customized according to the population and type of service being provided, emphasizing such important areas as length of care, freedom from child maltreatment, placement stability, and permanency (U.S. Department of Health and Human Services, 2000, 2001b, 2007a).

Unfortunately, recent reviews of state performance have revealed continuing problems in program performance (U.S. Department of Health and Human Services, 2003b). Consequently, pressure from private and public agencies, juvenile court judges, physicians, and other stakeholder groups is being applied (Wulczyn et al., 2005). In response to this poor program performance and poor foster care outcome data, questions about the effectiveness of the child welfare system continue to be raised. Suggested potential solutions include better community-based family support programs, lowering child welfare worker caseloads, providing more thorough worker training and supports to increase retention rates, more support of foster parents, and more explicit foster care practice philosophies and guidelines (Casey Family Programs, 2000, 2003a).

Rationale of the Northwest Alumni Study

The number of children in long-term (greater than one year) foster care is troubling, especially given a child's elongated sense of time and need for enduring positive relationships with caring adults (Berrick et al., 1998). As a child's time in care increases, the nature of a program's accountability shifts to focus more on long-term needs and development. Unfortunately, the data on how children who have experienced long-term foster care develop and

function as young adults are lacking. More information is needed to determine what experiences and services best result in adult success.

Research on the consequences of maltreatment (see Pecora, Wiggins, Jackson, & English, 2009b) indicates that many children in foster care have had significant preexisting physical and mental health, education, and behavioral problems that may be exacerbated by their placement experience and lack of services. Services provided to address these needs while a child is in foster care, however, may have important mediating effects upon the effects of maltreatment. While some studies have addressed drug abuse, alcoholism, and depression as consequences of maltreatment, there is little research regarding the post–foster care impact of maltreatment on education, employment, and social relationships. And, with few exceptions, standardized diagnostic measures, longitudinal approaches, retrospective studies, and experimental designs have not been used to answer two important questions: *(1)* How are maltreated youth placed in foster care faring as adults? *(2)* Are there key factors or program components linked with better functioning in adulthood? To begin to address these questions, findings must be compared to similar data for other populations (benchmarks). For the few studies that have examined the long-term effects of foster care, comparisons with other alumni of foster care studies, general population, mental health, or Census Bureau studies have been rare.

In sum, while there is much more research about child maltreatment and its effects and about the general trends of children placed in foster care, there is a dearth of rigorously gathered outcome data concerning youth in foster care, and there remain many unexamined questions regarding the long-term effects of placement and how certain elements of foster care might help youth overcome the effects of maltreatment and grow to become successful adults. The Northwest Alumni Study has attempted to address these and other questions.

The next section summarizes the program mission, goals, resources, and foster care practice models that were operational in the three agencies involved in the Northwest Alumni Study during the study period 1988–1998:

1. Casey Family Programs (Casey)
2. Oregon Department of Human Services, Children, Adults and Families (Oregon DHS)
3. State of Washington Department of Social and Health Services, Children's Administration, Division of Children and Family Services (Washington CA/DCFS)

Description of Casey Family Programs

Overview

Casey is a privately endowed operating foundation, established in 1966 by Jim Casey, the founder of United Parcel Service (Kupsinel & Dubsky, 1999). Casey began by providing planned long-term foster care to youth in Seattle,

Washington. Based on a business model, the explicit goal of the program was to support foster children's development by focusing on education, social achievement, and the long-term success of each child. Individual self-sufficiency, a primary focus of Casey programs, was different from that of most child welfare agencies of the time, which were more concerned with children's adjustment to foster care. Casey staff members were expected to contribute to the development of new techniques of providing foster care by carefully matching youth with foster families who wanted to raise one or two children to adulthood.

