United States Government Accountability Office

Report to the Committee on Finance, U.S. Senate

October 2015

FOSTER CARE

HHS Could Do More to Support States' Efforts to Keep Children in Family-Based Care

GAO-16-85

GAO Highlights

Highlights of GAO-16-85, a report to the Committee on Finance, U.S. Senate.

October 2015

FOSTER CARE

HHS Could Do More to Support States' Efforts to Keep Children in Family-Based Care

Why GAO Did This Study

About 14 percent of the more than 400,000 children in foster care nationwide lived in congregate care at the end of fiscal year 2013, according to HHS data. Given the importance of family-based care to foster children's well-being, GAO was asked to review state use of congregate care.

This report examines (1) how selected states have reduced their use of congregate care; and (2) some challenges with reducing congregate care placements, and efforts HHS has taken to help states reduce congregate care. GAO analyzed child welfare data from HHS; reviewed relevant federal laws, regulations, and documents; and interviewed state child welfare officials in eight states--Connecticut, Colorado, Kansas, Louisiana, Maryland, Minnesota, New Jersey, and Washington. In four of these states, GAO also visited and spoke with local child welfare officials and congregate care providers. The selected states varied in their use of congregate care and geographic location, but cannot be generalized nationwide. GAO also spoke with child welfare experts.

What GAO Recommends

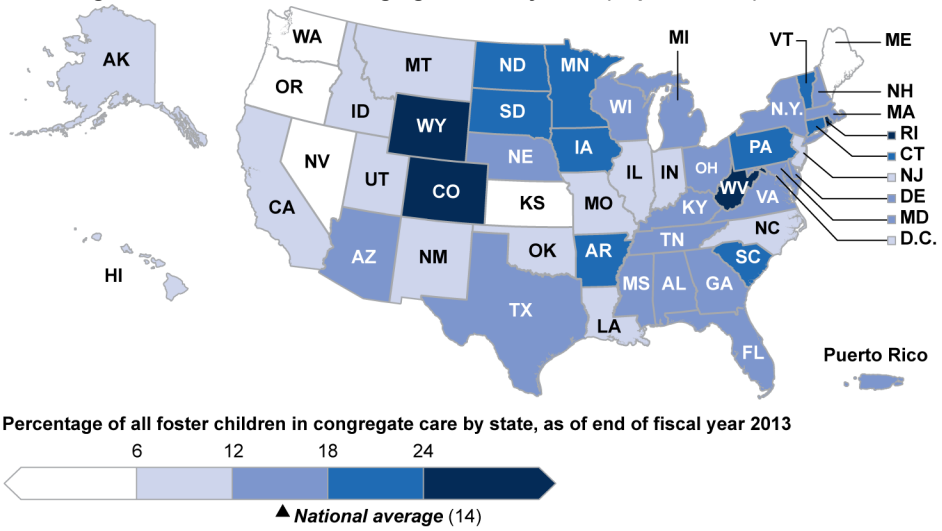
GAO recommends that HHS take steps to enhance its support of state actions to reduce use of congregate care as appropriate, by, for example, collecting additional information on state efforts and sharing best practices. HHS concurred with this recommendation.

View GAO-16-85. For more information, contact Kay E. Brown at (202) 512-7215 or brownke@gao.gov.

What GAO Found

Eight states GAO reviewed had a variety of efforts under way to help ensure they placed foster children in family-based settings rather than in group homes or institutions, also known as congregate care. Federal law requires that foster children have a case plan designed to achieve placement in the least restrictive (most family like) and most appropriate setting available, consistent with their needs. States' efforts to ensure appropriate placements included more oversight of decisions to place children in congregate care and the length of stay; enhanced recruiting and training for specialized foster families to care for children with serious emotional, behavioral, or medical problems; and increased supports for families in crisis. Officials in the eight states generally credited these efforts with declines in their use of congregate care—on average a 47 percent decline from fiscal years 2004 through 2013, based on the most recent available data from the Department of Health and Human Services (HHS). However, these states' percentages of foster children in congregate care still ranged from 5 percent to 34 percent, mirroring the variation nationwide in fiscal year 2013.

Percentage of Foster Children in Congregate Care by State (Sept. 30, 2013)



Source: GAO analysis of data states reported to HHS. | GAO-16-85

Selected stakeholders (state officials, service providers, and experts) cited challenges to more appropriate use of congregate care, such as providing specialized training to foster families, addressing shortages in mental health and other community services, and working with congregate care providers to focus more on providing services in family settings. In a May 2015 report, HHS said that states' progress in reducing congregate care was inconsistent and recognized that additional information was needed. HHS also proposed some relevant legislative changes. Stakeholders identified other HHS actions, such as additional data analysis and sharing of best practices that would help states facing challenges to transform their use of congregate care. HHS currently does not have plans to take further actions to support states.

Contents

Abbreviations

ACF	Administration for Children and Families
AFCARS	Adoption and Foster Care Analysis and Reporting System
CFSR	Child and Family Services Reviews
HHS	Health and Human Services
PASS	Preparing Adolescents for Self Sufficiency
PRTF	Psychiatric Residential Treatment Facilities

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

October 9, 2015

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

About 14 percent of more than 400,000 children in foster care nationwide were living outside of a family setting in a group home or institution, commonly referred to as congregate care, at the end of fiscal year 2013. This is based on the most recent data available from the Department of Health and Human Services (HHS). State and local governments administer foster care programs, and HHS oversees their implementation of applicable federal requirements. Title IV-E of the Social Security Act, originally enacted by the Adoption Assistance and Child Welfare Act of 1980, requires that children in foster care have a case plan designed to achieve placement in a safe setting that is the least restrictive (most family like) and most appropriate setting available, consistent with their best interests and special needs.[1] HHS data show that at the end of fiscal year 2013, states varied widely in the share of foster children living in congregate care settings, from a low of about 4 percent to a high of 34 percent.[2]

Given the variation among states and the requirements of Title IV-E, you asked us to review state use of congregate care and efforts to reduce its use, as appropriate. This report addresses the following questions:

(1) How have selected states reduced their use of congregate care?

[1] See 42 U.S.C. § 675(5)(A). States must comply with this and other requirements to be eligible to receive funding for foster care and adoption assistance programs under Title IV-E.

[2] National data in this report include data from the District of Columbia and Puerto Rico; we include these jurisdictions when we refer to all states in this report.

(2) What are the challenges with reducing congregate care placements and what efforts has HHS taken to help states reduce congregate care?

To gain an understanding of the usage of congregate care and efforts taken or under way to reduce these placements, we interviewed stakeholders from state and local child welfare agencies, congregate care provider organizations, as well national research and advocacy organizations. We interviewed state child welfare officials in eight states—Colorado, Connecticut, Kansas, Louisiana, Maryland, Minnesota, New Jersey, and Washington. For a more in-depth review, we conducted site visits in four of the eight states—Connecticut, Louisiana, Maryland, and Washington. In each state we visited, we interviewed state and local child welfare agency officials and congregate care providers. We interviewed a total of 14 providers and visited 7 localities representing a mix of rural and urban areas. We also toured several congregate care facilities in each of the four states for a better understanding of the types of congregate care facilities that are used in these states. We selected states to represent a mix of factors including: high and low share of foster children placed in congregate care, high and low rates of reduction in overall percentage of children placed in congregate care settings, and geographic dispersion. We did not assess the types, quality, or appropriateness of services provided by child welfare agencies or congregate care providers in each of the eight states. Information from the eight states cannot be generalized nationwide.

