Foster Care Today

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Introduction

Foster care is a complex service. It serves children who have experienced abuse or neglect, their birthparents and families, and their foster parents. Children in foster care may live with unrelated foster parents, with relatives, with families who plan to adopt them, or in group homes or residential treatment centers. Because foster care is designed as a temporary service that responds to crises in the lives of children and families, an expectation exists that children who enter care either will return to their parents as soon as possible, or will be provided with safe, stable, and loving families through placement with relatives or adoption. Some children, however, remain in foster care for extended periods of time. Many "age out" and go on to live on their own. Over the past decade, the population of children and young people in foster care has grown dramatically, and the challenges associated with achieving permanency for them have mounted. As foster care faces new and increasing demands, policies and practice must respond in ways that ensure that children, their families, and their caregivers receive the highest quality service possible.

Numerous factors have shaped foster care over the past several decades. One key force has been the heightening of societal expectations and standards for acceptable family functioning, a social shift that began in the 1960s and continues to the present. In 1962, Dr. Henry Kempe and colleagues published "The Battered Child Syndrome" (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962), which raised public awareness about child abuse. Over the following four years, all 50 states and the District of Columbia enacted some type of child abuse and neglect reporting law. In 1974, Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), which provided funding to assist states in developing their child protective services systems. As amended most recently in 1996 (PL. 104-235), CAPTA requires states to have in place procedures for reporting suspected child maltreatment, investigating such reports, and taking immediate steps to protect children found to be at risk of harm (U.S. House of Representatives, 2000).

At the same time that child abuse and neglect reporting and intervention laws were being enacted, concerted public education efforts were being made to raise awareness of child abuse and neglect. The general public and professionals responded to these efforts, and the number of child abuse and neglect reports began to increase. That trend, which continues to the present, has had important implications for foster care.

A second key dynamic that has shaped foster care is the convergence of factors that place great numbers of families at increased risk of child abuse and neglect. Poverty, homelessness, substance abuse, discrimination, declining informal and extended family supports, and other forces are undermining the resilience and coping capacity of families (Freundlich, 1997). At the same time, the service systems on which families traditionally have depended have not kept pace with demand. The capacity of key systems such as mental health and substance abuse treatment is being strained, and service reductions and long waiting lists are commonplace. Prevention and early intervention services are more difficult to obtain, and treatment resources often are not available except in crisis situations. In addition, previous safety nets for families, most specifically Aid to Families with Dependent Children and the children's disability program under the Supplemental Security Income program, have been redesigned so that financial and health benefits are not available to the extent to which they were in the past (Freundlich, 1997). As family needs increase and intensify and other service systems are unable to respond, child welfare is becoming the system that, both legally and socially, is expected to intervene.

The result is a growing reliance on foster care as *the service* to respond to crises affecting children and families.

A third dynamic affecting foster care relates to the child welfare system itself and ongoing tensions regarding its role. These tensions play out at both the philosophical and service delivery levels and are evident in law, policy, and practice. Over the past three decades, child welfare services in general-and foster care in particular-have changed, reflecting prevailing values about the role that such services should play in preserving and/or reunifying families or in promoting alternatives for children other than reunification with their families (such as adoption and long-term foster care). As debate has raged regarding the nature of child welfare as "child" or "family" focused, practice has been beset by ambivalence regarding which outcomes are in children's best interests. In this context, the child welfare system continues to struggle to define and achieve appropriate outcomes for children.

Chapter 1 begins this examination of foster care at the start of the 21st century by looking at the demographic trends that currently shape foster care (e.g., child abuse and neglect rates, number of children in care, length of stay in care), as well as the demographic characteristics of the children in foster care. Chapter 2 discusses the factors that affect the families and children served through foster care-poverty, homelessness, adolescent parenthood, parental substance abuse, and HIV/AIDS. Chapter 3 reviews the policy framework for foster care, starting with the Adoption Assistance and Child Welfare Act of 1980 (PL. 96-272), and describes key federal welfare reform and child welfare legislation over the past decade. Chapter 4 turns to key aspects of practice that shape foster care as it is currently provided-the changing roles of foster parents, the growth of foster care accountability, the development and retention of qualified professional staff, increases in the array of permanency options, the involvement of kin, the use of concurrent planning, and the use of specialized foster care placements. By way of conclusion, Chapter 5 looks to the future of foster care.

Chapter 1

Demographic Trends

Advances in federal data reporting over the past several years have made extensive information available on trends related to the incidence of child abuse and neglect and children's entry into and exit from foster care. Other available data supplement this information and help form a clear picture of the key demographic characteristics of children in foster care. These data provide a critical framework for understanding the issues that currently confront foster care and that are likely to pose challenges in the future.

Child Abuse and Neglect

One trend impacting foster care is the steady growth in the number of substantiated reports of child abuse and neglect. Beginning in the 1960s, the number of reports of child abuse and neglect grew dramatically—from 10,000 in 1962 (Lindsey, 1996), to 60,000 in 1974, to 1.1 million in 1980 (Reid, 1995), to almost three million in 1999 (U.S. Department of Health and Human Services, 2001a). Consistent with legal mandates that certain professionals report suspected child maltreatment, more than half (54.7%) of the reports in 1999 were from professionals (educators, medical staff, law enforcement personnel, social services personnel, and others); the remaining reports were from relatives, friends, neighbors, "other," and anonymous sources (U.S. Department of Health and Human Services, 2001a). Of the three million reports received in 1999, close to 40% were screened out as not appropriate for investigation; 30% (868,000) of the remaining 1.8 million reports that were investigated were substantiated for child abuse or neglect (U.S. Department of Health and Human Services, 2001a). Of the substantiated reports, the majority (58%) involved neglect, 21% involved physical abuse, and 11% involved sexual abuse (U.S. Department of Health and Human Services, 2001a).

Most children who enter foster care do so following a substantiated report of abuse or neglect, although the proportion of substantiated reports that result in a foster care placement vary from state to state. In 1999, the overall percentage of children determined to be abused or neglected who were subsequently placed in foster care was 21% (approximately 171,000 children, based on the reports of 41 states) (U.S. Department of Health and Human Services, 2001a). Placement percentages, however, ranged among the states from 2.3% to 62% of the children determined to have been abused or neglected (U.S. Department of Health and Human Services, 2001a). In addition to those children for whom abuse or neglect was substantiated, 3% of the children who were the subjects of unsubstantiated reports (an estimated 49,000 children in 49 states) were placed in foster care (U.S. Department of Health and Human Services, 2001a).

Number of Children in Foster Care

The number of children in foster care has steadily increased since the 1960s, with the exception of a few years in the early 1980s. In 1962, 272,000 children were in foster care; by 1972, the number had grown to 319,800, and by 1977, to 502,000 (Tatara, 1993; U.S. House of Representatives, 1998). The population of children in foster care dropped sharply in the early 1980s, immediately following the

enactment of the Adoption Assistance and Child Welfare Act of 1980, a development discussed later in greater detail. The number of children in foster care rebounded in the late 1980s, however, and began to grow at an even swifter pace than had been the case in the 1960s and 1970s. This growth in the number of children in foster care persists today. The number of children in care in March 2000—approximately 588,000—is, in fact, more than double the number of children in care in 1984 (U.S. Department of Health and Human Services, 2001c). As Table 1 shows, the proportion of U.S. children living in foster care likewise has increased, more than doubling between 1962 and 1999.

Table 1

Number and Rate (per 1,000) of Children in the United States Living in Foster Care

Year	Number	Rate
1962	272,000	3.9
1967	309,000	4.2
1972	319,800	4.4
1980	302,000	4.4
1982	262,000	3.9
1984	276,000	4.1
1987	300,000	4.5
1990	400,000	5.9
1991	414,000	6.0
1992	427,000	6.1
1993	445,000	6.3
1994	468,000	6.6
1995	468,000	6.6
1996	507,000	7.0
1997	516,000	7.4
1998	560,000	7.6
1999	568,000	8.1

Source: U.S. House of Representatives 2000.

Three key dynamics are associated with the increasing number of children in foster care: higher rates of entry into foster care than of exit from care; high rates of re-entry into care; and placement of children in foster care through other systems.

Consistently, more children enter foster care each year than exit. For the six-month period from October 1, 1999, to March 31, 2000, 146,000 children entered foster care and 124,000 children exited

care (U.S. Department of Health and Human Services, 2001c). National as well as state-based analyses of foster care caseloads in New York and Illinois have shown that yearly admissions and discharges from foster care, which were fairly equal until 1986, are exhibiting ever-widening disparities (U.S. Department of Health and Human Services, 1991). In FY 1986, a national net increase of 5,000 children in foster care occurred; by FY 1998 (October 1997 through September 1998), the net increase had risen to 20,000 (U.S. Department of Health and Human Services, 1991; U.S. Department of Health and Human Services, 2000b).

High re-entry rates also contribute to the growing numbers of children in foster care. Although re-entry data historically have been limited, changes in federal reporting requirements are resulting in greater information on this foster care dynamic. Nationally, in FY 1998, approximately 17% of children entering foster care had previously been in care (U.S. Department of Health and Human Services, 2000b). Re-entry rates, however, vary among the states. In several states, including Illinois and New York, re-entry rates for FY 1998 were above 20% (U. S. Department of Health and Human Services, 2000b).

