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☞ Details: Audit Report 06-1 and Report 06-2, Milwaukee County Child Welfare, Department of Health and Family Services

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Joint
(Assembly, Senate or Joint)

Committee on Audit...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

BMCW Audit 06-1

DHFS began to administer the program on January 1, 1998

- ***Out-of-home placements and use of safety services have declined.***
- ***DHFS contracts for the provision of most child welfare services in Milwaukee County.***
- In June 2005, the Bureau employed 153 FTE staff, while the four private contractors that provided case management, foster care, safety, and adoption services had approximately 500 FTE employees.
- In 2005, a single contractor provided all foster home placement services in that year, and another contractor provided all adoption placement services.
- ***From January 2001 through June 2005, program expenditures totaled $493.7 million ($288 million in GPR).***
- ***Program expenditures declined 9.8 percent from 2001 to 2004.***
- ***In the first six months of 2005, 74.6 percent of calls that alleged maltreatment were investigated.***
- the Bureau substantiated 15.4 percent of the allegations it investigated, while the independent contractor substantiated 10.0 percent of those it investigated. (page 24)
- ***Approximately one-third of children in out-of-home care in Milwaukee County are between 10 and 14 years old. (page 29)***
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Concerns:

- DHFS case management system is sometimes inaccurate and incomplete, largely due to data-entry errors made by state or contract staff. (page 11)
- For every 1,000 children in Milw. Cnty., 15.6 were in out-of-home placement. (page 14)
- ***Significantly more children receive out-of-home care in Milwaukee County than elsewhere in Wisconsin.*** (page 15)
- Bureau costs increased 24.4 percent, from $16.4 million in 2001 to $20.4 million in 2004, largely because of increased costs associated with maintaining and operating the Wisconsin Statewide Automated Child Welfare Information System (WiSACWIS), which contains the electronic case files for families in the child welfare program in Milwaukee County and in the balance of the state. (page 19)
- limited collaboration among child welfare staff has resulted in delays in services being provided in a timely manner. (page 29)
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Investigations of Child Abuse and Neglect

- ***From January 2003 through June 2005, the Bureau did not respond to most allegations within 24 hours.*** (page 22)
- ***Nearly one-third of investigations were not completed within 60 days. (page24)***
- the median time to complete Bureau investigations increased from 34.9 days in 2004 to 38.8 days in 2005, while the median time to complete independent investigations declined from 34.5 to 32.6 days. (page 24)
- neglect was the most common type of maltreatment alleged, but sexual abuse was the most likely to be substantiated. (page 25)
- ***Primary caregivers of children accounted for 56.3 percent of the 4,315 maltreaters and*** one-quarter of maltreaters were secondary caregivers ***(page 26)***

- More than 200 children were the subject of four or more investigations from January 2004 through June 2005 (page 26)
- ***From January 2004 through June 2005, 225 children were maltreated multiple times. (page 27)***
    - When children were maltreated multiple times, the Bureau was more successful in meeting the 60-day statutory deadline for completing investigations: 55.5 percent of these investigations were completed in 30 days or less, 22.5 percent required 31 to 60 days, and 22.0 percent required more than 60 days. (page 27)

Out-of-Home Care

Caseload Characteristics

- ***Approximately one-third of children in out-of-home care in Milwaukee County are between 10 and 14 years old***, and approximately three-quarters are African-American. ***(page 29)***
- The time children remain in out-of-home care has declined considerably. However, limited collaboration among child welfare staff has resulted in delays in services being provided in a timely manner. (page 29)

Ensuring Appropriate Placements

- ***Appropriate placements help ensure children are safe and achieve their permanency goals. (pg. 31)***
- ***Children are most likely to be placed in foster homes of non-relatives. (pg. 31)***
- Both the number and the percentage of higher-level-of-care placements increased because more children with considerable medical, emotional, and behavioral needs have been placed in out-of-home care in recent years. (pg. 32)
- Each year, the Bureau comprehensively reviews a random sample of more than 200 cases to determine whether families were served appropriately, and it uses these reviews to identify areas in which its own and contract staff need improvement.
    - The 2003 and 2004 comprehensive case reviews noted concerns with placement stability, including a lack of collaboration between case managers and foster care staff.
    - The 2004 review also found that case managers missed opportunities to make placements more stable by, for example, providing additional services and support to foster parents. (pg.32)
- On average, 22.9 foster homes were newly licensed each month, but 43.0 closed. It should be noted, however, that 29.4 percent of the closures occurred because families adopted the children in their care. (pg. 34)
- ***Coordination between case managers and foster care staff was minimal. (pg. 34)***
    - 16 cases, or 59.3 percent, had no record of any joint visits.
    - Two or more visits were made in only five cases.
    - They occurred within five days of only 2 of the 40 placement changes.

Achieving Permanency for Children

Case Management

- ***Only 27.4 percent of court-ordered services were in place shortly after children were removed from their homes. (pg. 35)***

- ***Required monthly contact occurred in 95.0 percent of the 48 cases we reviewed. (pg. 36)***
- Case notes for 65.8 percent of the contacts did not indicate whether the case managers spoke with children outside their caregivers' presence. Visit length was recorded for approximately one-third of documented contacts and **ranged from five minutes to seven hours.** The median was 45 minutes. (pg. 36)
- ***One-third of the required meetings among child welfare staff did not occur in 48 cases we reviewed. (pg. 36)***
- the Bureau's 2004 comprehensive case review found that nearly one-fourth of cases had no coordinated service team meetings. (pg. 37)

Permanency Planning

- As noted, state and federal laws require the Children's Court to approve a permanency plan within 60 days of a child's removal from the home, and to approve a new plan after every six months the child remains in out-of-home care. (pg. 37)
- ***The Bureau's policies for permanency planning are limited and*** do not provide guidance on how or when permanency goals other than reunification should be established, when concurrent planning should occur, when adoptions staff should become involved with cases, or which case management activities are needed. ***(pg. 37)***
    - Further, they do not specify when a TPR referral should be made...
    - Staff also indicate there can be significant delays between when a referral is made, the petition is filed, and the proceedings are finalized. (pg. 38)
- ***We identified problems related to permanency planning for 25 of the 48 cases we reviewed. (pg. 38)***

Assessing Effectiveness

- ***The median stay in out-of-home care has declined. (pg. 39)***
    - The median stay in out-of-home care declined from 39 months in June 2003 to 21 months in June 2005.
    - Children in Milwaukee County remain in out-of-home care longer than those in Brown, Dane, Kenosha, Racine, and Rock counties.

- ***The most common reasons for leaving out-of-home care are family reunification and adoption. (pg.40)***
    - If trends in the first half of 2005 continued for the entire year, fewer adoptions will have occurred in 2005 than in 2003 or 2004.
    - Contractors report that approximately 80 percent of adoptions are by foster parents, but confirming data were not readily available.

- The relatively low percentage of children who are reunified with their parents within two years of being removed from their homes suggests that earlier and more focused concurrent planning efforts may be needed. (pg. 41)
- ***One-fifth of children who were reunified with their parents reentered out-of-home care within 24 months. (pg. 42)***

- Reentry rates for children involved with transfers of guardianship were substantially lower, and only one child who left out-of-home care because of adoption reentered care within 24 months. (pg. 42)

Safety Services

- Safety services such as parenting education, counseling, and drug and alcohol treatment are available to entire families until the circumstances that endangered their children are ameliorated. Participation in safety services is voluntary, although children in danger of abuse or neglect may be removed from the home unless family members agree to receive them. ***(pg 43)***

Provision of Services

The Bureau refers families for safety services, which are managed by contractors that also manage safety services cases. (pg. 43)

- ***The number of families receiving safety services declined 39.6 percent since January 2003. (pg. 44)***
- Because limited data are compiled on the families who receive safety services, we reviewed case files for 50 randomly selected families who began receiving services in January 2004. (pg. 44)
- ***Milwaukee County is the only Wisconsin county to provide safety services. (pg. 45)***
    - Among six surrounding midwestern states, only Iowa and Michigan provide safety services that are similar to Milwaukee County's. Pg. 45)

Case Management Responsibilities

Audit focused on four primary requirements that are measurable regarding meeting with families and assessing outcomes of services. (pg. 46)

- As shown in Table 21, contractors' compliance with three of the four requirements has been poor. (pg. 46)
- ***In 35 of 50 case files we reviewed, service providers did not meet with the families as soon as required. (pg. 47)***
    - in 70.0 percent of the case files we reviewed, all serviceproviders did not meet with families within the first seven days, as required.
    - In addition, a total of 192 services were ordered for the 50 families, but only 127 services began within the required seven day period.
    - Appointments for the other 65 services were scheduled to begin after the seven-day period. These delays likely occurred because safety services managers misunderstood the requirements.
    - At least one meeting was not held as required in 66.0 percent of the cases we reviewed, primarily because families rescheduled or missed meetings or teenage children unexpectedly failed to attend.
- ***No coordinated service team meetings were held for 35 of the 50 cases we reviewed. (pg. 47)***

Length of Services

For each family served, safety services contractors are paid $4,776, regardless of which services are provided or how long the case remains open. That payment is calculated at a rate of $1,194

per month for four months. However, if families continue to need services after four months, contractors are supposed to continue to provide them without additional payment, and if families stop receiving services after less than four months, contractors are still paid the full $4,776. (pg 48)

- ***Receipt of safety services declined from an average of 110 days in January 2003 to 81 days in January 2005. (pg. 48)***
- Just 20.6 percent of families received safety services for more than 120 days in January 2005, compared to 40.7 percent in January 2003. (pg. 48)
- Because it seems unlikely that the severity of problems faced by families has decreased over time, the decline in the average number of days families received safety services raises concerns. (pg. 49)
- The staff of safety services contractors indicated they were sometimes told by their supervisors to close cases because contract payments were ending. (pg. 49)
- ***Some safety services cases were closed prematurely. (pg. 50)***

Assessing Effectiveness

- ***The Bureau does not monitor how often families return to the child welfare program. (pg. 50)***
- DHFS may withhold up to 0.4 percent of a contract's value if the reentry rate exceeds 4.0 percent. However, because the Bureau does not monitor contractors' compliance, no funds have ever been withheld. (pg. 51)
- 11.4 percent of families who ceased receiving safety services during the first 6 months of 2004 had children who entered out-of-home care within 12 months. *This rate is nearly three times the reentry limit specified in contracts.* (pg. 51)
- Contracts also require DHFS to monitor the number of families returning for additional safety services. If that number exceeds an acceptable limit, DHFS may require the contractor to review its procedures and complete a corrective action plan. Because the Bureau has not established this limit, it is not possible to fully assess the effectiveness of safety services or the extent to which contractors are meeting contractual requirements. (pg. 51)

Performance Standards

- Through June 2005, the Bureau has had mixed success in achieving the 14 mandatory and 10 monitoring standards required by the December 2002 settlement agreement. (page 53)
- Mandatory performance standards focus on three broad areas of the Bureau's ongoing operations:
    - helping children who have been removed from their homes to achieve permanency in a timely manner;
    - helping to ensure they remain safe from abuse and neglect while in out-of-home care; and
    - helping to ensure their well-being. (page 54)

Mandatory Performance Standards

- In 2005, the Bureau employed 11 program evaluation managers to ensure data the contractors enter into the files are complete and accurate and make recommendations to Bureau managers for improving how families are served by the child welfare program.