We also interviewed representatives from 12 national organizations who had expertise across multiple states based on their work researching child welfare issues, providing congregate care services, or advocating on behalf of children within the foster care system. We interviewed these experts to gain their perspective on the subject matter and considered recommendations from them especially to identify states that have had success in reducing the percentage of foster youth placed in congregate care settings. Experts and national associations were selected based on recommendations and previous published work on child welfare issues.

In the report, we refer to our interviews with “stakeholders” that represent the views of officials from the 8 state child welfare agencies, 7 local child welfare agencies, 14 congregate care providers that we visited in the four states, or 12 national organizations. In addition, in the report we use qualifiers, such as “several” and “many,” in some cases to quantify responses from stakeholders across our interviews with officials from 41 entities in total. These qualifiers are defined as follows:

- "All" stakeholders represents 41.
- "Most" stakeholders represents 21-40.
- "Many" stakeholders represents 10-20.
- "Several" stakeholders represents 4-9.
- "A few" stakeholders represents 2-3.

For the eight states included in our study, we analyzed state-reported Adoption and Foster Care Analysis and Reporting System (AFCARS) data for fiscal years 2004 and 2013 for information on the percentage of foster children and youth that are placed in congregate care settings and how these placements have changed over time, as well as how states vary in their usage of congregate care. We took a number of steps to assess the reliability of the AFCARS data, including discussions with HHS officials and statisticians and testing the reasonableness of selected data variables, and determined that the data were reliable for our purposes. We also interviewed HHS officials for an understanding of their efforts to assist states with reducing the usage of congregate care placements. In addition, we reviewed relevant federal laws, regulations and agency documents.

We conducted this study from January 2015 to October 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

State and local governments are the primary administrators of child welfare programs designed to protect children from abuse or neglect. Children enter state foster care when they have been removed from their parents or guardians and placed under the responsibility of a state child welfare agency. Removal from the home can occur because of reasons such as abuse or neglect, though in some cases a child's behavior may also be a factor. When children are taken into foster care, the state's child welfare agency becomes responsible for determining where the child should live and providing the child with needed support.

Federal Funding Sources for Child Welfare Programs

Title IV-E of the Social Security Act authorizes federal funding to states to help cover costs associated with states' foster care and adoption programs. Title IV-E funds, which make up the large majority of federal

funding dedicated to child welfare primarily provides financial support for the care of eligible children who have been removed from their homes due to abuse or neglect, as well as to families who adopt eligible children with special needs from the foster care system.[3] For example, funds may be used to reimburse states for a portion of expenses to support eligible children in foster care (such as for food, clothing, and shelter), and for the costs of subsidies to parents who adopt eligible children with special needs (adoption assistance), as well as for related case management activities, training, data collection, and other program administrative costs.

While Title IV-E funds are used primarily for eligible children in foster care, Title IV-B funds may generally be used for services for children and their families regardless of whether those children are living in their own homes, have been removed from their homes and placed in foster care settings, or have left the foster care system. Title IV-B funds are provided primarily through two formula grant programs.[4] Funds may be used for case planning and review services for children in foster care and other services to families such as parenting skills training or substance abuse treatment. Although Titles IV-B and IV-E are the primary sources of federal funding available to states for child welfare programs, states also use other federal funds, such as Temporary Assistance for Needy Families and Social Services Block Grant funds, as well as Medicaid.

Oversight and Monitoring of Child Welfare Programs

HHS provides oversight and monitoring of states in a variety of ways to ensure their child welfare programs are in compliance with federal law, regulations, and relevant approved state plans. For example:

[3] See 42 U.S.C. § 670 *et seq*. Title IV-E foster care support is limited to those children who are removed from homes with very low incomes (in most states the income standard is well below 100 percent of the federal poverty guidelines, according to HHS). Eligible children must meet certain additional federal criteria, such as age and certain requirements related to the child's removal and placement. 42 U.S.C. § 672. The Fostering Connections to Success and Increasing Adoptions Act of 2008 changed the eligibility criteria for Title IV-E adoption assistance for children with special needs to eliminate the income requirements for the family from which the child is removed. This change is being phased in over time based on the child's age at adoption. Beginning in 2018, the revised criteria will apply to children of all ages. 42 U.S.C. § 673.

[4] See 42 U.S.C. § 621 *et seq*.

- Twice a year, states are required to submit data on the characteristics of children in foster care. HHS compiles, validates, and reports data from state child welfare agencies on children in foster care and children who have been adopted from the child welfare system in AFCARS.
- HHS conducts statewide periodic assessments known as the Child and Family Services Reviews (CFSR) that involve case-file reviews and stakeholder interviews to ensure conformity with federal requirements for child welfare services. The reviews are structured to help states identify strengths and areas needing improvement within their agencies and programs.[5]
- HHS conducts periodic Title IV-E foster care eligibility reviews to monitor the state Title IV-E agency's compliance with certain requirements of the Title IV-E foster care maintenance payments program. As part of the review, HHS examines a Title IV-E agency's compliance with requirements related to placing a child in a licensed foster family home or child care institution, and ensuring that safety requirements are met by the child's foster care provider.
- HHS also provides support and training through centers that provide states with training, technical assistance, research, and information through referral and consultation.

For the purposes of collecting data from states on their foster care systems, HHS uses the two terms below to refer to non-family settings, called congregate care in this report:[6]

- Group home: a licensed or approved home providing 24-hour care for children in a small group setting that generally has from 7 to 12 children.

[5] In 2000, HHS issued regulations that specified that states must undergo a complete review of their child welfare programs every 5 years (every 2 years for states found not to be in substantial conformity). Title IV-E Foster Care Eligibility Reviews and Child and Family Services State Plan Reviews, 65 Fed. Reg. 4020, 4076-77 (Jan. 25, 2000) (codified in relevant part at 45 C.F.R. § 1355.32(b)). HHS has conducted two rounds of CFSRs to date. The third round, which should have started in 2012, was delayed because HHS was revising the instrument used to assess states to improve the CFSR process. HHS reports that the third round of reviews are expected to run from 2015-2018.

[6] The term congregate care is also used in other fields—such as elder housing—but in the context of foster care, these settings only house children. However, the children housed in a congregate care setting are not necessarily all in foster care; such facilities might also house children placed by the juvenile justice system, the mental health system, or privately by individual families.

- Institution: a child care facility operated by a public or private agency and providing 24-hour care and/or treatment for children who require separation from their own homes and group living experience. For example, these facilities may include: child care institutions, residential treatment facilities, or maternity homes, according to HHS.

