Placement Decisions for Children in Long-Term Foster Care:

Innovative Practices and Literature Review

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Washington State Institute for Public Policy

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EXECUTIVE SUMMARY

The 2000 Legislature directed the Washington State Institute for Public Policy to examine the best practices in other states regarding placement decisions for children in long-term foster care (EHB 2487 §607(c)). The term foster care generally refers both to family and institutional settings for children whose parents are unable to provide adequate care; placement decisions occur after a child is in state care.

The following topics are covered in this report:

- Placement decision-making;
- Research findings of children in foster care; and
- Innovative practices in other states.

A separate report describes the characteristics of Washington's children in long-term foster care and their placement history (Berliner and Fine 2001).

Findings

The research findings on foster care children and placement reveals, first and foremost, the connections between events and outcomes. In simple terms, these connections can be expressed as follows:

- Children in foster care longer than three months often enter this system with psychological injuries and vulnerabilities, as well as behavioral problems.
- Behavior problems can create difficulties in a child's placement and ultimately lead to multiple placements. Multiple placements are associated with worse outcomes for children.
- Even for children with few impairments, being moved from setting to setting often increases their problems.

Given the harm associated with multiple placements, the clear ideal is connecting children with the most appropriate setting at the onset of their foster care experience, taking into account their psychological and physical needs. To help standardize such decisions, a measurement instrument can be of great value to a state.

As is the case with many standardized instruments, however, the task has proven to be more complex than it originally appeared. Research findings have revealed the following:

- Instruments vary in their ability to accurately distinguish children's problems and needs.

- Caseworkers and clinicians often resist using such an instrument, viewing it either as unhelpful or not being sure how to apply it to individual decisions.

- Placement settings with the same label (treatment foster care, therapeutic residential services) may in fact offer very different levels of services and structure, thus mitigating the connection between assessment decisions and placement services.

In reviewing states, Georgia's system of decision-making and review emerged as the most comprehensive. All children entering foster care in Georgia are assessed with a standardized instrument. A multi-disciplinary team reviews this assessment and determines the best possible placement given available resources. This approach combines the benefits of a standardized instrument with a decision-making apparatus that is multi-disciplinary and has authority for placement.

OVERVIEW

Foster Care Basics

The category of foster care refers both to family and institutional settings for children whose parents are unable to provide adequate care. Several terms further differentiate the setting and services: family care (child resides with unrelated family), kinship care (child resides with relatives), residential or group care (child resides in some type of institution), and therapeutic or treatment foster care (child resides in family setting and receives extra services).

By law, foster care is a temporary service to be used only when support services cannot maintain children in their own home and until permanent arrangements can be made for children unable to return home. It is a basic tenet of child welfare practice, and a legal mandate, that children should be placed in the least restrictive (most family-like) setting possible. Foster families, particularly relatives, are generally considered the placement of choice. Group or residential care is usually selected only when children cannot tolerate the intimacy of a family setting, when they require specialized treatment that cannot be provided in a family home, or if they cannot be controlled or kept safe in a community setting.

While the majority of children in out-of-home placement are in family foster homes, nationally about 15 percent of children are in more intensive settings. Historically, group care or residential facilities were the primary placement options when children required a treatment-oriented setting. However, over the last decade, the concept of *therapeutic foster care or treatment foster care* has developed. These programs are intended to allow children to remain in family settings by providing extra support to the foster parents. In many cases, the parents devote themselves full-time to the care of the children or hire staff for assistance. They are sometimes referred to as professional foster parents.

Report Topics

This report examines the research findings on children in foster care and reviews innovative practices that other states have adopted to connect individualized assessments of children with placement decisions.

CHILD WELFARE PLACEMENT DECISION-MAKING

Because most children in out-of-home care are placed by child welfare agencies, child welfare objectives take priority over the child's psychosocial functioning and need for treatment (Martin, Peters, and Glisson 1998). Therefore, many factors must be taken into consideration in placement decision-making beyond a child's specific needs related to emotional and behavioral problems. Although legal and administrative requirements must be met in placement decision-making, Washington State does not require that children have standardized assessments nor do caseworkers routinely rely on standardized assessments to make placement decisions.