Permanency

- The settlement agreement established five permanency standards that are intended to:
  - increase the percentage of children who receive TPR petitions or exceptions after they have been in out-of-home care for 15 of the last 22 months;
  - increase the percentage of children who receive TPR petitions or exceptions after they have been in out-of-home care for more than 15 of the last 22 months;
  - reduce the percentage of children who remain in out-of-home care for more than 24 months;
  - increase the number of children who return home within 12 months of entering out-of-home care; and
  - increase the percentage of children who are adopted within 24 months of entering out-of-home care. (page 54)
- The requirements for achieving each standard have increased in each year since the settlement agreement took effect are shown in Table 25, (page 55)
- BMCW did not report meeting any permanency standards during the first six months of 2005, and it has never reported meeting the standard for adoption within 24 months. (page 56)
- ***We found errors with the Bureau's methodology for calculating*** performance related to children who receive TPR petitions or exceptions after they have been in out-of-home care for 15 of the last 22 months.
  - calculates the standard for children in out-of-home care for 16 months, rather than for the required 15 months;
  - includes children who are no longer in out-of-home care; and
  - counts children multiple times, even though federal law states that they should be counted only once.
  - when calculated correctly, the standard has never been met. (page 56)
- Table 26 shows the Bureau's actual performance declined from 44.2 percent of cases in 2003 to 30.5 percent in the first six months of 2005, and it has been significantly lower than the requirements specified in the settlement agreement. (page 56-57)
- From January 2003 though June 2005, TPR petitions were filed for only 5.5 percent of the children who were in out-of-home care for 15 of the last 22 months. The remaining 94.5 percent of children remained in out-of-home care because of exceptions. (pg. 57)
- ***The percentage of children in out-of-home care for more than 24 months is greater than the Bureau has reported. (pg. 58)***

Safety

- Four of the settlement agreement's performance standards relate to safety and are intended to:
  - reduce the percentage of children in out-of-home care who are maltreated by foster parents or the staff of licensed child care facilities, such as group homes;
  - increase the percentage of referrals within three business days to the contractor that independently investigates alleged maltreatment;

- increase the percentage of independent investigations assigned to an investigator within three business days of receipt; and
- increase the percentage of independent investigations completed within 60 days.
  - ***The Bureau has consistently met three of the four safety standards. (pg. 60)***

Well-Being of Children

- Five of the settlement agreement's performance standards relate to well-being of children and are intended to:
  - limit the three-month rolling average caseload at each of the Bureau's five sites to 11.0 cases per case manager;
  - increase the percentage of children with three or fewer placements while in out-of-home care;
  - ensure that placements in assessment centers do not exceed 30 days, or 60 days if two 15-day extensions are approved;
  - ensure that placements in stabilization centers, which provide short-term placements for children whose out-of-home placements are disrupted, do not exceed 20 days; and
  - ensure that case managers at each of the Bureau's five sites have monthly face-to-face visits with at least 90.0 percent of all children in out-of-home care. (pg. 61-62)
    - ***Four of the five well-being performance standards have been met. (pg. 62)***
    - BMCW has never met the standard for children having three or fewer placements while in out-of-home care. (pge. 62)
    -
- Each of the standards in the settlement agreement will remain in effect until there is agreement by the parties to the lawsuit or an arbitrator determines that it has been met during two consecutive six-month periods. (pg. 63)

Monitor-Only Performance Standards

The settlement agreement also includes ten monitor-only standards without required performance targets:

- determining the average number of children per case manager at each of the Bureau's five sites;
- determining the rate of case manager turnover at each of the five sites;
- providing health screening to all children within five business days of their first out-of-home care placement, except for children discharged from a hospital to a placement;
- providing all children in out-of-home care with annual medical examinations;
- providing all children in out-of-home care with annual dental examinations;
- having initial permanency plan hearings for all children within 60 days of their first out-of-home care placement;
- completing semiannual permanency plan reviews for all children in out-of-home care;
- providing assessments to families within 90 days of their children's first out-of-home care placement;
- providing foster parents with complete information packets regarding their children's health and educational backgrounds; and
- determining the percentage of children who reenter out-of-home care within one year.

- The Bureau's data indicate that performance related to these measures has also been mixed, with improvements in most areas from 2003 to 2004, but declines in the first half of 2005 as shown in Table 30. (pg. 64)
- ***Fewer children received timely initial health screenings than the Bureau has reported. (pg. 64)***
- LAB found that 65.5 percent of children received initial health screenings in 2004 (compared to the Bureau's reported 76.4 percent), and 45.3 percent received them in the first six months of 2005 (compared to the Bureau's reported 59.3 percent). (pg. 65)

Ensuring the Safety of Children

To evaluate the Bureau's efforts to ensure the safety of children in Milwaukee County, we analyzed files for 73 high-risk cases to determine whether allegations were appropriately investigated and children were appropriately served. In most instances, the Bureau and its contractors took reasonable and appropriate action, but we found four cases in which efforts were insufficient to ensure children's safety. (pg. 67)

Assessing Efforts to Protect Children

We reviewed 73 cases involving children most likely to be at risk from abuse or neglect, including 29 fatalities. (pg. 67)

- The 73 cases we reviewed included:
  - all 10 fatalities of children in out-of-home care that occurred from 2002 through 2004;
    - **eight fatalities occurred because of children's pre-existing medical conditions, and two occurred as a result of accidents.
  - all 19 child fatalities from 2002 through 2004 that occurred because of maltreatment;
    - **none were involved with the child welfare program at the time of the fatalities, although 3 families did have prior contact, typically at least several months before the fatalities occurred. Six families had no contact with the Bureau before the fatalities occurred.
  - 31 cases in which the Bureau substantiated allegations of maltreatment but did not remove children from their homes, and for which summary data indicate no services were provided in 2004; and 13 cases involving families against whom five or more allegations of maltreatment were made in 2004. (pg. 67-68)
- ***In most cases we reviewed, the Bureau and its contractors took appropriate action. (pg. 68)***
- However, in 4 of the 73 cases we reviewed, the Bureau and Wisconsin Community Services Network, which provided out-of-home care services for all cases, do not appear to have taken sufficient action to ensure the safety of the children. (pg. 69)
  - ***The first case involved multiple allegations that six children were neglected.***
  - ***The second case involved allegations of medical neglect. (pg. 70)***
  - ***The third case involved unsubstantiated and substantiated allegations against a foster parent. (pg. 71)***
  - ***The fourth case involved the death of a child. (pg. 71)***

Coordination of Services

Advocates have raised concerns about the extent to which families actually receive health care, work assistance, and other services, as well as the level of coordination among the programs. We found that service coordination is limited. (pg. 73)

Participation Levels

- Children who have been removed from their homes are automatically eligible to participate in the Medical Assistance program. More than 95.0 percent of eligible children likely receive Medical Assistance services annually. (pg. 73)
- Child welfare staff and advocates with whom we spoke said that providing health care services to children in out-of-home care is often challenging because not enough physicians and dentists are willing to accept Medical Assistance reimbursement rates. We found that approximately one-third of children in out-of-home care in the first half of 2005 did not receive annual medical or dental examinations. (pg. 74)
- ***Few mothers with children in out-of-home care participated in other support programs. (pg. 74)***
- If all children have been removed from the home, a mother typically loses her eligibility for Medical Assistance and is ineligible to receive W-2 cash payments or subsidized child care, which may partially explain the low participation rates. (pg. 74)
- Mothers receiving safety services were more likely to participate in other support programs, although relatively few received child care subsidies or participated in W-2 or other work programs. (pg. 74)
- ***Coordination of child welfare and W-2 program services is limited. (pg. 75)***
    - In a review of 48 out-of-home care case files, we found that W-2 staff did not attend any of 146 coordinated service team meetings that were held while those cases were open.
    - In a review of 50 safety services case files, we found instances of safety services managers never contacting a family's W-2 caseworker, including one case that was open for 146 days.
    - In the same review, we also found instances of W-2 caseworkers not returning telephone calls from safety services managers and parents. In one case, both the safety services manager and the mother left unreturned messages, although the mother was uncertain about the name of her W-2 caseworker because of personnel changes.
    - Some child welfare and W-2 staff did not fully understand eligibility requirements for each program. For example, one case file we reviewed indicated that the child welfare case manager gave incorrect information to a mother regarding her eligibility to receive W-2 benefits. (pg. 76)

Efforts to Improve Coordination

- In October 2004, two service integration pilot projects began in Milwaukee County. Each involves a W-2 and a child welfare contractor. (pg. 76)
    - First, United Migrant Opportunity Services (UMOS), a W-2 contractor, and La Causa, the primary child welfare contractor for Site 4, are working together to

minimize duplication of services and reduce the confusion of families who seek services from both programs. (pg. 76)

- Second, Maximus, a W-2 contractor, is funding a liaison staff position to be located at Children's Family and Community Partnerships, a child welfare contractor that began providing services in 2005. The two organizations expect the position to facilitate communication, train staff, and participate in meetings with families who are receiving safety services. No state funding has been provided to support this project. (pg. 77)

- ***DHFS is developing a managed care pilot program in Milwaukee County*** to improve children's access to health care. Children in foster care and those placed in the Kinship Care program by a court order will be enrolled in this program automatically, but children whose families are receiving safety services are not eligible for enrollment. (pg. 77)
  - The contract is not expected to be signed until March 2006, but the request for proposals requires:
    - a coordinated system of health care to meet the children's physical, dental, behavioral, developmental, mental health, and substance abuse needs;
    - initial and ongoing assessments of each child;
    - development of a coordinated health care plan within six weeks of a child's enrollment in the program; and
    - provision or arrangement for most health care services covered by Medical Assistance. (pg. 77)

Improving the Child Welfare Program

Additional efforts are needed to improve the child welfare program. (pg. 79)

Recent Program Modifications

- One strategy already underway to help achieve permanency goals in a timely manner is to provide financial incentives to relatives of children in out-of-home care. (pg. 79)
- Second, the Bureau's dual licensure project seeks to improve placement decisions for young children. (pg. 79)
- Third, to reduce statutory barriers that affect the TPR and adoption processes, the Joint Legislative Council's Special Committee on Adoption and Termination of Parental Rights was established in 2004. In 2005, the committee recommended statutory changes to:
  - clarify when a parent's rights can be involuntarily terminated by the Children's Court;
  - clarify the procedures and time lines for appealing the Children's Court's decision to terminate a parent's rights; and
  - require individuals who have not previously adopted a child to obtain training, for which DHFS pays, on issues that may confront adoptive parents. (pg. 80)
- ***In June 2005, DHFS contracted for a child welfare ombudsman in Milwaukee County. (pg. 80)***
- ***In 2006, DHFS plans to execute new child welfare contracts.*** (pg. 80)
- Under the new contracts, safety services contractors will continue to be paid $4,776 for each family served, regardless of which services are provided or how long a case remains

open. However, the contracts will change the way that case management contractors are paid. For example, case management contractors will be paid $1,036 per month for each case, regardless of the amount of services provided to families. Other contract provisions were not finalized at the time of our fieldwork, but the request for proposals anticipates additional changes:

- To limit contractors' risk of being underpaid under the flat case rate, DHFS may cover all their reasonable costs related to administration, as well as the case manager salaries and fringe benefits needed to keep the average caseload below 11.0 cases per manager.
- Case management contractors may be responsible for 50.0 percent of the first $250,000 in losses they incur to purchase services for families.
- Case management contractors that meet contractually specified permanence, safety, and well-being performance standards may earn up to 3.0 percent of the contract amount that is set aside as a reserve and use these funds to serve families. (pg. 81)

- case management contractors may be required to assume more financial risks.

Addressing Future Challenges

Additional efforts are needed to address the problems we noted, so that children will be served more effectively. (pg. 81)

- we have concerns about how case management contractors are paid under the 2006 contracts.
- under the new contracts, safety services contractors will continue to receive four monthly payments for each family served regardless of the actual time for which they provided services. (pg. 82)

Recommendations

Recommendation (pg. 52)

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by February 1, 2007, on:

- *the steps it will take to monitor the number and characteristics of families who return for safety services within 12 months, and the number of children who enter out-of-home care within 12 months of having received safety services;*
- *how it will enforce contractual penalty provisions if returning cases exceed the prescribed rates; and*
- *whether it plans to increase monetary penalties to levels that are more likely to compel contractors to achieve the prescribed results.*

Recommendation (pg. 57)

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by March 1, 2006, on the steps it has taken to ensure the Bureau of Milwaukee Child Welfare appropriately calculates the percentage of children who receive a termination of parental rights petition or an exception when the children have been in out-of-home care for 15 of the last 22 months, such as counting children only once and including only those children who are actually in out-of-home care at the 15-month point.