Although states report data to HHS on the number of foster care children placed in two types of congregate care settings, states do not necessarily use the same terminology and may vary in the way they classify and or describe similar facilities. For detailed information on the types of congregate care facilities used by states we visited see appendix I. HHS has proposed revising its AFCARS regulations to collect more detailed information from states on the types of congregate care used, although the proposed changes have not yet been finalized.[7]

Placement Decisions and Congregate Care

When children are removed from their homes, the child welfare agency may place the child in a foster home of a relative or non-relative, or in a congregate care setting, depending on the child's needs. Children generally remain in foster care until a permanent suitable living arrangement can be made, either by addressing the issues that led to the child's removal and returning the child to his or her family, or in cases where this is not possible in a timely manner, through adoption, guardianship, placement with a relative, or another planned permanent living arrangement. In some cases, the child reaches adulthood before leaving foster care, commonly referred to as "aging out of foster care". HHS's Title IV-E regulations require that each child's case plan include a discussion of how it is designed to achieve a safe placement for the child in the least restrictive (most family like) setting available and in close proximity to the home of the parent(s) when the case plan goal is reunification, and a discussion of how the placement is consistent with the best interests and special needs of the child.[8] However, states have flexibility and discretion to make decisions for each child on a case-by-

[7] HHS has proposed revising its AFCARS regulations to collect additional information from states on the types of congregate care used, although the proposed changes have not yet been finalized. Adoption and Foster Care Analysis Reporting System, 80 Fed. Reg. 7132 (Feb. 9, 2015). Among other things, HHS proposed to expand the types of living arrangements reported in AFCARS to include a variety of placement settings, such as therapeutic foster family homes, group homes that may provide shelter care or be operated by staff or a family, supervised independent living, and juvenile justice facilities.

[8] 45 C.F.R. § 1356.21(g)(3). See also 42 U.S.C. § 675(5)(A).

case basis to ensure that the most appropriate placement is made and the individual needs of the child are met.

HHS issued a report on congregate care in May 2015 that stated that in addition to federal law, child development theory and best practices confirm that children should be placed in family-like settings that are developmentally appropriate and least restrictive.[9] The report also stated that congregate care stays should be based on the specialized behavioral and mental health needs or clinical disabilities of children, and only for as long as needed to stabilize them so they can return to a family-like setting. Furthermore, the report noted that congregate care should not be used as a default placement setting due to a lack of appropriate family-based care, but as part of a continuum of foster care settings. Young children need family-like settings to form healthy attachments to adults, and older children need family-like settings to allow them to develop autonomy, according to research.[10] This is also in keeping with changes in the field of congregate care, which is increasing its focus on stays in a residential center as treatment interventions to meet specific needs rather than a placement of last resort for foster children.[11]

However, a recent HHS study using AFCARS data on states' use of congregate care found that for all children who entered foster care for the first time in 2008 (first-time entry cohort focusing on first episodes), an estimated 38,205 of these children experienced congregate care at some point during a 5-year follow-up period.[12]

[9] U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "A National Look at the Use of Congregate Care in Child Welfare" May 2015.

[10] For example, see Mary Dozier et al., "Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association," *Journal of Orthopsychiatry*, 2014.

[11] See, for example, American Association of children's Residential Centers (AARC), *Redefining the Role of Residential Treatment,* regarding efforts underway around the nation to redesign the role of residential treatment in local communities. Founded in 1956, AACRC is an association focused on the needs of children with serious mental and behavioral problems who are in residential or other milieu-based placements.

[12] U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, *"A National Look at the Use of Congregate Care in Child Welfare"* May 2015.

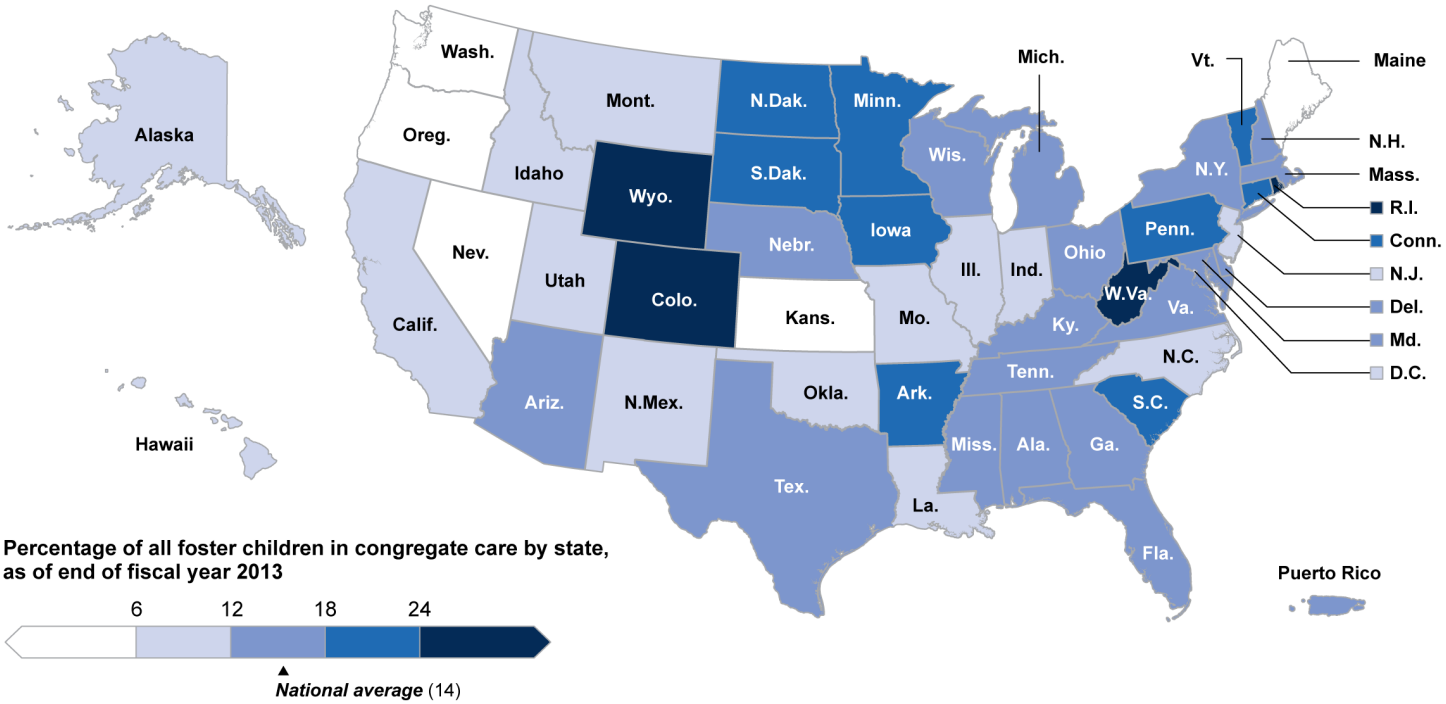
- Of these children, 31 percent were aged 12 or younger when they experienced congregate care at some point during the 5-year follow-up. While one-fifth of these young children who experienced time in congregate care were in these settings for less than a week, 24.1 percent were there for longer than a year.
- Of those aged 13 years or older who experienced some time in congregate care during that time period, about 40 percent were identified as entering foster care due to a child behavior problem and no other clinical or mental disability, highlighting the need for a thorough assessment to ensure children are placed in the least restrictive settings to meet their needs.

Additionally, of the children in care as of September 30, 2013, HHS found that the overall total time in foster care was longer for children in congregate care settings, with an average of 27 months in foster care compared to 21 months for children placed in other types of out-of-home settings.

National Trends

Over the past 10 years, the number of children and youth in the foster care system declined by 21 percent from 507,555 at the end of fiscal year 2004 to 402,378 at the end of fiscal year 2013, according to data reported to HHS by the states. HHS reported that there were fewer entries into foster care, an increase in exits, and shorter lengths of stay during this time period; it did not attribute the decline to any particular factor. The number of children in congregate care also declined, and at a greater rate than children in foster care, 37 percent compared to 21 percent. According to the most recent data available, nationally, 14 percent of children in foster care were in congregate care placements at the end of fiscal year 2013, although the rates of congregate care use varied among the states (see fig. 1).