Finally, the growing number of children in foster care is also related to placements from other systems, specifically the mental health and juvenile justice systems. Increasingly, foster care is being used to care for children and young people who previously would have been served through children's mental health programs or in correctional facilities. Landverk and Garland (1999) estimate that between one-half and two-thirds of the children who enter foster care have behavioral or emotional problems that warrant mental health treatment. Similarly, Gilberti (1999) found that growing numbers of children with serious emotional problems are being relinquished to child welfare agencies so that residential treatment can be arranged for them. Others point to the increasing trend to divert youth into foster care from the juvenile and criminal justice systems (Hornby & Collins, 1981; Timberlake & Verdieck, 1987). Between 1984 and 1990, for example, the number of children who entered foster care after committing status and delinquent offenses increased 52% (Tatara, 1993).

The 10% or greater annual growth rate of the population of children in foster care—a trend affected by increasing disparities between the number of children entering and exiting foster care, high re-entry rates, and placements of children in foster care from other systems—poses substantial practice and policy challenges related to case planning, decisionmaking, and service delivery. These challenges are likely to become even more significant in the future should the population of children in foster care continue to grow at recent rates.

Length of Time in Foster Care

Many children who enter care remain for significant periods of time. Throughout the 1980s, the length of time children spent in care decreased (Tatara, 1993). Beginning in 1990, however, the average length of time children were in care began to increase (Tatara, 1993). With some fluctuations, the average length of stay in foster care has remained at high levels, with a median length of stay for children in foster care on March 31, 2001 of 21 months (U.S. Department of Health and Human Services, 2001c). In a number of states, the average length of stay of children in foster care is even greater. The median length of stay for children in care as of October 1, 1997 was 30 months in the District of Columbia; 35.6 months in Illinois; and 32.1 months in New York (U.S. Department of Health and Human Services, 2000b).

Extended stays for children in foster care raise a number of practice and policy issues. First, the longer children remain in care, the more placements they are likely to have. In FY 1998, for example, a significant number of children in foster care (almost a quarter of whom had been in care for more than three years) had experienced multiple placements: 21% had three or four placements, 8% had five or six

placements, and 8% had seven or more placements (U.S. House of Representatives, 2000). Second, the longer children remain in care, the longer they are likely to stay in foster care, with mounting challenges to achieving permanency for them (Glisson, Bailey, & Post, 2000). Finally, as discussed later, the longer children remain in foster care, the greater the risks to their overall health and well-being (Fanshel, Finch, & Grundy, 1989).

Demographic Characteristics of Children in Foster Care

Key demographic characteristics of children in foster care—age, racial and ethnic backgrounds, and health status—have important implications for the services needed by the children, their foster parents, and their birthfamilies, and impact the nature of foster care today.

Age of Children in Foster Care

Two aspects of the age of children in foster care are key: the age at which children enter foster care and the distribution of children in foster care by age group. The age of children at the time of foster care entry has followed a cyclical pattern. In 1977, 12% of children entering foster care were under the age of 1 (U.S. Department of Health and Human Services, 1998a). The proportion of children entering foster care who were very young began to increase in the 1980s; by 1994, almost one-quarter (23%) of the children entering care were under the age of 1 (U.S. Department of Health and Human Services, 1998a). At the same time, the proportion of adolescents (ages 13 and up) entering care fell from 29% in 1977 to 16% in 1994 (U.S. Department of Health and Human Services, 1998a). Federal data for the period October 1, 1999 through March 31, 2000 indicate that the proportion of very young children entering foster care has fallen. Paralleling the data of the late 1970s, 13% of the children entering care during that six-month period were under age 1 (U.S. Department of Health and Human Services, 2001c). A significantly larger percentage of children (42%) were 11 and older at the time they entered care (U.S. Department of Health and Human Services, 2001c).

The age of children at time of entry into foster care and the age distribution of children residing in foster care are not directly related. As of March 31, 2000, an extremely small percentage of children in foster care (4%) were under the age of 1; about one-quarter were between 1 and 5 years old; another quarter were between 6 and 10 years old; close to half (45%) were age 11 and older; and a small percentage (2%) were 19 or older (U.S. Department of Health and Human Services, 2001c). Representation was most disproportionate for adolescents who, though less than 9% of the U.S. population (U.S. Census Bureau, 1999), make up approximately one-third of the children currently in foster care (National Resource Center on Permanency Planning, 1998).

These data indicate that although younger children continue to constitute a meaningful percentage of the children in foster care, a significant proportion of children who enter foster care and who are currently in care are older.

Racial and Ethnic Background

Historically, a large percentage of the children in foster care have been children of color. To some extent, this demographic is a byproduct of shifts in the racial and ethnic backgrounds of the U.S. population. Although people of color currently constitute approximately 25% of the U.S. population (U.S. Census Bureau, 2001a), moderate to significant increases in the populations of nonwhite ethnic groups have been documented. Between 1980 and 1998, the African American population increased by

25%; Native Americans and Alaskan Natives by 51%; Latinos by 107%; and Asians and Pacific Islanders by 177% (U.S. Census Bureau, 1999). Increased representation of people of color in the U.S. population as a whole is reflected in the increasingly diverse racial and ethnic makeup of children in the child welfare system. In 1980, 47.3% of children in foster care were children of color; by 1990, the proportion had reached 60.7%; and by 1999, it had increased to 64% (Tatara, 1993; U.S. Department of Health and Human Services, 2000a).

Despite the increasing representation of people of color in the U.S. population overall, children of color continue to make up a disproportionate proportion of the population of children in care (Stehno, 1990; Tatara, 1993; U.S. Department of Health and Human Services, 2000a). In 1999, white children represented 65% of all children in the U.S., but only 33% of the children in care (U.S. Census Bureau, 2001b; U.S. Department of Health and Human Services, 2000a). Among racial and ethnic minority groups, African American children are most disproportionately represented in the foster care system. Although representing 15% of the U.S. child population in 1999, these children represent 42% of the U.S. foster care population (U.S. Census Bureau, 2001b; U.S. Department of Health and Human Services, 2000a). In 1990, for the first time, more African American children than white children were in foster care (Tatara, 1993), a trend that has continued to the present (U.S. Department of Health and Human Services, 2000a).

Some studies have shown that increases in the number of children in foster care are attributable to increased entry rates for children of color. Wulczyn and Goerge (1990), for example, found that the dramatic increase in the number of children in foster care in Illinois between 1987 and 1988 was due entirely to African American children entering care in numbers disproportionate to their membership in the general population.

Nationwide, Latino, Native American/Alaskan Native, and Asian/Pacific Islander children (who, in 1999, respectively represented 9%, 1%, and 4% of the U.S. child population) are proportionally represented in the foster care population (U.S. Census Bureau, 2001b; U.S. Department of Health and Human Services, 2000a). Minority children from some of these groups, however, are disproportionately represented in the foster care populations of some states. In California, for example, the percentage of children in foster care who were Latino rose from approximately 20% in 1988 to more than 30% in 1994 (Wulczyn, Harden, & Goerge, 1997). Similarly, Native American/Alaskan Native children in FY 1998 represented 34% of the children in foster care in North Dakota, 13% of the children in care in Minnesota, and 15% of the children in care in Oklahoma (U.S. Department of Health and Human Services, 2000b).

The implications of the large and growing number of children of color in foster care extend to the quality of services these children receive while in care. Children of color often receive differential treatment in the foster care system. Research indicates that African American children remain in foster care longer, receive fewer services, are less likely to have services plans, and visit with their parents less often (Close, 1983; Olson, 1982; Stehno, 1990). Similarly, Latino children are less likely to have plans for regular parental contact than white children in care (Shyne & Schroeder, 1978).

These findings raise important issues related to the cultural competence and responsiveness of the child welfare system. The nationwide disparate impact of child welfare practices and policies on African American children and families and the state-level impact on other communities of color reflect race- and culture-based factors that cause interventions to last longer, families to be separated more frequently, and reunification to occur less often for these children and families (Morton, 1999). As early as 1972, Billingsley and Giovanni observed that racism had pervaded child welfare services in three key ways: in the kinds of services provided, in inequitable treatment based on race, and in inadequate efforts to change the system to ensure equivalent services for all racial and ethnic groups. Courtney (1996)

concludes that race and ethnicity remain central issues in child welfare and that inequity, based on racial and cultural factors, continues to characterize services and outcomes.

Health Status of Children in Foster Care

Children in foster care are at high risk for emotional, behavioral, developmental, and physical health problems (Halfon & Klee, 1991). In the 1980s, studies began to document the extent to which children in foster care suffered from emotional, behavioral, and developmental problems. A 1984 New York study found that 40% of the children in state foster care manifested emotional and behavioral problems, including thought disorders, paranoia, suicide attempts, eating disorders, self-abuse, and attention deficits (Ingalls, Hatch, & Meservey, 1984). Similarly, a California study in the mid-1980s found that children in foster care experienced a range of mental health problems, including sexual acting out and hostile behavior (Fitzharris, 1985). Other studies in the 1980s consistently found that children and young people in foster care tended to perform more poorly academically than children not in care (Ohio Department of Human Services, 1987); lagged behind in their education by at least one year (Jones & Moses, 1984); and had lower educational attainment than the general population (Festinger, 1983; Cook & Ansell, 1986).

