CWLA

CHILD WELFARE LEAGUE OF AMERICA

HEARING
ON
CHALLENGES FACING
THE
CHILD WELFARE SYSTEM

UNITED STATES
HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON INCOME SECURITY
AND FAMILY SUPPORT

May 15, 2007

2345 Crystal Drive, Suite 250, Arlington, VA 22202
Phone 703-412-2400; Fax 703-412-2401; www.cwla.org

The Child Welfare League of America (CWLA), representing public and private nonprofit, child-serving member agencies across the country, is pleased to submit testimony to the Subcommittee on Income Security and Family Support. CWLA commends the Subcommittee and its members for taking up the issue of child welfare. We feel that the children and the families affected by the child welfare system should become a national priority and we hope this hearing will be the start of reaching that goal.

Too often the policy debate in Washington is framed by two numbers, the 513,000 children in foster care placements at the end of the federal fiscal year and the approximate $7 billion in federal funds spent on the foster care and adoption assistance systems under the Title IV-E entitlement. In reality these numbers leave out other critical parts of child welfare. It ignores the fact that 800,000 children spend at least some time in foster care each year. It does not count the 3.3 million reports of abuse and neglect, the 899,000 children substantiated as abused or neglected, the more than 350,000 children who are substantiated as abused or neglected who do not receive follow up services, the 1.5 million families who receive prevention services, [1] the 22,000 youth who leave foster care simply because they became too "old' or they "aged-out" of the system and all the family members who are attached to these children. [2]

The Child Welfare League of America urges this Subcommittee and all policymakers in Washington to keep their focus on all of these children and families in any consideration of reform or investment. Too often the debate begins and ends with the unsubstantiated concept that the federal government already spends enough on child welfare through Title IV-E. It's not clear what formula this is based on but it is clear that these funds address only some of the foster care maintenance payments, some of special needs adoption assistance and some of the vital child welfare workforce needs that are essential to reunification and permanency. In fact the current federal eligibility requirements result in decreased support for these services each year.

CWLA urges the subcommittee to examine what is needed to fully support the range of services from prevention to foster care to permanency and then and only then to determine how much of the $2.7 trillion that makes up the federal budget can be devoted to the child welfare system.

BUILDING BLOCKS OF A COMPREHENSIVE CHILD WELFARE SYSTEM

A comprehensive child welfare system can be broadly framed around six areas. The first four basic elements to child welfare include prevention, intervention, reunification and permanency. However, to have a successful comprehensive child welfare system, two other critical components, access to health care including mental health and a strong child welfare workforce, are also required. To reduce the number of children in foster care and to protect our nation's children from harm we need to address not only prevention, intervention, reunification and permanency, but also access to health care including mental health and a strategies to support a strong child welfare workforce.

PREVENTION, INTERVENTION, REUNIFICATION AND PERMANENCY

Many services and programs fit into several categories that form the child welfare system. For example, access to substance abuse treatment or mental health services may be a key element of prevention services. These services can also be a necessary component of intervention as well a requirement before reunification of a family is possible, or to assure a permanent family for a child in the child welfare system.

Prevention

Studies have demonstrated the effectiveness or promise of several approaches to prevention of child maltreatment. Programs such as home visiting have produced evidence that positively impacted a variety of outcomes for children and families, including prevention of abuse and neglect[3]. Similarly, high quality pre-kindergarten programs such as the Chicago Child Parent Centers and Head Start, that include parental involvement and supports, have also demonstrated effectiveness.

Independent studies have found that the financial savings achieved by the most effective of these approaches far exceeds their costs. Rigorous cost-benefit analyses conducted by the Washington State Institute for Public Policy showed cost savings for several pre-kindergarten, family support, and home visitation programs as well as for Parent-Child Interaction Therapy, a center-based intervention that provides direct coaching to parents as they interact with their young children.[4]

Home visiting

Home visitation programs refers to different model programs that provide in-home visits to targeted vulnerable or new families. Home visitation programs—either stand-alone programs or center-based programs—serve at least 400,000 children annually between the ages of 0 and 5.[5] Eligible families may receive services as early as the prenatal stage. A child's early years are the most critical for optimal development and provide the foundation necessary for success in school and life. Therefore, home visiting services have the potential of making a tremendous impact on the life of a child and his or her family. Nurses, professionals, or other trained members of the community conduct home visits on a weekly, bimonthly, or monthly basis. Program goals could include an increase in positive parenting practices, an improvement in the health of the entire family, an increase in the family's ability to be self-sufficient, or enhanced school readiness for the children.