Figure 1: Percentage of All Foster Children in Congregate Care by State, as of September 30, 2013



Percentage of all foster children in congregate care by state, as of end of fiscal year 2013

6 12 18 24

▲ ***National average*** (14)

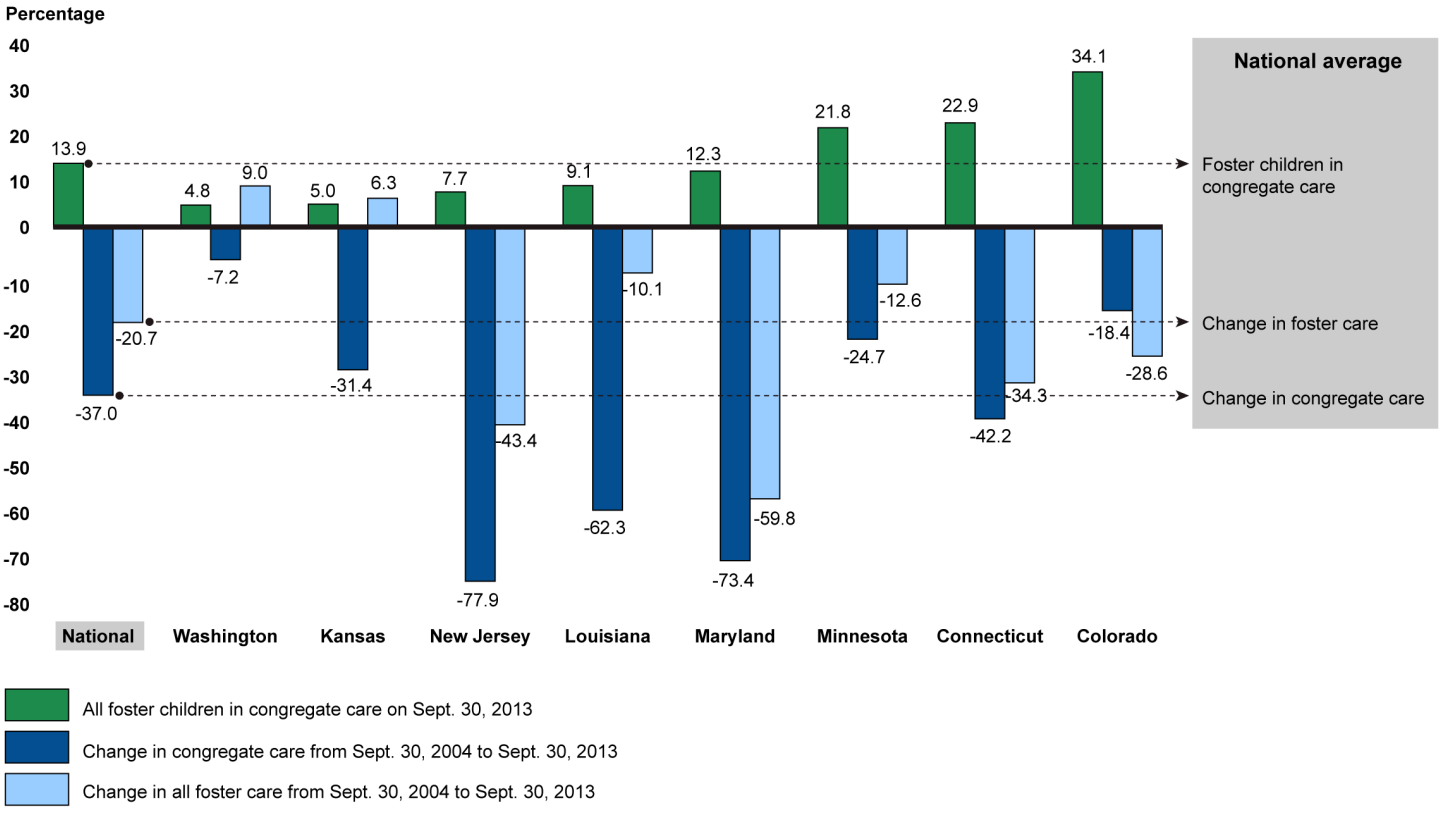
Source: GAO analysis of data states reported to HHS. | GAO-16-85

Eight Selected States Reduced the Use of Congregate Care Substantially Using Multiple Approaches, but the Rates of Use Varied Widely

The Eight Selected States Averaged a 47 Percent Reduction in Congregate Care Use, Although the Current Rates of Use Still Varied among These States

From September 30, 2004, to September 30, 2013, the share of all foster care children in congregate care in the eight states we reviewed declined 47 percent on average, with reductions ranging from 7 to 78 percent, according to the most recent data available from HHS. This decline outpaced these states' average decline of 26 percent in the number of foster children overall. However, the states' percentages of congregate care placements ranged from approximately 5 percent in Washington to 34 percent in Colorado (see fig. 2). Nationwide, congregate care placements are declining and this trend is reflected in the 8 selected states.

Figure 2: Changes in Congregate Care and All Foster Care in Eight States and the National Average (from September 30, 2004 to September 30, 2013)



Source: GAO analysis of data states reported to HHS. | GAO-16-85

Note: HHS officials told us that a state's congregate care numbers may include children and youth that are in the juvenile justice system as well as those in the child welfare system. For example, Colorado officials said that their data included youth placed in congregate care by the state division of youth corrections. According to the officials, the percentage of foster children in congregate care, excluding these youth corrections placements, was about 20.8 percent rather than 34.1 percent.

Selected States' Efforts to Reduce Congregate Care Included Expanding Services, Developing Alternative Placements, and Revising How They Used Congregate Care

The eight selected states reported a variety of efforts they took to help reduce their use of congregate care for foster children. In some cases, reform efforts were intended to reduce the number of children removed from their homes or to improve the state's overall child welfare system, while others focused specifically on reducing congregate care. Based on our analysis, we categorized these efforts into three areas: expanding services that may prevent entry into foster care, increasing availability of family-based placements in foster care, and revising how congregate care is used. These are discussed in more detail below.

- *Expanding services to avoid the need to remove the child in the first place and to support children in family-based settings.* When sufficient resources are available and circumstances warrant it, caseworkers may decide to provide services for at-risk families in the home to help stabilize the family rather than remove the child from the home, as we found in our previous work.[13] In addition, other resources can help ease the transition from congregate care to a family-based setting, whether in the foster care system or the home from which the child was removed.
- *Increasing the availability of family-based placement options.* Increased efforts to find relatives who can care for children who are removed from their homes can help children remain in family settings, according to one child welfare official.[14] In addition, caseworkers may also recruit or train foster families to serve as treatment or therapeutic foster families. These terms generally refer to a model of care that attempts to provide elements of traditional foster care with clinical treatment of a child's serious emotional, behavioral, and medical problems in a specialized foster home. One state child welfare official told us that in the past, children and youth with significant behavioral or other problems were often placed in congregate care because foster families or relatives with the requisite skills to help the child were not always available, nor were adequate supports available in the community.
- *Revising how congregate care is used for foster children.* When congregate care is considered as a placement by a caseworker, specific policies can affect the level at which the final decision is made, what criteria are used, the duration of stay, and if a plan for transitioning out of the congregate care setting is established. One child welfare official told us her state agency's efforts were often meant to ensure that all other placement options had been exhausted before congregate care could be considered, that the length of stay in congregate care was as short as possible, and that the child received appropriate treatment while in care. In addition, one congregate care provider noted that the provider had developed new service delivery

[13] GAO, *Child Welfare: States Use Flexible Federal Funds, but Struggle to Meet Service Needs,* GAO-13-170 (Washington, D.C.: Jan. 30, 2013).