      More recent studies have contributed to a broader understanding of the extent to which children in foster care experience emotional, behavioral, and developmental problems. A 1990 study found that the incidence of emotional, behavioral, and developmental problems among children in foster care (including depression, conduct disorders, difficulties in school, and impaired social relationships) was three to six times greater than the incidence of these problems among children not in care (Dubowitz, 1990). A 1994 study by the U.S. Department of Health and Human Services (1997a) found that 27% of the children in foster care were emotionally disturbed; 18% had learning disabilities; 11% had developmental disabilities; 8% had hearing, speech, or sight impairments; and 4% had other disabilities. Researchers in Texas conducted comprehensive assessments on 300 children at the time they entered foster care; they found that 60% of the children under age 7 exhibited developmental delays or behaviors that warranted additional evaluation or specialized interventions (Perry, Conrad, Dobson, Schick, & Runyon, 2000). Of the older children and adolescents assessed, 22% reported very severe posttraumatic stress symptoms and 50% had academic problems (Perry, et al., 2000). The American Academy of Pediatrics (2000) estimates that 30% of children in foster care have severe emotional, behavioral, or developmental problems.

      Children in foster care also are likely to suffer from a range of acute and chronic physical health problems (Wald, Carlsmith, & Liederman, 1985). A significant number of them frequently experience upper respiratory infections, dermatologic disorders, dental caries, and malnutrition (Silver, Haecker, & Forkey, 1999). In New York City, Chicago, Baltimore, and Canada, children in care, when compared to children not in care, have been found to have higher rates of vision, hearing, growth, and dental problems (Moffat, Peddie, Stulginskas, & Steinmetz, 1985; Swire & Kavaler, 1977; White, Benedict, & Jaffe, 1987). More recent studies have documented high rates of chronic medical conditions and physical growth disorders (Chernoff, Combs-Orme, Risley-Curtiss, & Heisler, 1994; Halfon, Mendonca, & Berkowitz, 1995; Rosenfeld, Pilowsky, Fine, Thorpe, Fein, Simms, Halfon, Irwin, Saletsky, & Nickman, 1997). Rates of HIV and other sexually transmitted diseases also appear to be higher among adolescents in foster care than among those in the general adolescent population (American Public Human Services Association, 1999).

      The number of children affected by mental health, developmental, and physical health problems, as well as the severity of these problems, has increased over time (U.S. General Accounting Office, 1998*).* In 1990*,* child welfare experts testified before the U.S. House of Representatives Budget

Committee that "children coming into the system today are significantly different from the children we saw five years ago... [with] a growing number of seriously handicapped infants at one end of the spectrum, and a preponderance of emotionally disabled teenagers at the other end" (American Public Welfare Association, 1990).

To a great extent, the increasing number of children in foster care with serious health problems is associated with the abuse and neglect they experience prior to foster care entry. One study of three major cities found that between 1986 and 1991, the rising number of young children in foster care with serious health-related problems (from 43% in 1986 to 58% in 1991) was associated with prenatal alcohol and drug exposure (U.S. General Accounting Office, 1994). Similarly, a more recent study of infants in foster care in two large California counties found that growing numbers of children in foster care have been prenatally exposed to illegal drugs (62% of the infants had documented histories of prenatal substance exposure and exposure was suspected in another 17%); the infants with known or suspected histories of prenatal drug exposure had significantly more health problems than the infants who were not exposed (McNichol, 1999). The number of children entering care because of the children's own physical; emotional, or behavioral problems (as opposed to parental behavior or condition) also has risen, increasing by 12% between 1984 and 1990 (Tatara, 1993).

Although many children come into care with significant health, mental health; and developmental problems, the foster care system itself may sometimes further exacerbate their problems. As children move from one setting to another, their already compromised physical and mental health and development may deteriorate further. Fanshel and colleagues (1989) found a direct relationship between the number of placements children experienced and the level of hostility they displayed. A Florida study found that children who experienced multiple placements tended to have higher levels of behavioral and emotional problems, remained longer in foster care, and had difficulty either returning home or making the transition to adoption (Office of the Auditor General, 1989).

The compromised health and developmental status of many children in foster care has important implications. The nature and severity of children's health problems present critical issues related to services for children, permanency planning, and supporting children and their families (whether their birthparents, relatives, or adoptive families) after they exit foster care.

Chapter 2

Factors Affecting Families and Children

Served Through Foster Care

Historically, broader economic and political realities have affected the welfare of families and children. These factors impact the overall functioning and well-being of families, and consistently play a key role in the extent to which child abuse and neglect occur and foster care is needed.

In 1933, as the Depression affected families across the U.S., the U.S. Children's Bureau, in collaboration with the Child Welfare League of America, convened a Conference on Present Emergencies in the Care of Dependent and Neglected Children. The conference report noted the social and economic conditions of the time and stated that

> the welfare of destitute and neglected children has been seriously affected by several factors arising from the Depression, including: reduction in state and local expenditures in many areas for the support of needy children in public and private agencies, and a lack of employment for needy children reaching the age of 16 or 17 years. Many children are suffering and the welfare of many more is seriously endangered. (Bremner, 1974, p. 613)

In the 1970s, a commission focused on child welfare issues noted the connection between economic and social stresses and heightened risks of child neglect, and stated that

> meager public assistance, coupled with the paucity of day care, homemaker services, and accessible medical services, make it hardly surprising that the one-parent family of low socioeconomic status is the most vulnerable to neglect and subsequent child placement. (Bremner, 1974, p. 675)

Contributors to a special issue of *Child Welfare* (1999) that focused on family foster care in the next century noted the potential impact on families as a whole, and poor families in particular, as health care and welfare services were being reorganized, financed in new ways, and delivered through new service models (Simms, Freundlich, Battiselli, & Kaufman, 1999).

Many of the same stresses that historically have been associated with increased risks of child maltreatment and the need to place children, away from their families and into foster care characterize the current economic and social environment. These factors include poverty, homelessness, adolescent parenthood; parental substance abuse, and the effects of HIV/AIDS.

Poverty

Poverty has always affected the well-being of children and families. Although the U.S. is one of the richest nations in the world, it has high rates of poverty, particularly child poverty (U.S. Census Bureau,

1993, 2000b). In 1999, almost 17% of U.S. children (12.1 million) lived at or below the federal poverty line (U.S. Census Bureau, 2000b).

Poverty in the U.S. disproportionately affects children of color and the children of single parents. Fifteen percent of white children live at or below the poverty line, compared to 34% of Latino children and almost 37% of African American children (U.S. Census Bureau, 2000a) Poverty also disproportionately affects the growing population of children being raised by single parents. In 1960, 9% of all U.S. children lived in one-parent homes (U.S. House of Representatives; 1994); by 1999, almost 28% of all children did so (Federal Interagency Forum on Child and Family Statistics, 2000). Children living with their mothers only (58%) are far more likely to live in a low-income family than children living with their fathers only (34%) or children living with two parents (16%) (U.S. Census Bureau, 1993). In 1999, more than one-half (56%) of all African American children and almost one-third (32%) of all Latino children lived in one-parent homes, compared to 23% of white children (Federal Interagency Forum on Child and Family Statistics, 2000). The combination of race and single parenting places children of color at an increased risk of poverty.

Poverty severely limits the ability of some families to provide basic necessities for their children, including food, shelter, clothing, health care, and transportation to school and needed services. In 1999, 17% of U.S. children experienced hunger and 30% of children being raised by single mothers were determined to be "food insecure" (that is, "uncertain of having, or unable to acquire, adequate food sufficient to meet their basic needs at all times due to inadequate household resources for food") (Andrews, Nord, Bickel, & Carlson, 2000, p. 1).

Poverty and poor health also are related. The health of poor children is worse than that of their better-off peers, and poor children are less likely than nonpoor children to receive adequate health care (Klerman & Parker, 1991). In a national survey, the Urban Institute (1999) found that low-income children and youth were more than three times as likely to be in fair or poor health as higher-income children. African American children and Latino children were more likely to be reported as being in fair or poor health than were white children (8% vs. 11% vs. 3%, respectively) (Urban Institute, 1999).

Given the impact of poverty on the ability of many families to provide adequately for their children, it is not surprising that children living in poverty are far more likely to be reported to child protective services as victims of child neglect (Duncan & Brooks-Gunn, 1998). In one study, however, children whose families had annual incomes below $15,000 were found to be at increased risk of every form of child maltreatment (Sedlak & Broadhurst, 1996). The extent to which determinations of child maltreatment lead to foster care placement also appears tied to poverty. Both Lindsey (1994) and Pelton (1989) found that the major determinant of children's removal from their parents' custody was not the severity of child maltreatment but unstable sources of parental income. Data from other sources confirm that a significant number of children in foster care are from poor families. In 1999, more than one-half of the children in foster care qualified for federally assisted foster care, which is tied to eligibility for welfare benefits (U.S. House of Representatives, 2000).

Critical questions remain unanswered about the relationship among poverty, child maltreatment, and decisions to place children in foster care. To what extent are determinations of neglect based on poverty as opposed to inadequate parenting that places children at risk of harm? Equally important, what is the relationship between poverty and foster care entry, particularly with regard to the overrepresentation of children of color in foster care?

Homelessness

Increasingly, the homeless population in the U.S. has come to include families with children. In 1999, families with children represented more than one-third (37%) of the homeless population (U.S.