Quality early childhood home visitation programs lead to several positive outcomes for children and families, including a reduction in child maltreatment. Annual data indicates that approximately 40% of the 899,000 children who have been substantiated as abused and neglected, but not removed from the home, never receive follow-up services.[6]More widely available and implemented home visitation services could help address this drastic shortcoming.

Home visitation services stabilize at-risk families. Research shows that families who receive at least 15 home visits have less perceived stress and maternal depression, while also expressing higher levels of paternal competence.[7] Home visitation programs may

also reduce the disproportionality or overrepresentation of children and families of color, while improving outcomes for these families.

Family Support Services
Family Support Services (FSS) were developed to respond to the concerns, interests, and needs of families within a community. Family Support Services are targeted to families with difficulties and concerns related to the proper functioning of the family and care of the children. The focus of the program is on prevention. The services address the need to improve the well-being of a child, family functioning, and the parent's ability to provide for the family, before they are in crisis. Family support programs work with outside community organizations such as schools and child welfare agencies. The aim is to provide temporary relief to families and to teach them how to better nurture their children. Involvement in these services is voluntary. Types of services include a broad spectrum of community-based activities promoting the safety and well-being of children and families such as structured activities involving parents and children, respite care services for parents and caregivers, parenting skills training, and information and referral services. Programs may also include services outside the traditional scope of child welfare, such as health care, education, and employment.

Intervention
Early intervention services play a vital role for children and families who may already be in trouble. Early intervention services may include services such as child care, housing, job training, and substance abuse services. These are the kind of non-traditional child welfare services that can enable families to stay together to the fullest extent possible.

To better target the needs of families a number of child protective service systems (CPS) utilize differential response which allows CPS to respond differently to accepted reports of child abuse and neglect. Family preservation services are additional programs which may incorporate several of these services in an effort to prevent the removal of a child.

Community-based child protection programs have demonstrated that many families can be helped before there is a need for protective intervention with the family. Often, the family can identify what is needed, be connected to resources and supports, and contact with the formal child welfare system can be averted. Often, after a formal report has been made, a child can be maintained safely at home with sufficient supports, clear expectations, and monitoring.

Differential Response
Differential response is a developing approach being implemented by a number of states which allows child protective services (CPS) systems to respond differently to accepted reports of child abuse and neglect, based on the circumstances.

Several states are implementing these models that are sometimes referred to as multiple track or alternate response. According to CWLA Best Practices Guidelines: Child Maltreatment in Foster Care (2003), "these approaches recognize the variety in nature of reports and that one approach does not meet the needs of every case."[14] This approach

may allow some CPS systems to provide services to a family without a formal complaint of abuse and neglect.

Substance abuse treatment

Alcohol and other drug problems devastate the lives of hundreds of thousands of children and their families each year. A major factor in child abuse and neglect, substance abuse is a factor in one to two-thirds of cases of children with substantiated reports of abuse and neglect and in two-thirds of cases of children in foster care.[8] Furthermore, children whose parents use drugs or alcohol are three times more likely to be abused, and four times more likely to suffer from neglect.[9] In addition, children from families with substance abuse problems tend to come to the attention of child welfare agencies younger than other children, are more likely than other children to be placed in out-of-home care, and once in out-of-home care, are likely to remain there longer.[10]

Many recent studies demonstrate that most substance abuse is a treatable public health issue with cost-effective solutions, and that treatment is effective for families involved with the child welfare system. Treatment has been shown to reduce alcohol and drug use and lower health care costs, as well as to increase family functioning.[11]

Too often, a lack of substance abuse treatment capacity poses a significant barrier to success. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), approximately 23.2 million Americans needed services for an alcohol or drug problem in 2005, but only 3.9 million actually received treatment. This is consistent with a 1997 CWLA study that found that child welfare agencies could provide drug abuse treatment to less than one-third of parents who needed it.[12] The supply of treatment services for women and children is especially inadequate.[13]

The significant rise in the number of children entering out-of-home care due to parental drug use over the last two decades represents one of the most serious policy challenges with the latest example being the spread in the use of methamphetamines. The overall shortening of timelines and movement to make quicker permanency decisions in out-of-home care cases required by the Adoption and Safe Families Act (ASFA) of 1997 has increased the sense of urgency and further emphasized the pressing need within the child welfare system to develop adequate capacities to address parental substance abuse issues. Good assessment, early intervention, and comprehensive treatment are key to determining when and if a child can safely stay at home or be reunited with his or her family.