Business and organizational values of United Parcel Service were transferred to Casey. These values included an emphasis on the following:

- *A primary focus.* There was a concentrated focus on one service: long-term family foster care.
- *Maintenance and improvement of service.* Youth, families, and staff played active roles in maintaining and improving the quality of service.
- *A culturally diverse and experienced staff:* Small, direct-service units (divisions) were intentionally composed of well-trained, culturally diverse, and experienced staff (with caseloads averaging 15–17 per worker).
- *Team decision making and shared responsibility.* The work style in these divisions reinforced team decision making and shared responsibility for work with youth and families.
- *Staff reward and development.* Staff retention and internal promotion opportunities were supported through fringe benefits and a focus on professional development.
- *Quality improvement:* Improvement of public and private services for children and youth was advocated, particularly for the nation's out-of-home care systems.
- *Use of resources.* Funds were invested to increase the organization's ability to serve as a nationally recognized information and learning center in the field of child welfare (Casey Family Programs, 1995).

Program Focus and Design

There were few changes in the core Casey program mission during the study period, with the exception of the development of life-skills tools and training (e.g., Ansell-Casey Life Skills Assessment [ACLSA]) in the mid-1990s. Early in the study period (1990–1992), Casey systematically reviewed best practices in foster care and developed a manual for child assessment and case planning: *Practice Guidelines for Clinical Practice and Case Management.* The manual was used agencywide, along with standardized child assessment instruments to help gauge the needs of children (e.g., the Ansell-Casey Life Skills Checklist and the Achenbach Child Behavior Checklist, Teachers Report Form, and Youth Self-Report). Eight case-planning factors were used to organize and guide assessments of each child's strengths and deficits (Perry, Pecora, & Traglia, 1992):

- Emotional health
- Family adjustment and other relationships

- Cultural identification
- Competence and achievement
- Physical health
- Educational development
- Self-sufficiency
- Legal involvement

The initial and ongoing service planning was driven by quarterly assessment of each of these case-planning factors. Outcomes were determined by the use of subjective and objective measures, including normed educational and behavioral reports, DSM-III clinical diagnostics and assessments, as well as periodic child and family self-reports of behaviors and relationships (e.g., the Child Behavior Checklist). Additionally, Casey staff placed great emphasis on ensuring that youth, foster parents, and other caregivers were full partners in the development of service plans.

To facilitate comprehensive case-planning policies and guidelines, Casey staff had access to greater financial resources to ensure that children's social, emotional, and behavioral needs were met. Services included a broad array of normalizing child developmental experiences—art, music, group activities (e.g., Boys and Girls Clubs, scouting)—as well as child-specific therapeutic services. Further, Casey aides assisted by transporting youth to activities and to tutoring sessions.

Work in extending services beyond age 18 was initiated early in the 1990s, depending on the youth's needs and his or her level of investment in further work to prepare for the future. Providing youth with an organizational anchor was intended to extend surrogate parental involvement into young adulthood, to help youth cope with unfinished or delayed development tasks, especially in completing education. To further help youth, Casey provided a postsecondary educational scholarship program—Continuing Education and Job Training (CEJT). CEJT scholarships were offered to any past or current youth from care through age 22 who had been the recipient of Casey services for one year or more. Youth applied for one of three different program scholarships:

1. The Jim Casey Scholarship (for full-time schooling at vocational and technical schools, undergraduate schools, and apprenticeship and/or entrepreneurial training)
2. The Marguerite M. Casey Scholarship (for full-time graduate schooling toward a master's degree, doctorate degree, or professional certificate)
3. The Henry J. Casey Scholarship (for part-time vocational or undergraduate schooling requiring a stable, long-term job, held either full-time or part-time; may also apply to college classes taken while still in high school)

In addition to extending services to youth beyond foster care, Casey emphasized recruitment, development, ongoing training, and retention of foster parents. The program actively recruited families that were willing to embrace the values of the organization by conducting a comprehensive

assessment of prospective foster families. Foster families were assessed on their motivation to be foster parents, ability to work with Casey, personal history of caregiving, family values and beliefs, family system functioning, and parenting skills. After the family was accepted, Casey staff disclosed to foster families all the essential elements of a child's background that were directly relevant to the child's successful adjustment to the home.