Federal Law

The Adoption Assistance and Child Welfare Act of 1980 made placement prevention and permanency planning explicit objectives of federal child welfare policy and required states to establish standards and procedures consistent with the law. This legislation required that out-of-home placements be arranged in the *least restrictive, most family-like setting* available located in *close proximity* to the parents' home, consistent with the *best interests and needs of the child*, and that children be discharged to *permanent homes* in a timely manner.

Washington State Placement Decision-Making

The mandates of the federal Adoption Assistance and Child Welfare Act of 1980, with respect to the selection of child placements, are contained in RCW 74.13.065. This statute requires a social study for any out-of-home placement and an assessment of the following:

- Physical and emotional strengths and needs of the child;
- Proximity of placement to the child's family to aid reunification;
- Possibility of placement with relatives or extended family;
- Racial, ethnic, cultural, and religious background of the child;
- Least-restrictive, most family-like placement reasonably available and capable of meeting the child's needs; and
- Compliance with RCW 13.34.260 regarding parental preferences for placement of their children.

Consistent with federal policy and state law, the Department of Social and Health Services' Children's Administration ranks placement settings from least to most restrictive. It is expected that less restrictive placements are ruled out before progressing to more restrictive options (CA 2000a). The least to most restrictive placement settings are as follows:

- Child's own home.
- Relatives/Tribe, sometimes called *kinship care.*
- Out-of-home care in a family setting, sometimes called *family foster care.* This includes a family setting that provides the child with a primary parental attachment figure.
- Family foster care can be augmented with services to become *treatment or therapeutic foster care* with live-in house parents.
- Rehabilitative group placement, including non-institutional settings staffed 24 hours a day, often called *group care*.
- Short- and long-term psychiatric facilities (versions of group care), and other institutions accessed only through court commitment.

The Children's Administration requires social workers to work with biological families, and, when possible, follow their wishes in selecting a placement. Social workers must consider a child's special needs, the placement provider's ability to cooperate with the overall permanency plan, and the child's need for stability in relationships. The following considerations must also be taken into account: proximity to home, closeness to school, presence of other children in the home, ability of the caregiver or a substitute to transport the child to necessary appointments, experience and skill level of the foster parent, and capability of the foster parent to meet the behavioral or physical needs of the child (CA 2000a).

In order to provide children with special needs the benefit of family foster care, the Children's Administration provides "exceptional cost" funds to parents that augment basic foster care rates.

Rehabilitation Treatment Services. Rehabilitative treatment services, also referred to as Behavior Rehabilitation Services (BRS), can be authorized for emotionally/behaviorally disordered, sexually aggressive, developmentally disabled, or medically fragile children who require a more intensive treatment-oriented setting than can be provided in kinship or family foster care. These services are provided by contract with private agencies that offer a continuum of care that includes enhanced in-home services, treatment foster care, and group/residential care (CA 2000a).

RESEARCH FINDINGS: CHILDREN IN FOSTER CARE

Only a small percentage of children coming into contact with the child welfare system enter placement, and many children placed into care do not remain longer than a few months. In Washington, a high percentage (41 percent) of the approximately 7,000 children placed each year leave care within the first month, and close to half (48 percent) leave within the first three months of placement (CA 2000b).

The majority of children enter care because of abuse or neglect, parental absence, or parental inability to provide care (RDA 2000).[1] A few children enter care due to their emotional or behavioral problems or a condition such as autism. Children placed into foster care are disproportionately poor, adolescent, and members of minority groups. Nationally, African American and Latino children, in particular, are disproportionately represented in foster care relative to their numbers in the general population (Ways and Means Committee 1998).

Mental Health Problems

Children in foster care experience a combination of risk factors, including exposure to maltreatment and the trauma of at least one separation from a parent, which make them especially vulnerable to psychological problems (Schneiderman et al. 1998; VanBergeijk, McGowan, and Stutz in press). There is a consensus that children in out-of-home care demonstrate significant mental health needs (Armsden et al. 2000; VanBergeijk, McGowan, and Stutz in press; Schneiderman et al. 1998; Leslie et al. 2000; Courtney 1998; Kupsinel and Dubsky 1999). Studies have found that between 35 to 85 percent of children entering foster care have mental health problems (Leslie et al. 2000). It has also been reported that foster children have 3 to 7 times more chronic medical conditions, birth defects, emotional disorders, and academic failure than children from similar socioeconomic backgrounds not in foster care (Blatt and Simms 1997).