Family Preservation Services

Family Preservation Services (FPS) are comprehensive, short-term, intensive services for families delivered primarily in the home and designed to prevent the unnecessary out-of-home placement of children or to promote family reunification. The services are intended to protect a child in a home where allegations of child abuse or neglect have occurred, prevent subsequent abuse or neglect, prevent placement of a child, or reduce the stay for a child in out-of-home care. Families in need of family preservation services are usually

referred by public welfare agencies. Services are provided within 24 hours of referral and the family's involvement is voluntary. These services respond to families on a 24-hour basis, including services such as family therapy, budgeting, nutrition, and parenting skills.

Reunification

Reunification is the first permanency option states consider for children entering care. Yet, in many ways, it is the most challenging option to achieve. We know that of the 280, 660, children exiting out-of-home care in 2004, sixty-four percent were reunited with their parents or other family members.[15]

Successful reunification requires skilled workers, readily available supportive and treatment resources, clear expectations and service plans, and excellent collaboration across involved agencies. Reunification also requires culturally appropriate support and treatment services for families and the critical need for after care or post-permanency services to ensure that safety and permanency are maintained following reunification.

Children's experiences in out-of-home care can significantly affect their health and well-being. Separation from parents and in some cases from siblings, frequent changes in placements and caregivers, and a sense of instability and uncertainty about the future can undermine children's physical, emotional, and developmental well-being. Children often hold strong attachments to their birthparents even when they are in out-of-home care for long period periods of time and parent-child separation can result in children experiencing escalating emotional and behavioral problems. [16] The negative emotional effects on children when they experience frequent changes in placements and caregivers have been well-documented. Children who enter foster care with few apparent health issues may, over time, develop physical, emotional, and behavioral problems that were not evident at the time they entered out-of-home care. [17]

Studies have documented that children and youth in out-of home care experience higher rates of physical and emotional problems and that significant percentages of children in care have chronic medical conditions,[18] developmental delays, [19] and mental health problems.[20] One study, for example, found that approximately 60% of children in care had a chronic medical condition, and one-quarter had three or more chronic health problems. Studies further suggest that up to 60% of preschoolers in out-of-home care have developmental delays. One study found that children younger than 6 in out-of-home care had higher rates of respiratory illnesses (27%), skin problems (21%), anemia (10%), and poor vision (9%) than the general population of young children. [21]

In relation to mental health problems, it is estimated that between 54% and 80% of children in out-of-home care meet clinical criteria for behavioral problems or psychiatric diagnosis. In one study, researchers found that between 40% and 60% of children in out-of-home care had at least one psychiatric disorder and that this population of children used both inpatient and outpatient mental health services at a rate 15 to 20 times higher than the general pediatric population.[22]

Successful reunification requires access to health care for both the child and family and this includes access to mental health services. It also requires dedicated, fully training and adequately supported caseworkers who can address the range of issues and needs of that foster child.

Permanency

Research demonstrates the importance of children's being nurtured in a stable family environment, confirming the need to move those who must enter foster care into permanent living situations as quickly as possible. Recent studies suggest that, when children must leave their families, well-supported kinship placements have the potential to provide more stable and normalizing environments than unrelated family care (Webster, Barth, Needell, 2000). [23]

When it is not possible for a child to return to their families of origin, alternatives such as adoption or subsidized guardianship can offer long term stability. Cost analyses of child welfare services have linked kinship care and subsidized guardianship to cost savings. One study found the cost of effecting an adoption for children in foster care to range from $6,000 to $28,539, or an average of $19,141, suggesting that this permanency alternative has the potential to achieve a substantial savings over long term foster care. [24] Findings concerning the stability of adoptions are also encouraging; overall, disruptions occur in 10% to 16% of adoptions, while rates may be higher for some placements such as those of much older youth or in families lacking prior experience in foster care or adoption. The rate of adoption dissolutions after the adoption is finalized is very low. [25]

Post-permanency services are critical to ensuring the option selected as a child's permanent placement is an enduring one. These services would support reunification, prevent children from reentering foster care, and maintain permanence for children who are adopted and those in guardian-ship arrangements. Subsidies should be available to all resource families, including guardian and adoptive families. An aftercare workforce should offer ongoing support to prevent dissolution,[26] including linking families to community-based networks of family supports developed for at-risk families. In addition to post-permanency services for adoptive and kinship families we also need to assist youth preparing to age out of the child welfare system by providing them with the resources and support networks necessary to make a successful transition into adulthood.