Recommendation (pg. 59)

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by March 1, 2006, on the steps it has taken to ensure the Bureau of Milwaukee Child Welfare:

- *considers other ways to calculate the percentage of children who have been in out-of-home care for more than 15 of the last 22 months and subsequently receive a termination of parental rights petition or an exception; and*
- *uses the actual number of children in out-of-home care to calculate the percentage of children who remain in out-of-home care for more than 24 months, and reports these results along with the results from the methodology specified in the settlement agreement.*

Recommendation (pg. 66)

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by February 1, 2007, on the steps it has taken to ensure:

- *children in out-of-home care receive annual medical and dental examinations; and*
- *the Bureau of Milwaukee Child Welfare uses an appropriate methodology for calculating the percentage of children who receive initial health screenings within five business days of entering out-of-home care.*

Recommendation (pg. 82-83)

We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by February 1, 2007, on its progress at meeting key performance measures, including:

- *improving the timeliness of its investigations of child abuse and neglect;*

- ☐ *improving the timeliness of services ordered for each family when a child is removed from the home;*
- ☐ *continuing efforts to reduce the time children spend in out-of-home care;*
- ☐ *ensuring the adequacy of safety services provided by contractors; and*
- ☐ *improving coordination of services with Medical Assistance, W-2, and other social services providers.*

Tables - BMCW Audit Rpt 06-1

Investigations of Child Abuse and Neglect

Out-of-Home Care

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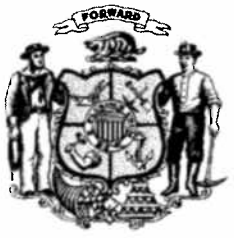
Appendix

WISCONSIN STATE LEGISLATURE



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ANALYSIS OF LEGISLATIVE AUDIT BUREAU REPORTS ON MILWAUKEE CHILD WELFARE, FEBRUARY, 2006

This memo originally was sent to reporters at the Milwaukee Journal-Sentinel *on February 14, 2006.*

Yes, it's rotten for a foster-care agency to be throwing away money meant for kids on jackets and sports tickets. But there is a lot worse in the recent legislative audit of Milwaukee foster care, which deserves a lot more attention.

Huge upsurge in children taken from their homes

First of all, there is the alarming escalation in the number of children taken from their parents. Compare January through June 2003 to the same period in June 2005 (Table 11, p.30) and you'll see a 47 percent increase in the number of children torn from their parents.

If , at this point, you're thinking: "Wait a minute I thought the number of children in Milwaukee foster care went down" – we're talking about two different numbers.

The number that's gone down is the "snapshot number" – how many children are in Milwaukee County foster care on one given day. That number can fall for lots of reasons – including children simply turning 18 and aging out, the system never having found them a permanent home. Or it may be going down because CRI's settlement pushes adoption at all costs, at the expense of better approaches to permanence.

The number I'm talking about is the number of children taken from their parents over the course of a given time period, in this case six months.

Churning

The fact that this number is going up even as the snahpshot number goes down suggests there may be a great deal of "churning" in the Milwaukee system. That is, caseworkers take away children at the drop of a hat, realize they've made a mistake and send them home again, much the worse for the experience.

Such churning may well explain the fact that average length of stay in out of home care declined from 39 months to 21 months during this same period (p. 39). The decline, instead of being a sign of improvement, may actually mean only that the system is grabbing ever more children needlessly, but for much shorter periods, because workers quickly realize the initial removal was a mistake.

It would be interesting to know what proportion of Milwaukee children are in foster care for a very short time, perhaps a month or less.

Milwaukee County takes children at nearly three times the rate of Cook County Ill.

Though the auditors said they weren't able to find comparisons at other than statewide levels, it's actually quite easy to find data for Chicago/Cook County, Ill. They're published monthly and available online. Compare the number of children taken from their homes in each jurisdiction to the number of impoverished children in each jurisdiction (to factor in the counties' relative poverty rates) and you find that Milwaukee County's rate of child removal is nearly three times the rate in Cook County. Yet it is the Illinois system that is widely regarded as a national model, and it is the Illinois system in which independent court-appointed monitors have found that, as foster care has plummeted, child safety has improved.

Increased removal follows cuts in prevention

The number of families receiving "safety services" – in effect services to prevent harm to children and needless foster care -- was cut by 39.6 percent during the same period in which placements escalated.

A shocking increase in the worst form of care

Instititutionalization, the worst form of substitute care, is soaring in Milwaukee County. There were 134 children in "higher level of care" placements in June, 2003. In just two years that number more than tripled, to 471. While some of these children are in "treatment foster homes" a better option than institutions, the audit does not break down how many are in such homes and how many are institutionalized. It's hard to believe that the county's children actually deteriorated so quickly. Rather, this raises questions about whether Milwaukee's deservedly famous Wraparound program is experiencing problems.

Co-ordinated Service Team Meetings are a sick joke

The process goes by a variety of names around the country, Family Group Conferencing, Family Team Meetings, Team Decisionmaking. It involves quickly and frequently gathering together everyone who might be able to help a family, including extended family, friends, neighbors, etc. to work out a safety plan. Apparently, in Milwaukee County, these meetings are called coordinated service team meetings. And they apparently exist only on paper. Repeatedly the audit documents failure to hold the meetings. When they are held, key participants often are not present, rendering the meetings useless.

Upside Down Financial Incentives

One of the biggest problems in child welfare involves perverse financial incentives for private agencies that hold children in foster care or group homes. These agencies typically are paid for every day they keep a child in substitute care – creating a dreadful incentive: Give a child permanence and you won't get paid; prolong the limbo of foster care and we'll keep paying you day after day.

One way to avoid these perverse incentives is to pay agencies a flat amount for every child in foster care. If they can get a child safely back to his own home or, when that is not possible, into an adoptive home sooner, they keep the savings; force a child to linger in foster care limbo and it costs the agency more money. You ensure that children are not returned to unsafe homes by requiring the agency to care for the child again, with no additional payment, if the child must be returned to foster care.

Such a system makes sense for foster care, because the idea is to reduce foster care.

Incredibly, Milwaukee County has turned this system on its head (p.48) – applying it not to foster care, but to safety services. Thus, agencies have an incentive to cut back not on foster care, but on programs to prevent foster care.

What in the world were they thinking? Was somebody just not listening carefully at the class where they taught Financial Incentives 101?

Little effort to provide concrete help

In September, 2004, The scholarly journal of the Child Welfare League of America (an organization that is no friend of family preservation) published a special issue on child welfare and housing. The lead article dealt specifically with a study of Milwaukee County. Among the findings:

"The level of housing problems reported by these [Milwaukee County] parents calls into question the effectiveness of either family preservation or family reunification services that are not designed to assist families in finding and maintaining stable and adequate housing...

"...severity of housing problems may distinguish families whose children require placement from those that do not...

"The data provide strong evidence that housing problems plague the population that comes to the attention of child welfare agencies and that these problems ought to be a continuing focus of services and supports for this population...

"Case managers reported that families needed help finding housing less than one-third of the time ... in contrast, nearly half the caregivers receiving in home safety services reported that they needed help finding a place to live, as did nearly three fifths of caregivers receiving ongoing services pursuant to having a child placed ... The data cannot speak to the reasons for this mismatch between parents' expressed needs for housing assistance and case managers' perceptions and actions. Perhaps child welfare workers are more focused on parental functioning and less attentive to concrete needs such as housing because of the principles guiding agency practice and the workers' education and training. Alternatively, workers may simply not be in a position to provide assistance with housing due to a lack of resources. If this is true, they may tend to ignore housing as a problem rather than deal with the cognitive dissonance caused by the recognition that they cannot help their clients with this important need..."

The audit shows that little has changed. Counseling and parent education – the soft services that helpers love to provide – are by far the dominant services offered to families (Second report, table 7), and little effort is made to help families get access to any form of concrete help with the problems of poverty (first report, p.74).

Failure of self-policing

As you may recall, when CRI first settled its Milwaukee County lawsuit, I said one of the key problems was the failure to provide for independent monitoring. Instead, BMCW would simply report on its own performance. As I recall, after I raised this issue, CRI offered pious assurances that this would be no problem at all.

But the audit reveals at least two cases in which BMCW miscalculated – both times in ways that made the agency look better than it deserved. (pp. 56, 64). In a third instance, incredibly, CRI agreed to a method of calculation that effectively covers up BMCW's true performance (p. 58).

Alleged cover-up of abuse in foster care

One case cited in the audit deserves much more attention. A foster parent claims that the children's case manager told her to lie to investigators and falsely claim she did not hit a foster child (p.71).

How many other such cases are there?

Auditors' error

Not all of the errors were by BCMW. In one case, the auditor's claim BMCW acted improperly when, in fact, it appears BMCW did what was best for a child.

The case involves a grandmother who was caring for her grandchild as a kinship foster parent (P.38). The grandmother took nearly two years to agree to adopt the child – all the while, still caring for the child as a foster parent. The auditors maintain that BMCW should have looked for a stranger to adopt the child instead. But elsewhere in the audit, the auditors themselves acknowledge that, in the absence of a subsidized guardianship program, this can be a severe financial hardship for grandparents.

Even the draconian so-called Adoption and Safe Families Act includes an exception to its demand that agencies seek termination of parental rights after set time periods if the child has been placed with relatives. The law recognizes that foster care with family often is better than adoption by strangers. BMCW recognized that in this case. The auditors should have recognized it as well.

NATIONAL COALITION FOR CHILD PROTECTION REFORM

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February 15, 2006

Mr. Paul Stuiber
Deputy State Auditor
Legislative Audit Bureau
State of Wisconsin
22 E. Mifflin Street (Suite 500)
Madison, WI 53703

Dear Mr. Stuiber:

Thank you for sending me your two recent audits concerning Milwaukee County Child Welfare. I have enclosed a memo I sent to some reporters and editors at the *Milwaukee Journal-Sentinel* yesterday, highlighting what I think are the most significant issues raised by the audit.

Before discussing those issues, I want to offer some context, including a bit about myself and the organization I represent. The National Coalition for Child Protection Reform is a non-profit organization dedicated to trying to make the child protection system better serve America's most vulnerable children. The group was established at a 1991 Harvard Law School conference by Elizabeth Vorenberg, former Deputy Director of the Massachusetts Advocacy Center and a former member of the National Board of the ACLU.

Members of our Board of Directors include Ira Burnim, a former Legal Director of the Children's Defense Fund who now holds that position with the Bazelon Center for Mental Health Law, and Prof. Martin Guggenheim, former Director of Clinical and Advocacy Programs at New York University Law School. My own background is in journalism: 19 years as a practitioner, (including two years, long ago, at Wisconsin Public Radio), three as a professor. I spent much of my time covering child welfare, work that culminated in publication of a well-received book. But I was not hired by NCCPR because I wanted to stop being a reporter. I helped to *found* NCCPR because of what I learned *as* a reporter.

Funding for NCCPR's national advocacy activities comes from the Annie E. Casey Foundation, the nation's largest foundation dealing with child welfare issues and the Open Society Institute, a part of the Soros Foundations Network devoted to "working to strengthen public discourse in areas where one view of an issue dominates all others, precluding alternative approaches."

What informs all of our work is the knowledge that child removal does not equal child safety.

Often you will hear child welfare agencies say that only adults are harmed when children are wrongfully taken from them, and we have to "err on the side of the child." In fact, there probably is no phrase in the English language that has done more harm to children than "err on the side of the child."