Conference of Mayors, 1999). In a growing number of cases, homelessness leads to involvement with the child welfare system and children's entry into foster care. Often, children either are involuntarily removed from their parent's custody or families voluntarily place their children after they have lost their homes and find that they have no other option (Shinn & Weitzman, 1996). In 1988, homelessness was a factor in over 40% of placements into foster care in New Jersey and the sole precipitating cause in 18% of those placements (Ooms, 1990). A 1994 national study found that children whose families had housing problems were almost twice as likely to be in foster care as children whose families did not have housing problems (U.S. Department of Health and Human Services, 1997a). These trends raise important questions about the nature and quality of services provided to families confronted with homelessness or unstable housing. It is not unusual to find that housing services are not provided to assist families to remain together or that judgments are made that homeless families do not "deserve" to keep their children (as, for example, when families reach the limits of allowable stays at city and county financed shelters for homeless individuals and families).[*]

Homelessness and unstable housing also pose challenges to the reunification of children in foster care with their families (Child Welfare League of America, 1990). The service deficiencies and biases that may result in homeless families losing custody of their children often stand as obstacles to reunification. At the same time, the housing issues that many families confront may be further complicated by parental substance abuse (Robertson, 1991) and mental health problems (Roll, Toro, & Ortola, 1999). Absent effective interventions that can address the combined effects of homelessness, substance abuse, and mental health problems, the ability of parents to work toward reunification may be severely compromised.

Homelessness also has a significant impact on young people who leave foster care. Adults who, as children, were placed in foster care or another out-of-home setting; experienced physical or sexual abuse (often precursors to out-of-home care); were raised by parents who abused alcohol or other drugs; or experienced homelessness or housing instability, often face an increased risk of homelessness (Burt, 1999). As many as three in ten homeless adults were formerly children in foster care (Roman & Wolfe, 1995). Parents who spent time in foster care as children and who experience homelessness as adults are almost twice as likely to have their own children placed in foster care as parents who are homeless but who were never in foster care (Roman & Wolfe, 1995).

The complex relationship between homelessness and foster care involves a number of social, familial, and institutional factors. At issue are the relationships between homelessness and parental substance abuse and mental illness; the connection between a history of physical or sexual abuse and the risk of later homelessness; and the extent to which the risk of homelessness is related to the quality of services that are provided to youth as they prepare to leave foster care at the age of majority (Roman & Wolfe, 1995).

Adolescent Parenthood

Although the rate of births to adolescents has declined significantly since the early 1990s (from 62 per thousand births in 1991 to a record low of 49.6 per thousand births in 1998) (U.S. Department of Health

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[*] In an effort to avert the need for children to enter foster care solely because of their families' housing problems, Congress authorized the Family Unification Program in 1990 (P.L. 101-625). That program has been found to be effective in assisting families to stay together and in minimizing the need for foster care entry solely for housing-related reasons. (Gilbert-Mongelli, Lundy, & Rog, 1998).

and Human Services, 1993; Curtin & Martin, 2000), close to half a million children in 1998 were born to teenage mothers (Curtin & Martin, 2000). The children of adolescent mothers face particular risks because of higher rates of pregnancy complications among their mothers, including premature delivery; a lower likelihood that their mothers obtained prenatal care; and the academic and employment disadvantages that their mothers face (a higher likelihood of not completing high school than their nonparenting peers and half the lifetime income of women who do not give birth until they are in their 20s) (Alan Guttmacher Institute, 1994). Likewise, children of teenage fathers face the disadvantages associated with their fathers' lower incomes and more limited education (Alan Guttmacher Institute, 1994).

Adolescent parenting has also been associated with increased rates of child maltreatment. In Illinois, researchers found that the age of the mother was associated with higher rates of abuse and neglect and foster care entry. Children born to teenage mothers were twice as likely to be victims of abuse and neglect as children born to 20- or 21-year-old mothers (Goerge & Lee, 1996). About one-fourth of the abuse and neglect reports involving adolescent mothers result in foster care placements, compared to one-fifth of those involving older mothers (Goerge & Lee, 1996).

The realities that adolescent parents and their children face raise key questions about the extent to which services are available to young parents whose ability to care for their children may be compromised by their own personal abilities as well as by limited resources and supports. The same factors that heighten the risk of foster care entry for children of adolescent parents—factors related to maturity, sound decisionmaking, and ability to support a child—affect efforts to reunify children in foster care with their adolescent parents. Absent effective, ongoing services to strengthen and support them, young parents are likely to face significant challenges in their efforts to regain custody of their children.

Parental Substance Abuse

Since the 1980s, parental substance abuse has increased markedly, with a significant growth in maternal drug use as a result of the "crack" cocaine epidemic (Freundlich, 2000). Based on a survey of women who gave birth during the period from 1992-1993, the National Institute on Drug Abuse (1996) estimated that 221,000 women used an illegal drug and 757,000 used alcohol during pregnancy. Chasnoff (1989) estimated that 11% of all infants born each year had been exposed to illegal drugs. Others estimate that approximately 7,600 infants are born each year with Fetal Alcohol Syndrome and another 16,500 to 22,000 infants are born exhibiting effects of prenatal exposure to alcohol (Streissguth & Giunta, 1988). Based on prenatal drug and alcohol exposure data, Schipper (1991) calculated that a substance-exposed infant is born more frequently than every 90 seconds. The impact of parental substance abuse extends to children who, though not prenatally exposed to drugs or alcohol, are subject to their parents' drug- or alcohol-related behavior. In 1996, some 8.3 million children lived with a parent who abused alcohol or other drugs (U.S. Department of Health and Human Services, 1999a).

Parental alcohol and other drug abuse has been linked to domestic violence (National Clearinghouse for Alcohol and Drug Abuse, 1995), as well as to poor outcomes for children, including depression and anxiety, poor academic performance, and substance abuse by children themselves (Children of Alcoholics Foundation, 1999). Parental substance abuse has been associated directly with child abuse and neglect and foster care entry (U.S. Department of Health and Human Services, 1999a; North American Commission on Chemical Dependency and Child Welfare, 1992). The U.S. Department of Health and Human Services (1999a) found that parental substance abuse is a factor in one-third to two-thirds of all reports of child abuse or neglect. In particular, prenatal alcohol and drug exposure has been found to account for the growing number of very young children entering foster care (U.S. General

Accounting Office, 1997). Estimates are that from 48% to 80% of all infants prenatally exposed to drugs or alcohol need child welfare services before their first birthdays (Curtis & McCullough, 1993; Child Welfare League of America, 1996a). Children who enter foster care because of parental abuse of alcohol or other drugs tend to remain in foster care longer than children whose parents do not abuse substances. One study found that children whose parents abuse alcohol or other drugs remain in foster care an average of 11 months as opposed to 5 months for children whose parents are not substance abusers and are less likely to leave foster care within a year (55% as opposed to 70%) (U.S. Department of Health and Human Services, 1999a).

The relationship between parental substance abuse and foster care entry and length of stay is an important one, with implications for the delivery of services to children and families and for permanency planning. This large and growing group of children may have a range of physical health and developmental needs, particularly if they were prenatally exposed to alcohol or drugs, and reunification may pose special challenges.

HIV/AIDS

As the HIV/AIDS pandemic has broadened and transmission patterns have shifted from homosexual to heterosexual populations and from men to women, the impact of HIV/AIDS on children has become more apparent. Although the number of children who are infected with HIV/AIDS has declined with the development of drugs to prevent perinatal transmission (Centers for Disease Control and Prevention, 2000), the number of women infected by HIV has increased, almost doubling between 1993 and 1998 (from just under 30,000 to approximately 58,000 women) (Centers for Disease Control and Prevention, 2000). Women of color constitute the majority of this population. Of the new HIV cases reported in 1999, 81% of the women were African American or Hispanic (Centers for Disease Control and Prevention, 2000).

Each year, an estimated 7,000 children are born to HIV-positive mothers (Centers for Disease Control and Prevention, 1998). Although the majority of these children will not themselves be HIV positive (Centers for Disease Control and Prevention, 1998), many will lose their parents to AIDS. In 1992, Michaels and Levine projected that by the year 2000, between 72,000 and 125,000 children and youth in the U.S. would lose their mothers to AIDS (Michaels & Levine, 1992). Although definitive data on the number of children orphaned by AIDS are not available, it has become clear that a growing number of children whose parents are HIV infected are entering foster care (Merkel-Holguin, 1996). Some of these children already have lost their parents to AIDS and are in need of services to place them permanently with relatives or adoptive families (Merkel-Holguin, 1996). Others are in need of temporary care because they have parents who are experiencing episodes of serious illness associated with HIV, but who will likely regain sufficient health to resume the care of their children. This latter population of children needs temporary placement services to support them during their parents' health crises (American Academy of Pediatrics, 1999)

Chapter 3

The Policy Framework

Public policy is most clearly expressed through legislation. Beginning with the Adoption Assistance and Child Welfare Act of 1980 and continuing through the Foster Care Independence Act of 1999, federal legislation has addressed a range of critical foster care issues, and has set many of the parameters of current foster care practice.