Kinship Care

Kinship care is a situation in which an adult family member, such as a grandparent, aunt, uncle, or other relative, provides a caring home for a child who is not able to live with his or her parents. The practice is not new, but it is growing partly because repeated studies and *CWLA Best Practice Guidelines* have revealed the value of placing children with a relative when appropriate. The financial difficulties many relatives experience potentially threaten the use and merit of this practice, however.

Kinship placements for children in the child welfare system have increased in recent years. The U.S. Children's Bureau gives three major reasons for this growth: the number of non-relative foster parents has not kept up with need, child welfare agencies view the

kinship option more positively, and courts have placed a higher value on the rights of relatives to act as foster parents. [27]

Subsidized Guardianship

Subsidized guardianship is another important permanency option for relatives who care for children. The number of states implementing guardianship programs reflects growing national interest in the use of guardianship as an alternative permanency option for some children in foster care, particularly for children who are placed with relatives, who cannot be safely reunified with birth parents, and who cannot, or do not, wish to be adopted.

In 2005, the U.S. Department of Health and Human Services (HHS) released findings and evaluations of the seven state waiver demonstration programs that allow federal Title IV-E Foster Care and Adoption Assistance funding to support guardianship programs. These initial findings reflect that non-relative guardianship is a viable and effective option for child welfare workers to consider. The major findings include: the availability of assisted guardianship as a permanency option may decrease the length of out-of-home placements; Combined data from two states reveals that less than 5% of the children in guardianship placements return to foster care; children in guardianship placements fare as well as those in other permanency settings on several measures of well-being, including school performance, engagement in risky behaviors, and access to community resources; and the use of guardianship placements shows statistically significant signs of positive outcomes, with more exits from foster care resulting in reunification or adoption. [28]

Adoption

Adoption has long been a vital service for children who need families, bringing children whose birth parents cannot or will not be able to provide for them together with nurturing adults who seek to build or add to their families. Although only 2 to 3% of the U.S. population is adopted, adoption touches the lives of many people. In 1938, the Child Welfare League of America published the first professional standards to guide adoption agencies. Over the past decades, families choosing to adopt have become increasingly diverse. A growing number of foster families, families of color, older individuals and families with children, two-parent working families, single parents (both male and female), gay and lesbian couples, families with modest incomes, individuals with physical disabilities, and families of all education levels, religious persuasions, and from all parts of the country now adopt. These individuals and families have one important thing in common: they are willing and able to make a lifelong commitment to protect and nurture a child not born to them by providing a safe and loving family for that child.

Historically, most of the federal adoption support has been targeted toward promoting adoptions. As adoptive families increase in number and as time passes, however, there is a corresponding, increased need to address some of the challenges that may surface in later years for these families through post-adoption services. The most common post-adoption services are subsidies. The other services include support groups, crisis intervention, child and family advocacy, adoption searches, case management, family therapy, mental health treatment, respite care, and targeted case management. Some adoption agencies also provide chemical abuse treatment, day treatment, and intensive in-home supervision, indicating a strong commitment to making adoption placements work.

Funding for these important services has been drawn from a mix of federal, state, local and private funds. In a 2006 survey of CWLA member agencies involved with adoption, over a third of respondents reported using contract money through the state or county child welfare agency to support these services. Other government funding includes Temporary Assistance for Needy Families (TANF), adoption incentive grants, adoption opportunities grants, Medicaid, and state mental health funding. For the rest of the agencies, funding appears to be challenging, with many using funding sources other than public agency contracts or funds to pay for their post-adoption services. A few agencies receive small grants from foundations to pay for programs. Some agencies charge families for post-adoption services, using a sliding scale based on family income. Over two-thirds of agencies surveyed support these services independently because they either have no outside funding, or the funding does not cover the total cost of services. [29]

Youth Leaving Foster Care

Every year, it is estimated that 20,000-25,000 [30]young people exit the foster care system. Young people transitioning out of foster care are significantly impacted by the instability that accompanies long periods of out of home placement. Youth in the foster care system are often confronted with emotional, behavioral, developmental, and health challenges. The life events of these young people place them at an increased risk for experiencing adversity. In the midst of elevated rates of homelessness, poor educational outcomes, low wages, unemployment, long-term dependency on public assistance, incarceration and health issues, young people "aging out" of the foster care system are also experiencing pregnancies and early parenthood. Confronting and overcoming these challenges without support networks or familial connections make it challenging for these young people to successfully transition into adulthood.