During the study period, a greater focus on preserving kinship systems and recruiting extended family members to be caregivers to children who could not remain with their biological parents was established. For example, in 1992, nearly 25% of children were in relative placements; in 1996, that proportion increased to 31%. For both kin and nonrelated foster families, the goal was to nurture and support multiple healthy caregivers to children, including respite providers and Casey aides. By doing this, staff and foster families were offering each youth a network of caregivers, the same idea portrayed in the African proverb "It takes a village to raise a child."

Lastly, stable, well-trained staff members were a key component of Casey Family Programs. During the study period, Casey had a 6%–10% turnover rate, which was lower than that of most public child welfare agencies (Russell, 1987, p. 36). Factors contributing to the low staff turnover were the rewards and opportunities for professional development provided to Casey staff.

Characteristics of the Casey Foster Care Population

During the study period of 1988–1998, Casey recruited children from the nation's public child welfare system. Youth requiring long-term foster family care were usually referred by county or state foster care systems, with community sanction and oversight almost always provided by the legal system. The main intake criteria were as follows (Perry et al., 1992):

- Children accepted into Casey were between the ages of 6 and 15 years.
- Long-term foster family care was the plan of choice for the child at the time of intake. Children whose placement needs could best be met by any other permanent plan, including adoption or return to birth parents, were not appropriate for placement with Casey.
- The child must have been capable of self-sufficiency as a young adult. The program was not intended to serve children with disabling conditions at the time of intake that would interfere substantially with their likelihood to attain self-sufficiency.
- Community sanction must have been secured for all placements made with Casey Family Programs. *Community sanction* was legal recognition by the community that Casey was responsible for the care of a child (the day-to-day case management authority to make a variety of decisions and plan for the welfare of the child), regardless of the agency, entity, or individual with ultimate legal responsibility.

As displayed in Table 1.1, the Casey program model during the time of the study was long-term in nature, with workers having reasonable caseloads

Table 1.1. Characteristics of Services Provided by Casey Family Programs and the State Agencies During Most or All of the Study Period of 1988–1998

Characteristic	*Casey*	*Oregon DHS*	*Washington CA/DCFS*
Average size of foster care caseloads	Low: 15–17	Moderate: 25	High: 31[a]
Staff education:			
MSW level staff	Over 90%	20%	23%[c]
MSW and/or MA in another field	Over 98%	36.5%[b]	42%
Frequency with which children and foster parents were seen	Monthly	Monthly for children	Every 90 days
Worker turnover	Low (6–10%)[d] per year	Statistic not available	High (24.6% in 1999)[e]
Monthly foster parent retention payment (about $100 per month)	Yes	No	No
Child clothing allowance	Substantial	Moderate	Moderate
Foster parent satisfaction	High[f]	Moderate—High[g]	Moderate[h]
Foster parent training hours	Generally at or above the state minimum requirements[i]	Most foster parents met the annual training requirements	Most foster parents met the annual training requirements[j]
Foster parent turnover	10–12%[f]	32% [k]	28%[l]
Availability of supplemental services such as mental health counseling and employment experience	High[m]	Moderate	Generally low but varied by region[n]
Access to mental health counseling during the course of their time in the foster care program. (Note: All Casey youth had access to supplemental services, while youth in the public systems had less access due to funding limitations [expressed in percent])	98.6% (0.5)[o]	98.6% (0.7)[o]	92.6% (0.9)[o]
Use of mental health counseling during the course of their time in the foster care program (expressed in percent)	75.8% (2.4)[o]	70.8% (5.8)[o]	66.0% (1.8)[o]
Access to alcohol or drug treatment programs during the course of their time in the foster care program (expressed in percent)	98.5% (0.5)[o]	95.2% (1.4)[o]	91.2% (1.1)[o]
Use of alcohol or drug treatment programs during the course of their time in the foster care program (expressed in percent)	12.4% (1.6)[o]	13.5% (2.4)[o]	14.7% (1.3)[o]

