Direct Service Workers' Recommendations for Child Welfare Financing and System Reform

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Introduction

Federal child welfare financing reform has been debated by policymakers and child welfare advocates around the country since the 1996 welfare reform legislation was enacted. People with creative policy ideas and extensive knowledge about how government services are funded have offered up a variety of proposals to use federal dollars to improve outcomes for children in the system and appropriate resources more efficiently. Participants in this debate can be found in the White House, federal agencies, Congressional offices and committees, state governments, think tanks, non-profits, trade associations, foundations, and more. However, one voice has largely been missing from that debate: the frontline workers who have the most direct contact with children and families in the child welfare system.

Frontline workers handle the daily responsibilities aimed at promoting children's safety, permanence, and well-being. They and their supervisors play a critical role in the process of determining whether an abuse or neglect report is substantiated, what services families that come into the system should receive, if a child should be removed from their home, where a child who has been removed from the home will be placed, when they will see their biological family and if they will be reunited with them, where they will attend school, and more. Their unique perspectives and rich expertise can and should help inform the ongoing debate about child welfare financing reform.

Accordingly, the Child Welfare League of America (CWLA)—uniquely positioned as an organization with members that provide direct services in all 50 states—conducted a series of webinars with groups of frontline workers and supervisors, along with a few executives, from its membership agencies over six months spanning November 2010 to May 2011. The webinars combined registration questions, group discussion, and in-session polling to learn these participants' perspective on child welfare financing reform. In total 142 people with direct, first-hand knowledge of the child welfare system contributed responses. Of those, 67 answered all registration and polling questions and participated in a discussion focus group.

Participants were questioned about their roles, familiarity with federal policy, obstacles they face in improving outcomes for children and families, and supports that might enable them to do their jobs more effectively. They also gave their perspective on the availability and effectiveness of resources and service approaches and shared their views on how they and the children and families they serve can have a stronger voice in improving the system.

The participants in CWLA's focus group survey provided an enlightening glimpse into their daily lives so that policymakers and advocates can understand what happens at the frontline level. This report summarizes their responses and analyzes the implications their answers have on con-

Summary of Recommendations

The single most frequently mentioned recommendation was to enhance family support services. Direct service workers see the lack of support for families as the most pressing need in the child welfare system. Family strengthening, training for parents, homemaker help, home visiting and supports to overcome dysfunction, crises, and emergencies facing families were among many family-focused suggestions made by the focus group and survey participants.

Additional funding for services and supports and particularly for prevention services was also mentioned frequently by the participants. Many participants mentioned the lack of resources focused on keeping families intact as an effective prevention strategy. Many recommended more support and attention to strategies focused on the family.

Support for the child welfare workforce was also recommended highly. Increased salary and benefits, and more training both for front line workers and supervisors were mentioned frequently. More emphasis on reducing caseloads was also highly recommended.

tinuing efforts to craft comprehensive and effective federal child welfare financing reform. An update on the latest financing reform developments and CWLA's policy positions will first be summarized in order to provide the proper context.

Recent Financing Reform Developments

Over the past few years, momentum toward comprehensive child welfare financing reform has been building. Legislation has just passed Congress to reinstate the authority of the U.S. Department of Health and Human Services (HHS) to allow states to implement new innovative demonstration projects through a five-year waiver of Title IV-E. While IV-E waiver authority falls short of CWLA's idea of comprehensive reform, innovative and effective practices can be developed through the research, development, testing, and evaluation processes allowable under waiver authority. Perhaps most importantly, House supporters of the waiver bill have publicly committed to continuing to fight for more far-reaching financing reform.

In addition, a Senate Congressional Caucus on Foster Youth has been formed and has conducted a series of forums to examine shortcomings in the child welfare system. One session in particular focused specifically on financing reform and Senate staff heard a variety of viewpoints on what the next steps should be. The work of the Caucus culminated last year in a "Call to Action" paper supporting the idea of pursuing financing reform and listing some generally agreed upon principles to guide reform. The Caucus' work also continues with additional forums planned moving forward.

In response to Congressional action, several financing reform proposals were developed last year by various experts and advocacy organizations, including the American Public Human Services Association (APHSA), Casey Family Programs (CFP), the American Bar Association (ABA), and Chapin Hall at the University of Chicago. In addition, CWLA and a number of other advocacy groups have been working on developing a consensus proposal through the Partnership to Protect Children and Strengthen Families.

> "CWLA is committed to safety, permanence and well being. Federal funding for child welfare is targeted mostly on safety and out-of-home care. Congress should enact urgently needed finance reform to better align resources with an array of services and programs to meet the unique needs of children and families."
> - Christine James-Brown, CEO, CWLA

CWLA's Position on Major Financing Reform Provisions

While each of the financing reform proposals mentioned above is unique in its own way, there are several recurring themes and provisions in them that will presumably shape both the final Partnership proposal as well as financing reform legislation that may be pursued in Congress. Below is a list of these recurring provisions and CWLA's position on them.

- ***Maintaining the IV-E Entitlement***

  Since IV-E is an entitlement, it is not subjected to the annual appropriations process and it provides guaranteed, mandatory funding to states based on the number of eligible children in foster care. The amount of money sent to the states is directly tied to the number of kids in foster care eligible for assistance. Its status as an entitlement ensures a guaranteed level of financial support for each eligible child, which would otherwise be in jeopardy to the political situation in Congress and the appropriations process.

  Title IV-E provides support for out of home placement, including foster care, adoption, and kinship/guardianship. There is real concern that children placed in out of home care are not attaining the outcomes we would like to see, and CWLA continues to support efforts to reduce the number of children placed in care through preventative services, post-permanency services, and alternative arrangements like kinship care. However it is critical that those children who *are* placed in foster care receive maximum support and care. CWLA believes that this can best be achieved by continuing a guaranteed funding stream, via the

current IV-E open-ended entitlement, acknowledging that the federal responsibility for this population should not be based on political support but rather directly based on the number of children in care, providing resources for each eligible child.

- ***De-linking IV-E Eligibility from Income Standards***

  Because IV-E eligibility is linked to outdated income standards, less than half of children in foster care are currently supported by IV-E. Furthermore, because the income restrictions that IV-E is linked to are frozen in place and not adjusted for inflation, the rate of foster children covered by IV-E, which is known as the penetration rate, saw a dramatic decline since 1998 (see Appendix II). As the number of eligible children decreases, states face increasing pressure and decreasing federal IV-E reimbursements to maintain the support for these vulnerable children and families. This implies that the federal government is only half-concerned in providing care for foster children, which should not be the case.

  For a full federal partnership in protecting all children who have been removed from their homes, CWLA believes that the IV-E entitlement should be not only maintained but strengthened by extending its guarantee to all children in out-of-home care, regardless of the income levels of their parents or caregivers. This can be done immediately or if necessary it can be phased in gradually to reduce the cost.

- ***Reinvestment and Maintenance of Effort***

  Many of the proposals would allow states to project their foster care costs over a given period of time based on current practices and caseloads. If they were then able to reduce foster care placements over this time they would be allowed to reinvest the amount saved into their Title IV-B programs, which support children who have come to the attention of the system but who have not yet been removed from their homes. This would create an incentive for states to reduce the number of children they place in foster care without forgoing any funding. It would also provide important resources to supplement many states' underfunded interventions and innovative services, which would further reduce the number of children in foster care.

  Others have proposed opening up Title IV-E to cover a range of services, from prevention to post-permanency. Under these proposals, any child who was the subject of an abuse or neglect report would be eligible for a full range of approved services that have been determined to be effective in improving outcomes for children and families. States would be required to continue to match Title IV-E funding for these services.

  CWLA supports both proposals that would open up IV-E eligibility to other child welfare services and those that would redirect and reinvest IV-E savings incurred by reducing foster care placements into IV-B programs. In both cases, financial limitations would most likely restrict funding to improving the outcomes for families who have already come to the attention of the system via an abuse or neglect report. With or without reform, CWLA continues to support other anti-poverty and social service programs that target other at-risk families who have not yet come into the child welfare system.

- ***Rates of IV-E Reimbursement for the Continuum of Services***

  Some have suggested establishing new levels of reimbursemenvt for different methods of care, in effect creating a tiered system of reimbursement rates by providing higher rates of reimbursement for preferred placements and lower or decreasing rates of reimbursement for less desirable placements. Others have proposed placing time limits on reimbursements for certain types of care, including foster care, as another means to discourage certain placements. CWLA supports maintaining funding for the full continuum of services and does not endorse structuring or time-limiting reimbursement rates in a way that might hamper caseworkers' ability to meet the unique treatment and daily care needs of the children and families served.

- ***Workforce Support, Administration, and Reporting Issues***

  It is important to preserve the separate funding streams for training and administration under Title IV-E to ensure that they are not

shortchanged. Some of the proposals would merge all Title IV-E programs into one account, making it difficult to ensure that things like workforce training and staff development, which are critical to ensuring that the foster care caseloads are being properly managed, are adequately funded. CWLA believes that the separate, dedicated funding streams for training and administration should be maintained.

Accountability is a critical consideration to ensure that any refinancing plan accomplishes its intended purpose of better ensuring the safety, permanence, and well-being for every child. Financing reform will give greater discretion to states to determine how to use resources, and they must be held accountable to these goals.

- ***Cost Issues and Offsets***

  While none of the various financing reform plans have been officially scored by the Congressional Budget Office for their cost, it is evident that they represent a great range of cost. For example, allowing states to redirect Title IV-E savings to Title IV-B programs would undoubtedly cost less than opening Title IV-E up to the full range of services. The likely political reality is that any financing reform proposal will have to minimize cost to the federal government in order be given serious consideration by the current Congress. Some have suggested achieving cost savings through reduced reimbursement rates for certain forms of care, others suggest eliminating other programs like CAPTA that might become duplicative if the uses of IV-E were to be expanded, and others have suggested capping funding levels or block grants.