Lack of Affordable Housing & Homelessness

Young people aging out of the foster care system need economic security and affordable, safe and stable housing. The 2000 Census reported that nearly 4 million people between the ages of 25 and 34 live with their parents due to economic realities – jobs are scarce and housing is expensive. This phenomenon has been has been identified as "adultolescence", an extended period of adolescence during which it is has become common and expected for young people to live with their parents. Unfortunately, foster youth do not always have the option of turning to their families for financial support. Former foster youth are often prematurely confronted with the harsh reality of the gap between the wages they earn and the cost of housing. As a result, young people aging out of the foster care system are becoming homeless at disconcerting rates.

Former foster youth are experiencing homelessness anywhere from 12% to 36%.[31] It has been reported that as many as three in ten of the nation's homeless adults report foster care history. Homeless parents who report a history of foster care are almost twice as likely to have their own children placed in out-of-home care as homeless people who never experienced foster care. Youth transitioning out of the foster care system are facing critical housing needs upon discharge. This is a particularly critical issue for young people with mental health needs. These youth frequently face service gaps while waiting

to transition from the foster care system to the adult services system, sometimes resulting in periods of homelessness.

In order to successfully transition into adulthood, youth need to be appropriately prepared to exit the foster care system. It is imperative that youth work in partnership with their caseworker to create an effective discharge plan. An effective discharge plan focuses on the development of independent living skills, including securing housing, developing a financial plan, obtaining and maintaining employment, continuing education, and creating social networks and connections. In an effort to close the gaps that allow so many youth to fall through the cracks, it is necessary to have cross-system dialogue, collaboration on and coordination. These exchanges will allow systems to educate each other in order to integrate programs and improve services for young people aging out of the foster care system. Creating connections, developing effective discharge plans and integrating services will prevent the intersection of foster care with homelessness, health issues, incarceration, unemployment, pregnancy and early parenthood. Instead, these partnerships along with a solid discharge plan, will allow these resilient youth to become thriving, productive, and contributing members of society.

Education

Children and youth in foster care encounter numerous barriers to school success. In addition to the abuse and neglect initially bringing them to the attention of the child welfare system they must deal with the emotional consequences of being removed from their homes and communities, separation from siblings, being bounced from home to home, and having the child welfare agency and court system involved in all aspects of their lives.

Schools should represent stability for foster children during times of transition and instability, but due to poor coordination and communication between schools and child welfare agencies, this often does always happen. Federal law falls short in assuring school stability and access to supportive services for children in care. Too often there is as much movement among schools as there is in living arrangements. When children change schools, education records frequently do not follow in a timely fashion. Indeed, youth in foster care in some states have been reported to move through an average of nine different schools during their tenure in foster care. These children and youth are commonly out of school for weeks or months and fall behind academically, cognitively, and socially. They often need to repeat courses and are unable to access the support services that could improve education outcomes. Schools need a better understanding of the unique situations and experiences of children in foster care and child welfare agencies need to focus more on the educational needs and outcomes of the children and youth they are serving. The reauthorization of No Child Left Behind (NCLB) provides an opportunity to do both and to better address the needs of children and youth in foster care.

HEALTH CARE AND WORKFORCE

Health Care Including Mental Health

Child welfare agencies are responsible for meeting the health and mental health needs of all children in state custody, and virtually all children in foster care are eligible for and obtain health care services through Medicaid. Other federal programs that support the

child welfare system do not provide coverage for acute or long-term health services. The need for comprehensive Medicaid coverage for this population of vulnerable children is particularly significant, as research has extensively documented that children in foster care have more health problems, especially mental health problems, than the general population of children from low-income families.

Children in foster care are at higher risk for having physical and mental health needs, stemming either from the maltreatment that led to their placement, or from preexisting health conditions and long-term service needs. Exposure to domestic violence, abuse, substance abuse, neglect, homelessness, separation from family, and other traumas are just some of the many pressures that children in the child welfare system face. Previous studies have found that up to 80% of youth involved with child welfare agencies suffer from emotional or behavioral disorders, developmental delays, or other issues requiring mental health intervention.[32] This is striking when compared to the general population of youth in which a mental health diagnosis is present only 20% of the time. One major study found that half of all adults who had been placed in foster care as children experience serious mental health problems into adulthood, and one-quarter suffer from post-traumatic stress disorder.