• When a child is needlessly thrown into foster care, he loses not only mom and dad but often brothers, sisters, aunts, uncles, grandparents, teachers, friends and classmates. He is cut loose from everyone loving and familiar. For a young enough child it's an experience akin to a kidnapping. Other children feel they must have done something terribly wrong and now they are being punished. The emotional trauma can last a lifetime. One recent study of foster care "alumni" found they had twice the rate of Post Traumatic Stress Disorder of Gulf War veterans and only 20 percent could be said to be "doing well." How can throwing children into a system which churns out walking wounded four times out of five be described as "erring on the side of the child?"

• And that assumes the foster home will be a good one. The majority are. But the rate of abuse in foster care is far higher than generally realized and far higher than in the general population. That same alumni study found that one-third of foster children said they'd been abused by a foster parent or another adult in a foster home. (The study didn't even ask about one of the most common forms of abuse in foster care, foster children abusing each other). Switching to orphanages won't help -- the record of institutions is even worse. Furthermore, the more a foster care system is overwhelmed with children who don't need to be there, the less safe it becomes, as agencies are tempted to overcrowd foster homes and lower standards for foster parents. If a child is taken from a perfectly safe home only to be beaten, raped or killed in foster care, how is that "erring on the side of the child"?

• But even that isn't the worst of it. Everyone knows caseworkers often are overwhelmed. They often make bad decisions in both directions – leaving some children in dangerous homes, even as more children are taken from homes that are safe or could be made safe with the right kinds of services. The more that workers are overwhelmed with children who don't need to be in foster care, the less time they have to find children in real danger. So they make even more mistakes in both directions.

Contrary to the common stereotype, most parents who lose their children to foster care are neither brutally abusive nor hopelessly addicted. Far more common are cases in which a family's poverty has been confused with child "neglect." For example, a major study of child welfare in Milwaukee County found many cases in which children could be back home with their parents right now – if only those parents had decent housing. But the study also found that caseworkers were unwilling to face up to the issue.

Other cases fall on a broad continuum between the extremes, the parents neither all victim nor all villain. What these cases have in common is the fact that there are a wide variety of proven programs that can keep these children in their own homes, and do it with a far better track record for safety than foster care. But such programs are smeared when, for example, the label "family preservation" is slapped onto any decision to leave any child in any home under any circumstances, when something goes wrong.

Sometimes, these in-between cases involve substance abuse. And that raises another question: Why even bother with parents – usually mothers -- in these cases? But the reason to "bother" is not for the sake of the parents, but for their children.

University of Florida researchers studied two groups of infants born with cocaine in their systems. One group was placed in foster care, the other with birth mothers able to care for them. After six months, the babies were tested using all the usual measures of infant development: rolling over, sitting up, reaching out. Consistently, the children placed with their birth mothers did better. For the foster children, being taken from their mothers was more toxic than the cocaine.

It is extremely difficult to take a swing at "bad mothers" without the blow landing on their children. If we really believe all the rhetoric about putting the needs of children first, then we need to put those needs ahead of everything – including how we may feel about their parents. That doesn't mean we can simply leave children with addicts – it does mean that drug treatment for the parent is almost always a better first choice than foster care for the child.

And finally, because our organization works to compare and contrast systems and highlight best practices, we have found that it is possible to compare some systems on a local level. Thus you'll find in our memo data comparing Milwaukee County and Cook County, Ill.

So with that context in mind, enclosed please find our analysis of the audits. I've also enclosed NCCPR's Issue Papers, our brief review of "best practices" around the country, *Ten Ways to do Child Welfare Right,* some exceptionally insightful comments from a foster-parent in Maine, and some other NCCPR publications you may find useful.

If NCCPR can be of assistance in any other way, please contact me at any time.

Sincerely,

Richard Wexler
Executive Director

Cc: Sen. Carol A. Roessler
Rep. Suzanne Jeskewitz

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TEN WAYS TO DO CHILD WELFARE RIGHT

Successful alternatives to taking children from their families

At the National Coalition for Child Protection Reform, we often are asked what can be done to prevent the trauma of foster care by safely keeping children with their own families. There are many options, and we've listed some below. None of the alternatives described below will work in every case or should be tried in every case. Contrary to the way advocates of placement prevention often are stereotyped, we do not believe in "family preservation at all costs" or that "every family can be saved." But these alternatives can keep *many* children now needlessly taken from their parents safely in their own homes. Similarly, even communities that have turned their child welfare systems into national models still have serious problems. All of the things that go wrong in the worst child welfare systems also go wrong in the best – but they go wrong less often.

1. **Doing nothing.** There are, in fact, cases in which the investigated family is entirely innocent and perfectly capable of taking good care of their children without any "help" from a child welfare agency. In such cases, the best thing the child protective services worker can do is apologize, shut the door, and go away.

2. **Basic, concrete help.** Sometimes it may take something as simple as emergency cash for a security deposit, a rent subsidy, or a place in a day care center (to avoid a "lack of supervision" charge) to keep a family together. Indeed, the federal Department of Housing and Urban Development has a special program, called the Family Unification Program, in which Section 8 vouchers are reserved for families where housing is the issue keeping a family apart or threatening its breakup. Localities must apply for these subsidies. By doing so, they effectively acknowledge what they typically deny: that they do, in fact, tear apart families due to lack of housing.

3. **Intensive Family Preservation Services programs.** The first such program, Homebuilders, in Washington State, was established in the mid-1970s. The largest replication is in Michigan, where the program is called Families First. The very term "family preservation" was invented specifically to apply to this type of program, which has a better track record for safety than foster care. The basics concerning how these programs work – and what must be included for a program to be a real "family preservation" program -- are in NCCPR Issue Papers 10 and 11. Issue Paper 11 lists studies proving the programs' effectiveness.
CONTACTS: Charlotte Booth, executive director, Homebuilders (253) 874-3630, cbooth@bsihomebuilders.org, Susan Kelly, former director, Families First (734) 547-9164, susan.kelly@cssp.org

4. **The Alabama "System of Care."** This is one of the most successful child welfare reforms in the country. The reforms are the result of a consent decree growing out of a lawsuit brought by the Bazelon Center for Mental Health Law. The consent decree requires the state to rebuild its entire system from the bottom up, with an emphasis on keeping families together. The rate at which children are taken from their homes is among the lowest in the country, and re-abuse of children left in their own homes has been cut by 60 percent – to less than half the national average. An independent monitor appointed by the court has found that children are *safer* now than before the changes.

CONTACTS: Ira Burnim, Legal Director, Bazelon Center for Mental Health Law (202) 467-5730, ext. 129. Mr. Burnim also is a member of the NCCPR Board of Directors. The Bazelon Center also has published a book about the Alabama reforms. **Paul Vincent, Child Welfare Policy and Practice Group, Montgomery, Ala. (334) 264-8300.** Mr. Vincent ran the child protection system in Alabama when the lawsuit was filed. He worked closely with the plaintiffs to develop and implement the reform plan. **Ivor Groves, independent, court-appointed monitor, (850) 422-8900.**

5. **Family to Family.** This is a multi-faceted program developed by the Annie E. Casey Foundation (which also helps to fund NCCPR). One element of the program, Team Decisionmaking (which is similar to an approach called family group conferencing) often is confused with the entire program, which has many more elements. The program is described at the Casey website www.aecf.org/familytofamily. Also on the website is a comprehensive outside evaluation of the program, showing that it led to fewer placements, shorter placements, and less bouncing of children from foster home to foster home – with no compromise of safety. **CONTACT: Gretchen Test, Annie E. Casey Foundation (410) 547-6600.**

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TEN WAYS TO DO CHILD WELFARE RIGHT

6. **Community/Neighborhood Partnerships for Child Protection.** These partnerships, overseen by the Center for the Study of Social Policy in Washington, are similar to the Family to Family projects. They mobilize formal and informal networks of helpers to prevent maltreatment and avoid needless foster care placement. In Florida's Duval County, where substantiated cases of child abuse soared 60 percent from 1999 to 2002, cases in areas served by the neighborhood partnership program declined by 27 percent. Partnerships in Iowa and Georgia also have demonstrated better safety outcomes. **CONTACTS: Marno Batterson, Center for the Study of Social Policy, (641) 792-5918, marno. batterson@cssp.org Florida: Barbara Alexander, First Coast Family Center, Balexander @fcfcenter.org (904) 348-3251.**

7. **The turnaround in Pittsburgh.** In the mid-1990s, the child welfare system in Pittsburgh and surrounding Allegheny County, Pa. was typically mediocre, or worse. Foster care placements were soaring and those in charge insisted every one of those placements was necessary. New leadership changed all that. Since 1997, the foster care population has been cut by dramatically. When children must be placed, half the children in foster homes stay with relatives and siblings are kept together 82 percent of the time.

   They've done it by tripling the budget for primary prevention, more than doubling the budget for family preservation, embracing innovations like Family to Family and adding elements of their own, such as housing counselors in every child welfare office so families aren't destroyed because of housing problems. And, as in Alabama, children are safer. Reabuse of children left in their own homes has declined and there has been a significant and sustained decline in child abuse fatalities. **CONTACT: Karen Blumen, Allegheny County Department of Human Services, Office of Community Relations (412) 350-5707.**

8. **Reform in El Paso County, Colorado.** By recognizing the crucial role of poverty in child maltreatment, El Paso County reversed steady increases in its foster care population. The number of children in foster care declined significantly – and the rate of reabuse of children left in their own homes is below the state and national averages, according to an independent evaluation by the Center for Law and Social Policy, available here: http://m15080.kaivo .com/LegalDev/CLASP/DMS/Documents/1043875 845.58/El_Paso_report.pdf **CONTACT: Barbara Drake, El Paso County Department of Human Services, (719) 444-5532.**

9. **The Bridge Builders, Bronx, New York.** Combine the giving and guidance of ten foundations with the knowledge and enthusiasm of eight community-based agencies, then partner with the child protective services agency and what do you get? A significant reduction in the number of children taken from their homes, with no compromise of safety, in a neighborhood that is among those losing more children to foster care than any others in New York City. That's the record of the Bridge Builders Initiative in the Highbridge section of The Bronx. (NCCPR has received a grant to assist the Bridge Builders with media work). **CONTACTS: Francis Ayuso, Project Director, ayusof@highbridgelife .org, (718) 681-2222; Mike Arsham, executive director, Child Welfare Organizing Project, co-chair Bridge Builders Executive Committee, mike@ cwop.org, 212-348-3000.** Throughout the City, the Administration for Children's Services has made significant progress in safely keeping children in their own homes. Since 1998, the number of children taken from their parents over the course of a year has been cut by 60 percent with no compromise of safety. **Contact: Sharman Stein, Administration for Children's Services 212-341-0999**

10. **Changing financial incentives.** While not a program per se, making this change spurs private child welfare agencies to come up with all sorts of innovations they previously had claimed were impossible. This is clear from the experience in Illinois. Until the late 1990s, Illinois reimbursed private child welfare agencies the way other states typically do: Though the agencies were told to seek permanence for children, they were *paid* for each day they kept a child in foster care. Thus, agencies were rewarded for letting children languish in foster care and punished for achieving permanence.

    Now those incentives have been reversed, in part because of pressure from the Illinois Branch of the ACLU, which won a lawsuit against the state child welfare system. Today, private agencies in Illinois are paid for permanence. They are rewarded both for adoptions (which often are conversions of kinship placements to subsidized guardianships) *and* for returning children safely to their own homes. They are penalized for prolonged stays in foster care. As soon as the incentives changed, the "intractable" became tractable, the "dysfunctional" became functional, and the foster care population plummeted. And children are safer. Today, Illinois takes away children at one of the lowest rates in the country, and independent, court-appointed monitors have found that child safety has improved. **CONTACT: Ben Wolf, Illinois Branch, ACLU, (312) 201-9760, ext. 420, bwolf@aclu-il.org**

Updated, September 6, 2005

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80 PERCENT FALURE:

A Brief Analysis of the Casey Family Programs *Northwest Foster Care Alumni Study*

By Richard Wexler, NCCPR Executive Director

Imagine for a moment that you went to a doctor and he told you the following:

- 80 percent of my patients don't get any better.
- A lot of the time, they get worse.
- One-third of the time, I commit malpractice.