  As noted above, CWLA supports maintaining funding for the full continuum of services and does not endorse using reimbursement rates in a way that might hamper caseworkers' ability to serve the unique needs of children and families. Moreover, CWLA believes that the current child welfare system is already greatly under-resourced. As the financing reform discussion moves forward, CWLA will continue to weigh any proposed cost-cutting ideas against our principles and standards, and will only endorse compatible proposals.

Focus Group Survey: Responses and Implications

Participants

Over the course of six months, CWLA hosted 14 webinar discussions with small groups of workers in the child welfare system. A total of 67 individuals participated in all aspects of this process. Each registered for one of the scheduled webinars by providing basic demographic information and responding to nine multiple choice questions. The average webinar discussion took one hour and involved a series of eight multiple choice questions, opportunity for elaboration on each question, and a concluding section where respondents provided additional open-ended feedback to a series of five broader questions. CWLA is grateful to those who generously devoted their time and shared their knowledge with us through the surveys.

97% of participants work with children and families. 73% have worked in child welfare longer than 5 years.

Participants had a mix of job titles distinguishing them as frontline workers (73%), supervisors (17%) and administrators (10%); however, when asked about their duties, 97% reported direct contact with children and families. Public and private agency workers were fairly evenly represented, with 48% coming from the public sector, 45% from the private sector, and 7% from agencies that have various public and private features. Geographically, those surveyed were from both small and large jurisdictions across the country, although the mid-atlantic and southern regions were more heavily represented than the rest of the country. Almost half of participants predominantly provide foster care services, just over a third provide services in child protection, with the

The high stress, low compensation nature of the field results in high turnover between 23 and 85% yearly.[2] The average child welfare worker lasts two years on the job.[3]

remaining fifth split between working in adoption and specialized services.

The vast majority of those questioned are veterans in the child welfare workforce. 73% answered that they have at least five years of experience and 40% have been in the field for a decade or more. These are professionals who are resilient and are overcoming the challenges that lead to the high turnover in the field. Only 15% of respondents reported being in the field for less than 3 years. Experience was predictably greatest with supervisors and administrators, but even among workers with predominantly frontline duties, 63% of respondents indicated that they have worked in child welfare for at least five years. The vast experience possessed by those surveyed at all levels of the field, and the wisdom and knowledge they have gained along the way, is beneficial for those interested in reforming the financing of child welfare.

When queried about their level of familiarity with current federal child welfare legislation and ongoing federal child welfare activity, 78% of frontline workers, 55% of supervisors, and 71% of administrators self-identified as either very familiar or somewhat familiar. Workers in public agencies were more likely to be familiar with federal policy, but the majority of both sectors are more familiar than not. This confirms an expected selection bias, considering workers responding to a policy survey are more likely to be interested in and following federal child welfare policy. Nonetheless, most participants were responding to the questions with some understanding of the federal partnership in responding to child maltreatment. Nobody reported that they were not at all familiar with federal policy.

Participants are experienced, work directly with children and families, and are knowledgeable about federal policy. They also work across the continuum of services as 36% are in child protective services, 43% are in foster care, 9% are in adoption and 12% are in specialized services. Their personal familiarity within the system and the lessons they have derived over the course of their careers were the focus of this project. CWLA believes these often overlooked voices can and should significantly contribute to the financing reform policy debate, as this focus group survey demonstrates.

Responses

Workforce

Because they work to improve difficult human experiences, it is vital that frontline workers be

CWLA Caseload Standards

Worker Type	Caseload Standard
Workers making initial CPS assessments	No more than 12 active reports per month
Workers providing ongoing CPS support	No more than 17 active families, assuming the rate of new families assigned is no more than one for every six open families
Working both making initial CPS assessments and providing ongoing CPS support	No more than 10 active ongoing families and no more than 4 active initial assessments.[5]
Worker providing Intensive Family-Centered Services	2-6 families
Worker providing Family-Centered Casework	No more than 12 families[6]
Worker counseling with birth families, preparing and assessing adoptive applicants for infant placements and supporting these families following placement	20-25 families
Worker preparing children for adoption who are older or who have special needs	10-12 children
Worker assessing and preparing adoptive applicants for the placement of children who are older or have special needs and providing support to these families following placement	12-15 families
Worker assessing and preparing adoptive applicants for inter-county adoption	30-35 families[7]
Family foster care social worker	12-15 children, depending on the level of services required to meet the assessed needs of each child[8]

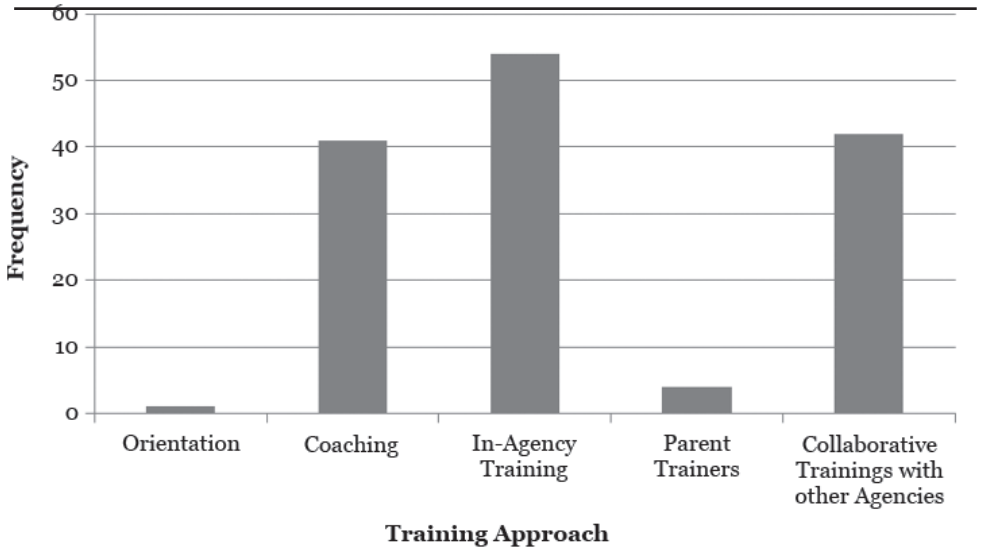
supported. One worker put it this way, "child welfare is a very meaningful job, but challenging and scary." Another explained, "We are dealing with families with real issues. Overloading [us] is not benefitting the families or the children." When polled as a whole about which self-care resource is the most promising for supporting frontline workers, they overwhelmingly selected meaningful supervision. In fact, workers on both ends of providing and receiving supervision pointed to this as the most promising work support. One respondent elaborated that support for the workforce could best be provided by "having knowledgeable supervisors to guide workers to do their job efficiently and with less negative impact on the families."

For the same question about how workers can be best supported, each of the remaining options was picked by six to eleven percent of participants—peer support, secondary trauma/burnout prevention, and employee assistance. In pointing to the need for support in general, one worker called for "understand[ing] that working with families is one of the most difficult and important jobs in this country [and] recogni[tion of] of our professionalism and education." Another worker described child welfare work as a "commitment," while another agreed that workers experience a "large burden" but are "underappreciated." Indeed, frontline workers often make incredibly difficult decisions that can have tremendous consequences. This makes proper training essential.

Another question investigated the best training approach to prepare workers to identify and tend to the needs of children and families. As one participant explained, training enables workers "to assess families and their needs and respond appropriately." There was general agreement regarding the importance of training, but some workers pointed to a deficiency in their training experience. One described that "training is rushed" and another requested "more training with regard to policy and procedure" and "more ongoing training or refresher courses as well in order to ensure that we can adequately serve our families." With respect to the particular form of training, 43% of participants picked in-agency training as the best approach, 30% picked coaching, 25% picked collaborative trainings with other agencies, and 2% picked parent trainers or orientation. As is evident, forms of training that are ongoing were selected over orientation training. Without discounting the importance of proper orientation, the workers on our surveys are pointing to the importance of continuous active learning in their immediate agency, from their peers and with other agencies with whom they interact.

With high turnover rates, keeping workers motivated is integral to retaining a skilled, knowledgeable, and effective workforce. One worker points out, "Families become frustrated with turnover as well." The average caseworker makes just $35,000[4] per year, and thus predictably a plurality of respondents (34%) cited increased salary and benefits as the most effective way to motivate frontline workers. "Those of us in [in the field] need to be compensated for it better," sum-

Best Training Approaches to Prepare Frontline Workers to Identify and Tend to the Needs of Children and Families

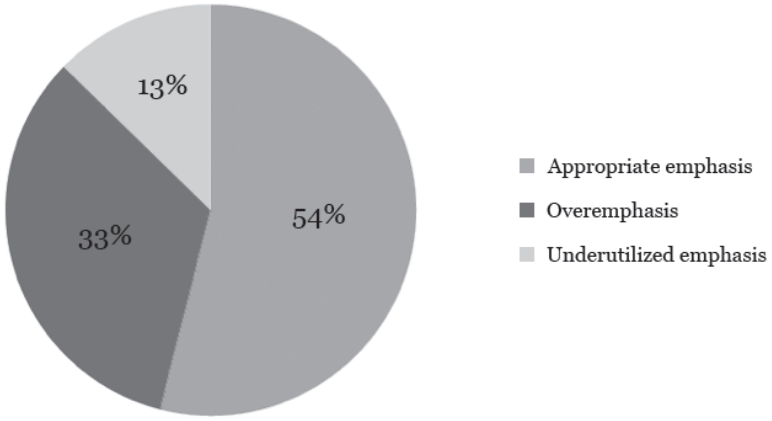


marized one worker. Another says, "We are rarely rewarded for what we do and it's always about what we don't do, which does not help." A significant number also believe flexible scheduling and adequate leave time (27%) and collaborative teams (26%) would be a good motivator. Resource staff (13%) could also prove helpful, according to others.