In addition to relying on Medicaid for a broad range of acute and long-term health services, children in foster care differ from other children because of their greater need for mental health and disability-related services. Beyond funding the direct provision of basic physical health care services, Medicaid currently allows many states to provide critical rehabilitative, therapeutic, psychiatric, and targeted case management (TCM) services to children in foster care. Such funding is essential for the child welfare system to ensure children in foster care receive the necessary physical and mental health supports while in protective custody.

TCM is an optional Medicaid benefit that helps a specified group of Medicaid beneficiaries within a state gain and coordinate necessary medical services. Use of TCM allows states to target a select population (for example, children in foster care, people with severe mental illness, or people with HIV/AIDS) to receive in-depth case management services. TCM for children in foster care facilitates the provision of essential health and mental health services, while Title IV-E Foster Care and Adoption Assistance funding cannot be used for such health care purposes. TCM increases the likelihood that children in foster care will receive the health care services—both physical and mental and short-term and long-term—they need and are entitled to.[33]

Medicaid also provides the optional Rehabilitative Service benefit for children in the child welfare system. These services aim to reduce physical or mental disabilities and help recipients reach their optimal functioning level. Some of these key services include therapeutic or treatment foster care, behavioral management services, day treatment services, and family functioning interventions. Use of the rehabilitative services Medicaid option often plays a critical role in allowing states to provide essential mental health services in the least restrictive setting to children in foster care.

Among the 2000 and 2001 CFSR reviews, only one state demonstrated strength under the well-being indicator for meeting the mental health needs of children in foster care.[34] In 2002, common concerns in the other states included a scarcity of mental health services, the questionable quality of mental health services, and the lack of mental health assessments of children, even when there was adequate reason to conduct such an assessment. Most states have included actions in their Program Improvement Plans responding to the CFSR reviews that aim to better address the mental health needs of children and families in the child welfare system. An optimal array of mental health services supporting children and families who enter the child welfare system would include prevention and early intervention services, home-based services, and out-of-home services. Out-of-home mental health services for children in the foster care system must include accessible options such as outpatient mental health services, day treatment, therapeutic/treatment foster care, or, if ultimately necessary, inpatient child and adolescent mental health and/or substance abuse treatment. Children and adolescents in foster care who need mental health treatment should receive services in the least restrictive environment possible.

More federal resources must be dedicated to research and services for children in out-of-home care so that they can receive the mental health services they need and deserve to live healthy, productive lives. A complex nexus of state Medicaid, child welfare, and behavioral health care systems currently works with extremely limited resources to provide the mental health services needed by so many children in foster care. Congress must ensure the already limited funding streams for critical mental health services to children in foster care, including the Medicaid options of Targeted Case Management and Rehabilitative Services, are protected and aggressive efforts are made to improve the national mental health system for children and adults. It is crucial that federal policymakers recognize the vital role comprehensive mental health care plays in enhancing a child's chance for health development, reducing stress for caregivers, stabilizing foster care placements, and providing the services families need to care for their children.

Child Welfare Workforce

Successful outcomes for children and families in child welfare depend heavily on the quality of services received, and in turn, on the ability of the workforce delivering them. Yet, child welfare agencies across the country are facing a workforce crisis on many fronts. Attracting, training, and retaining qualified staff at all levels has become increasingly challenging. Staff shortages and high turnover rates have grown with the increasingly rigorous demands of the work, low to modest compensation, and competition with other more attractive options in the current booming job market. Child welfare workers must be prepared to handle caseloads typically well beyond recommended national guidelines. Every day they work with children and families with complex problems and often in situations that may jeopardize their safety.

A report from the U.S. Government Accountability Office[35] found that states failed to meet some of the outcome measures in the Child and Family Services, due, at least in part, to workforce deficiencies. Areas where measures were not met due to workforce issues included: timely investigation of abuse complaints, efforts to reduce the risk of harm to the child, the ability to maintain stable foster care placements, establishing

permanency goals for the child in a timely manner, involvement of children and families in case planning, and adequately monitoring child safety and well-being.

The need for training for both new staff and on-going training for current staff is a critical part of the workforce issue. States must be able to ensure worker competencies through the provision of comprehensive, rigorous, competency based training programs. We believe that an important part of this strategy is to allow states that contract their services to private agencies to be able to use federal IV-E training dollars to train this important part of the workforce.