But, the doctor continues, if you'll just pay me even more money than I already get and build me a fancy new hospital, I'm sure I can reduce my failure rate to only about 60 percent. Do we have a deal?

Odds are you'd look for another doctor.

But what if all the other doctors told you the same thing? And what if none of them let on that there were, in fact, better treatments with fewer side effects?

Odds are you'd be furious.

Now, consider a study released on April 7, 2005 by a large, Washington State-based foster-care provider, Casey Family Programs, and Harvard Medical School. The study used case records and interviews to assess the status of young adult "alumni" of foster care.

When compared to adults of the same age and ethnic background who did not endure foster care:

- Only 20 percent of the alumni could be said to be "doing well." Thus, foster care failed for 80 percent.
- They have double the rate of mental illness.
- Their rate of Post Traumatic Stress Disorder was double the rate for Iraq War veterans.
- The former foster children were three times more likely to be living in poverty – and fifteen times *less* likely to have finished college.
- And nearly one-third of the alumni reported that they had been abused by a foster parent or another adult in a foster home.

The authors went on to design a complex mathematical formula to attempt to figure out how much they could improve these outcomes if every single problem besetting the foster care system were magically fixed. Their answer: 22.2 percent.

Even if one argues that foster care didn't cause all of these problems, clearly foster care didn't cure them. Yet the authors of the study recommend only more of the same: Pour even more money into foster care to "fix" it to the point that maybe the rotten

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outcomes could be reduced by 22.2 percent.

At a two-and-a-half-hour briefing for advocates, there was barely a word about keeping children out of foster care in the first place.

Why, then, do we continue to pour billions of dollars into a system which fails 80 percent of the time and actually abuses at least one-third of those forced into it?

We do it because, over 150 years, we've built up a huge, powerful network of foster-care "providers" – "a foster-care industrial complex" with an enormous vested interest in perpetuating the *status quo*. They feed us horror stories about foster children whose birth parents really were brutally abusive or hopelessly addicted. But such cases represent a tiny fraction of the foster-care population.

As is documented in NCCPR's Issue Papers, elsewhere on this site, far more common are cases in which a family's poverty is confused with child "neglect." Several studies have found, for example, that one-third of foster children could be back home right now if their parents simply had adequate housing. (See NCCPR Issue Paper 5.)

Other cases fall on a broad continuum between the extremes, the parents neither all victim nor all villain. What these cases have in common is the fact that the children would be far better off if states and localities used safe, proven alternatives to foster care – alternatives that don't come with an 80 percent failure rate, and a 33 percent risk of child abuse. (See *Nine Ways to do Child Welfare Right*).

Nearly as disturbing as the study's findings is how the study authors attempted to spin them.

The finding about the rate of abuse in foster care is not mentioned in the press release accompanying the study. It's not in the Executive Summary. It's not in any of the glossy material that accompanies the report. One must dig it out of the report itself, on page 30. (The full report is available here: http://www.casey.org/NR/rdonlyres/4E1E7C77-7624-4260-A253-892C5A6CB9E1/300/nw_alumni_study_full_apr2005.pdf)

During the entire briefing for advocates, I waited in vain for the study authors to even mention the issue of abuse in foster care. When I finally asked about it, at the very end of the briefing, one of the researchers tried to blame birth parents, speculating, without a shred of evidence, that maybe the foster children had been abused during visits.

But that is contradicted by the study itself, which states:

"One third (32.8%) of the sample, however, reported some form of maltreatment *by a foster parent or other adult in the foster home* during their foster care experience, *as recorded in their case files"* [emphasis added].

If anything, this underestimates the true rate of abuse, since a major problem in foster care is foster children abusing each other (see NCCPR Issue Paper 1) and those cases apparently were not counted in the study.

Of course, some will rush to conclude that because family foster care has failed so badly, we should go back to orphanages. There's just one problem with that. Over a century of research is nearly unanimous: The outcomes for children warehoused in orphanages are even worse. (See NCCPR Issue Paper 15.)

Though the authors try desperately to ignore the obvious, their study is one more indication that the only way to fix foster care is to have less of it. Until we realize that, foster care systems will continue to churn out walking wounded – four out of five times.

April 9, 2005

A FOSTER PARENT SPEAKS OUT

Mary Callahan is an author of two books, an emergency room nurse, and a foster parent in Maine, a state forced to confront the failures of its Department of Human Services (DHS) when five-year-old Logan Marr was taken from her mother, Christie, only to die in foster care, bound to a high chair with 42 feet of duct tape. The foster mother was convicted of manslaughter.

As new leadership faced up to the problems in Maine, Mary Callahan became a respected voice for reform. She was invited to give a presentation to an Advisory Commission working on restructuring human services in Maine. This is the text of that presentation, given on August 7, 2003, reprinted with permission.

My name is Mary Callahan. I am a mother, a foster mother, and a nurse. Some of you are already familiar with me from the opinion pieces and letters to the editor I've had in the papers. Some of you have even read the book I wrote on my experiences as a foster parent in Maine. And some of you are saying to yourself, "Here it comes again, Mary Callahan and more of her crazy stories."

I know exactly how you feel. I felt the same way for the first two years I was doing foster care when I had to deal with the birth parents of Marie. Every time there was a case review, they would wait for me in the parking lot afterwards to plead their case.

It was all I could do not to roll my eyes. They tried to tell me that DHS lied about them, that DHS tricked them, even that DHS forced them to say things to their kids that they didn't want to say. I wanted to tell them it was time to start taking responsibility for their own actions.

Then I found out they were telling the truth. The case worker, who was leaving his job, admitted to me that everything the parents said was true, and most of what I had been told about them was fiction, made up by the worker before him who hated the dad and was determined to see him lose his kids.

This would be bad enough if it stood alone. But I knew what had happened to Marie since she came into foster care. That's when the real abuse began. For six years she lived in a foster home that I would describe as sadistic. She came to me malnourished and reading four years below grade level, thanks to the constant stress she was under. People outside the system are horrified by her story. The people I went to within the system looked blankly at me and waited for me to tell them something they didn't already know.

You may think their vision is to keep children safe. In reality the vision is to keep children safe *from those horrible parents that we hate.* Sometimes it is *those horrible foster parents that we hate.*

That was my first clue that the Child Welfare System in Maine isn't really about the welfare of children.

By the time I wrote my first letter to the editor, I was convinced of that. I wrote that the system should be torn down and rebuilt "from the vision on up," and I still believe it. You may think their vision is to keep children safe. In

reality the vision is to keep children safe *from those horrible parents that we hate*. Sometimes it is *those horrible foster parents that we hate.*

The emphasis on hating parents instead of caring about children was never clearer than at the foster parent workshop I attended where a speaker was introduced as The Terminator because of the record she had set in terminating parental rights. They didn't say, "She freed this many children for adoption." That might have been an even bigger, more impressive number. It was how many parents she had stuck it to. And the shocking part to me was that the audience applauded.

I would have thought, in a business as delicate as this one, where the stakes are so high, that great care would be taken to prevent the hating from becoming more important than the caring, that supervisors would be constantly on the lookout for workers who let their personal biases cloud their judgment or used the families to grind their own axes. Instead the contempt for families can be spoken out loud and even applauded.

The attitude is so pervasive that it trickles down to people on the periphery of the system, like mandatory reporters. I saw an example of that in the Emergency Room recently. A family brought in their 6-year-old son because they couldn't control him any more. He had a mental health diagnosis and was on medications, but that day he was tearing the curtains down and threatening family members with kitchen knives. I took the family back to the crisis area where, I thought, they would talk with a social worker and come up with a plan.

A few hours later that worker came up to the triage booth with a big grin on his face. "I think we've got 'em," he told me."

"Who?" I asked.

"Those parents. I've been sitting with them for an hour and I counted 14 times that the child bit himself, hard." He demonstrated. "The parents didn't do anything. They just looked at him. It's a total parent/child disconnect. I think I have enough to call DHS."

The delight in that social worker's eyes was the same delight I saw at that workshop in The Terminator's eyes. He was so proud of himself, but what will be the end result of his actions? If those parents manage to keep their child, they will never come to the ER for help again. They will handle their problems themselves at home. And who knows what that might mean? We are creating real child abuse when we react with blame when asked for help.

Since I started speaking out, people have come to me with their own stories. I get e-mails, phone calls and letters, and they fall into two categories. They are either professionals who have seen what I have seen and don't know what to do about it, or they are victims.

By professionals, I mean lawyers and psychologists, even social workers who have seen terrible suffering inflicted in the name of protecting children. An example is a police officer who e-mailed me to say that he accompanied a caseworker once when children were being removed only to hear the worker tell a complete fabrication in court about what they had found when they were at the home and how the parents reacted.

I got this email from a foster parent, "Would anyone out there believe how bad the foster care system is in Maine if they were not involved in it? I set out with the desire to try to help a few children while I still had the energy to do it. I never knew I would be asked to lie, look the other way when some major mistakes were made, be part of a cover-up to hide the mistakes of those who were supposed to be protecting children. I watched my children's medical needs not be met. My voice meant nothing at team meetings. I have had 8 families in my area leave foster care in the past two years. They are good, honest people and that was the problem. They are not willing to be a part of a team that doesn't care about the children."

Would any of these people go public with me? No. They don't want to become DHS's next victims.

When I talk to people who see themselves as DHS victims, I know I am only hearing one side of the story. But I also recognize that the same factors come up over and over again, and they are things I have seen for myself. Here are those

factors:

1) Lying. Everyone claims the department lied about them. I don't doubt it any more because they have lied about me. Just one example, a foster child asked to move back with me after his kinship placement failed and was told that I said no. Now I ask you to think how that must feel to a child to be rejected by his former foster parent. He is already in the system because we have rejected his parents, now he is being personally rejected. Only he wasn't. I would have taken him back in a second, but his DHS worker didn't like me, so she lied to him. His next placement was told not to let him contact me because I supposedly provided drugs and alcohol for him when he lived with me.

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2) Divide and conquer. Just as Christie Marr was told to cut ties with her mother, many of the people who call me say they were forced to cut ties with someone important to them. One mother claims she had to cut her father out of her life when he was terminally ill. She never knew him to hurt anybody, but the department said he had, and made her choose between him and her children.

3) The set-up. "She said to call her if I had any problems, that she would be happy to help, and when I did call, she came out with the cops and took my kids." I've heard that more than once. Another set up is the parenting evaluation. Parents are told if they take it and pass, that it will help them in court. What they are not told is that 95% of the people who take that test fail. They are really taking the test just so the department will have more justification for removing children. I call it the Kiss-of-Death Parenting Eval.

4) Disrespect. Yelling seems to be acceptable behavior. When a parent or grandparent tells me that the worker yelled at them in the DHS waiting room, I believe it because I have seen it happen. I've been yelled at on the phone. As a nurse, I don't even yell back when a drunk berates me in the Emergency Room. I handle it professionally because that's what's expected of me. They don't seem to have the same expectation at DHS.

5) Child removal on a whim. When foster parents contact me it is usually about some child who has been removed with no warning, and apparently no grasp at all on the part of the department of how painful this is for the child. Children are like pawns in a big game, moved more easily than we would move a pet from one household to another. One foster father said he had someone come up to him and ask why he hadn't been to the transition meetings for his foster child. He didn't know the child was moving. What he finally found out was that the caseworker's best friend had become a foster parent and was interested in that particular child, so she was giving her the child like some kind of a gift.