Over the course of the webinars, many workers brought up high caseloads as a major workforce problem. One frontline worker suggested when caseworkers have "high caseloads, it's hard to deliver the quality of service we want." A different survey participant pointed out that smaller caseloads not only allows workers to devote more time to helping a family stabilize, but also to "stay on the path of stabilization." Another simply declared, "Overloading the workers is not benefiting the families or the children." Elaborating on the problem, a worker explained, "Caseload expectations are not realistic at all. It's impossible for the workers to go to court, implement services, complete their monthly visits, [address] providers not giving appropriate services, as well as all the documentation that needs to be put in the system." On top of understanding how many demands a caseworker is under, another worker adds that the "life and death decision[s that we are making] cannot be made when you are overloaded with other cases and issues."

Emphasis Placed on Foster Care as a Service for Children and Families[10]

Percent Selected



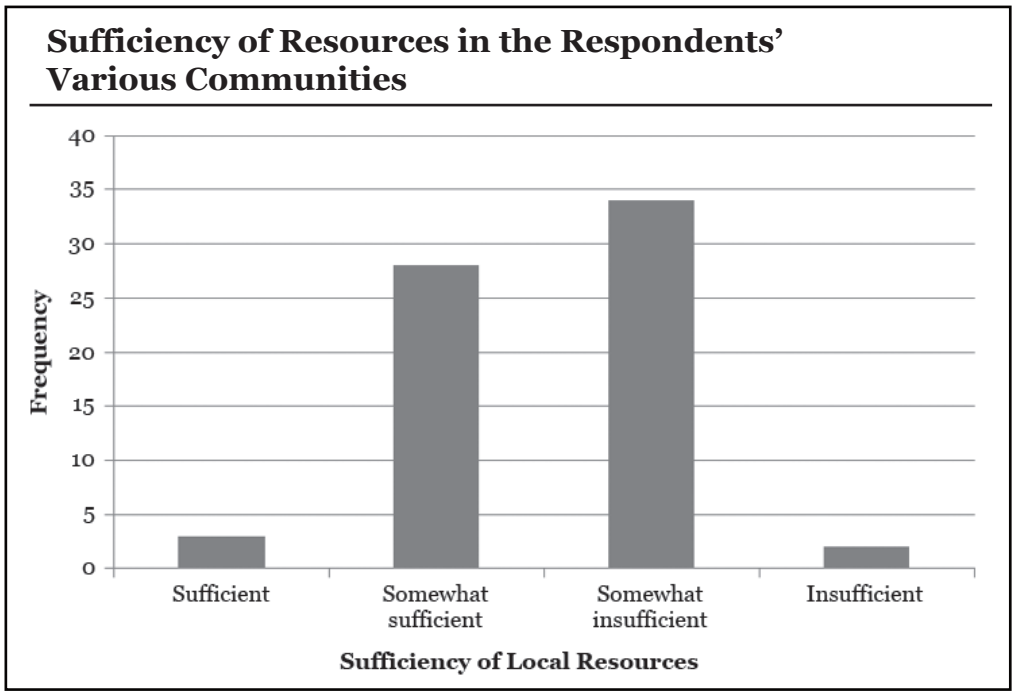
Intervention

Even though foster care caseloads have been declining across the nation for some time,[9] many believe that foster care continues to be utilized more often than it is necessary. However, our survey paints a more complex picture. With the expressed understanding that service provision varies from system to system, respondents were asked about of the level of emphasis currently placed on foster care as a service for children and families in their community. 54% responded that there is an appropriate emphasis, 33% believe it is overemphasized, and 13% believe it is underemphasized.

> "In NJ, the result of our lawsuit was the modified settlement agreement which limits our caseloads: 15 families per permanency workers and 12 per intake/ investigation worker. I feel this was one of the best reforms I've seen."
> – Focus Group Participant

The use of foster care can be a contentious issue. One respondent described foster care as a "band aid" that "doesn't heal the community: it breaks it apart." Some worried that foster care placements were sometimes a resource decision, with federal Title IV-E funds and Medicaid being available for children placed in foster care. Still, two-thirds of these workers do not believe that foster care is used too frequently in practice, and on this issue there was agreement from both the public and private sectors. A worker from a large suburb believed the use of foster care there is appropriate, noting that they "only pull the kid out if the family cannot meet their needs and foster care is the last option." Another noted that their agency only used foster care "when we need to" in order to ensure child safety and well-being.

Even so, the workers generally agreed on the need for greater investment in preventative services to further reduce placements. "If you had more resources at the front end, you could stop a



lot of foster care situations. More money is put into care for the children, instead of the families first," elaborated one participant. Several similarly concluded that resources are widely available for kids placed in foster care while resources to keep families intact are often lacking.

When asked to consider a scenario in which sufficient federal funds for child welfare services are available, respondents were split between adding funding to prevention (41%) and throughout the child welfare system (44%) when forced to choose one service. The remaining choices, permanency services, supportive services for parents, or post-permanency services, were each selected by 3-6% of respondents. A similar breakdown was consistent from respondents at both public and private agencies, up and down the workforce, and across the continuum of services. "Funding is a continuous problem and the biggest one we have," summarized one worker succinctly, while a second believed that "funding would make a difference across the board." Somebody else stated that if prevention services were more heavily invested in, "it could reduce the overall cost of child welfare." A former worker in their state's department of social services agreed, recalling "children came into care for reasons that could have been resolved with more funding for preventive services." A different respondent wished that the system was more "proactive" than "reactive."

"While funding would make a difference across the board, the facts still point to prevention as a more efficient solution than fixing issues that already are present."

Taking this perspective down to the local level, when asked about the sufficiency of resources in their communities, respondents do not believe the system is broken; however, neither do they believe it is fully sufficient. Half responded that the resources available are somewhat insufficient, while 42% think they are somewhat sufficient. Some of those decrying a lack of resources specified that clothing and housing, in-school services and extracurricular activities, and services for older youth are specifically lacking. Another noted that their community was trying to address agency collaboration issues but was attempting to do so without any dedicated funding.

State and local budget cuts have contributed to reduced services and amplified the resource insufficiency problem. One worker pointed out that federal matching funds are sometimes also lost when state cuts go into effect, "In California, we have suffered double or triple cuts—federal budget cuts, state budget cuts, and additional loss of federal funds due to state cuts." A different person has noticed that budget cuts are causing the system to break down and resulting in kids re-entering the system more frequently. "I would want Congress to

> "There needs to be a mechanism to poll the children and families to say how they feel about the services received. We should seek to treat every child as if they were are own children in every facet of their lives."
> – Focus Group Participant

know that cutting funding will not help out children and families. Before making any recommendations regarding funding, talk to those in the community that are experts," they advised.

Service Needs

When asked about barriers to meeting the needs of children and their families, the most frequently identified was limited resources and services that are family-focused and strength-based, which was checked by almost half of respondents (48%). Limited time for direct contact with children and families was checked by 24%, failure in service system collaboration by 16%, limited training and skill level of the workforce by 9%, and limited ability to measure success by 3%. Here, the barriers most selected are at the point of contact with clients.

Several of the remaining multiple choice questions sought to glean the worker's perspectives on the most effective and efficient services[11] in various categories. These services and resources are examples of what can be incentivized to eliminate the major barrier just cited. In each category, the workers were forced to choose one service and elaborate on why that was chosen and why the others were not selected. This elicited some insight into services that should be available as a tool to workers.

In comparing community supports for the parent/guardian role, participants most often pointed to parent education and training as the most effective and efficient (37%). Many of the workers followed up by explaining the importance of teaching parents about their children's development and helping them build skills to gain insight into their parenting practices. One worker gave an example that parents often do not know what to do with safety plans, but parent education helps them to practice a goal of "not hitting and screaming at their child." The class gives them viable alternatives and the goal becomes something they can conceive and actively work on. There was some concern that some models are not individualized enough and that lecture style classes are not effective. Another participant worried that her parents do not feel like they get anything out of their parenting class because they feel judged. Bringing up a similar point, community-based parenting education was recommended by another participant.

Community Supports for the Parent/Guardian Role

Support	Frequency	Percent
Home Visiting	8	12.7
Early Learning, Child Care & Head Start	6	9.5
Parent Support Group and Peer Assistance	16	25.4
Homemaker Help, Respite Care and Crisis Nurseries	10	15.9
Parent Education and Training	23	36.5

"Families are experts on themselves and must be empowered." – Focus Group Participant

Developing good parent skills are essential, and other participants highlighted additional approaches. One participant has noticed that some families are stuck in the child welfare cycle as "many parents are 3rd and 4th generation in the system and need modeling." Another worker has had the "most success with parents who feel confident." Peer support, homemaker help, respite, and therapeutic education were variously cited by other participants. Services covered under federal programs were also mentioned as playing an important role. "Home visiting is important and helps parents utilize other services, targeting efficiency," said one, while someone else pointed to Early Head Start's successes.

For strength-based services, parent job education, training, and skill development (34%) was most often selected as the most effective and efficient. Throughout the discussion, multiple people cited the stress that financial struggles have on families and brought up parent job training as helpful. Many pointed to their client's struggles with poverty and one worker pointed out the toll that lacking resources takes on the family dynamic, particularly the parent role.