RECOMMENDATIONS

CWLA has joined a number of national groups to propose a comprehensive approach to building and funding a child welfare reform initiative. Working with groups as diverse as The American Public Human Services Association (APHSA), the American Federation of State, County and Municipal Employees (AFSME); Catholic Charities USA; the Center for Law and Social Policy; the Children's Defense Fund; the National Child Abuse Coalition; and Voices for America's Children, the initiative covers three primary areas of reform. These reforms include guaranteeing services, supports, and safe homes for *every child* who is at-risk of being or has been abused or neglected. It strengthens the federal-state child welfare partnership by amending the federal Title IV-E statute to promote program effectiveness and to enhance accountability without converting any of the Title IV-E to a block grant. CWLA looks forward to working with our colleagues and with the subcommittee in advancing this proposal to enact a comprehensive child welfare reform.

Short of a comprehensive reform, several legislative proposals now in Congress could begin to address some of the shortfalls in the current system. In both houses of Congress bills have been introduced to extend Title IV-E funding to kinship placements. Legislation in the Senate, S. 661, and in the House, H.R. 2188, offer a bipartisan way forward to enhance the ability to use kinship placements and to extend permanency to many of the children now in the system. Similarly, there is bipartisan legislation in the Senate that would provide targeted funding to home visiting programs. S. 667 has bipartisan sponsorship and would help strengthen this prevention and intervention strategy. HR 1376 has been introduced in the House and would extend Medicaid coverage to youth leaving the foster care system due to their age up to age twenty-one. Continued access to health care is one component that is needed if these former foster youth are to have a successful transition to adulthood. Congress will also have an opportunity to address some of the education barriers that now exist for children in foster care when it takes up the reauthorization of the No Child Left Behind (NCLB) law.

Appropriators also need to provide greater support to intervention and prevention services by fully funding the Promoting Safe and Stable Families program and the Child Abuse Prevention and Treatment Act (CAPTA) as well as preserving the funding for the Social Services Block Grant (SSBG). CWLA urges you to reject the proposed cuts offered by the White House. We also urge Congress to take greater oversight in regard to the Medicaid program and recent administrative actions that will restrict states in their ability to use Targeted Case Management (TCM) and the use of rehabilitative services for children in foster care. If we are serious about giving these children safe and permanent

families then this is not the time to be restricting access to needed services through the Medicaid program.

In the coming weeks as this subcommittee takes a more detailed look at the child welfare system we urge you to examine the need for reforming the restrictive eligibility under Title IV-E, examine proposals to extend that funding to age twenty-one, to tribal nations and to expand access to Title IV-E training funds to private agencies.

CONCLUSION

CWLA appreciates the opportunity to offer our comments to the Subcommittee in regard child welfare reforms. As this Subcommittee moves forward we look forward to a continued dialogue with the members and all Members of Congress. We hope this hearing serves as a building block for future efforts that will create a comprehensive reform that results in reduced numbers of children being abused and neglected and safer and permanent families for those children who do come into contact with the child welfare system