[14] When a child is removed from the home, Title IV-E requires that the state exercise due diligence to identify adult relatives and notify them of the child's removal and the relatives' options to become a placement resource for the child. 42 U.S.C. § 671(a)(29).

models, which in some cases included providing services when the child returned to the home and community.

See table 1 for examples of selected state efforts and examples as described by state officials.

Table 1: Examples of Efforts Reported by Eight States to Reduce Congregate Care for Children in Foster Care

State efforts	Specific examples
Expanding services to avoid the need to remove the child in the first place and support the child upon returning home	
Intensive in-home therapy	Clinical services provided in the child's home and community to prevent the child from entering into care.
Increased community wrap-around services	A team or group of individuals providing a range of services to youth with complex needs both in foster care and those still in the home.
Utilization of crisis mobilization units	Crisis intervention specialists who are dispatched into the community 24/7 to stabilize a child or family in crisis.
Increasing the availability of family-based placement options	
Intensive family searches	Expanding search options to locate relatives to care for a child prior to entering into the foster care system or as a relative foster family.
Targeted recruitment for foster families	Specific recruitment for foster families to care for children with specific needs to avoid a congregate care placement.
Family team decision meetings	Involving family and others connected to the child when making decisions regarding a child's safety and placement.
Revising how congregate care is used	
Changes in removal and placement approval processes	Requiring multiple levels of approval before a child is approved for a congregate care setting.
Time limits and monitoring of congregate care placements	Requiring specified time limits (e.g., 6-18 months) for certain congregate care placements (e.g., shelter care placements and periodic review of need for congregate care).
Changing models of how congregate care is delivered	Finding new ways of working with congregate care providers, for example, by contracting with them to provide more diverse services, including for children in their own or foster homes and by ensuring providers plan for transitioning the child back to a family setting with appropriate support and services.

Source: GAO analysis of interviews with state and local officials in selected states.| GAO-16-85

The eight states used a combination of policies and practices noted above in their efforts to reduce or limit the use of congregate care. Because child welfare systems are complex with many interrelated features, states' efforts often resulted in the need to transform several features of their systems at the same time, as described in the summaries below.

Washington had the smallest proportion of its foster care caseload placed in congregate care of the eight states we reviewed, as well as the smallest reduction from the end of fiscal years 2004 through 2013. According to officials, intensive family searches to locate family members to care for youth has been a successful effort used by caseworkers in the state to help reduce congregate care. The state and local child welfare officials and service providers we spoke with placed emphasis on placements with available family members or foster homes, even for youth with a high need for treatment or other services. One official noted that the emphasis on family placements first has been a longstanding policy preference in the state. In addition, about 15 years ago, Washington changed its model of care for how services are delivered by congregate care providers. Officials said that the state changed its contract with providers from a structure with a set number of beds and service levels to a contract for an array of services which could be delivered in multiple settings, such as congregate care, treatment foster homes, regular foster homes, and family or relative homes.

Kansas had the second lowest percentage of foster children in congregate care of the eight states we reviewed with 5 percent as of September 30, 2013. Officials attributed a 31 percent decline in their congregate care population over the 9 year period to several factors. In 1996, according to officials, the state began contracting with private non-profit organizations to provide family preservation, foster care and adoption services. State officials told us that prior to establishing these contracts, up to 40 percent of their foster children were in congregate care settings. Officials also cited as contributing factors the method of payment to contractors and holding foster care providers accountable for meeting outcome goals established by the state to place children in a family-like setting when possible or face monetary penalties.

New Jersey began reforming its child welfare system about 10 years ago, and according to state officials, it has resulted in reductions in the state's overall foster care population and congregate care. Officials explained that the state adopted a new family model of care that included extensive recruitment of foster, adoption, and kinship caregivers—

referred to as resource families—that helped to reduce the overall foster care population and congregate care placements.[15] In this model, these resource families are provided with extensive training and a resource worker is assigned to help provide services to the child in the home. One official told us that this is a new paradigm of care that is very intensive. They work with the family and bring in as many community resources as possible to keep children in their homes, which has been effective in reducing the number of children entering foster care overall.

Louisiana officials told us that following Hurricane Katrina in 2005, state officials worked with the Annie E. Casey Foundation[16] to improve performance in key areas in child welfare. Hurricane Katrina caused widespread destruction and displacement of youth. Many of the state's foster children were temporarily displaced and child welfare officials did not have current emergency contact information, which made it difficult for them to find the foster families that had to evacuate. According to officials, over a 2-year period, they reduced the number of children in congregate care settings by approximately 200 youth through various efforts, including: (1) focused efforts on stepping down youth placed in residential levels of care into less restrictive placements; (2) recruited foster/adoptive homes that could accept placement of youth stepping down when relative resources were not available and recruited homes that could provide placement to children/youth entering care without relative resources; (3) increased availability of in-home services so that youth were stepped down, the services would be in place to assist in supporting the placement. To support the foster home recruitment piece, dedicated recruiters were hired and placed in all 9 regions of the state with the sole task of recruiting homes. Another effort officials described during this time was the revision of the licensing regulations for residential facilities and child placing agencies.

[15] According to the New Jersey Resource Family Handbook (revised May 2015), kinship caregivers are related to a child in placement through blood, marriage, civil union, domestic partnership, or adoption. Kinship caregivers may also be connected to the child by an established positive psychological or emotional relationship. The guide notes that kinship caregivers may provide care before being licensed by the state, as may foster and adoption parents, if they are eligible for licensure and are in the process of being licensed.

[16] The Annie E. Casey Foundation states that it is a private charitable organization dedicated to helping build better futures for disadvantaged children in the United States. The primary mission of the Foundation is to foster public policies, human systems reforms, and community supports that more effectively meet the needs of today's vulnerable children and families.

Maryland launched a statewide initiative in 2007 called "Place Matters" that greatly affected the state's child welfare system and improved outcomes for all children in the state, including those in congregate care, according to state officials. The goals of the "Place Matters" initiative include: (1) providing more in-home support to help maintain children with their families; (2) placing children in family settings (either with relatives or family-based care); and (3) reducing the length of stay in foster care and increasing the number of reunified families. By 2014, Maryland officials reported a reduction in the number of children in out-of-home care by over 50 percent and a reduction of children placed in congregate care of almost 60 percent. Maryland officials also described changes in the placement and review process that they said have helped reduce the number of children in congregate care. For example, a placement protocol was instituted to ensure that family settings were ruled out before children could be placed in congregate care settings. According to officials, several layers of review have also been added to ensure that more restrictive placements are warranted and necessary based on the child's needs. Maryland also instituted a state-wide initiative that included an extensive search for relatives of a foster child, according to officials.

Minnesota continues to explore alternatives to group settings for children in foster care needing specialized services, such as behavioral and mental health needs that a foster family may not be capable of providing, according to state officials. The state is currently in the process of developing intensive treatment foster care services, as provided for under a Minnesota statute enacted in 2013, according to officials. These include intensive treatment services that will be provided within a foster family setting to help reduce the need for congregate care placements. In addition, in January 2015, the state implemented Northstar Care, a program intended to help children who cannot return home to find other permanent families. Officials expect that with the implementation of Northstar Care and other services, like treatment foster care services, the number of children in congregate care will continue to decline.