Strength-based Services

Service	Frequency	Percent
Family Group Decision Making	17	27.4
Parent Job Education, Training and Skill Development	21	33.9
Family Resource Centers	14	22.6
Parent Leadership Roles	2	3.2
Differential Response	8	12.9

Family group decision making (FGDM) (27%) and family resource centers (23%) were also picked often. Workers found the family driven aspect of FGDM most helpful. One explains, "it provides the family with a forum to voice what they feel that they need to do to succeed, rather than being told what to do." Meanwhile, family resource centers were cited as another way to address the concrete service needs of families in poverty. Differential response was selected by 13%, but often discussed. Not everyone sees it being effectively implemented, but one participant who believes it works explained, "Differential response allows the family to address the issues before being passed out to a plethora of agencies which will include more than one person coming into the lives of the families, which can be overwhelming."

In terms of permanency services, the respondents most often selected family strengthening as having the most potential. "It is critical to invest in family strengthening because most children end up returning home, even those who have been in foster care for years," as one survey respondent has noticed. Someone else remarked, "I always have kids reconnecting with their families.....When you don't address that connection, it's broken." If you strengthen the family, you may not need other options listed," stated one respondent, concisely encapsulating the importance of reunification services. "If the family can be strengthened there is a better likelihood of continued success," agreed another.

Other successful permanency services identified were post adoption support services (31%) and kinship navigator and intensive family finding (24%). Several comments were recorded on the importance of post-permanency services. One participant went as far as to say that all adoptive parents need support because of the great likelihood that adoptive children have challenges resulting from the circumstances of their needing new caretakers. Another respondent agreed that, "Intensive Family Finding brings a connection of family which can mean the world to many," observed that participant. Many registered their support for locating and supporting relatives, and one worried that "reasonable efforts" are sometimes not always made. Kinship was cited frequently as an important way to provide consistency to children and a better alternative to foster care in many cases Several who elaborated on their responses also said that mentoring, while not always readily available, should be expanded because it "can help children understand the roles and help them understand what their parents are going through."

Permanency Services

Service	Frequency	Percent
Family Strengthening	22	37.9
Kinship Navigator and Intensive Family Finding	14	24.1
Specialized Adoption Recruitment and Photo Web Listing/Matching	1	1.7
Mentoring	3	5.2
Post Adoption Support Services	18	31

Mental Health Services

Service	Frequency	Percent
Mental health services for children living at home	40	69
Mental health services for children in foster or kinship care	11	19
Foster family-based treatment	4	6.9
Community-based residential	0	0

With respect to children with mental health needs, the survey inquired which services are most needed in the communities of those responding. The need to provide mental health services for children living at home was by far the most popular choice, receiving 69% of the vote. There seemed to be a clear agreement that the mental health needs of children who have come to the attention of the child welfare system, but who continue to live at home, are not being met. Here again there was an emphasis on strengthening prevention services. Family members need to be "taught more information on health services" and children's behavior problems, thought a participant.

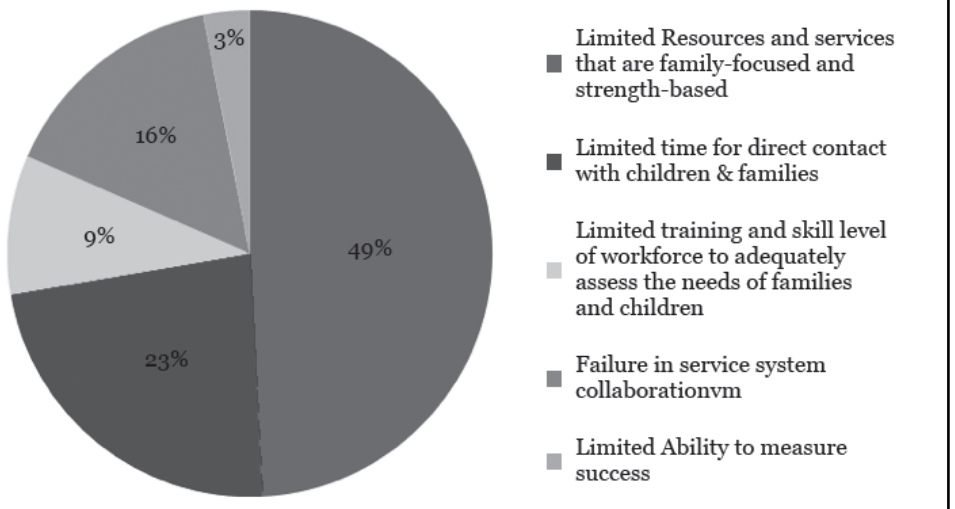
Mental health services for children in foster or kinship care was chosen by 19%. "Mental health services are not always effective or timely to prevent deterioration of children in foster care," observed someone. Another went on to explain, "We do not have a lot of foster homes that understand the needs of children that have mental health needs. They do not know how to work with the children with these problems and therefore request immediate removal of the children and do not want to work towards helping the children deal with the issues."

Foster family-based treatment received 7%, and community-based residential received 5%. Treatment should "involve family and community" noted multiple respondents, although one acknowledged that getting family and community members to participate can be challenging. "A lot of mental health issues are treated one on one as opposed to a more family-focused treatment," declared one disappointed worker. Finally, while one respondent from New York lauded the "great residential services" in their state, another worried that their state was "backing off of residential care, and that is not the answer" while a third opined, "they do not have enough" community-based or traditional residential services in their community.

Several more concrete service needs were mentioned throughout the webinar, including housing, substance abuse services, navigating public assistance systems, parent's inability to access required services that are only held during their working hours, access to public transportation, services for older youth, services for undocumented immigrants and systems collaboration. As can be imagined, many workers struggled to pick just one service in each of these categories. Many workers explained that unique clients need different services and supports depending on their history, current circumstances, and the place they are in the continuum. One worker explained, "To be truly strength-based, families should be able to choose from lots of services that meet their skills and strengths." Several respondents also pointed to the need to raise the voice of the children and families touched by the system.

Barriers to Meeting the Needs of Children and their Families

Percent Selected



Conclusion and Reccomendations

What Does This Mean for Financing Reform?

As expected when surveying a diverse group of workers from multiple regions, with different experience levels, serving variable roles within a complicated system, there was not always complete agreement on each question. In many cases the collective voices of these workers support what is being currently advanced by legislators and the advocacy community at the federal level. Yet in other instances it challenges those positions. With that said, a number of recurring themes were revealed throughout the survey. This ground level perspective on what works, what doesn't work, and what is lacking within the child welfare system will help elected officials and child welfare advocates get a fuller picture of where the system needs to be reformed.

The Need for More Prevention Funding

To begin with, the limits of the current federal child welfare financing structure were broadly recognized and frequently raised by survey participants. Because of the way the system is currently constructed, the federal government spends heavily on placements that provide the least desirable outcomes for children, like foster care, while shortchanging services that address the safety and well-being of children while keeping them with their families. More specifically, in fiscal year 2011, the federal government budgeted about $4 billion for Title IV-E of the Social Security Act, which reimburses states and tribes for out-of-home care. By comparison Title IV-B programs and programs authorized under the Child Abuse Prevention and Treatment Act (CAPTA), were funded at about $800 million combined.

Not only are there large discrepancies in funding between Titles IV-E and IV-B, but there are also major differences in how much flexibility the funds include. Title IV-E payments are highly restrictive to reimbursing the daily care and supervision of children in out-of-home care and limited to only those eligible based on an outdated income standard. Only recently have they even been allowed to be used for kinship care or directly accessed by tribes. On the other hand, Title IV-B funds are considerably more flexible. States can use Title IV-B funds for a range of services as long as they are consistent with the broad goals of the program. Funds can be used for abuse and neglect prevention, child protection services, post-adoption support, services for at-risk children who remain with their families, efforts to improve the safety, permanence, and well-being of children in foster care, supporting the child welfare workforce, and a number of other interventions to keep children safe and families intact.

Many of the workers surveyed through this project mentioned the importance of these prevention services and their potential to address problems within families early while reducing the need for more drastic measures like removal of the child. CWLA agrees with the concept that increasing investments in front-end preventive services can reduce the need for more expensive, less ideal placements later. Dedicating more resources to prevention would create a sensible and more comprehensive system. Unfortunately, as outlined above, the federal government currently provides many times more funding for kids in the child welfare system that have been removed from their homes than those who are still living at home. This must change to create a balance that reflects the blend of services that children need to stay safe.

Maintaining Support for the Full Continuum of Services

As highlighted above, front-end services are all too scarcely funded by the federal government while foster care for children who are IV-E eligible is reimbursable as a federal entitlement. This dichotomy of federal resources creates a financial incentive for children who come to the attention of the child welfare system to be placed in foster care. It also means that as states and tribes make progress in reducing their foster care caseloads over time, they are receiving less federal resources each year.

Some believe that these resource issues influence placement decisions. They worry that financial

calculations are leading to more children being placed in foster care than necessary. While this is almost impossible to verify, CWLA recognizes the perversity of the current federal child welfare financing structure and believes that sufficient resources should be devoted to at-risk children and families before removal becomes necessary. The lack of family supportive prevention funding may contribute to the use of placement services when children cannot otherwise be kept safely at home.

It should be reiterated here that 2/3 of the workers surveyed rejected the idea that foster care is overutilized. In fact, 13% even think it is underutilized. These workers have dealt personally with the system, most for many years, and they have first-hand experience with placement decisions. It is also important to point out that reimbursement rates vary from state to state, but even in the states with high levels of reimbursement there is still a significant cost to the state for placing a child in foster care.