1 Administration on Children, Youth, and Families (ACYF). (2006). *Child maltreatment 2005*, Washington, DC: U.S. Department of Health and Human Services (HHS).
2. Children who aged out of foster care are captured by the AFCARS emancipation data element. Children who exit care to emancipation are those who reached the age of majority; CWLA, Special tabulation from AFCARS. back
3. Daro, D., Howard, E., Tobin, J. & Hardin, A. (2005). *Welcome home and early start: an assessment of program quality and outcomes.* Available online at: http://www.chapinhall.org/article_abstract.aspx?ar=1365. Chicago, IL:
4 Aos, S., Lieb, R., Mayfield, J., Miller, M., Pernucci, A. (2004). Benefits and costs of prevention and early intervention programs for youth. Olympia: Washington State Institute for Public Policy. Available online at http://www.wsipp.wa.gov.
5 Chapin Hall.Center for Children at the University of Chicago. (2006). *Challenges to building and sustaining effective home visitation programs: lessons learned from states.* Available online at:
http://chapinhall.webex.com/seminar/251028/play/335933617/PPT_presentations.pdf. Chicago, IL: Author.
6 Administration on Children, Youth, and Families (ACYF). (2006). *Child maltreatment 2005*, Washington, DC: U.S. Department of Health and Human Services (HHS).
7 Daro, D., Howard, E., Tobin, J. & Hardin, A. (2005). *Welcome home and early start: an assessment of program quality and outcomes.* Available online at: http://www.chapinhall.org/article_abstract.aspx?ar=1365. Chicago, IL:
8 U.S. House of Representatives, Committee on Ways and Means. (2004). *Substance abuse, section 11.* (In *2004 Green Book).* Washington, DC: U.S. Government Printing Office.
9 Wells, K., & Wright, W. (2004, Sept. 14). *Medical summit.* Presented at Idaho's Second Annual Drug Endangered Children Conference, Post Falls, Idaho. Available online at http://www.isp.state.id.us/DEC_Conference/2004Materials.html.
10 Semidei, J., Radel, L.F., & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare, 80*, (2) 109-128.
11 "Safe and Sound: Models for Collaboration Between the Child Welfare & Addiction Treatment Systems." *Arthur Liman Policy Institute, Legal Action Center.* April, 2003. New York: NY; (2) Substance Abuse and Mental Health Services Administration. The National Treatment Improvement Evaluation Study. Preliminary Report: The Persistent Effects of Substance Abuse Treatment One Year Later. Rockville, MD: SAMHSA, 1996; (3) Center for Substance Abuse Treatment. (2000). "Substance Abuse Treatment: Reduces Family Dysfunction, Improves Productivity." Rockville, MD.
12 "Alcohol and Other Drug Survey of State Child Welfare Agencies." Child Welfare League of America. February, 1998.
13 Price, R. (1997). "What we know and what we actually do: Best practices and their prevalence in substance abuse treatment." In J.A. Egertson, D.M. Fox & A.J. Leshner, (Eds). Treating Drug Abusers Effectively. Malden, MA: Blackwell.
14 Child Welfare League of America, (2003) CWLA Best Practices Guidelines: Child Maltreatment in Foster Care. Washington, DC.
15 Child Welfare League of America (CWLA). (2006). Special tabulation of the Adoption and Foster Care Analysis Reporting System (AFCARS). Washington, DC: Author.
16 Child Welfare League of America (2007). *Standards of Excellence for Health Care Services for Children in Out of Home Care.* CWLA Standards of Excellence.
17 Ibid.
18 Ibid.
19 Ibid.
20 Ibid.
21 Ibid.
22 Ibid.
23 Webster, D., Barth, R.P. & Needell, B. (2000). Placement stability for children in out-of home care. *Child Welfare, 79*(5), 614-631.
24 Barth, R. (2002). *Institutions vs. foster homes: The empirical basis for the Second Century of Debate.* Chapel Hill, NC: University of North Carolina School of Social Work, Jordan Institute for Families.
25 Barth, R. (2002). *Institutions vs. foster homes: The empirical basis for the Second Century of Debate.* Chapel Hill, NC: University of North Carolina School of Social Work, Jordan Institute for Families.
26 An adoption placement that is not successful aftercare is considered a dissolution while an adoption that fails after it has become final is considered a disruption
27 U.S. Children's Bureau. (2000). *Report to congress on kinship foster care.* Available online at http://aspe.hhs.gov/hsp/kinr2c00. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families.
28 U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, & Children's Bureau (2005). *Synthesis of findings: Assisted guardianship child welfare demonstrations.* Available online at
http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/agissue/. Washington, DC:
29 Child Welfare League of America (2006). *Survey of Post Adoption Service.* Available online at
http://www.cwla.org/programs/adoption/adoptionsurvey.htm Washington , DC.
30. 22, 718 in 2004, Children who aged out of foster care are captured by the AFCARS emancipation data element. Children who exit care to emancipation are those who reached the age of majority; CWLA, Special tabulation from AFCARS. back
31 Cook, R. (1991). A national evaluation of title IV-E foster care independent living programs for youth. Rockville, MD: Westat Inc. Courtney, M., & Piliavin, I. (1998). Foster youth transitions to adulthood: Outcomes 12 to 18 months after leaving out-of-home care. Madison: University of Wisconsin.
32 Farmer, E. M. Z., Burns, B. J., Chapman, M. V., Phillips, S. D., Angold, A., &Costello, E. J. (2001). Use of mental health services by youth in contact with social services. *Social Service Review, 75*(2): 605–24.
33 Geen, R., Sommers, A., & Cohen, M. (2005). Medicaid spending on foster children. Available online at
http://www.urban.org/publications/311221.html. Washington, D.C.: Urban Institute.
34 National Child Welfare Resource Center for Family-Centered Practice, a service of the Children's Bureau. (2003, Summer). Mental health issues 33in the child welfare system: A focus on children and families. *Best Practice/Next Practice: Family-Centered Child Welfare.* Washington, DC: Author.
35 U.S. General Accounting Office (GAO). (2003). *HHS could play a greater role in helping child welfare agencies recruit and retain staff.* (GAO-03-357). Available online at www.gao.gov.