At the center of any of these situations is a power struggle. Parents think they have a certain amount of control over the circumstances surrounding their own children. DHS workers are determined to show them they are wrong. I think we saw that on *The Caseworker Files* on *Frontline* when the statement "They're not taking me seriously yet," kept being repeated, until the child was finally taken.

What I experience is a system that is about power, control and hate. But you know what never comes up? Love never comes up. The only time we talk about it, we use a euphemism. When we call kids attachment disordered, we are really saying they don't love the new parents we have given them. And we send them to therapy to fix that. We even say it is caused by a lack of

bonding in the first six months of life, another strike against the birth parents. Doesn't it seem illogical to expect kids to love someone just

When I went into this business I never thought I would end up saying this, but these mothers who have lost their children to foster care are no different than me. They have just had harder lives. Much harder. Many of them grew up in foster care. And now they have broken hearts on top of it because they couldn't save their children from the same fate.

because we have plopped them down in their home? And even if we have given them a half a dozen sets of really lovable foster parents, doesn't it make sense that the kids would be afraid to take the chance of loving again and losing again?

And speaking of logic, how logical is it to take a child because the parent moves too much, as we are told the department did to Logan Marr? No one moves more than a foster child and those moves are made alone. Again, we're leaving out the love factor. Think of your own children. What do you think would be harder on them, moving from place to place with you, the parent they love, or losing you and everyone else in your family, then spending the rest of their childhood waiting for you to come and get them, wondering what they did to lose your love, wanting to go back and find you and ask you why. Love doesn't seem to count for anything in this system.

I spend a lot of time with the families of my foster kids now. I see how easily they fall into each others arms, the way they finish each other's sentences, the way they accept each other for who they are and forgive each other. I've gotten to know the parents myself and I like them. When I went into this business I never thought I would end up saying this, but these mothers who have lost their children to foster care are no different than me. They have just had harder lives. Much harder. Many of them grew up in foster care. And now they have broken hearts on top of it because they couldn't save their children from the same fate.

This state is littered with broken hearts. I see it in my own foster kids and their families. I hear it in the voices at the other end of the phone. I also see it in the Emergency Room when patients come to the crisis unit sobbing because they miss their children so much, children that DHS has taken. One man was actually psychotic in his grief over losing his children, hallucinating that they were still there, looking through the house as if they were just misplaced. And his children had been gone for years. I see it at my other job too, where I teach people to live with heart and lung disease. Three, so far this year, have shared with me their secret pain, that there is a grandchild out there that they may never see again because DHS took them.

And it doesn't have to be that way. Other states have undertaken real reform, working to keep kids with their families in all but the worst of cases and to support those families while they are going through tough times. I've heard some encouraging things lately, things that give me hope that Maine might be going the same way.

The news coverage on the workshop that was held last week said the department was going to work on preventing child abuse instead of reacting to it, focus on a family's strengths instead of their weaknesses. But they also said something that frightened me. Someone said they were going to be focusing on "children who

One man was actually psychotic in his grief over losing his children, hallucinating that they were still there, looking through the house as if they were just misplaced. And his children had been gone for years.

don't get enough attention." I would have thought it was embarrassing enough when, on *Frontline's Caseworker Files*, a Maine social worker said that she thought "not paying enough attention" to a child might be the worst abuse of all. This was an absurd statement, on a program about a foster child who had been duct taped to a chair and suffocated.

As a mandatory reporter for as long as there have been mandatory reporters, I can tell you that ten years ago spankings and long timeouts were not reportable offenses. They are now. We shouldn't be surprised when the number of child abuse reports goes up at the same time that the definition has been expanded. Reports will go up again if the public can be convinced that they should report children who don't get enough attention. How do they expect to prevent child abuse deaths if they are busy sifting through those kinds of reports and possibly taking those children into foster care? I suggest that if you see a child who doesn't seem to be getting enough attention, give him some attention!

Letting the people who make their livings off child abuse define it sounds like a conflict of interest to me. Imagine if the health care industry worked that way. Hospitals could mandate hospitalizations for cold symptoms and then reap in the bucks. Insurance companies would just keep paying and no one would listen to the occasional voice of reason saying that there were worse infections to be caught inside the hospital and this was doing more harm than good.

We are losing the distinction between child abuse and parenting we don't agree with, just as we have long since lost the distinction between poverty and neglect. Pity the parents who have taken on two jobs to provide for their children, to avoid being accused of neglect, only to be accused of not paying enough attention to them. They might as well just give their children to the state at birth. They can no longer win, no matter what they do.

My greatest hope for the future in Maine is Paul Vincent and the Child Welfare Policy and Practice Group. They have come here to introduce Family Team Meetings to Maine, a program that brings all the players to the table *before* a child removal to explore and possibly choose an alternative. Hopefully this is only the beginning. He has done wonderful things in other states. If he does here what he did in Alabama, I will have gotten my wish, the foster care system will be torn down and rebuilt from the vision on up.

Pity the parents who have taken on two jobs to provide for their children, to avoid being accused of neglect, only to be accused of not paying enough attention to them. They might as well just give their children to the state at birth. They can no longer win, no matter what they do.

But even then, I will have one remaining concern. What of those hearts already broken? I said in my book that "DHS means never having to say you're sorry." Will that remain true? Will the powers-that-be say, "It's too late" as Marie's worker said to me when I asked why she wasn't returned to her parents after he took the job and realized what had happened to her? Will the grandparents have to go to their graves with their pain and the parents keep coming to the ER when they feel like dying? Will the children keep going to bed every night asking why somebody had to be paid to love them.

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THE 2003 NCCPR RATE-OF-REMOVAL INDEX

Updated August 2005

The NCCPR rate-of-removal index is an attempt to compare the propensity of states to adopt a "take-the-child-and-run" approach to child welfare. The index compares the number of removals of children in each state during the year 2003, the most recent year for which data are available, to a Census Bureau estimate of the number of children living in poverty in that state. The result is the number of removals of children from their homes for every 1,000 impoverished children in that state.

THIS IS NOT THE "SNAPSHOT NUMBER"

The measure of a state's foster care population usually seen in news accounts is the so-called "snapshot number" indicating the number of children in foster care in a state on one particular day – usually September 30 of each year. That is a very important number, but it is a less accurate measure of a state's propensity to remove children.

A state may have a high snapshot number even if it takes away very few children, if it hangs on to those it takes for a very long time. (That is, in itself, a serious problem, but not a measure of the state's propensity to take away children in the first place). Conversely, a state can have a low snapshot number and still take away many children, but take them for only a very short period of time. Thus, a state which takes away many children in January, but returns most of them by August will have a low number when the "snapshot" is taken in September. Also, a state which took away a great many children a decade or more ago and let them languish in foster care may have a low snapshot number now simply because those children are "aging out" of the system at 18 – hardly a testament to a system's success.

RATHER, THIS INDEX USES REMOVALS OVER THE COURSE OF A YEAR

So instead of measuring the foster care population on any given day, the NCCPR Rate-of-Removal Index relies on federal data listing the number of children removed at some point over the course of a given year.

HOW THE INDEX IS COMPILED

The source for data on removals is the Department of Health and Human Services Adoption and Foster Care Analysis and Reporting System (AFCARS). The most recent state-by-state data are available online at http://www.acf.hhs.gov/programs/cb/dis/tables/ entryexit2002.htm

This is a different source than NCCPR used for its 2001 data, which came from another part of the Department of Health and Human Services. Although both branches of HHS posed a similar question to state agencies, they got significantly different answers from the same states for the same years. When compiling data for 2002 and 2003, we used the AFCARS data because they are more recent and more complete, including all 50 states and Washington, D.C.

In addition, states periodically send update information to HHS. The data in this chart are accurate as of August, 2005, but it is advisable to check the chart online to see if data for your state have changed.

COMPARISON DATA

We could have simply compared the number of children removed to a state's total child population. But then all the states with high rates of removal and high child poverty rates would complain that this was unfair because we didn't consider the single largest risk factor for actual abuse, (not to mention the factor most often confused with "neglect") – poverty. So, in order to factor that out, and come closer to an apples-to-apples comparison, we used the Census Bureau's Current Population Survey, Annual Demographic Survey to determine the number of people under age 18 living in poverty in each state.

This is a statistical sample, as opposed to the head count used every ten years in the census. This has led to wide fluctuations from year to year, which are probably a result of sampling problems. To minimize these errors, we've adopted a method used by one of the nation's most authoritative sources of information about impoverished children, the National Center for Children in Poverty at Columbia University. They use the *average* from the last three Annual Demographic Surveys to estimate the number of impoverished children in each state.

We then compare the number of children removed from their parents in each state to this three-year average estimate of the number of people under age 18 in that state who are living in poverty. *However, for those who prefer making the comparison to the total child population, we have included charts computing the index that way as well.*

CAUTIONS AND CAVEATS

• As a group that believes strongly in family preservation, we feel that a high rate-of-removal almost always is a sign of a bad system. But a low rate-of-removal is not necessarily a sign of a good system. A low rate-of-removal can be accomplished either by embracing safe, proven programs to keep families together, or by ignoring children in real danger. We are confident that Alabama's low rate-of-removal indicates a relatively good system, because that state also has slashed the rate of reabuse of children left in their own homes, and an independent court-appointed monitor says the reforms in Alabama have improved child safety. We have similar confidence in Illinois. We have no such assurances for Mississippi. That doesn't mean Mississippi necessarily needs to take away more children. But it may need to take away *different* children.

• The data don't reveal trends over time. A state that still has a relatively high number of removals but has been steadily and safely reducing them may be a better "role model" than a state which removed relatively few children in 2003, but now is in the midst of a foster-care panic. Limited trend data are available at http://www.acf.hhs.gov/ programs/cb/dis/tables/entryexit 2002. htm

• In at least 11 states, individual counties run their child protection systems. Statewide data may obscure success stories or extreme failures in individual counties.

• One cannot say, based on these data, that state X "took Y percent of its poor children from their parents in 2002." That would be inaccurate because, while the overwhelming majority of children taken from their parents are poor, not all of them are. Thus, we are comparing a pool of children – those removed from their parents – which is mostly poor, to a general population that is entirely poor. One can say only that, for example, according to this index, in 2003, authorities in Minnesota appeared more prone to resort to foster care than their counterparts in any other state, since this index shows that Minnesota has the highest removal rate.

• Some states may claim they don't really take away as many children as the federal data show. In fact, they're probably wrong and the feds probably are right. The federal government doesn't make these numbers up, and it doesn't do the counting itself. It relies for its data on state human services agencies – the same agencies which, in some states, offer up lower numbers for public consumption.

The difference probably has to do with definitions. The federal government uses a standard definition: If a child has been taken away for more than 24 hours it "counts" as an entry into foster care. And that makes sense – you can be sure it "counted" to the child who underwent the experience. So the numbers states give the federal government are supposed to include all such children.

But when states give figures to newspapers or post them on their websites they can use any definition they want. Some states may count a child as "removed" only if s/he is still in foster care at the time of the first court hearing, which can be anywhere from 48 hours to two weeks after removal. All the children agencies take, then change their minds about and return before that hearing -- much the worse for the experience -- are not counted under this definition.

Some states also don't count "kinship care" placements – children placed by the court, at the behest of a child welfare agency, with a relative instead of a stranger. While kinship care cushions the blow of foster care, it is still foster care. Some states also don't count institutional placements or pre-adoptive homes. But these, too, are foster care.

It's also true, however, that federal data have been known to contain errors. For example, data from March 1999 giving the "snapshot number" for each state showed only 208 foster children in the entire state of Iowa. That was a considerable underestimate.