(*continued*)

Table 1.1. Continued

Characteristic	*Casey*	*Oregon DHS*	*Washington CA/DCFS*
Access to employment training or location services in the last placement longer than three months (expressed in percent)	89.9% (1.5)[o]	84.9% (2.4)[o]	81.3% (1.5)[o]
Use of employment training or location services in the last placement longer than three months (expressed in percent)	48.1% (2.8)[o]	51.2% (3.5)[o]	45.8% (1.9)[o]
Cost per day (1998)[p]	$82.00	$49.16	$50.53
Mean time in care (in years)	9.8	4.4	5.3

[a] Washington State, Department of Social and Health Services. (Undated). *DCFS case count percentage comparison FY 1994—FY 1999* (Carol Brandford, personal communication, November 7, 2005).

[b] Oregon data are taken from a study of the Oregon CPS system conducted by the University of Southern Maine (Hornby & Zeller, 1992).

[c] November 2000 data.

[d] See Ezell et al. (2002).

[e] November 2000 data. The social worker turnover rate includes promotions, transfers, demotions, reassignments, retirements, deaths, and so on.

[f] Estimated by senior staff working in the Casey Family Program offices during the time of the study. See Doucette, Tarnowski, and Baum (2001); Le Prohn, Barenblat, Godinet, Nicoll, and Pecora (1996); Le Prohn and Pecora (1994); Vaughn (2002).

[g] Hornby and Zeller (1992) noted that 70% of the families who stopped fostering did so as a result of a change in their family circumstances and not as a result of their relationship with the agency (satisfaction).

[h] Washington State Department of Social and Health Services (1996) (Carol Brandford, personal communication, November 7, 2005).

[i] Le Prohn et al. (1996); Le Prohn and Pecora (1994).

[j] For example, annual governor's recognition event, steady increase in foster parents trained (e.g., in 1988, 342 trained; in 1998, 3,790 trained). In 1994, CA/DCFS received enhancement dollars to increase workshops for foster parents on special topics, worked collaboratively with the Foster Parent Association of Washington State (FPAWS) on preservice training—15 hours, 60 hours of a basic foster parent training course, and a special topic workshop (Sharon Newcomer, Washington State Department of Social and Health Services, Children's Administration Program Manager, personal communication, November 7, 2005).

[k] Compared to a Child Welfare League of America national average of 40%. See Hornby and Zeller (1992). Hornby and Zeller noted that 70% of the families who stopped fostering did so as a result of a change in their family circumstances and not as a result of their relationship with the agency (satisfaction).

[l] See footnote h above and Washington State Department of Social and Health Services. (Undated). *Report to the legislature: Recruitment of adoptive and foster homes 07/98—06/99. Olympia, WA: Author.*

[m] See Le Prohn et al. (1996); Le Prohn and Pecora (1994).

[n] Washington State Department of Social and Health Services (2004a). *Washington DSHS has made improvements in this area* (Carol Brandford, personal communication, November 7, 2005).

[o] Data taken from the Northwest Alumni Study alumni interviews. Numbers in parentheses are standard errors.

[p] The year 1998 was chosen for calculating the cost per day because this was the last year of the ten-year study period and cost data were more likely to be located. Neither Casey nor state costs include mental health costs, because the State of Oregon could not calculate these costs (Edgbert et al., 2004).

(averaging 16 youth per worker); low staff turnover (averaging 8.2% for 1995 to 1998 and 10% in 1998); good foster parent retention; and a variety of mental health, education, and other services available to the youth in care. The 1998 cost per child per day for Casey family foster care was $82.00 (not including physical health and mental health costs).

Description of the Oregon Department of Human Services, Children, Adults, and Families

Overview

Oregon child welfare services were state-administered and provided comprehensive programming in local communities. Between 1988 and 1998, the State of Oregon reorganized the delivery of child welfare services from what was called the Children's Services Division by creating three separate state agencies with overlapping responsibilities.[9] The Oregon State Office for Services to Children and Families (SOSCF) was part of this state-administered system, providing programming in local communities throughout the state. Its programs were governed by federal and state legislation, as well as state-specific policies and program guidelines.