Connecticut officials told us that the primary impetus for their focus on reducing congregate care was a change in leadership that occurred in 2011. At that time, the newly appointed head of the state child welfare agency set a goal of reducing the percentage of foster children in congregate care from 23 percent to 10 percent. Connecticut officials described going through the case files of all youth in foster care and working, in consultation with the youth, to identify possible options for a home for the youth that may include family members or close friends. Through this process, Connecticut officials told us they were able to place

some children into a home and out of a congregate care setting. According to officials, targeted family outreach and also engaging people not related by birth or marriage who have an emotionally significant relationship with a child has also resulted in a significant reduction in the number of children coming into foster care in general. Officials believe that this shift in attitude around connecting youth to their families and communities is leading to better outcomes for youth. Other efforts described by officials included increasing the availability of community-based supports across the state to help prevent children from coming into care. Specifically, officials said the state modified its contracts with health care providers to increase access to emergency psychiatric services for anyone in the state, including those who are not currently in foster care.

Colorado had one of the higher percentages of youth in congregate care among our eight states, according to HHS data. The state is currently working with Casey Family Programs[17] and the Annie E. Casey Foundation to improve placements for children in congregate care by finding creative ways of placing children into family homes. Colorado state officials described changes and new ways of working with the congregate care provider community to develop models of care that are more treatment-oriented to help children transition back into a community settings. For example, state officials held two forums with providers in their state to educate them on how to adjust their services and the service delivery expectations as the state is shifting towards using providers more for treatment than just a placement. State officials said they are also working with the judicial system to identify alternative options, such as in-home services, because according to these officials some judges are used to ordering that children be placed into a congregate care facility, often as a consequence of behavioral issues.

[17] Casey Family Programs states that it is a foundation focused on safely reducing the need for foster care and that it works nationwide. State officials said they received additional resources from Casey Family Programs for the initiative.

Stakeholders Cited Challenges in Developing Alternatives to Congregate Care and HHS Has Begun Efforts to Help States

Developing a Sufficient Supply of Appropriate Family Placements and Needed Services While Transitioning to a More Treatment–Based Model of Congregate Care Poses Challenges

Stakeholders we interviewed described challenges involved as efforts were made to reduce reliance on congregate care where appropriate, or as one child welfare foundation says, to "right-size" states' use of congregate care.[18] From this information, we identified four areas that posed challenges in the selected states and that may inform other states' efforts to reduce the role of congregate care in their child welfare systems.

Building capacity for family placements. While developing alternative family placements is a part of states' efforts to reduce congregate care, stakeholders we spoke with said that doing so posed challenges. Several stakeholders told us that too few foster families were available generally, and that traditional foster families can be overwhelmed by the needs of some foster children and youth, such as those with behavior problems. Officials in one state also told us that building capacity in appropriate family placements to replace congregate care placements requires recruitment and training of specialized foster families and training to change caseworker's existing practices. A few stakeholders also told us that this can require additional resources or a redirection of existing resources. In addition, because congregate care placements typically cost more than traditional foster families, less use of congregate care should free up state resources for developing more foster families with the training and skills to support children and youth with greater needs, according to an expert we spoke with.

[18] See the Annie E. Casey Foundation. *Rightsizing Congregate Care: A Powerful First Step in Transforming Child Welfare Systems*. (Baltimore, Md.: 2010)

A few stakeholders we spoke with agreed that a shift away from congregate care must be planned and implemented carefully to ensure that children are placed with families adequately prepared to meet their needs and to avoid unintended consequences. For example, if a child with significant needs that require more attention is placed in a traditional foster family without adequate supports, the result may be multiple unsuccessful placements, inappropriate medications to manage a youth's behavior, or entry into the juvenile justice system, according to some of the officials we spoke with. One expert said that, based on her observation, one state had rushed to reduce congregate care without first putting sufficient supports in place for foster families, which resulted in unintended consequences, such as unsuccessful placements.

Addressing shortages of needed services. In addition, several stakeholders noted the shortage of services that can help bolster supports for at-risk children and families before the child or youth is removed from home or during foster care to help avoid or reduce the length of a congregate care stay. This is consistent with the findings from our 2013 report in which we reported that local child welfare systems use existing community resources, which are sometimes in short supply, leading to gaps in areas such as substance abuse treatment, assistance with material needs, and mental health services.[19] One stakeholder noted there is a lack of more holistic support systems in some communities, including access to behavioral and mental health services; crisis support 24 hours a day, 7 days a week; housing; and education that would facilitate more use of family settings rather than congregate care. However, Title IV-E funds are generally not available for services for children and families not in the foster care system.

*Improving assessment*s. Having accurate information on a child or youth's physical and mental health needs is a factor in identifying what, if any, treatments and services may be needed, and the eight states we reviewed told us they had assessment processes in place. While we did not review the types or quality of the assessment processes in these states, two experts we spoke with raised concerns about the variation in types and quality of assessments performed nationwide. This is due in part to insufficient caseworker training and large workloads in states and

[19]GAO, *Child Welfare: States Use Flexible Federal Funds, but Struggle to Meet Service Needs,* GAO-13-170 (Washington, D.C.: Jan. 30, 2013).

localities generally, as we have also found in our previous work. [20] More specifically, one of these experts said that some child welfare assessments may result in an incorrect diagnosis due to lack of understanding of trauma-based conditions and treatments.[21] In this expert's opinion, children in congregate care were sometimes diagnosed with other conditions, such as bi-polar disorder, and were overmedicated to contain the issue rather than treat it. In our previous work, we have found that foster children may receive psychotropic drugs at higher rates than children not placed in foster care.[22] We found in the five states analyzed that the higher rates do not necessarily indicate inappropriate prescribing practices, as they could be due to foster children's greater exposure to traumatic experiences and the unique challenges of coordinating their medical care. However, experts that we consulted during that work explained that no evidence supports the concomitant use of five or more psychotropic drugs in adults or children, yet hundreds of both foster and non-foster children were prescribed such a medical regimen.

Retaining capacity for congregate care. State child welfare officials in all of the eight states told us that even though they have worked to reduce congregate care placements, they believed that they still require some amount of congregate care for children and youth with specific treatment needs and that retaining sufficient congregate care capacity may be difficult. In Washington, with its already relatively low use of congregate care, some officials were concerned about retaining enough congregate

[20] GAO, *Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff,* GAO-03-357 (Washington, D.C.: Mar. 31, 2003).

[21] A trauma-based child welfare system is one that recognizes and responds to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers. Such an approach may require changes from existing practices including shifting the goals of child welfare services from substantiating an occurrence of maltreatment and ensuring a child's physical safety to broadening the focus to include healing the impact of trauma and improving a child's social and emotional well-being. (Child Welfare Information Gateway. *Developing a trauma-informed child welfare system,* (Washington, D.C.: U.S. Department of Health and Human Services, Children's Bureau, 2015.))