The Adoption Assistance and Child Welfare Act of 1980

The Adoption Assistance and Child Welfare Act of 1980 (PL. 96-272) has played and continues to play a key role in shaping foster care. In the late 1970s, criticism of foster care began to mount as the number of children entering care mushroomed, the length of stay began to increase significantly, and children in care were neither being returned to their families nor placed with adoptive families. The term *foster care drift* was coined to describe the deleterious effects of the foster care system on children and families (Guggenheim, 1995). P.L. 96-272 legislatively introduced the concepts of permanency and "reasonable efforts" as the touchstones for services for children in foster care and their families. The law required child welfare agencies to make "reasonable efforts" to keep families together and, when children entered foster care, "reasonable efforts" to reunite them with their families. It also outlined alternative permanency outcomes for children in foster care who could not or would not be reunited with their families, including placement with relatives and adoption. With the implementation of PL. 96-272, the number of children in foster care decreased, falling to 276,000 in 1984 (Tatara, 1993); the median length of stay in foster care also declined (U.S. Department of Health and Human Services, 1997a).

By the mid-1980s, however, as the economy became less vital, and families began experiencing the first effects of the crack cocaine and HIV/AIDS epidemics, the number of children in foster care and their length of stay both began to rise. By 1992, the population of children in foster care had increased by 54% over the number of children in care in 1984; length of stay had risen as well (U.S. Department of Health and Human Services, 1999c). Gershenson (1990) observed that "the initial gains resulting from the new philosophy of permanency planning [as set forth in P.L. 96-272] have seemed to disappear as far as reducing the number of children in foster care."

The Family Preservation and Family Support Program/Promoting Safe and Stable Families Program

In the late 1980s and early 1990s, concern grew that appropriate efforts were not being made to keep or reunify children with their families and that foster care was being used in situations in which children could remain at home or be returned to their families if services were provided. Practice evolved into models that were "family-centered," "family-focused," and "family-based"—approaches that assessed the needs and welfare of children within the context of their families and their communities. In line with these developments, Congress enacted the Family Preservation and Family Support Program (P.L.

103-66) in 1993 to provide funding to states for family preservation and community-based family support services. Broadly defining "family" as birthparents, extended family members, and adoptive parents, the law (which became Part 2 of Title IV-B) translated family-centered theory and practice into public policy and required states to engage in a comprehensive planning process for the development of a "meaningful and responsive family support and family preservation strategy" (U.S. Department of Health and Human Services, 1994). *Family preservation services* were defined as "service programs designed to help children ...where appropriate, return to families from which they have been removed; or be placed for adoption, with a legal guardian, or, if adoption or legal guardianship is determined not to be safe and appropriate for a child, in some other planned, permanent living arrangement" (42 U.S.C. 629A(1)). *Family support services* were defined as "services to promote the safety and well-being of children and families... (and) to increase the strength and stability of families (including adoptive, foster, and extended families)" (42 U.S.C. 629A(2)).

In 1997, Congress reauthorized the program (as part of the Adoption and Safe Families Act of 1997 discussed later) and changed its name to Promoting Safe and Stable Families. The law added two additional categories of services to the program: time-limited reunification services and adoption promotion and support services. The law required that states devote "significant portions" of their expenditures to each of the four service categories (U.S. House of Representatives, 2000). Federal regulations subsequently clarified that states must have a "strong rationale" for spending less than 20% of their funding on each of the service categories (U.S. House of Representatives, 2000). Some evaluations suggest that the Promoting Safe and Stable Families Program has expanded services for children in foster care, their birthfamilies, and their adoptive parents (Freitas, Milligan, LeCroy & Irvine, 1999). Importantly, the program makes funding available for time-limited reunification services while children are in care, family preservation services following reunification or adoption, and postadoption services for children and their adoptive families. The extent to which states have utilized these funds to develop such services varies.

The Personal Responsibility and Work Opportunity Reconciliation Act

In 1996, Congress enacted The Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193), popularly known as welfare reform. The act ended the 61-year-old Aid to Families with Dependent Children (AFDC) program, replacing it with Temporary Assistance for Needy Families (TANF), a state-administered block grant (U.S. House of Representatives, 2000). Income assistance under TANF, unlike AFDC, is time limited, and most recipients must work to retain benefits.

Although not child welfare legislation per se, welfare reform nonetheless has had important implications for foster care in at least two key ways. First, the law limited eligibility for Title IV-E assistance (and accompanying Medicaid) to only those children in foster care who would have been income eligible for AFDC as of July 16, 1996. As time passes, it is likely that fewer children will meet this income eligibility standard, and states will be able to claim decreasing levels of federal reimbursement for their foster care programs under Title IV-E. States may be required to absorb a greater share of the overall costs of foster care, with a consequent fiscal impact on their foster care programs overall.

Second, the implementation of welfare reform may significantly affect the well-being of children and families, particularly as time limits for benefits expire and families can no longer rely on TANF for financial assistance and Medicaid. As growing numbers of families lose income assistance, more children will likely enter foster care. Although it is too soon for definitive data regarding this potential impact of welfare reform, Shook (1999), in a study of AFDC data from Chicago, found a relationship between a reduction in welfare benefits and involvement with the child welfare system. The relationship

was offset to some extent by greater income through employment but was exacerbated by other stresses such as housing and health problems. The National Bureau of Economic Research (Paxson & Waldfogel, 1999) also found that reductions in welfare benefits were related to higher rates of foster care. Until more comprehensive studies have been undertaken and the full impact of welfare reform is realized, much remains to be understood about its relationship to foster care.

The Indian Child Welfare Act

Predating P.L. 96-272 by two years, the Indian Child Welfare Act of 1978 (ICWA) (P.L. 95-608) was enacted by Congress in response to the widespread practice among states in which American Indian children were removed from their families and tribes and were placed with non-Native families and in institutions. ICWA was designed to address the "alarmingly high percentage of Indian families" that were being "broken up by the removal, often unwarranted, of their children from them" and the placements of Indian children outside their families and cultures (ICWA, section 1901). ICWA was the first federal legislation to address the role of culture in the lives of children and families who come into contact with the child welfare system, and unlike federal legislation in the 1990s (discussed in the next section), it expressly recognized the vital importance of maintaining children's connections with their cultural heritage in the provision of foster care and adoption services.

Recognizing the unique sovereign status of American Indian tribes, ICWA made clear that tribes have the primary right and responsibility for the welfare of tribal children. Thus, ICWA required that child welfare agencies determine for American Indian children, the child's tribal ancestry and relationship to one or more federally recognized tribes. At the same time, the primary intent of ICWA is to prevent the breakup of the Indian family. To that end, the law placed the burden on the court to notify the child's tribe and the Indian parent or custodian of proceedings that could lead to the child's out-of-home placement or termination of the Indian parent's rights. When tribe is not known, the courts must give notice to the Bureau of Indian Affairs. Under ICWA, tribes have the right to intervene in court proceedings and may be given additional time to prepare motions of intervention or requests for transfer to tribal court venues.

To achieve its goals of protecting the best interests of Indian children and promoting the stability and security of Indian tribes and families, ICWA set minimum federal standards for the removal of Indian children from their families and the placement of Indian children in foster care -- standards designed to recognize and reflect the "the unique values of Indian culture" (ICWA, section 1902). Among these standards were heightened evidentiary requirements for removing an Indian child from the custody of her family ("clear and convincing evidence") and terminating the rights of Indian parents ("beyond a reasonable doubt") (ICWA, section 1912). ICWA also created a "preferencing" system that orders the priority by which Indian children are to be placed in foster care and with adoptive families (ICWA, section 1915). In relation to foster care, ICWA provides that an Indian child first be placed with a member of the child's extended family; if such a placement is not feasible, the child is to be placed with another member of the same Indian tribe as the child; if that is not possible, the child is to be placed in a foster home licensed, approved or specified by the child's tribe, or as the next alternative, in an Indian foster home licensed or approved by an authorized non-Indian licensing agency; and as a final option, the child is to be placed in an institution approved by the child's tribe or operated by an Indian organization which has a program suitable to meet the Indian child's needs. The placement preference provisions of ICWA have important implications for concurrent planning (which is discussed more fully in the next chapter) with American Indian children and families. Finally, ICWA specified that child welfare agencies' efforts to reunify American Indian children and their parents be "active" as opposed to merely "reasonable."

The Multiethnic Placement Act and the Interethnic Placement Act

In the 1990s, Congress focused twice on issues related to race in the provision of foster care and adoption services. First, in 1994, Congress enacted the Multi Ethnic Placement Act (MEPA) (P.L. 103-382)*,* which prohibited agencies that receive federal funding under Titles IV-B or IV-E of the Social Security Act from discriminating on the basis of a child's or a prospective foster or adoptive parent's race, color, or national origin. MEPA, however, allowed agencies to consider in making placements a child's cultural, ethnic, or racial background as well as a prospective foster or adoptive parent's ability to meet those needs. In 1996*,* Congress repealed the MEPA provision that permitted consideration of race, color, and national origin as a factor in placement decisions. The Interethnic Placement Act (part of the Small Business Protection Act, P.L. 104-188) expressly prohibits states and other entities that make foster care or adoptive placements from "delaying" or "denying" a child's placement on the basis of the child's or prospective parent's race, color, or national origin. It further imposes financial penalties for violations of the antidiscrimination requirement and allows private individuals to bring suit if they believe that they were subjected to discrimination on impermissible grounds. The law retains the original provision of MEPA that requires states to diligently recruit foster and adoptive parents who reflect the racial and ethnic diversity of the children in the state who need foster and adoptive families. It does not, however, provide additional resources to states to effectively expand such recruitment efforts and ensure the availability of foster and adoptive parents who reflect the diversity of children in care. Neither the original MEPA nor the subsequent amendments apply to children who fall within the protections of the Indian Child Welfare Act.