> "We need to focus on being fearless and ethical in advocating for our children. Sometimes we get lost in the political process and you see direct impact in service. If we start making fearless decisions, they're clinically more sound than fearful decisions. Fearless is always putting the child's rights ahead of our own personal interests or political interests, or even funding issues."
> – Focus Group Participant

Still, in order to address the foster care incentive issue some have advocated placing limits on or adjusting IV-E reimbursement rates. Proposals to place time limits on reimbursements and to create variable tiers of reimbursement levels depending on the specific type of placements have been floated. As noted before, CWLA does not endorse this approach. There are other ways to address the incentive issue and maintaining support for the full continuum of child welfare services is critical. Every child that comes to the attention of the child welfare system has unique circumstances and needs. Whether they will best be served by remaining at home or being placed with relatives, a foster family, or in a residential facility is a determination that should be made by a professional caseworker in consultation with the family. The full range of these options should be available to children and should not be influenced by levels of reimbursement or other financial incentives.

Why Income Restrictions Should be Removed

Income restrictions on IV-E eligibility are also a bureaucratic challenge and time sink for an already overburdened workforce, as we learned from our survey respondents. This revealed itself to be especially true for public sector child welfare agencies. Every hour that a frontline worker has to spend researching income data and filling out corresponding paperwork is an hour that they are not able to spend working with the families within their caseloads. If the Aid to Families with Dependent Children (AFDC) link is removed and all children in out-of-home care are automatically eligible for federal support, these caseworkers would no longer face this issue.

As previously mentioned, eligibility for IV-E reimbursements is tied to an outdated measurement of income. Specifically, in order to be eligible for IV-E a child's parents would have to have an income low enough to qualify for the defunct AFDC program, commonly known as welfare, back in 1996. The percentage of children eligible for IV-E is known as the penetration rate. These income standards have not been adjusted for inflation in 15 years, so fewer children in out-of-home care are eligible for IV-E than when the standard was locked in place in 1996. In numerical terms, as of September 31, 2010 there are 408,425[12] children in foster care. Yet because of these outdated income standards, only 44% are receiving federal support.[13]

CWLA believes the federal government has an interest in and responsibility for all children who have been removed from their homes. Recently a similar restriction for adoption assistance eligibility was phased out via federal legislation. IV-E eligibility should be de-linked from AFDC likewise.

Not only is the link to AFDC a moral shortcoming, but it is placing further financial pressures on states as they are increasingly becoming the sole

supporter of children in out-of-home care. States that are already not receiving adequate federal support for most child welfare services like prevention are finding it progressively more difficult to fund such services because they have to shoulder more and more of the cost of out-of-home care.

Reinforcing and Developing the Workforce

The workers that participated in this project, and their colleagues across the country that they are representing, are the linchpin of an effective child welfare system that is responsive to the needs of children and families. Unfortunately, the child welfare workforce is hampered by turnover while individual employees face unacceptably high levels of stress, discouragement, and burnout. They feel frequently unrecognized and unappreciated and sometimes vilified. They worry that they are overburdened with bureaucratic requirements like paperwork that keep them from serving their families. Many workers do not believe they are properly trained or supported. We must find ways to simplify the process. Paperwork and procedural requirements must be eased so workers can focus more on providing services.

With respect to training, finance reform should provide more opportunities for the workforce to be trained not just initially but through continual professional development. Training funds should be flexible and training should be made available in a number of forms so that workers can find the types of training opportunities that best suit them. The separate, dedicated funding stream for training and administration under IV-E should be preserved if and when IV-E is reformed to include other services besides out-of-home care. While it is important that prevention and other services be sufficiently funded, this should not come at the expense of training funding which ensures that all of the other programs and services can be carried out effectively.

> "It seems that no one asks frontline workers for our opinions and/or concerns about the child welfare system. We are working with children and families in an effort to improve situations. We do positive work, trying to make sure the children and families receive the services needed. It's extremely difficult without needed resources."
> – Focus Group Participant

While acknowledging the challenges inherent in their jobs, survey respondents resoundingly showed their passion for their jobs and the people they work with. They want to make a difference and they want the federal government to join them in the cause by providing them with the resources they need to improve the lives of children and families in the child welfare system. One respondent may have summed it up best, "To Congress- assisting families to be the strongest building block is the most important thing that they can spend money on for our country's success."

In order to achieve the best outcomes for the children and families served by the system, its workers need to be better engaged, trained, supported, and compensated. Their voices as reflected in this survey should be heard, acknowledged, and welcomed into the finance reform debate.

Appendix I

Survey terms & definitions

Community-Based Residential – Community Based Residential programs represent community based group homes, therapeutic group homes, and Small Group Homes or Alternative Living Units (ALU's). The facilities covered under the Community Based Residential umbrella are psychiatric treatment & residential treatment facilities; therapeutic, campus-based, and community-based group homes; small group homes and ALU's, and Shelters.14

Differential response – An approach that allows agencies and practitioners to differentiate their responses to reports of abuse or neglect. It allows practitioners to utilize multiple pathways when responding to such reports. The type, severity, as well as the parent's cooperation in addressing safety concerns are all factors which can influence differential response.[15]

Family-Finding – Family-Finding is a form of search technology used to identify biological

relatives or other important adult connections for children in the child welfare system. When relatives are identified the goal is to establish relationships, build upon those relationships, and strive to reach permanent family connections for children.[16]

An effective family-finding program should include: Information Gathering, Documentation, Search, Identification, Contact, Assessment, Engagement, and Permanent Family Placements and/or Relationships.[17]

Family-Focused – The *Family-Focused* principle implies working with the family unit to strengthen its capacity and ensure the best possible outcomes for children. It focuses on family empowerment, family strengths, and community strengths to prevent abuse and neglect while providing children and families with a safe and stable environment.[18]

Family Group Decision Making - Family Group Decision Making (FGDM) recognizes the importance of involving family groups in decision making about children who need protection or care. It can be initiated by child welfare agencies whenever a critical decision about a child is required. FGDM brings together a child's wider family group, who in partnership with child welfare professionals, lead decision-making about how to best care for and protect the children involved.[19]

Family Resource Centers – Family resource centers provide family support services by creating a central location for health, mental health, educational, and recreational services. Designed to control service duplication, Family Resource Centers promote community connections that empower families and enhance the lives of young children. These centers provide core services such as medical care, counseling, parenting classes, literacy classes, referrals for childcare & specialty medical services, and direct contact with early childhood and child development programs.20

Family Strengthening – The family strengthening approach is a framework for serving children and families. Family Strengthening recognizes that the family is the most fundamental factor influencing the lives and outcomes of children; and families are strongest when they are supported by safe and thriving environments.21

Home Visiting – Home visitation programs refer to a number of different model programs that provide in-home visits to targeted, vulnerable, or new families. The programs can be either stand-alone or be part of a center based program.[22]

Kinship Navigator – Kinship Navigator programs assist caregivers with navigating child-family programs and services. The purpose of Kinship Navigator programs is to help the diverse families learn about and obtain assistance to meet the needs of the children they are raising, and themselves.[23]

Parent Education and Training – Parent education programs focus on decreasing parenting practices and behaviors associated with child abuse and neglect. It provides comprehensive information for the expansion of knowledge, understanding, and encouragement of positive attitudes relevant to children, parents, and communities.[24]

Post Adoption Support Services – Post adoption services provide support to families and children who have recently completed the adoption process. The services may include counseling, respite care, emergency assistance, crisis intervention, family therapy, social skills training, child and family advocacy, and more.[25]

Strength-Based –The Strengths Based Approach refers to policies, practice methods, and strategies that identify and draw upon the strengths of children, families, and communities. This approach acknowledges each child and family's unique set of strengths and challenges. It engages the family as a partner unit in developing and implementing the service plan.[26]

Appendix II[27]

United States

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	559,000	305,194	55%	192,251
1999	562,712	302,499	54%	260,213
2000	547,415	287,847	55%	260,168
2001	540,305	264,676	49%	275,629
2002	514,400	256,566	50%	257,834
2003	503,006	243,391	48%	259,615
2004	499,790	238,359	48%	261,431
2005	504,109	236,597	47%	267,512
2006	501,785	211,483	42%	273,671
2007	488,246	211,216	43%	277,030
2008	456,606	197,214	43%	259,392
2009	421,490	186,306	44%	235,184
2010	408,425	181,078	44%	227,347

Alabama

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	5,198	1,230	24%	3,968
1999	5,511	1,305	24%	4,206
2000	5,621	1,441	26%	4,180
2001	5,859	1,647	29%	4,212
2002	5,883	1,777	31%	4,106
2003	6,079	1,932	32%	4,147
2004	5,934	1,574	27%	4,360
2005	6,913	1,726	25%	5,187
2006	7,157	1,891	26%	5,266
2007	7,262	2,043	28%	5,219
2008	6941	2,254	32%	4,687
2009	6,894	1,891	27%	5,003
2010	5,350	2,097	39%	3,253

Alaska

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	405	N/A	N/A
1999	2,248	487	22%	1,761
2000	2,193	409	19%	1,784
2001	1,993	392	20%	1,601
2002	2,072	288	14%	1,784
2003	2,040	190	10%	1,850
2004	1,825	364	20%	1,461
2005	1,789	644	36%	1,145
2006	1,993	759	38%	1,234
2007	2,107	659	30%	1,448
2008	2,168	641	30%	1,527
2009	2,166	627	29%	1,539
2010	1,801	665	37%	1,136

Arizona

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	5,608	3,078	54%	2,530
1999	7,034	3,634	51%	3,400
2000	6,475	3,098	47%	2,477
2001	6,050	3,090	51%	2,960
2002	6,173	3,133	51%	3,040
2003	7,469	3,069	41%	4,400
2004	9,194	4,554	50%	4,629
2005	9,685	3,736	39%	5,949
2006	9,731	3,851	40%	5,880
2007	9,099	3,842	40%	5,257
2008	9,590	4,143	43%	5,447
2009	10,175	4,378	43%	5,797
2010	9,930	4,403	44%	5,527