(continued)

NCCPR RATE-OF-REMOVAL INDEX, 2003

State	Average number of children living in poverty, 2001-2003	Children removed from their homes in 2003	Rate per 1000/ national ranking
Alabama	240,000	3,246	13.5/46
Alaska	22,334	943	42.2/12
Arizona	303,667	6,208	20.4/39
Arkansas	194,667	3,543	18.2/41
California	1,714,000	45,796	26.7/31
Colorado	135,000	7,613	56.4/08
Connecticut	86,000	3,130	36.4/18
Delaware	21,334	861	40.4/13
D.C.	35,000	719	20.5/38
Florida	707,000	20,549	29.1/26
Georgia	404,334	10,568	26.1/33
Hawaii	43,667	2,409	55.2/07
Idaho	55,334	1,292	23.3/35
Illinois	542,000	5,794	10.7/48
Indiana	182,000	6,179	34.0/20
Iowa	74,000	5,736	77.5/02
Kansas	92,334	2,677	29.0/27
Kentucky	185,667	5,485	29.5/24
Louisiana	297,667	2,809	9.4/49
Maine	42,667	860	20.2/40
Maryland	119,000	3,470	29.2/25
Mass.	178,000	6,507	36.6/16
Michigan	352,334	9,650	27.4/30
Minnesota	104,000	8,495	81.7/01
Mississippi	183,334	1,658	9.0/50
Missouri	197,667	6,342	32.1/22
Montana	39,334	1,175	29.9/23
Nebraska	54,667	3,304	60.4/05
Nevada	69,334	3,302	47.6/08
N Hampshire	21,000	578	27.5/29
New Jersey	206,000	6,971	33.8/21
New Mexico	126,000	1,898	15.1/44
New York	914,334	13,598	14.9/45
N. Carolina	412,000	5,461	13.3/47
N. Dakota	22,334	1,050	47.0/09
Ohio	411,667	13,997	34.0/19
Oklahoma	166,000	6,632	40.0/14
Oregon	137,000	5,158	37.6/15
Pennsylvania	404,667	13,981	34.5/17
R.I.	35,334	1,567	44.3/11
S. Carolina	198,667	3,410	17.2/42
S. Dakota	22,000	1,370	62.3/04
Tennessee	272,334	6,305	23.2/36
Texas	1,378,000	11,824	8.6/51
Utah	92,667	1,928	20.8/37
Vermont	15,667	725	46.3/10
Virginia	214,333	3,351	16.5/43
Washington	233,000	6,196	26.6/32
West Va.	95,667	2,347	24.5/34
Wisconsin	173,334	5,010	28.9/28
Wyoming	14,000	979	69.9/03
NAT. TOT.	12,220,845	294,235	
National mean			**24.1**
Nat. median			**29.1**

See chart on following page, for data by rank.

NCCPR RATE-OF-REMOVAL INDEX, BY RANK, 2003

State	Average number of children living in poverty, 2001-2003	Children removed from their homes in 2003	Rate per 1000/ national ranking
Minnesota	104,000	8,495	81.7/01
Iowa	74,000	5,736	77.5/02
Wyoming	14,000	979	69.9/03
S. Dakota	22,000	1,370	62.3/04
Nebraska	54,667	3,304	60.4/05
Colorado	135,000	7,613	56.4/06
Hawaii	43,667	2,409	55.2/07
Nevada	69,334	3,302	47.6/08
N. Dakota	22,334	1,050	47.0/09
Vermont	15,667	725	46.3/10
R.I.	35,334	1,567	44.3/11
Alaska	22,334	943	42.2/12
Delaware	21,334	861	40.4/13
Oklahoma	166,000	6,632	40.0/14
Oregon	137,000	5,158	37.6/15
Mass.	178,000	6,507	36.6/16
Connecticut	86,000	3,130	36.4/17
Pennsylvania	404,667	13,981	34.5/18
Ohio	411,667	13,997	34.0/19
Indiana	182,000	6,179	34.0/20
New Jersey	206,000	6,971	33.8/21
Missouri	197,667	6,342	32.1/22
Montana	39,334	1,175	29.9/23
Kentucky	185,667	5,485	29.5/24
Maryland	119,000	3,470	29.2/25
Florida	707,000	20,549	29.1/26
Kansas	92,334	2,677	29.0/27
Wisconsin	173,334	5,010	28.9/28
N Hampshire	21,000	578	27.5/29
Michigan	352,334	9,650	27.4/30
California	1,714,000	45,796	26.7/31
Washington	233,000	6,196	26.6/32
Georgia	404,334	10,568	26.1/33
West Va.	95,667	2,347	24.5/34
Nat. Average			**24.1**
Idaho	55,334	1,292	23.3/35
Tennessee	272,334	6,305	23.2/36
Utah	92,667	1,928	20.8/37
D.C.	35,000	719	20.5/38
Arizona	303,667	6,208	20.4/39
Maine	42,667	860	20.2/40
Arkansas	194,667	3,543	18.2/41
S. Carolina	198,667	3,410	17.2/42
Virginia	214,333	3,351	16.5/43
New Mexico	126,000	1,898	15.1/44
New York	914,334	13,598	14.9/45
Alabama	240,000	3,246	13.5/46
N. Carolina	412,000	5,461	13.3/47
Illinois	542,000	5,794	10.7/48
Louisiana	297,667	2,809	9.4/49
Mississippi	183,334	1,658	9.0/50
Texas	1,378,000	11,824	8.6/51

See following pages for data using total child population instead of impoverished child population.

NCCPR RATE-OF-REMOVAL INDEX/6

NCCPR RATE-OF-REMOVAL INDEX BASED ON TOTAL CHILD POPULATION, 2003

State	2003 Child Population	Children removed from their homes in 2003	Rate per 1000/ national ranking
Alabama	1,107,973	3,246	2.9/42
Alaska	189,289	943	5.0/20
Arizona	1,519,312	6,208	4.1/29
Arkansas	682,013	3,543	5.2/18
California	9,419,970	45,796	4.9/22
Colorado	1,152,751	7,613	6.6/09
Connecticut	835,375	3,130	3.7/36
Delaware	198,842	861	4.3/28
D.C.	108,403	719	6.6/09
Florida	3,924,123	20,549	5.2/18
Georgia	2,296,759	10,568	4.6/24
Hawaii	297,142	2,409	8.1/02
Idaho	372,027	1,292	3.5/37
Illinois	3,230,606	5,794	1.8/51
Indiana	1,603,901	6,179	3.9/31
Iowa	693,428	5,736	8.3/01
Kansas	695,081	2,677	3.9/31
Kentucky	994,182	5,485	5.6/14
Louisiana	1,177,555	2,809	2.4/46
Maine	286,746	860	3.0/40
Maryland	1,378,092	3,470	2.5/45
Mass.	1,487,118	6,507	4.4/27
Michigan	2,538,920	9,650	3.8/33
Minnesota	1,248,770	8,495	6.8/08
Mississippi	761,268	1,658	2.2/47
Missouri	1,407,342	6,342	4.5/26
Montana	215,774	1,175	5.4/16
Nebraska	440,840	3,304	7.5/05
Nevada	581,397	3,302	5.6/14
N Hampshire	306,231	578	1.9/48
New Jersey	2,131,617	6,954	3.3/40
New Mexico	502,034	1,898	3.8/35
New York	4,532,748	13,598	3.0/40
N. Carolina	2,087,443	5,461	2.6/43
N. Dakota	146,827	1,050	7.2/06
Ohio	2,815,289	13,997	5.0/20
Oklahoma	878,243	6,632	7.6/04
Oregon	849,172	5,158	6.1/12
Pennsylvania	2,830,694	13,981	4.9/22
R.I.	244,049	1,567	6.4/11
S. Carolina	1,023,504	3,410	3.3/40
S. Dakota	195,426	1,370	7.0/07
Tennessee	1,394,479	6,305	4.6/24
Texas	6,240,162	11,824	1.9/48
Utah	742,927	1,928	2.6/43
Vermont	137,446	725	5.3/17
Virginia	1,798,767	3,351	1.9/48
Washington	1,496,581	6,196	4.1/29
West Virginia	390,901	2,347	6.0/13
Wisconsin	1,332,894	5,010	3.8/33
Wyoming	121,073	979	8.1/02
NAT. TOT.	72,504,997	294,235	
National mean			**4.1**
Nat. median			**4.6**

See chart on following page, for data by rank.

NCCPR RATE-OF-REMOVAL INDEX BASED ON TOTAL CHILD POPULATION, BY RANK, 2003

State	2003 Child Population	Children removed from their homes, 2003	Rate per 1000/ national ranking
Iowa	693,428	5,736	8.3/01
Hawaii	297,142	2,409	8.1/02
Wyoming	121,073	979	8.1/02
Oklahoma	878,243	6,632	7.6/04
Nebraska	440,840	3,304	7.4/05
N. Dakota	146,827	1,050	7.2/06
S. Dakota	195,426	1,370	7.0/07
Minnesota	1,248,770	8,495	6.8/08
Colorado	1,152,751	7,613	6.6/09
D.C.	108,403	719	6.6/09
R.I.	244,049	1,567	6.4/11
Oregon	849,172	5,158	6.1/12
West Virginia	390,901	2,347	6.0/13
Kentucky	994,182	5,485	5.6/14
Nevada	581,397	3,302	5.6/14
Montana	215,774	1,175	5.4/16
Vermont	137,446	725	5.3/17
Arkansas	682,013	3,543	5.2/18
Florida	3,924,123	20,549	5.2/18
Alaska	189,289	943	5.0/20
Ohio	2,815,289	13,997	5.0/20
California	9,419,970	45,796	4.9/22
Pennsylvania	2,830,694	13,981	4.9/22
Georgia	2,296,759	10,578	4.6/24
Tennessee	1,394,479	6,305	4.6/24
Missouri	1,407,342	6,342	4.5/26
Mass.	1,487,118	6,507	4.4/27
Delaware	198,842	861	4.3/28
Arizona	1,519,312	6,208	4.1/29
Washington	1,496,581	6,196	4.1/29
Nat. Average			**4.1**
Indiana	1,603,901	6,179	3.9/31
Kansas	695,081	2,677	3.9/31
Michigan	2,538,920	9,650	3.8/33
New Mexico	502,034	1,898	3.8/33
Wisconsin	1,332,894	5,010	3.8/33
Connecticut	835,375	3,130	3.7/36
Idaho	372,027	1,292	3.5/37
New Jersey	2,131,617	6,971	3.3/38
S. Carolina	1,023,504	3,410	3.3/39
Maine	286,746	860	3.0/40
Alabama	1,107,973	3,246	2.9/42
New York	4,532,748	13,598	3.0/40
N. Carolina	2,087,443	5,461	2.6/43
Utah	742,927	1,928	2.6/43
Maryland	1,378,092	3,470	2.5/45
Louisiana	1,177,555	2,809	2.4/46
Mississippi	761,268	1,658	2.2/47
N Hampshire	306,231	578	1.9/48
Texas	6,240,162	11,824	1.9/48
Virginia	1,798,767	3,351	1.9/48
Illinois	3,230,606	5,794	1.8/51
NAT. TOT.	72,504,997	294,235	

See following page for sources.

Sources:
Child population: U.S. Census Bureau, *Annual Estimates of the Population by Sex and Age*, available online at: http://www.census.gov/popest/states/asrh/SC-EST2003-02.html
Impoverished child population: U.S. Census Bureau, *Current Population Survey, Annual Demographic Survey, 2004 Annual Social and Economic Supplement*, available online at http://www.census.gov/hhes/www/poverty.html#cps Scroll down to "Current Population Survey."
Removals: U.S. Department of Health and Human Services, Administration for Children and Families, State-by-State Adoption and Foster Care Statistics, available online at: http://www.acf.hhs.gov/programs/cb/dis/tables/entryexit2002.htm
National Rankings were compiled by NCCPR.