The Adoption and Safe Families Act of 1997

With the enactment of the Adoption and Safe Families Act of 1997 (ASFA) (P.L. 105-89), Congress made the most significant changes in federal child welfare law since 1980. Intended to ensure the safety of children in foster care and to promote adoption, ASFA clarified that a child's safety must be the paramount consideration when family preservation or family reunification is pursued. Although ASFA retained the principle of "reasonable efforts" found in P.L. 96-272, it established certain exceptions to the "reasonable effort" requirement, as well as shorter timelines and less stringent conditions for seeking termination of parental rights. It requires a 12-month time frame for permanency hearings (at which time a definitive permanency plan for the child must be made); criminal background checks for all prospective foster and adoptive parents; and development by the states of standards to ensure that children's health and safety are protected while they are in foster care. To further promote permanency for children, ASFA requires that reasonable efforts be made to place children in a timely manner when the goal is adoption or another alternative to reunification. To further promote permanency for children, ASFA requires that reasonable efforts (or the higher standard of "active efforts" for Indian children protected by the Indian Child Welfare Act) be made to place children in a timely manner when the goal is adoption or another alternative to reunification. When adhering to the time frames for permanency planning specified by ASFA, child welfare agencies nonetheless must continue to comply with ICWA requirements

Since ASFA's enactment, the number of adoptions of children in foster care has increased dramatically. Between 1998 and 1999 alone, the number of finalized adoptions of children in foster care increased 28% (U.S. Department of Health and Human Services, 2000a). Of the 46,000 finalized adoptions of children in foster care in FY 1999, the majority (64%) were by children's former foster parents, 16% were by relatives, and 20% were by families who had not previously had a relationship

with the child (U.S. Department of Health and Human Services, 2000a). At the same time, ASFA's implementation has created a large and growing group of children in foster care who are waiting to be adopted. As of March 31, 2000, 134,000 children in foster care were awaiting adoption (U.S. Department of Health and Human Services, 2001c). Some of these children (approximately 64,000) were in need of adoptive families immediately, as their parents' rights had already been terminated. The remaining children had a goal of adoption, and would clearly need adoptive families in the near future (U.S. Department of Health and Human Services, 2001c). These results have led to a number of questions regarding the capacity of the foster care system to recruit, prepare, and support an adequate number of adoptive families for the many children in care who are currently waiting to be adopted and the many children who will be freed for adoption in the future under ASFA time mandates.

The Foster Care Independence Act of 1999

The Foster Care Independence Act of 1999 (P.L. 106-169) was enacted in response to the realities confronting youth who remain in foster care and are discharged to live on their own. Many adolescents in foster care "age out" without any of the personal, social, financial, and health care supports that families typically provide to young people as they move out to life on their own. In March 2000, close to 5,000 young people were in supervised independent living situations, preparing to live on their own. Close to 8,000 youth, however, had aged out of foster care during the preceding six months and another 2,600 youth had run away and their status was unknown (U. S. Department of Health and Human Services, 2001c).

Too often, youth who leave foster care are unprepared to live on their own. When surveyed on independent living services in 1993, only about 25% of CWLA member agencies indicated that they provided employment-related services for young people in care; 17% provided employment and career planning assessments; 16% provided job search training; and 24% provided vocational training (DeWoody, Ceja & Sylvester, 1993). In a 1998 study, 40 states reported that they provided youth in foster care with vocational services, including job readiness (28 states); job search (25 states); job training (9 states); and job placement (18 states) (U.S. General Accounting Office, 1999). Although these findings may suggest that preparation services are being provided for many youth leaving foster care, young people in foster care are consistently found to be ill-equipped to live independently. One longitudinal study found that only 49% of the young people discharged from foster care were employed, compared to a national employment level for young people ages 16 to 24 of 65% (Westat, 1991). Researchers at the University of Wisconsin, in a study of youth who had been out of care for 12 to 18 months, found that 37% had not finished high school and 32% were receiving public assistance (Courtney & Piliavin, 1998). In addition to poor employment and education outcomes, youth formerly in foster care have high rates of homelessness and incarceration. Westat (1991) found that 25% of the youth were homeless at least one night. Courtney and Piliavin (1998) found that 27% of the males and 10% of the females had been incarcerated at least once.

Building on the Independent Living Program (42 U.S.C. 677) established by Congress in 1986 as a relatively limited service for youth in foster care (National Foster Care Awareness Project, 2000), the Foster Care Independence Act of 1999 requires states to provide youth ages 18 to 21 who were formerly in foster care with services to help them make the transition to self-sufficiency; offer education, training, and services so that they can obtain employment; provide personal and emotional support through mentors and dedicated adults; and provide financial, housing, counseling, employment, education, and other supports and services (U.S. Department of Health and Human Services, 2001b). The act also heightens state accountability for positive outcomes for youth who leave foster care to live

independently and requires states to track such outcomes as educational attainment, employment, and avoidance of dependency, homelessness, nonmarital childbirth, incarceration, and high-risk behaviors.

Chapter 4

Foster Care Practice Today

Foster care practice at the beginning of the 21st century is affected by a number of factors: the diminished number of foster parents and the changes in their expected roles, increasing reliance on kin as caregivers for children, the use of concurrent planning, the use of an expanded array of permanency options, and increases in the use of specialized foster care placements, in foster care accountability, and in the attention being given to the development and retention of qualified professional staff.

Availability of Foster Parents as Resources for Children

In much of the U.S., foster parents are in short supply, especially in large cities (Chamberlain, Moreland, & Reid, 1992; Kahn & Kammerman, 1990). In the 1970s and 1980s, unrelated foster families provided care for most of the children in foster care, but by 1999, the estimated 142,000 licensed foster families cared for less than half (48%) of the children in care (U.S. Department of Health and Human Services, 2000a; Dougherty, 2000). Although the number of children in foster care increased by 68% between 1984 and 1995, the number of foster parents decreased 4% (Child Welfare League of America, 1997; U.S. House of Representatives, 2000).

Recruitment and retention of foster parents have become critical issues. Broad social and economic changes, such as larger numbers of women working out of the home and an increase in single parent families, have made the recruitment of foster parents more challenging. Additionally, although many foster parents leave fostering because they age and retire, many others leave because they are dissatisfied with their experiences as foster parents.

Financial and systemic factors also challenge efforts to recruit and retain foster parents. Historically, foster parents have been reimbursed at low rates for the care they provide and have been expected to subsidize children's care with their own funds. In 1996, the average monthly foster care reimbursement rate was $356 for children age two, $373 for children age nine, and $431 for youths age 16 (U.S. House of Representatives, 1998). These low rates often combine with the lower incomes of many foster parents who are single, older, and parents of color and whose incomes fall within a low-to-middle earnings bracket (Barbell, 1996; Fein, Kluger, & Maluccio, 1990). Despite concerns to the contrary, few individuals choose to foster as a way to increase their incomes (only about 7% according to one study) (James Bell Associates, Inc., 1993). Instead, low- to moderate-income families often are stressed financially by the need to continuously subsidize the care of the children whom they foster.

Looking to systemic factors affecting foster parent recruitment and retention, surveys of foster parents repeatedly find that the primary reason foster parents leave fostering is a lack of agency responsiveness, communication, and support. According to the National Commission on Family Foster Care (1991), as many as 60% of foster parents withdraw from the program within the first 12 months. As reasons, the foster parents often cited insufficient emergency, weekend, or vacation respite; inadequate consultation and support from social workers; poor agency response to crisis situations;

disrespect for foster parents as partners and team members; difficulty obtaining liability insurance to protect them in the event that children in their care caused harm to their or others' property; inadequate training; and few opportunities to provide input into training or services for foster parents (National Commission on Family Foster Care, 1991).

These issues, which obviously affect retention, also impact recruitment. Consistently, those currently serving as foster parents have proven to be the most effective recruiters of new foster parents (Barbell & Sheikh, 2000). Foster parents' attitudes about the agency with which they are affiliated—perspectives shaped to a great extent by agency responsiveness, communication, and support—affect not only their own participation but their willingness to assist agencies in bringing new foster parents to the program.

The Changing Role of Foster Parents

Historically, foster parents have been viewed as temporary caregivers—or "babysitters"—for children in foster care. Children generally have been placed and removed from foster parents' care with little regard to the caregivers' rights or feelings about the children (Dougherty, 2001). Traditionally, foster parents were not considered as potential adoptive parents for the children for whom they were caring, even when the children had deeply bonded with them (Dougherty, 2001). In the 1980s, however, foster parents began to be viewed as more integral to the planning for the children whom they were fostering. With the emphasis on permanency for children, agencies began to ask foster parents to become more involved with the children's birthparents and more frequently sought them out as adoptive parents for the children being fostered (Dougherty, 2001). Nonetheless, agencies typically have not clearly defined the roles that foster parents were expected to play and, to the extent that foster parents have been asked to take on new responsibilities, often have offered little training or support (Dougherty, 2001).