Arkansas

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	3,138	1,600	51%	1,538
1999	2,919	1,624	56%	1,295
2000	3,045	2,705	89%	340
2001	2,959	2,739	93%	220
2002	2,971	3,021	101%	-50
2003	3,014	1,882	62%	1,132
2004	3,124	1,873	60%	1,251
2005	3,238	2,309	71%	921
2006	3,434	2,311	67%	1,123
2007	3,616	1,982	54%	1,634
2008	3,522	1,899	54%	1,623
2009	3,657	1,749	48%	1,908
2010	3,770	1,789	47%	1,981

California

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	112,767	79,982	71%	32,785
1999	117,937	78,222	66%	39,715
2000	112,807	74,469	66%	38,338
2001	107,168	65,960	62%	41,208
2002	90,692	58,747	65%	31,945
2003	87,278	56,266	65%	31,012
2004	82,641	52,738	64%	29,903
2005	80,247	49,803	62%	30,444
2006	78,373	47,486	61%	30,887
2007	73,998	43,930	57%	30,068
2008	67703	40,981	61%	26,722
2009	60,198	36,993	61%	23,205
2010	57,708	33,188	58%	24,520

Colorado

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	7,951	3,004	38%	4,947
1999	7,639	2,653	35%	4,986
2000	7,533	2,552	34%	4,981
2001	7,138	2,673	37%	4,465
2002	9,209	2,345	25%	6,864
2003	8,754	2,645	30%	6,109
2004	8,196	2,538	31%	5,658
2005	8,213	2,624	32%	5,589
2006	8,139	2,554	31%	5,585
2007	7,777	2,325	29%	5,452
2008	7,964	2,170	27%	5,794
2009	7,927	2,104	27%	5,823
2010	6,980	2,041	29%	4,939

Connecticut

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	6,683	4,315	65%	2,368
1999	7,487	4,528	60%	2,959
2000	6,996	3,292	47%	3,704
2001	7,440	2,788	37%	4,652
2002	6,007	1,996	33%	4,011
2003	6,742	1,777	26%	4,956
2004	6,803	2,714	40%	4,089
2005	6,249	2,530	40%	3,719
2006	6,365	2,358	37%	4,007
2007	5,764	2,453	42%	3,311
2008	5,373	2,273	42%	3,100
2009	4,761	1,951	41%	2,810
2010	4,462	1,670	37%	27,920

Delaware

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	1,480	386	26%	1,094
1999	1,193	378	32%	815
2000	1,098	410	37%	688
2001	1,023	405	40%	618
2002	886	403	45%	485
2003	814	290	36%	524
2004	849	279	33%	570
2005	962	225	23%	737
2006	1,074	195	18%	879
2007	1,157	193	16%	964
2008	938	213	22%	725
2009	814	188	23%	626
2010	739	201	27%	538

District of Columbia

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	3,188	1,241	40%	1,897
1999	3,466	1,297	37%	2,169
2000	3,054	1,960	64%	1,094
2001	3,339	1,619	48%	1,720
2002	3,321	1,435	43%	1,886
2003	3,092	1,500	49%	1,592
2004	2,641	1,263	48%	1,378
2005	2,519	1,218	48%	1,301
2006	2,378	961	40%	1,417
2007	2,197	887	40%	1,310
2008	2,217	877	40%	1,340
2009	2,111	919	44%	1,192
2010	2,066	902	44%	1,164

Florida

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	26,320	8,374	32%	17,946
1999	34,292	8,842	26%	25,450
2000	36,608	9,395	26%	27,213
2001	32,477	6,852	21%	25,625
2002	31,963	8,345	26%	23,618
2003	30,677	7,863	26%	22,814
2004	28,864	9,069	31%	19,795
2005	29,312	7,903	27%	21,409
2006	29,229	7,540	26%	21,689
2007	26,788	7,308	27%	19,480
2008	22,187	6,266	28%	15921
2009	19,156	5,261	27%	13,895
2010	18,753	6,127	33%	12,626

Georgia

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	9,937	4,291	43%	5,646
1999	11,991	4,209	35%	7,782
2000	11,204	4,191	37%	7,013
2001	13,175	4,658	35%	8,517
2002	13,149	5,268	40%	7,881
2003	13,578	3,367	25%	10,211
2004	14,216	4,321	30%	9,895
2005	13,965	5,135	37%	8,830
2006	13,175	4,670	35%	8,505
2007	12,197	3,801	31%	8,396
2008	9,984	3,613	36%	6,371
2009	8,020	3,384	42%	4,636
2010	6,895	2,755	40%	4,140

Hawaii

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	2,441	1,186	49%	1,255
1999	2,205	1,101	50%	1,104
2000	2,401	1,126	47%	1,275
2001	2,854	1,195	42%	1,659
2002	2,655	1,182	44%	1,473
2003	2,919	996	34%	1,923
2004	2,942	1,103	37%	1,839
2005	2,745	1,271	46%	1,474
2006	2,355	1,271	54%	1,084
2007	1,940	977	50%	963
2008	1,622	628	39%	994
2009	1,455	471	32%	984
2010	1,215	473	39%	742

Idaho

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	963	441	46%	522
1999	959	510	53%	449
2000	1,015	568	56%	447
2001	1,114	491	44%	623
2002	1,246	542	43%	704
2003	1,401	692	49%	709
2004	1,565	819	52%	746
2005	1,818	896	49%	922
2006	1,850	1,001	54%	849
2007	1,870	1,035	55%	835
2008	1,723	1,000	58%	723
2009	1,446	1,005	70%	441
2010	1,462	963	66%	499

Illinois

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	48,737	32,646	67%	16,091
1999	34,327	28,592	83%	5,735
2000	29,565	23,289	79%	6,276
2001	28,202	20,210	72%	7,992
2002	24,344	19,628	81%	4,716
2003	21,608	20,486	95%	1,122
2004	19,931	20,080	100%	-149
2005	19,431	18,070	93%	1,361
2006	18,367	16,944	92%	1,423
2007	17,864	15,462	86%	2,402
2008	17,843	14,449	81%	3,394
2009	17,080	13,727	80%	3,353
2010	17,730	13,292	75%	4,438

Indiana

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	5,070	3,741	74%	1,329
1999	8,933	3,963	44%	4,970
2000	7,482	3,293	44%	4,189
2001	8,383	2,589	31%	5,794
2002	8,478	2,601	31%	5,877
2003	8,815	2,366	27%	6,449
2004	9,778	1,680	17%	8,098
2005	11,243	1,898	17%	9,345
2006	11,401	2,109	18%	9,292
2007	11,295	2,693	23%	8,602
2008	11,903	2,394	20%	9,509
2009	12,437	2,811	23%	9,626
2010	12,276	3,087	25%	9,189

Iowa

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	2,107	N/A	N/A
1999	4,854	2,810	58%	2,044
2000	5,068	2,796	55%	2,272
2001	5,202	2,281	44%	2,921
2002	5,238	1,560	30%	3,678
2003	5,011	1,502	30%	3,509
2004	5,384	1,972	37%	3,412
2005	6,794	2,060	30%	4,734
2006	9,040	2,188	24%	6,852
2007	8,005	1,926	23%	6,079
2008	6,743	1,659	25%	5,084
2009	6,564	1,514	23%	5,050
2010	6,533	1,471	23%	5,062

Kansas

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	8,488	775	9%	7,713
1999	6,774	2,356	35%	4,418
2000	6,569	2,252	34%	4,317
2001	6,409	2,270	35%	4,139
2002	6,190	1,777	29%	4,413
2003	5,781	1,535	27%	4,246
2004	6,060	2,282	38%	3,778
2005	5,833	2,327	40%	3,506
2006	6,237	2,578	41%	3,659
2007	6,631	1,813	27%	4,818
2008	6,306	1,201	19%	5,105
2009	5,691	1,281	23%	4,410
2010	5,979	1,245	21%	4,734

Kentucky

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	2,936	N/A	N/A
1999	5,942	3,019	51%	2,923
2000	6,017	3,161	53%	2,856
2001	6,165	3,248	10%	2,917
2002	6,814	3,227	47%	3,587
2003	6,888	3,432	50%	3,456
2004	6,998	3,417	49%	3,581
2005	7,220	3,462	48%	3,758
2006	7,606	3,589	47%	4,017
2007	7,207	3,562	47%	3,645
2008	7,182	3,387	47%	3,795
2009	6,872	3,279	48%	3,593
2010	6,983	2,921	42%	4,062

Louisiana

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	6,301	3,138	50%	3,163
1999	5,581	2,908	52%	2,673
2000	5,406	2,555	47%	2,851
2001	5,024	2,547	51%	2,477
2002	4,829	3,060	42%	1,769
2003	4,541	3,043	67%	1,498
2004	4,397	2,995	68%	1,402
2005	4,833	3,024	63%	1,809
2006	5,213	3,074	59%	2,139
2007	5,333	2,820	52%	2,513
2008	5,065	2,857	56%	2,208
2009	4,786	2,688	56%	2,098
2010	4,453	2,562	58%	1,891

Maine

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	3,595	1,659	46%	1,936
1999	3,154	2,013	64%	1,141
2000	3,191	2,453	77%	738
2001	3,226	2,484	77%	742
2002	3,084	2,028	66%	1,056
2003	2,760	1,380	50%	1,380
2004	2,584	1,319	51%	1,265
2005	2,309	1,472	64%	837
2006	2,076	1,405	68%	671
2007	1,971	1,035	52%	936
2008	1,864	988	53%	876
2009	1,646	931	57%	715
2010	1,543	957	62%	586