[22] GAO, *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions,* GAO-12-201 (Washington, D.C.: Dec. 14, 2011). GAO*, Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations*, GAO-14.362 (Washington, D.C.: Apr. 28, 2014).

care capacity to meet the needs of children and youth they thought would require some time in a group setting. One stakeholder noted that adjusting to an appropriate level of congregate care can be challenging, as congregate care providers generally need to be assured of a sufficient level of "beds filled' to continue their operations. He added that some providers have long-standing relationships with a state or county and have an interest in continuing their operations. This stakeholder said that in his view the number of "beds" or openings in a congregate care setting may have factored into the determination of where a child or youth is placed in some situations. In such cases, he noted, the supply of available beds may have driven the placement rather than the needs of the child.

However, according to a few stakeholders, congregate care providers are beginning to diversify their services, which could include providing care in a group setting as well as supports and services in a family setting. Two congregate care providers told us that their business model had changed in recent years, from predominantly caring for children residing in their facilities to providing services to children in their foster or original homes, and also planning for service provision when a child or youth left congregate care. A few stakeholders we spoke with confirmed that providers are re-evaluating their relationships with the states as states are moving toward offering a continuum of services to help youth stay out of or transition out of congregate care as quickly as possible.

HHS Has Recently Taken Steps to Encourage States to Examine Their Use of Congregate Care, but Could Enhance Its Support to States

HHS's Administration for Children and Families (ACF) recently took steps to examine how states were using congregate care and as previously mentioned issued a report in May 2015 to help inform states and policymakers about the use of congregate care for foster children.[23] HHS officials told us that the report was their initial effort to understand congregate care as a placement option for foster children because the agency had not taken a national look at congregate care previously. In the report, HHS raised concerns about some of its findings—which we discussed earlier—about the use of congregate care for children aged 12 or younger and for placements for youth who do not appear to have high

[23] U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, *"A National Look at the Use of Congregate Care in Child Welfare"* (May 2015). We have included some data from the HHS report in the background section of this report.

clinical needs that might be better served in appropriate family settings. In addition, while the report cited that the decline in the percentage of children placed in congregate care nationwide suggested that child welfare practice is moving toward more limited use of congregate care, it also noted that the depth of improvement is not consistent across states.

In addition to its findings in the report, HHS included a legislative proposal in its fiscal year 2016 budget request to increase monitoring of congregate care use and support family-based care as an alternative to congregate care. More specifically, the proposal would, among other things, amend Title IV-E to require (1) documentation to justify the use of congregate care as the least restrictive setting to meet a child's needs, and (2) judicial review every 6 months while a child is in that placement to confirm that the placement remains the best option. It also would provide support for a specialized case management approach for caseworkers with reduced caseloads and specialized training for caseworkers and foster parents to address the needs of children. HHS estimated that these changes would increase costs in the first few years of the proposal going into effect, and that overall it would result in a reduction in costs of Title IV-E foster care maintenance payments. More specifically, HHS estimated that this proposal would increase fiscal year 2016 funding by $78 million and reduce foster care maintenance costs by $69 million over 10 years.[24]

Based on our discussions with stakeholders, we identified other areas in which state efforts could benefit from additional HHS support, independent of the legislative proposal. One stakeholder noted that the information HHS currently collects does not focus on congregate care, and there is a wide variation in state experiences, which our review of AFCARS data and HHS's own May 2015 report confirm.[25] However,

[24] In recent years, various groups and members of Congress have also put forth proposals to reform the child welfare system and related financing mechanisms, with a focus on increasing services and supports to keep families together or encouraging placements of children in family settings when they must be removed from their homes. Proposals have included features such as increasing Title IV-B funds for community-based services, permitting use of Title IV-E funds for time-limited services for a family in crisis, limiting Title IV-E support for children placed in group care settings, or limiting the length of time a foster child may be in group care and receive Title IV-E assistance.

[25] Fred Wulczyn et al. *Within and Between State Variation in the Use of Congregate Care* (the Center for State Child Welfare Data, Chapin Hall, University of Chicago (Chicago: June 2015).

without more information on states' efforts to reduce their use of congregate care, HHS is unable to fully understand states' activities in this area, including relevant changes in the states' use of congregate care and their effect on state child welfare systems. Although HHS conducted some initial research in its May 2015 report, HHS has the opportunity to further enhance its understanding of state efforts, for example, by leveraging its CFSR process, its AFCARS database, and future research activities. Internal control standards for the federal government call for agencies to have the information needed to understand program performance.[26]

Similarly, stakeholders noted that given the relative recency of some of the state efforts and the potential for unintended consequences, HHS's support in sharing best practices and providing technical assistance would be helpful to the states as they make changes to their systems. For example, consistent with the challenges we identified, states could benefit from HHS's assistance in the areas of increasing capacity for specialized foster family placements and working with congregate care providers to diversify their services. As an HHS study has noted, system changes in the child welfare area can be difficult, and require leadership, stakeholder involvement, and capacity building, among other things, as well as time and sustained attention to succeed.[27] In addition, our previous work has identified similar key practices that facilitate successful transformations, including leadership from the top, focus on and communication of key

[26] GAO, *Standards for Internal Control in the Federal Government*. AIMD-00-21.3 (Washington, D.C.: November 1999). Internal control calls for the establishment and review of performance measures and indicators. Activities need to be established to monitor performance measures and indicators. These controls could call for comparisons and assessments relating different sets of data to one another so that analyses of the relationships can be made and appropriate actions taken. Controls should also be aimed at validating the propriety and integrity of both organizational and individual performance measures and indicators.

[27] Western and Pacific Child Welfare Implementation Center, *A Framework for Implementing Systems Change in Child Welfare: A Practice Brief*, U.S. Department of Health and Human Services, Children's Bureau.

priorities, and monitoring progress, particularly because transformations may take a long time to complete.[28]

HHS officials told us they did not currently have plans to provide additional support for states related to congregate care, although with a new Associate Commissioner of Children, Youth, and Families in place as of August 2015, they may consider additional actions.

Conclusion

States' foster care systems are responsible for some of the most vulnerable children in the nation. This includes responsibility for placing children removed from their homes in the most family-like settings that meet their needs. The eight states we reviewed reflect the downward trend in the use of congregate care nationwide, which could be seen as a sign of progress in states' "right-sizing" of congregate care. At the same time, the wide variation in the percentage of foster children in congregate care among our eight—and all 50—states suggests that more progress could be made. HHS has taken an important first step by issuing its report on congregate care and recognizing that additional information is needed on how states use congregate care and what changes are appropriate. It is important that HHS continues to progress in its understanding of the national landscape of congregate care so that it can be better positioned to support states through their transitions. Significant changes in child welfare programs require thoughtful leadership, relevant information, and sustained attention. HHS's continued leadership and support will be needed, particularly by states facing challenges in developing alternatives to congregate care, to make progress nationwide.

Recommendation for Executive Action

We recommend that HHS take steps to enhance its support of state actions to reduce the use of congregate care as appropriate. These steps could include:

- collecting additional information on states' efforts to reduce their use of congregate care; and

[28] GAO, *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations,* GAO-03-669 (Washington D.C.: July 23, 2003). GAO, Highlights of a *GAO Forum: Mergers and Transformation: Lessons Learned for Department of Homeland Security and Other Federal Agencies*, GAO-03-293SP (Washington D.C.: November 2002).

- identifying and sharing best practices with the states and providing technical assistance that states could use to address challenges in the areas of building capacity for family placements, addressing shortages of needed services, improving assessments, and retaining sufficient numbers of congregate care providers, or other areas as needed.