Program Focus and Design

At the time of the study, SOSCF under the direction of the Department of Human Services (DHS) was the entity primarily responsible for child protection, foster care, residential treatment, and adoption services. The Oregon Commission for Children and Families (OCCF) developed programming at the state and local levels that responded to traditional family preservation and prevention services. The third entity created, the Oregon Youth Authority was mandated to work with juvenile corrections and focus on youth who had been adjudicated delinquent and who were in the juvenile justice system.

Oregon law assigned to SOSCF, the child protection organization, a broad mission in the area of child protective services. This organization was tasked with preventing child abuse and neglect, protecting children who had been maltreated, and, when possible, rehabilitating families in which children had been maltreated. More specifically, it was designed to provide a wide range of services to families and children, to take custody of endangered and maltreated children when necessary, to regulate private agencies dealing with endangered or maltreated children, to investigate and assess child maltreatment cases, to administer programs for foster care and adoption, and to play a key role in court proceedings on behalf of maltreated children.

The legal mission of SOSCF was balanced between child protection and family preservation. At least three separate legislative statements expressed basic policy concerning the mission of SOSCF. First, in listing its basic

powers, ORS418.005(1) stated that such powers had been created "in order to establish, extend and strengthen welfare services for the protection and care of homeless, dependent, or neglected children." Second, ORS418.745 provided that "the Legislative Assembly finds that for the purpose of facilitating the use of protective social services to prevent further abuse, safeguard and enhance the welfare of abused children, and preserve family life when consistent with the protection of the child by stabilizing the family and improving parental capacity, it is necessary and in the public interest to require mandatory reports and investigations of abuse of children." Third, ORS418.485 established policy concerning the purchase of care and services, providing in part, that "it is the policy of the State of Oregon to strengthen family life and to insure the protection of all children either in their own homes or in other appropriate care outside their homes."

During the study period, one of the major initiatives in Oregon was the development and expansion of the use of family decision meetings. Originally called *family unity meetings,* the purpose of these meetings was to focus on the needs of the child and to provide a forum to elicit the best thinking from a significant group of people on the safety and permanency needs of the child. Oregon became known for conducting multiple family decision meetings with families.

During the early 1990s and into the middle of the decade, SOSCF in Multnomah County expanded the role and accessibility of child welfare services to the community. One such function was in the decentralization of the single Multnomah County office into five separate neighborhood-based branches throughout the county. Each of the separate branch offices was staffed as a full-functioning, independent office under one judicial jurisdiction.[10] The branch office boundaries were based on the public school districts and the school catchment areas, which enabled the educational system to have a single point of entry into child welfare services. This configuration is important to note because this structure naturally lent itself to the practice of identifying school liaisons within child welfare. School staff then had a child welfare professional whom they could consult about specific children and families. Child abuse calls and mandatory reporter laws still required a formal process, but the liaisons provided a sounding board and troubleshooter for the schools.[11]

Throughout this period, SOSCF strengthened services to address the growing concerns about parent drug and alcohol abuse. Teams consisting of a caseworker, a drug counselor, and a community health nurse were established in order to provide a comprehensive approach to the issues involved in families struggling with drug dependency. These *Family Support Teams* were established in a number of the larger local offices across Oregon, including the Multnomah County Juvenile Court (the Portland site for the Northwest Alumni Study toward the end of the study period).

Toward the end of the study period, SOSCF entered into a settlement agreement with a group of child advocates to address a series of common concerns in the child welfare protective services and foster care systems. This

agreement resulted in SOSCF implementing a series of child welfare reforms called *System of Care* (SOC). It was based on a strengths/needs-based practice approach that addressed children's safety, permanency, and well-being needs, including attachment through more integrated services.