Maryland

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	12,890	4,785	37%	8,105
1999	13,455	5,091	38%	8,364
2000	13,113	5,764	44%	7,349
2001	12,564	5,612	45%	6,952
2002	12,026	5,055	42%	6,971
2003	11,521	4,547	40%	6,974
2004	11,111	4,051	36%	7,060
2005	10,867	3,613	33%	7,254
2006	10,681	3,391	32%	7,290
2007	8,415	3,346	33%	5,069
2008	7,613	3,250	43%	4,363
2009	7,052	2,697	38%	4,355
2010	6,098	2,145	35%	3,953

Massachusetts

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	7,464	N/A	N/A
1999	11,169	7,340	66%	3,829
2000	11,619	3,935	34%	7,684
2001	11,568	4,399	38%	7,169
2002	12,510	4,212	34%	8,298
2003	12,608	4,349	34%	8,259
2004	12,562	4,974	40%	7,588
2005	12,197	4,678	38%	7,519
2006	11,499	3,619	31%	7,880
2007	10,497	2,856	27%	7,641
2008	10,427	2,648	25%	7,779
2009	9,650	2,285	24%	7,365
2010	8,958	2,191	24%	6,767

Michigan

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	8,826	N/A	N/A
1999	20,300	9,338	46%	10,962
2000	20,034	9,923	50%	10,111
2001	20,896	9,313	45%	11,583
2002	21,251	8,258	39%	12,993
2003	21,376	7,458	35%	13,918
2004	21,173	6,742	32%	14,431
2005	20,498	6,044	29%	14,454
2006	20,142	4,841	24%	15,301
2007	20,830	4,385	21%	16,445
2008	20,171	4,144	21%	16,027
2009	17,723	4,047	23%	13,676
2010	16,412	4,165	25%	12,247

Minnesota

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	8,618	3,805	44%	4,813
1999	8,996	4,115	46%	4,881
2000	8,530	4,069	48%	4,461
2001	8,167	3,873	47%	4,294
2002	8,052	3,566	44%	4,486
2003	6,770	3,205	47%	3,565
2004	6,540	2,809	43%	3,731
2005	6,978	2,969	43%	4,009
2006	7,156	2,733	38%	4,423
2007	6,711	2,661	39%	4,050
2008	6,028	2,503	42%	3,525
2009	5,410	2,110	39%	3,300
2010	5,050	1,800	36%	3,250

Mississippi

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	3,359	1,016	30%	2,343
1999	3,196	1,000	31%	2,196
2000	3,292	1,034	31%	2,258
2001	3,443	839	34%	2,604
2002	2,686	500	19%	2,186
2003	2,712	652	23%	2,060
2004	2,989	640	21%	2,349
2005	3,269	688	21%	2,581
2006	3,126	882	28%	2,244
2007	3,328	888	26%	2,440
2008	3,292	921	28%	2,371
2009	3,320	1,005	30%	2,315
2010	3,582	999	28%	2,583

Missouri

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	12,495	5,748	46%	6,747
1999	12,577	5,621	45%	6,956
2000	13,181	5,695	43%	7,486
2001	13,349	5,770	43%	7,579
2002	13,029	5,766	44%	7,263
2003	11,900	5,806	49%	6,094
2004	11,778	5,401	46%	6,377
2005	11,433	4,978	44%	6,455
2006	10,181	4,999	49%	5,182
2007	10,282	4,024	40%	6,258
2008	7,607	3,298	43%	4,309
2009	9,912	3,091	31%	6,821
2010	9,880	3,166	32%	6,714

Montana

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	1,991	857	43%	1,134
1999	2,156	950	44%	1,206
2000	2,180	940	43%	1,240
2001	2,008	737	37%	1,271
2002	1,912	767	40%	1,145
2003	1,866	1,734	93%	132
2004	2,030	932	46%	1,098
2005	2,222	967	44%	1,255
2006	1,909	1,110	58%	799
2007	1,737	944	54%	793
2008	1,600	808	51%	792
2009	1,639	588	36%	1,051
2010	1,723	627	36%	1,096

Nebraska

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	1,569	N/A	N/A
1999	5,146	1,477	29%	3,669
2000	5,674	1,643	29%	4,034
2001	6,254	1,211	20%	5,043
2002	5,724	1,047	18%	4,677
2003	5,148	1,043	20%	4,105
2004	6,292	1,493	24%	4,799
2005	6,231	2,032	33%	4,199
2006	6,187	1,244	20%	4,943
2007	5,875	1,403	23%	4,472
2008	5,591	1,493	27%	4,098
2009	5,343	1,310	25%	4,033
2010	5,358	1,369	26%	3,989

Nevada

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	1,119	N/A	N/A
1999	N/A	1,345	N/A	N/A
2000	1,615	1,335	83%	280
2001	2,959	983	33%	1,976
2002	3,027	769	25%	2,258
2003	3,605	1,442	40%	2,163
2004	4,037	1,275	32%	2,762
2005	4,654	1,348	29%	3,306
2006	5,069	1,451	29%	3,618
2007	5,070	1,454	28%	3,616
2008	5,023	1,910	38%	3,113
2009	4,779	2,190	46%	2,589
2010	4,806	2,083	43%	2,723

New Hampshire

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	714	N/A	N/A
1999	1,385	625	45%	760
2000	1,311	791	60%	520
2001	1,288	563	44%	725
2002	1,291	560	43%	731
2003	1,217	664	55%	553
2004	1,236	648	52%	588
2005	1,178	695	59%	483
2006	1,146	612	53%	534
2007	1,102	554	51%	548
2008	1,029	556	54%	473
2009	930	471	51%	459
2010	839	436	52%	403

New Jersey

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	9,191	5,593	61%	3,598
1999	9,494	6,124	64%	3,371
2000	9,794	6,238	64%	3,556
2001	10,666	6,366	60%	4,300
2002	11,442	6,388	56%	5,054
2003	12,816	5,800	45%	7,016
2004	12,289	4,971	40%	7,318
2005	11,211	3,456	31%	7,755
2006	10,623	2,865	27%	7,758
2007	9,056	3,325	36%	5,731
2008	8,510	2,911	34%	5,599
2009	7,809	3,461	44%	4,348
2010	7,172	4,226	59%	2,946

New Mexico

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	821	782	95%	39
1999	1,941	1,183	61%	758
2000	1,912	1,505	79%	407
2001	1,757	1,289	73%	468
2002	1,885	1,340	71%	545
2003	2,122	1,399	66%	723
2004	2,157	1,649	76%	508
2005	2,316	1,696	73%	620
2006	2,357	1,692	72%	665
2007	2,423	1,531	63%	892
2008	2,221	1,447	65%	774
2009	2,009	1,258	63%	751
2010	1,869	1,092	58%	777

New York

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	53,555	40,762	76%	12,793
1999	51,159	38,049	74%	13,110
2000	47,118	33,529	71%	13,589
2001	43,365	28,916	67%	14,449
2002	40,753	25,173	62%	15,580
2003	37,067	21,735	59%	15,332
2004	33,445	18,923	57%	14,522
2005	30,458	16,426	54%	14,032
2006	29,973	12,313	41%	17,660
2007	30,072	12,837	42%	17,235
2008	29,493	13,206	45%	16,287
2009	27,992	12,769	46%	15,223
2010	26,783	12,724	48%	14,059

North Carolina

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	11,314	4,662	41%	6,652
1999	11,339	4,854	43%	6,485
2000	10,847	4,118	38%	6,729
2001	10,130	3,864	38%	6,266
2002	9,527	2,438	26%	7,089
2003	9,534	3,024	32%	6,510
2004	10,077	4,021	40%	6,056
2005	10,698	4,189	39%	6,509
2006	11,115	4,434	40%	6,681
2007	10,827	4,791	44%	6,036
2008	9,841	4,480	46%	5,361
2009	9,547	3,597	38%	5,950
2010	8,828	3,197	36%	5,631

North Dakota

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	1,125	493	44%	632
1999	1,131	486	43%	645
2000	1,129	492	44%	637
2001	1,167	454	38%	713
2002	1,197	512	43%	685
2003	1,238	526	42%	712
2004	1,314	495	38%	819
2005	1,370	483	35%	887
2006	1,331	449	34%	882
2007	1,263	423	33%	840
2008	1,223	363	30%	860
2009	1,224	376	31%	848
2010	1,077	375	35%	702

Ohio

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	19,007	15,289	80%	3,718
1999	19,249	15,183	78%	4,066
2000	19,364	15,472	78%	3,892
2001	20,696	16,448	79%	4,248
2002	21,038	14,783	70%	6,255
2003	19,323	13,888	72%	5,435
2004	18,004	12,821	71%	5,183
2005	17,446	12,100	69%	5,346
2006	16,631	**	**	**
2007	14,532	7,799	45%	6,733
2008	13,703	6,599	48%	7,104
2009	12,197	8,027	66%	4,170
2010	11,949	7,446	62%	4,503

Oklahoma

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	7,233	3,413	47%	3,820
1999	8,173	4,039	49%	4,134
2000	8,406	5,111	61%	3,295
2001	8,674	5,201	60%	3,473
2002	8,812	4,402	50%	4,410
2003	9,252	4,025	43%	5,227
2004	11,325	3,808	34%	7,517
2005	11,393	4,563	40%	6,830
2006	11,816	5,186	44%	6,630
2007	11,785	5,296	44%	6,489
2008	10,595	4,929	47%	5,666
2009	8,712	3,895	45%	4,817
2010	7,857	3,308	42%	4,549