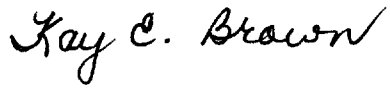
Agency Comments and Our Evaluation

We provided a draft of this report to the Secretary of Health and Human Services, for review and comment. HHS provided general comments that are reproduced in appendix II. HHS also provided technical comments which we incorporated as appropriate.

HHS concurred with our recommendation stating that it was consistent with its current approach for supporting states. HHS stated that federal law and policy make it clear that children who come into care should be placed in the least restrictive setting possible. However, it noted that states have the flexibility and discretion to make decisions for a child on a case by case basis to ensure that the best placement is made and the individual needs of the child are met. HHS also noted that to assist states in reducing their use of congregate care, the fiscal year 2016 President's budget request includes a proposal to amend title IV-E to provide support and funding to promote family based care for children with behavioral and mental health needs as well as provide oversight of congregate care placements, as we noted in the report. Additionally, HHS stated that it offers individualized technical assistance to help child welfare agencies build capacity and improve outcomes for children and families, and it has recently begun providing tailored services to two public child welfare agencies working to reduce their use of congregate care through a Title IV-E waiver demonstration program. HHS also stated it will continue to explore research opportunities as well as how to build state capacity for family placements. We encourage HHS to identify and take additional steps to assist states with reducing their use of congregate care.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions concerning this report, please contact me at (202) 512-7215 or brownke@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.



Kay E. Brown
Director
Education, Workforce, and Income Security Issues

Appendix I: Types of Congregate Care Facilities Used by Four States We Visited

Connecticut	Louisiana	Maryland	Washington
Acute Inpatient Psychiatric Hospital: Inpatient treatment at a general or psychiatric hospital; stabilization of psychiatric symptoms. **Psychiatric Residential Treatment Facilities (PRTF):** Community-based inpatient facility for children with treatment needs that require a structured 24-hour setting. Less restrictive than a hospital, but more restrictive than a residential treatment center. **Residential Treatment Center:** Integrated therapeutic services, education, and daily living with individually tailored treatment plans. **Therapeutic Group Home:** A small, four to six bed program in a neighborhood setting with intensive staffing and services. **Preparing Adolescents for Self Sufficiency (PASS) Group Home:** A 6-10 bed education program located in a neighborhood staffed with non-clinical paraprofessionals. **Level 1 Non-Clinical Group Home:** A 6-12 bed program in a neighborhood staffed with non-clinical paraprofessionals. These may have a special focus, such as transitional living apartment program or a maternity program. **Short Term and Respite Home:** Homes provide temporary congregate care with a range of clinical and nursing services. Also used for respite. **Safe Home:** Temporary service providing 24-hour care for children. To engage, stabilize, and assess each child, generate level of care recommendation, and transition to an appropriate placement.	**Psychiatric Residential Treatment Facilities (PRTF):** Highest level of care for youth between the ages of 8-17 with severe behavioral and emotional issues. **Therapeutic Group Homes:** Community based care in a home-like setting, generally for children and youth. Homes are less restrictive than PRTF, have no more than eight beds, and are run under the supervision of a psychiatrist or psychologist. **Non-Medical Group Homes:** Generally serve older youth that are not able to be placed in a lower level of care and do not meet the eligibility requirements for the higher level care facilities. These homes have no more than 16 beds.	**Alternative Living Unit:** Small homes (limited to three beds) that are specifically focused on children with developmental disabilities. **Diagnostic Evaluation and Treatment Program:** For children with significant needs, but the needs do not meet the requirements for placement in a residential treatment facility. **Group Home (also known as Residential Child Care Facilities):** Traditional group homes for children with low-end needs. **Medically Fragile:** Similar to an alternative living unit. **Therapeutic Group Home/High Intensity:** Homes with a lower staff-to-child ratio, on-call social workers, and on-site licensed mental health professionals.	**Licensed Group Home:** Typically stand-alone (6-8 bed) residential home programs in a community setting. There are a few settings where multiple programs and services are delivered on site. **Licensed Staff Residential Home:** Typically a smaller residential home of less than six beds. These homes are in community settings and have a rotating 24 hour staff.

Source: GAO analysis of information from state interviews and documents.| GAO16-85

Appendix II: Comments from the Department of Health & Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

SEP 29 2015

Kay E. Brown
Director, Education, Workforce,
and Income Security Issues
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Brown:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Foster Care: HHS Could Do More to Support States' Efforts to Keep Children in Family Based Care" (GAO-16-85).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: HHS COULD DO MORE TO SUPPORT STATES' EFFORTS TO KEEP CHILDREN IN FAMILY-BASED CARE (GAO-16-85).

The U.S. Department of Health and Human Services (the Department) appreciates and extends their thanks to GAO for the opportunity to review and comment on this draft report.

GAO Recommendation
The Government Accountability Office recommends that the Department take steps to enhance its support of state actions to reduce the use of congregate care as appropriate.

HHS Response
The Department concurs with this recommendation as it is consistent with the Department's current approach to supporting states in addressing system challenges. The findings in the GAO report mirror our results found in our data brief, *A National Look at the Use of Congregate Care in Child Welfare.*

Reducing the numbers of children and youth in congregate care is not a new initiative for the Department. Consistent with our standard practice, Federal law and policy make clear that children who come into care should be placed in the least restrictive placement setting possible. Specifically, the case plan for each child must include a discussion of how the child's case plan is designed to achieve a safe placement for the child in the least restrictive (most family-like) setting available and in close proximity to the home of the parent(s) when the case plan goal is reunification, as well as a discussion of how the placement is consistent with the best interests and special needs of the child (section 475(5)(A) of the Act, CFR 1356.21(g)(3). However, states have the flexibility and discretion to make decisions for a child on a case by case basis to ensure that the best placement is made and the individual needs of the child are met.

To this effort, the President's budget contains key initiatives that will assist states in reducing their use of congregate care. The budget requests amending title IV-E to provide support and funding to promote family based care for children with behavioral and mental health needs and provide oversight of congregate care placements. Specifically, the proposal would:

- Add a new eligibility requirement under title IVE requiring the agency to provide documentation to justify congregate care as the least restrictive foster care placement setting for a child and/or youth.
- Require the court to make a judicial determination at six months and at every six months thereafter that the placement in the congregate care facility is the best option for meeting the child/youth's needs and that the child is progressing towards readiness for a more family like setting.
- Provide support for specialized case management using smaller caseloads and specialized training so workers can focus on supporting family based care specialized casework.
- Provide specialized training and salaries for foster parents who provide a therapeutic environment for a child/youth.

In addition to the President's budget proposal, the Department offers individualized technical assistance to help child welfare agencies build capacity and improve outcomes for children and families. The

Department recently began providing tailored services to two public child welfare agencies that are working to reduce their use of congregate care through the title IV-E waiver demonstration program. We will continue to explore other avenues for building state capacity and how we might address the research gaps that must be filled to improve performance in this area.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Kay E. Brown, (202) 512-7215 or brownke@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gale Harris (Assistant Director), Anjali Tekchandani (Analyst-in-Charge), and Vernette G. Shaw made significant contributions to this report. Also contributing significantly to this report were Sarah Cornetto, Kirsten Lauber, Amber Sinclair, Greg Whitney, and Charlie Willson.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or E-mail Updates.
Listen to our Podcasts and read The Watchblog.
Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548