Characteristics of the Oregon State Foster Care Population

During the study period, Oregon's child welfare system continued to serve a wide range of children and families. Approximately half of the children and families served received in-home services and half were served in substitute care. Youth requiring long-term foster care, the population for this study, represented one group of the youth served in substitute care. The number of children in foster care grew during this period from 4,266 on December 31, 1988, to an average daily population of 6,543 in December 1998. Throughout this period, approximately 30% of the children in family foster care were placed with relatives. One-third of the children in foster care were between the ages of 0 and 5 years, one-third were between 6 and 12 years, and one-third were over 12 years. Lastly, in 1988, the median length of stay for children in out-of-home care was 49 days (the mean was 228 days). By 1998, the median length of stay had risen to 139 days (the mean was 404 days).[12]

In sum and as displayed in Table 1.1, Oregon's state family foster care program model focused on child safety and rehabilitating families. The average caseload for workers was moderate (averaging 25 youth per worker); foster parent retention was moderate; and there was high availability of mental health, education, and other services available to the youth in care. (Note that the staff turnover rate for this time period was not available.) The 1998 cost per child per day for Oregon family foster care was $49.16 (not including physical health and mental health costs).

Description of Washington State Department of Social and Health Services, Children's Administration

Overview

The Washington State Department of Social and Health Services, Children's Administration, Division of Children and Families (CA/DCFS) is part of a state-administered and state-provided child welfare service delivery system. Children and families enter CA/DCFS through three primary program areas: *(1)* Child Protective Services (CPS), *(2)* Child Welfare Services (CWS), and *(3)* Family Reconciliation Services (FRS). These programs are responsible for the investigation of child abuse and neglect complaints, child protection, family preservation, family reconciliation, in-home services, foster care, group care, adoption services, and independent living services for children ages 0 to 18 years.[13] At the time of the study, the CWS program provided

both permanency planning and intensive treatment services for children and families when children were in out-of-home care, dependents of the state, or legally free for adoption. The Office of Foster Care Licensing within the Division of Licensed Resources was responsible for the licensing and monitoring of out-of-home care facilities, including foster care, group care, and child placement agencies.

Program Focus and Design

Since 1987, the State of Washington's vision for child welfare services provided by the CA/DCFS has been described in mission statements that focus on protecting children, supporting the ability of families to care safely for their own children, ensuring that children are provided quality care in permanent family settings in a timely manner, and involving child welfare stakeholders (i.e., communities and tribes) in the state's efforts (Washington State Department of Social and Health Services, 1987, 1989, 1991, 1993, 2004b, 1995b).

Specifically, the mission of the CA/DCFS was to provide a comprehensive range of services that protected children from abuse, neglect, and exploitation; rehabilitated youthful offenders while providing community support and protection; and promoted healthy child growth and development. Services were intended to promote preservation, rehabilitation, and reunification of families to the maximum extent possible while providing services in the least intrusive and restrictive means possible.

Between 1988 and 1998, the goals and objectives for the CA/DCFS were identified as prevention, placement, substitute care, permanency, effective service to minorities, community support, and administrative practice (Washington State Department of Social and Health Services, 1987, 1989, 1991, 1993, 1995b). With regard to prevention, the CA/DCFS pursued ongoing goals of improving preventative services by implementing intensive placement prevention units and services, and by increasing funding for and availability of home-based placement prevention services (Washington State Department of Social and Health Services, 1987, 1989, 1991, 1993, 1995b).

A focus on placement decision making included expansion of Child Protection Teams to review decision making related to placement, developing tools to assess relatives as a placement resource, and regulating evaluation of local placement practices (Washington State Department of Social and Health Services, 1987, 1989). The primary goal of the service delivery system was to reduce placement rates overall while ensuring that children remained safe from serious maltreatment during and subsequent to involvement with child welfare services (Washington State Department of Social and Health Services, 1989, 1995b).

During this time period, the CA/DCFS pursued several objectives to meet the goals of improving social work practices and services for children removed from parental custody (foster and relative care) and to ensure that the agency