Currently, foster parents take on a number of roles. They nurture the children they foster; support the children's healthy development; provide guidance and discipline; advocate on behalf of the children with schools; mentor birthparents; support the relationship between children and birthparents; and recruit, train, and mentor new foster parents (Child Welfare League of America, 1995; Dougherty, 2001).

The roles of nurturing, promoting child development, and providing guidance and discipline are traditional foster parent responsibilities. As agencies move toward new models of permanency and recognize the strengths that foster parents bring beyond these traditional roles, many foster parents are assuming roles of advocacy, mentoring, facilitation, and recruitment and training of new foster parents (Dougherty, 2001). In addition to serving in these new roles, a growing number of foster parents are adopting the children they have fostered.[*]

Agencies today are also placing increased emphasis on foster parents as members of the permanency planning team. Under ASFA, foster parents must be given notice of and an opportunity to be heard in any court review or court hearing regarding a child in their care. This federally recognized legal right makes clear that foster parents should be valued as partners in assessing the needs of children, planning for permanency, and providing courts with key information (Center for Families, Children and

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[*] As stated earlier, 64% of the adoptions of children in foster care in 1999 were by the children's former foster parents (U.S. Department of Health and Human Services, 2000a), a trend that is likely to continue as the use of concurrent planning (discussed later), increases.

the Courts, 2000). Although at the practice level not all agencies have involved foster parents as partners and team members, many have worked to change agency culture to make it possible for foster parents to play a viable role—as full team members—in assessment, service planning, and decisionmaking (Dougherty, 2001). Training and support are essential to ensure that foster parents have the tools they need to fully meet their responsibilities in this regard (Dougherty, 2001).

In response to both the dwindling supply of foster parents and the increased expectations of foster parents, a trend to professionalize foster care has emerged (Testa & Rolock, 1999). Professional foster parents are hired as members of the agency's professional staff to care for children with specialized behavioral, emotional, physical health, and developmental needs (Testa & Rolock, 1999). As trained professional foster parents, these staff are paid an annual salary at a rate that exceeds the monthly room and board payments typically paid to other types of foster parents (Testa & Rolock, 1999). Although professional foster care programs are associated with positive outcomes regarding stability, sibling placement, and community-based placements for children (Testa & Rolock, 1999), the practice also raises questions in an era of welfare reform: Are birthparents being penalized for remaining at home to care for their children while professional foster parents receive salaries to provide "stay-at-home" foster care? (Testa & Rolock, 1999, p. 123).

Increasing Reliance on Kin

Recent years have seen dramatic growth in the use of kinship care (sometimes referred to as formal kinship care or relative foster care) as a resource for children served through the foster care system (U.S. House of Representatives, 2000). In 1986, 18% of the children in foster care lived with relatives who were not their parents; by 2000, 25% of the children in care lived with kin (Office of the Inspector General, 1992; U.S. Department of Health and Human Services, 2001c). As a resource for children, kinship care is used more often in urban settings, typically involves the care of young children, and is much more likely to be the caregiving arrangement for African American children (who in one study were found to be eight times as likely as other children to be in formal kinship care) (U.S. Department of Health and Human Services, 1997b).

Outside the formal child welfare system, more than two million children in 1994 lived with relatives without a parent present (U.S. Department of Health and Human Services, 1997b). By providing care for their relative children, these informal kinship caregivers often make it possible to avoid placing the children in formal foster care. These caregivers, however, may face a range of stresses. Most informal kin caregivers are grandmothers; are more likely to be unmarried, poor, and unemployed; and tend to be less educated than the parents who care for their own children (U.S. Department of Health and Human Services, 1997b).

Kinship care has come to be viewed as an essential option in the array of child welfare services, and in many states, it is expressly favored over care by nonrelatives (Child Welfare League of America, 1999; U.S. Department of Health and Human Services, 1998b). States have had different policies regarding kinship caregivers, however, including how they define an eligible "relative" (Boots & Geen, 1999). Some states limit kinship care to biological relatives; others extend the definition of kin to neighbors, godparents, and other adults with a close relationship but no biological ties to the child (Boots & Geen, 1999). Licensing (and corresponding payment) policies also have varied. In January 2000, however, federal regulations were issued that now require states to use the same licensing or approval requirements for relative foster homes as they do for nonrelative homes (some exceptions are permitted for requirements not related to safety) to obtain Title IV-E reimbursement for the care of children formally placed with kin (U.S. House of Representatives, 2000).

As kinship care has come to play an increasingly important role in foster care, attention has been placed on the principles that underlie this aspect of children's care. In 2000, the U.S. Department of Health and Human Services provided Congress with a report on kinship care (as required by the Adoption and Safe Families Act). The report listed a number of principles as guidelines for ongoing discussions about the use of kinship care, including the following:

- safety, permanency and the well-being of children should continue to be the focus of the child welfare system;

- the best interest of the child should guide kinship placements;

- the child welfare system should not supplant families' own efforts or income assistance programs through foster care funding; and

- although relatives should be viewed as resources for children, each situation should be individually assessed. (U.S. Department of Health and Human Services, 2000c)

As these principles suggest, kinship care is a vital component of foster care today, but there is a need to continue to assess the decisionmaking processes involved in using kinship care and the supports and services that should be mobilized for kin (including financial resources).

Use of Concurrent Planning for Children in Foster Care

Since 1980, the primary focus in the provision of foster care services has been permanency planning, that is, providing services that will lead to children's exit from foster care to safe and stable families as soon as possible. In relation to permanency planning,

> the foster care population can be conceptualized as two or more distinct populations. One subgroup fits the permanency model and moves through the system fairly rapidly, with most exits resulting in reunifications. At the same time, other subgroups do not fit that model, and apparently stay in the system a long time. (Wulczyn, Harden, & Goerge, 1997, p. 64)

The children in this second group are principally those who entered foster care under the age of one year; are disproportionately African American, Native American, or Latino; and most often come from families who are dealing with chronic poverty, domestic violence, and substance abuse (Katz, 1999).

For these children, concurrent planning—that is, work toward the reunification of the family while simultaneously developing an alternative plan for the child (Katz, Robinson, & Spoonemore, 1994)—can be used to ensure permanency. Concurrent planning incorporates a number of key components: (1) differential diagnosis early in children's stays in foster care to identify families who are less likely to successfully achieve reunification, (2) timelines, (3) visiting between children and parents, (4) written agreements, and (5) the development of a "Plan A" and a "Plan B" (Katz, 1999, p. 80). In each case in which concurrent planning is undertaken, children are placed with a family—either foster parents or relatives—who are willing and able to work closely with the child's parents but who also are prepared to become the permanent family for the child should reunification not prove possible (Katz, 1999). The birthparent(s) is fully advised of both the concurrent planning process and the nature of the child's placement (Katz, 1999).

Of critical importance in the concurrent planning process are foster parents who can incorporate and balance the multiple roles that they are asked to play (Katz, 1999). As concurrent planning approaches are implemented, several programmatic components must be in place to support caregivers

throughout the concurrent planning process. Communication is critical. Children's caregivers (whether foster parents or kin) must be given some assessment of the probability that the child will be reunited with his or her parents or will be freed for adoption (or another alternative will be pursued). At the same time, agencies must also clearly communicate to caregivers that the level of "risk" is not quantifiable (Katz, 1999, p. 84). Specialized training must be provided for caregivers to help them support the child's birthparents and the agency's plan to work toward reunification over a planned period of time (Katz, 1999). Finally, nonrelative caregivers must be given the opportunity to become personally acquainted with the children's birthparents and must be provided with support as they develop effective relationships with them (Katz, 1999).

A Range of Permanency Alternatives

Reunification continues to be the principal permanency goal for children in foster care. In 2000, 43% of children in care had a permanency goal of reunification, and 60% of the children who left care (between October 1, 1999, and March 31, 2000) were reunited with their birthparents (U.S. Department of Health and Human Services, 2001c). Adoption, however, as discussed earlier, has become the permanency goal for a growing number of children in care since the 1997 enactment of the Adoption and Safe Families Act (U.S. Department of Health and Human Services, 2000a, 2001c). The number of children in foster care adopted each year has increased substantially (U.S. Department of Health and Human Services, 2000a, 2001c).

An emerging permanency option for children in foster care is guardianship. For many kin and children, adoption is not a viable alternative because of hesitancy to change family relationships in a way that may undermine existing relationships; strong cultural resistance to the termination of parents' rights; or the desires of the child, particularly adolescents, that adoption not be pursued (Cornerstone Consulting Group, 2001). Increasingly, guardianship is being considered as a permanency option for these kin and children. A number of states have developed subsidized guardianship programs, which provide kin not only with the legal status of guardian but with financial support and access to follow-up services (Cornerstone Consulting Group, 2001). Much remains to be learned about the outcomes of these relatively new programs, but early results show that for kin and children in guardianship arrangements, relationships are as stable and as permanent as adoption (Westat, 1999).

The Adoption and Safe Families Act (ASFA) revised the list of permanency goals for children originally provided in P.L. 96-272 and eliminated reference to long-term foster care as an option. ASFA, however, did define as a successful permanency outcome "permanent living arrangements" other than reunification or adoption. In 2000, 8% of the children in care had long-term foster care as a permanency goal (U.S. Department of Health and Human Services, 2001 c). As the mandates of ASFA are fully implemented, fewer children will likely remain in foster care for extended periods of time, and long-term foster care will be used less frequently as the permanency goal for children. In many states, long-term foster care is currently used in only certain situations and, by policy, is permitted only for young people in care who are 12 or older (Children's Rights, 2001).