Oregon

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	7,266	3,325	46%	3,941
1999	9,278	3,193	34%	6,085
2000	9,193	3,715	40%	5,478
2001	8,966	3,490	39%	5,476
2002	9,101	3,520	39%	5,581
2003	9,117	3,787	41%	5,330
2004	10,048	4,241	42%	5,807
2005	11,020	4,554	41%	6,466
2006	10,661	4,848	45%	5,813
2007	9,562	4,515	45%	5,047
2008	8,988	3,418	38%	5,570
2009	8,650	3,045	35%	5,605
2010	9,001	3,190	35%	5,811

Pennsylvania

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	23,070	18,586	81%	4,484
1999	22,690	15,054	66%	7,636
2000	21,631	12,548	58%	9,083
2001	21,237	11,334	53%	9,903
2002	21,410	13,485	63%	7,925
2003	21,845	10,952	50%	10,893
2004	21,944	10,076	46%	11,868
2005	21,691	14,381	66%	7,310
2006	21,135	13,410	63%	7,725
2007	20,999	14,868	71%	6,131
2008	19,218	14,564	76%	4,654
2009	16,878	14,690	87%	2,188
2010	15,346	14,690	96%	656

Rhode Island

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	2,844	755	27%	2,089
1999	2,621	629	24%	1,992
2000	2,302	743	32%	1,559
2001	2,414	751	31%	1,663
2002	2,383	702	30%	1,681
2003	2,357	669	28%	1,688
2004	2,414	601	25%	1,813
2005	2,509	692	28%	1,817
2006	2,842	804	28%	2,038
2007	2,768	751	27%	2,017
2008	2,407	703	29%	1,704
2009	2,112	683	32%	1,429
2010	2,086	592	28%	1,494

South Carolina

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	4,644	1,350	29%	3,294
1999	4,545	1,146	26%	3,349
2000	4,525	1,339	30%	3,186
2001	4,774	1,587	33%	3,187
2002	4,818	1,914	40%	2,904
2003	4,801	1,594	33%	3,207
2004	4,635	1,169	25%	3,466
2005	4,757	1,039	22%	3,718
2006	4,920	676	14%	4,244
2007	5,147	1,017	19%	4,130
2008	4,999	1,141	23%	3,858
2009	4,938	1,153	23%	3,785
2010	4,485	1,174	26%	3,311

South Dakota

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	253	N/A	N/A
1999	1,101	340	31%	761
2000	1,215	413	34%	802
2001	1,367	463	36%	904
2002	1,396	500	36%	896
2003	1,537	470	31%	1,067
2004	1,582	446	28%	1,136
2005	1,704	378	22%	1,326
2006	1,648	428	26%	1,220
2007	1,566	376	24%	1,190
2008	1,482	323	22%	1,159
2009	1,484	431	29%	1,053
2010	1,485	590	40%	895

Tennessee

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	N/A	6,405	N/A	N/A
1999	10,796	6,327	59%	4,469
2000	10,144	6,290	62%	3,854
2001	9,679	6,078	63%	3,601
2002	9,359	5,647	60%	3,712
2003	9,487	5,479	58%	4,008
2004	9,590	5,375	56%	4,215
2005	9,017	5,980	66%	3,037
2006	8,618	3,264	38%	5,354
2007	7,751	2,831	36%	4,920
2008	7,219	2,507	35%	4,712
2009	6,723	2,408	36%	4,315
2010	6,786	2,981	44%	3,805

Texas

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	17,103	6,405	37%	10,698
1999	16,326	6,757	41%	9,569
2000	18,190	7,123	39%	11,067
2001	19,739	7,609	39%	12,130
2002	21,353	8,431	39%	12,922
2003	21,880	9,429	43%	12,451
2004	24,529	10,951	45%	13,578
2005	28,883	13,239	46%	15,644
2006	30,848	14,266	46%	16,582
2007	30,137	14,362	47%	15,775
2008	28154	12,764	45%	15,390
2009	26,686	11,810	44%	14,876
2010	28,954	11,971	41%	16,983

Utah

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	2,468	1,122	45%	1,346
1999	2,273	730	38%	1,543
2000	1,805	763	42%	1,042
2001	1,957	797	41%	1,160
2002	2,025	707	35%	1,318
2003	2,033	710	35%	1,323
2004	2,108	836	40%	1,272
2005	2,285	820	36%	1,465
2006	2,427	872	36%	1,555
2007	2,765	938	34%	1,827
2008	2,714	867	32%	1,847
2009	2,759	867	31%	1,892
2010	2,886	902	31%	1,984

Vermont

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	1,316	1,091	83%	225
1999	1,445	1,151	80%	294
2000	1,389	1,159	83%	230
2001	1,382	997	72%	385
2002	1,526	986	65%	540
2003	1,409	931	66%	478
2004	1,432	816	57%	616
2005	1,436	816	57%	620
2006	1,379	785	57%	594
2007	1,309	750	57%	559
2008	1,200	664	55%	536
2009	1,062	664	63%	398
2010	933	528	57%	405

Virginia

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	6,838	3,297	55%	3,086
1999	6,778	3,260	48%	3,518
2000	6,789	3,327	49%	3,462
2001	6,866	3,251	47%	3,615
2002	7,109	4,137	58%	2,972
2003	7,046	4,200	60%	2,846
2004	6,869	4,232	62%	2,637
2005	7,022	4,115	59%	2,907
2006	7,843	3,680	47%	4,163
2007	7,718	3,549	47%	4,169
2008	7,099	3,694	52%	3,405
2009	5,927	3,369	57%	2,558
2010	5,326	2,870	54%	2,456

Washington

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	8,980	2,259	25%	6,721
1999	8,688	2,603	30%	6,085
2000	8,945	2,694	30%	6,251
2001	9,101	3,127	34%	5,974
2002	9,669	3,576	37%	6,093
2003	9,213	3,473	38%	5,740
2004	9,368	3,592	38%	5,776
2005	10,068	3,728	37%	6,340
2006	10,457	4,019	38%	6,438
2007	11,107	4,024	36%	7,083
2008	11,167	4,175	37%	6,992
2009	9,922	4,175	42%	5,747
2010	10,136	4,159	41%	5,977

West Virginia

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	3,082	792	26%	2,290
1999	3,169	823	26%	2,346
2000	3,388	855	25%	2,533
2001	3,298	881	27%	2,417
2002	3,220	956	30%	2,264
2003	4,069	864	21%	3,205
2004	3,990	813	20%	3,177
2005	4,627	524	11%	4,103
2006	4,012	892	22%	3,120
2007	4,432	1,245	28%	3,187
2008	4,412	980	22%	3,432
2009	4,237	980	23%	3,257
2010	4,097	1,012	25%	3,085

Wisconsin

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	10,076	5,365	12%	4,711
1999	10,868	4,037	37%	6,831
2000	10,504	4,329	41%	6,175
2001	9,497	4,311	45%	5,186
2002	8,744	3,796	43%	4,948
2003	7,824	3,025	39%	4,799
2004	7,812	2,390	31%	5,422
2005	8,109	2,920	36%	5,189
2006	7,556	2,822	37%	4,734
2007	7,541	2,789	37%	4,752
2008	7,403	2,217	30%	5,186
2009	6,785	2,217	33%	4,568
2010	6,575	2,151	33%	4,424

Wyoming

	Total Caseload	IV-E Caseload	% of IV-E	Non-IV-E Caseload
1998	883	324	37%	559
1999	774	242	31%	532
2000	815	311	38%	504
2001	965	309	32%	656
2002	921	312	34%	609
2003	1,052	289	27%	763
2004	1,184	203	17%	981
2005	1,244	145	12%	1,099
2006	1,304	161	12%	1,143
2007	1,231	138	11%	1,093
2008	1,154	130	11%	1,024
2009	1,155	130	11%	1,025
2010	981	120	12%	861

[1] Quantitative statistical reporting summarizes and analyses only the responses of the 67 who answered every question and participated at every stage. Qualitative reporting and quotes may include perspectives from the larger group of participants.

[2] McGowan, B., Auerbach, C., & Strolin-Goltzman, J. (2009) Turnover in the child welfare workforce: A different perspective. Journal of Social Service Research, 35 (3), 228-235; Thoma, R. (2003). A critical look at the child welfare system caseworker turnover. Washington, DC: CWLA

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[5] CWLA Standards of Excellence for services for abused and neglected children and their families (1999)

[6] CWLA Standards of Excellence for Services to Strengthen and Preserve Families with Children 2003

[7] CWLA Standards of Excellence for Adoption Services 2000

[8] CWLA Standards of Excellence for Family Foster Care Services 1995

[9] "Trends in Foster Care 2002-2010" http://www.acf.hhs.gov/programs/cb/stats_research/afcars/trends_june2011.pdf

[10] This polling question read, "In reference to the capacity of the child welfare services available in your community, how much emphasis is placed on foster care as a service for children and families?" The responses included, (1) "Appropriate emphasis, I feel that foster care is used when determined appropriate," (2) "Overemphasis, I feel that foster care is the main resource available or used," and (3) Underutilized emphasis, I feel that foster care is either underutilized or not available at the level it is needed."

[11] See appendix for definitions of the services mentioned.

[12] AFCARS

[13] See appendix for penetration rates over time.

[14] J. McComb, CWLA Senior State Leadership Liason, e-mail, September 1, 2011.

[15] National study on differential response in child welfare. (2006). Available online at http://www.americanhumane.org/assets/pdfs/children/pc-2006-national-study-differential-response.pdf . Washington, DC. American Humane Association.

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Note: The penetration rate is a CWLA calculation of special Children's Bureau data on state IV-E Foster Care expenditures.