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COMPARISON OF CHILD WELFARE SPENDING

The charts on the following pages compare child welfare spending among the states. The first set of charts divides total spending by the total number of *impoverished* children in each state. The second set of charts divides total spending by the total number of children in each state, regardless of income. Since child maltreatment overwhelmingly is linked to – and, often, confused with, poverty, we believe using the impoverished child population is more valid.

There are some important caveats about this comparison:

- The spending data are the most recent available, but they still are relatively old – from FY 2002.

- It is very difficult to figure out exactly how much a state spends on child welfare, because there are so many different pots of money to choose from – at least 30 federal "funding streams" plus state and, in some states, local dollars. Indeed, that's why the Urban Institute, which compiled the data, did not try to make state-by-state comparisons itself.

- Data on child poverty come from the Census Bureau's Current Population Survey, Annual Demographic Survey. This is a statistical sample, as opposed to the head count used every ten years in the census. This has led to wide fluctuations from year to year, which are probably a result of sampling problems. To minimize these errors, we've adopted a method used by one of the nation's most authoritative sources of information about impoverished children, the National Center for Children in Poverty at Columbia University. They use the *average* from the last three Annual Demographic Surveys to estimate the number of impoverished children in each state.

Despite these cautions, we believe that for looking at states that differ significantly from each other and from the national average, the comparison is useful.

Sources:
Child population, impoverished child population: U.S. Census Bureau

Spending: Roseana Bess, et. al., The Cost of Protecting Vulnerable Children IV, (Washington, DC: Urban Institute, December 20, 2004.) Per child and per impoverished child figures compiled by NCCPR.

*Washington DC, as a city, cannot properly be compared to states.

n/a: The state did not provide spending data in several significant categories.

National Rankings were compiled by NCCPR.

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CHILD WELFARE SPENDING PER CHILD LIVING IN POVERTY, FY 2002
ALPHABETICALLY, BY STATE

State	Average number Of children living in poverty 2001-2003	Total child welfare spending FY 2002	Child welfare spending per impoverished child, FY 2002, and rank
Alabama	240,000	$ 271,997,873	$ 1,133/38
Alaska	22,334	82,246,655	3,683/05
Arizona	303,667	263,162,613	867/43
Arkansas	194,667	68,005,126	349/47
California	1,714,000	3,969,123,381	2,316/17
Colorado	135,000	369,968,558	2,741/12
Connecticut	86,000	n/a	n/a
Delaware	21,334	51,369,725	2,408/16
D.C.*	35,000	218,074,750	6,231/na
Florida	707,000	766,109,440	1,084/40
Georgia	404,334	385,718,188	954/41
Hawaii	43,667	80,423,767	1,842/26
Idaho	55,334	49,785,800	900/42
Illinois	542,000	1,373,409,026	2,534/14
Indiana	182,000	383,761,912	2,109/21
Iowa	74,000	317,371,621	4,289/04
Kansas	92,334	183,960,499	1,992/24
Kentucky	185,667	331,951,216	1,788/28
Louisiana	297,667	205,212,594	689/44
Maine	42,667	143,503,838	3,363/08
Maryland	119,000	431,512,479	3,626/06
Mass.	178,000	634,846,929	3,567/07
Michigan	352,334	760,995,545	2,160/19
Minnesota	104,000	621,865,000	5,979/01
Mississippi	183,334	56,899,368	310/48
Missouri	197,667	487,278,630	2,465/15
Montana	39,334	44,723,037	1,137/37
Nebraska	54,667	143,945,744	2,633/13
Nevada	69,334	78,232,653	1,128/39
N Hampshire	21,000	58,082,783	2,766/11
New Jersey	206,000	460,389,862	2,235/18
New Mexico	126,000	77,273,580	613/45
New York	914,334	2,552,961,000	2,792/10
N. Carolina	412,000	n/a	n/a
N. Dakota	22,334	32,237,497	1,443/33
Ohio	411,667	860,302,907	2,090/26
Oklahoma	166,000	195,095,580	1,175/36
Oregon	137,000	259,147,279	1,892/25
Pennsylvania	404,667	1,281,310,642	3,166/09
R.I.	35,334	166,940,105	4,725/02
S. Carolina	198,667	239,800,000	1,207/35
S. Dakota	22,000	39,441,666	1,793/27
Tennessee	272,334	425,944,946	1,564/31
Texas	1,378,000	824,978,690	599/46
Utah	92,667	120,228,300	1,297/34
Vermont	15,667	67,265,907	4,293/03
Virginia	214,333	335,031,670	1,563/32
Washington	233,000	396,477,199	1,702/29
West Va.	95,667	154,448,327	1,614/30
Wisconsin	173,334	349,464,994	2,016/23
Wyoming	14,000	30,087,462	2,149/20
NAT. MEAN	**12,220,845**	**22,156,246,128**	**1,813**
NAT. MEDIAN			**1,942**

CHILD WELFARE SPENDING PER CHILD LIVING IN POVERTY, FY 2002 BY RANK

State	Average number Of children living in poverty 2001-2003	Total child welfare spending FY 2002	Child welfare spending per impoverished child, FY 2002 and rank
D.C.*	35,000	$ 218,074,750	$ 6,231/na
Minnesota	104,000	621,865,000	5,979/01
R.I.	35,334	166,940,105	4,725/02
Vermont	15,667	67,265,907	4,293/03
Iowa	74,000	317,371,621	4,289/04
Alaska	22,334	82,246,655	3,683/05
Maryland	119,000	431,512,479	3,626/06
Mass.	178,000	634,846,929	3,567/07
Maine	42,667	143,503,838	3,363/08
Pennsylvania	404,667	1,281,310,642	3,166/09
New York	914,334	2,552,961,000	2,792/10
N Hampshire	21,000	58,082,783	2,766/11
Colorado	135,000	369,968,558	2,741/12
Nebraska	54,667	143,945,744	2,633/13
Illinois	542,000	1,373,409,026	2,534/14
Missouri	197,667	487,278,630	2,465/15
Delaware	21,334	51,369,725	2,408/16
California	1,714,000	3,969,123,381	2,316/17
New Jersey	206,000	460,389,862	2,235/18
Michigan	352,334	760,995,545	2,160/19
Wyoming	14,000	30,087,462	2,149/20
Indiana	182,000	383,761,912	2,109/21
Ohio	411,667	860,302,907	2,090/22
Wisconsin	173,334	349,464,994	2,016/23
Kansas	92,334	183,960,499	1,992/24
NAT. MEDIAN			**1,942**
Oregon	137,000	259,147,279	1,892/25
Hawaii	43,667	80,423,767	1,842/26
NAT. MEAN			**1,813**
S. Dakota	22,000	39,441,666	1,793/27
Kentucky	185,667	331,951,216	1,788/28
Washington	233,000	396,477,199	1,702/29
West Va.	95,667	154,448,327	1,614/30
Tennessee	272,334	425,944,946	1,564/31
Virginia	214,333	335,031,670	1,563/32
N. Dakota	22,334	32,237,497	1,443/33
Utah	92,667	120,228,300	1,297/34
S. Carolina	198,667	239,800,000	1,207/35
Oklahoma	166,000	195,095,580	1,175/36
Montana	39,334	44,723,037	1,137/37
Alabama	240,000	271,997,873	1,133/38
Nevada	69,334	78,232,653	1,128/39
Florida	707,000	766,109,440	1,084/40
Georgia	404,334	385,718,188	954/41
Idaho	55,334	49,785,800	900/42
Arizona	303,667	263,162,613	867/43
Louisiana	297,667	205,212,594	689/44
New Mexico	126,000	77,273,580	613/45
Texas	1,378,000	824,978,690	599/46
Arkansas	194,667	68,005,126	349/47
Mississippi	183,334	56,899,368	310/48
Connecticut	86,000	n/a	n/a
N. Carolina	412,000	n/a	n/a

FY 2002 STATE CHILD WELFARE SPENDING, PER CHILD, ALPHABETICALLY, BY STATE

State	2003 Child Population	Spending per child, 2002, and ranking
Alabama	1,107,973	245/28
Alaska	189,289	435/08
Arizona	1,519,312	173/40
Arkansas	682,013	100/47
California	9,419,970	421/11
Colorado	1,152,751	320/16
Connecticut	835,375	n/a
Delaware	198,842	258/26
D.C.*	108,403	2,012/*
Florida	3,924,123	195/36
Georgia	2,296,759	168/41
Hawaii	297,142	271/22
Idaho	372,027	134/45
Illinois	3,230,606	425/10
Indiana	1,603,901	239/29
Iowa	693,428	457/06
Kansas	695,081	265/23
Kentucky	994,182	334/14
Louisiana	1,177,555	174/39
Maine	286,746	500/03
Maryland	1,378,092	313/17
Mass.	1,487,118	427/09
Michigan	2,538,920	300/21
Minnesota	1,248,770	498/04
Mississippi	761,268	75/48
Missouri	1,407,342	346/13
Montana	215,774	207/34
Nebraska	440,840	327/15
Nevada	581,397	147/44
N Hampshire	306,231	190/37
New Jersey	2,131,617	216/33
New Mexico	502,034	154/43
New York	4,532,748	563/02
N. Carolina	2,087,443	n/a
N. Dakota	146,827	220/32
Ohio	2,815,289	306/18
Oklahoma	878,243	222/31
Oregon	849,172	305/19
Pennsylvania	2,830,694	453/07
R.I.	244,049	684/01
S. Carolina	1,023,504	234/30
S. Dakota	195,426	202/35
Tennessee	1,394,479	305/19
Texas	6,240,162	132/46
Utah	742,927	162/42
Vermont	137,446	489/04
Virginia	1,798,767	187/38
Washington	1,496,581	265/23
West Virginia	390,901	395/12
Wisconsin	1,332,894	262/25
Wyoming	121,073	249/27
NAT. TOT.	72,504,997	
National mean		306
Nat. Median		263.5

FY 2002 STATE CHILD WELFARE SPENDING, PER CHILD, BY RANK

State	2003 Child Population	Spending per child, 2002, and ranking
R.I.	244,049	684/01
New York	4,532,748	563/02
Maine	286,746	500/03
Minnesota	1,248,770	498/04
Vermont	137,446	489/05
Iowa	693,428	457/06
Pennsylvania	2,830,694	453/07
Alaska	189,289	435/08
Mass.	1,487,118	427/09
Illinois	3,230,606	425/10
California	9,419,970	421/11
West Virginia	390,901	395/12
Missouri	1,407,342	346/13
Kentucky	994,182	334/14
Nebraska	440,840	327/15
Colorado	1,152,751	320/16
Maryland	1,378,092	313/17
Nati. mean		**306**
Ohio	2,815,289	306/18
Oregon	849,172	305/19
Tennessee	1,394,479	305/19
Michigan	2,538,920	300/21
Hawaii	297,142	271/22
Kansas	695,081	265/23
Washington	1,496,581	265/23
Nat. Median		**263.5**
Wisconsin	1,332,894	262/25
Delaware	198,842	258/26
Wyoming	121,073	249/27
Alabama	1,107,973	245/28
Indiana	1,603,901	239/29
S. Carolina	1,023,504	234/30
Oklahoma	878,243	222/31
N. Dakota	146,827	220/32
New Jersey	2,131,617	216/33
Montana	215,774	207/34
S. Dakota	195,426	202/35
Florida	3,924,123	195/36
N Hampshire	306,231	190/37
Virginia	1,798,767	187/38
Louisiana	1,177,555	174/39
Arizona	1,519,312	173/40
Georgia	2,296,759	168/41
Utah	742,927	162/42
New Mexico	502,034	154/43
Nevada	581,397	147/44
Idaho	372,027	134/45
Texas	6,240,162	132/46
Arkansas	682,013	100/47
Mississippi	761,268	75/48