Specialized Placements for Children in Foster Care

Increasingly, the complex needs of children in foster care call for specialized placements that can provide the children with the level of care and services that they require. Over the past decade, agencies have developed specialized foster care programs that offer a high level of care for children with significant behavioral, emotional, physical health, and developmental needs (Testa & Rolock, 1999).

Specialized foster parents are recruited, trained, and paid higher monthly rates for the care that they provide children with intense needs (Testa & Rolock, 1999). Although these resources play a vital role in ensuring that children's needs are appropriately met (Testa & Rolock, 1999), they raise questions about the use of specialized foster care. For example, foster care encompasses the concept of "step down," that is, the placement of children at lower levels of services and at reduced reimbursement rates as their behavioral, emotional, physical, and developmental problems improve. In some instances, children are "stepped down" through their removal from specialized foster families with whom they are doing well and progressing; in other cases, children are "stepped down" by reducing the services provided and the reimbursement rate given to the specialized foster parents who are caring for the child. Are such practices in the children's best interest? What incentives do such approaches create? The use of specialized foster care also brings questions related to permanency planning for children in specialized foster care and the impact of such placements on the use of adoption as the permanency plan.

A growing number of children also are being served through group and residential care. In March 2000, almost 106,000 children in foster care lived in group homes and institutional settings (U.S. Department of Health and Human Services, 2000a). This figure represents a 58% increase since 1990 (U.S. Department of Health and Human Services, 2000a; Tatara, 1993). Some children are placed in group or residential settings as soon as they enter foster care because of behavioral and emotional problems; others are eventually placed in group or residential care because of repeated placement failures in family settings. Of increasing concern has been the extent to which group and residential care is being and should be used for children in foster care. Among the issues that must be examined more closely are (1) the growing use of specialized foster care as a community-based alternative to institutional placements for children in foster care and (2) earlier use of residential treatment for children with serious behavioral and emotional problems so that they do not experience repeated placement failures before being deemed eligible for more intensive treatment services.

Increased Accountability

In 2001, the U.S. Department of Health and Human Services mandated that each state conduct periodic child and family service reviews of its federally funded child welfare services, including foster care. These reviews are designed to assess each state's performance on three key outcomes: child safety, permanence, and child and family well-being (U.S. House of Representatives, 2000). Federal law and accompanying regulations identify seven criteria as indicators of states' compliance with the standards set by law and regulations (see Table 2). In addition, the federal government has seven specific national standards that states must meet. Of the seven standards, five relate to foster care: (1) the rate at which children re-enter foster care within 12 months of a previous stay in care; (2) the percentage of children reunified with their parents within less than 12 months of entering foster care; (3) the percentage of children who were adopted and who left foster care within 24 months of foster care entry; (4) the percentage of children in foster care for less than 12 months who have two or fewer placements; and (5) the median length of time that children remain in care (U.S. House of Representatives, 2000).[*] If a state is found not to be in substantial conformity with the federal requirements, it must develop and

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[*] An additional standard relates to the recurrence of maltreatment for children for whom there had been a substantiated or indicated report within the previous six months. The seventh standard, length of time in foster care, unlike the other six standards, has not as yet been assigned a performance target (U.S. House of Representatives, 2000).

implement a corrective action plan approved by the U.S. Department of Health and Human Services. Should the state fail to comply with the plan, the federal government may withhold federal funding as a penalty (U.S. House of Representatives, 2000). The new federal review processes, the national outcome standards, and the penalties that may be assessed when states fail to provide child welfare services at an acceptable level signal a new level of accountability for foster care services.

Table 2

Child and Family Services Reviews: Outcomes and Indicators

Outcomes	Indicators
Child Safety	• Protection of children from abuse and neglect
	• Safe maintenance of children in their own homes whenever possible
Permanency	• Permanency and stability in children's living situations
	• Preservation and continuity of family relationships and connections
Child and Family Well-Being	• Capacity of families to provide for children's needs
	• Appropriate services to meet children's educational needs
	• Adequate services to meet children's physical and mental health needs

Developing and Retaining Qualified Child Welfare Professionals

Of critical importance to quality foster care practice is an adequate number of qualified professional staff. This goal, however, has been difficult to achieve because of ever-expanding caseloads, high levels of staff turnover, and budget-driven staff reductions and decreases in staff supports such as training (Rycraft, 1994). Rising demands for out-of-home care services have caused caseloads to expand, resulting in unmanageable workloads and, in many instances, low morale. One survey found that annual caseworker turnover rates ranged from 20% for public agencies to 40% for private agencies (Child Welfare League of America, American Human Service Association, & Alliance for Children and Families, 2001). Although average caseload sizes vary, in numerous systems they far exceed those recommended by the Child Welfare League of America (Children's Rights, 2001). Under such conditions, social workers are unlikely to have frequent and consistent contact with birthparents, children, or foster parents, or to develop and implement effective permanency plans.

Caseworkers who provide foster care services often lack the education and experience they need to provide quality services. Only 25% to 27% of child welfare caseworkers who provide direct services have any social work training, and of these, only 9% to 10% have graduate degrees in social work (Child Welfare League of America, 1996b). Only 50% of caseworkers have experience in working with children and families in any human service field (Child Welfare League of America, 1996b). Low salaries (the result of agency declassification of caseworker positions and deletion of requirements for

professional social work education) contribute to the difficulties in attracting experienced and professionally trained staff (Rycraft, 1994). At the same time, the deprofessionalization of child welfare has made the field less attractive to professionally trained social workers (McDonald & McCarthy, 2000).

Given the educational backgrounds and experience levels of many foster care caseworkers, the need for ongoing staff training is critical. Although training programs have been developed over the past decade, programs often struggle with transmitting the requisite knowledge and skills that all levels of foster care staff must have to deliver effective foster care services. Particularly when staff turnover is high and caseloads are large, programs confront real challenges in achieving high competency levels among staff. Ongoing quality supervision becomes particularly important under such circumstances.

Chapter 5

The Future of Foster Care

If foster care is to be most responsive to the needs of children and families, it must be shaped by five key principles: (1) a family focus that views foster care as a service for the entire family as opposed to a service for the child or for the parents; (2) a child-centered orientation that places the needs of the individual child at the forefront of case planning; (3) the delivery of services from a community-based perspective so that children remain in contact with the important people in their lives and live in familiar environments; (4) developmental appropriateness so that the care and services that a child receives are responsive to the child's age and physical, cognitive, behavioral, and emotional status; and (5) cultural competence so that the cultural strengths and values of all families are respected and accommodated (Dougherty, 2001).

In the past, foster care was trapped in a debate that pitted those in favor of "protecting children" against those invested in "preserving families." Some viewed foster care as antithetical to preserving families and, therefore, a "bad" service choice for all children; others viewed foster care as a necessary and preferred vehicle for protecting children from maltreating, "bad" families (see Guggenheim, 2000; Gelles, 2000). In the course of this debate, questions were raised about the value of foster care and the role it should play as a child welfare service. With the passage of the Adoption and Safe Families Act, the value of foster care has been reaffirmed and its role as a temporary vehicle for the care of children on their way to permanent families has been clarified, providing a basis on which foster care will continue to be developed and refined.

As foster care looks to the future, we must recognize that birthfamilies will always play a key role in children's lives, irrespective of the permanency outcomes that are planned for the children. The majority of children who enter foster care will be reunified with their parents or will be placed with members of their extended families. Children who cannot physically return home and who become members of new families through adoption will continue to have psychological connections with their birthfamilies. These connections and relationships are critical to children's sense of self, ability to cope with and resolve loss, and ability to form new and more lasting attachments (Fahlberg, 1991; Jewett, 1982).

Foster care must also acknowledge that families play a vital role for youth who age out of foster care. A majority of youth who leave foster care to live independently (about 60%) return to live with their families upon discharge (DeWoody, et al., 1993); other youth who age out of care seek connections with adults who, though not biologically related to them, can offer the support of family (Courtney & Piliavin, 1998).

Because of its temporary nature, foster care must recognize and translate the needs of children and families into practices that ensure that children are placed with families within their own cultural groups, neighborhoods, and communities whenever possible. When children must enter foster care, a community-based approach must be taken that allows the involvement of the many individuals who know and care about the child: members of the child's extended family, neighbors, friends, teachers, and others already involved in the family's life. A community-based approach to foster care broadens the definitions of *family* and *helping* to include a variety of individuals and organizations that can assist families and children in more inclusive and, often, less conventional ways.

Foster Care Today

A family-focused, community-based approach to foster care is the basis on which we can build a fully responsive service system. The trends in foster care over the last decade have been ones of growing numbers, longer stays, and multiple placements. Increasingly, families are being affected by economic, social, and health factors that undermine their strengths and ability to care for their children. Although supports have increased in some areas (e.g., the availability of family support services), they have dramatically decreased in others (e.g., the limits imposed by welfare reform). Too often, foster care is serving as the "safety net" for families in crisis. Foster care has responded well to these challenges, but it cannot on its own meet the full range of complex needs that children and families have. As foster care looks to the future, community partners will be critical to the goal of providing children with temporary care on their way to permanency with a family.

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