Although children in care may suffer from anxiety, depression, or low self esteem, the most common behavioral problems occur when children's psychological problems are "externalized." These children are likely to be disruptive, aggressive, and/or dangerous to others (Armsden et al. 2000).

Risk of Poor Placement

The presence of behavioral problems is a major risk factor for foster family breakdown and placement instability (Scholte 1997; Nugent and Glisson 1999; Palmer 1996; Stone and Stone 1983; Newton, Litrownik, and Landsverk 1999). Studies have documented that children who externalize their problems are at greater risk of multiple placements (Nugent and Glisson 1999; Newton, Litrownik, and Landsverk 1999; Stone and Stone 1983). Children with multiple

[1] Approximately 61 percent of children placed in Washington State enter placement due to child abuse or neglect on the part of one or both parents, 18 percent enter care due to family conflict, and 21 percent enter care due to the child's mental and emotional problems.

placements are more likely to come back into care after being returned home (VanBergeijk, McGowan, and Stutz in press; Kupsinel and Dubsky 1999).

Children with behavioral impairments are also likely to remain longer in foster care. A recent study of foster children in Nebraska found that behavioral impairment was the strongest predictor of length of time in care (Kupsinel and Dubsky 1999). Longer stays in foster care place children at risk for negative placement outcomes (Nissim and Simm 1994). In Washington State, school age children and emotionally disturbed children, in particular, are more likely to experience multiple placements than younger children (Wilson 1999).

Placement instability also contributes to the behavioral problems of foster children. Some children who initially do not demonstrate clinical levels of emotional or behavioral problems appear vulnerable to the effects of placement disruption. A recent study of foster children in California found that for children who were "normal" at entry, the number of placements was associated with an increase in problems (Newton Litrownik, and Landsverk 1999). A study of children entering care with the Casey Family Program found that more placement volatility prior to referral was strongly associated with greater hostility and oppositional behavior at intake (VanBergeijk, McGowan, and Stutz in press). The level of hostility at entry was found to be the best predictor of children's eventual adjustment to placement.

The literature suggests that services provided to children in care may in fact not be closely related to their psychological and behavioral needs (Nugent and Glisson 1999; Glisson 1996; Berrick, Courtney, and Barth 1993). Minority children may be even less likely than Caucasian children to receive the services they need (Nugent and Glisson 1999). A lack of adequate assessment may contribute to the failure to meet children's clinical needs, as demonstrated by a British study which found that a significant number of adolescents in care were suffering from severe, potentially treatable psychiatric disorders which had gone undetected (McCann et al. 1996).

Matching Placement Settings With Children's Needs

An association has been found between the type of placement (e.g., kinship care, family foster care, group care) and placement outcomes, such as the child's length of stay, receipt of services, and risk of re-entry to care (VanBergeijk, McGowan, and Stutz in press; Kupsinel and Dubsky 1999; Testa and Rolock 1999).

Children without significant problems may do better in kinship or family foster care, but when children have major problems, therapeutic settings are preferable. Children in kinship care may experience fewer moves than children in non-kinship care (VanBergeijk, McGowan, and Stutz in press; Kupsinel and Dubsky 1999; Testa and Rolock 1999). In a study of foster children in Illinois, children had greater stability in homes with relatives than in family foster homes. However, research suggests that the use of family foster care instead of more intensive settings (e.g., group or residential care) for older children with behavioral problems places them at increased risk of disruption (Barth and Berry 1989; Scholte 1997).

Children generally benefit from placements in close proximity to family members. The literature suggests that children who have continued contact after placement with parents, siblings, or

other relatives are less likely to experience disrupted placement (Thoburn 1994; VanBergeijk, McGowan, and Stutz in press; Kupsinel and Dubsky 1999; Leathers 1999). When children are placed far from their families, parental contact can be inhibited. Children placed in residential treatment programs or group homes are usually a greater distance from their families than children in family foster homes.

Access to services may be directly or indirectly affected by placement. In one study, children residing in kinship care at some point during out-of-home placement were found to have accessed fewer mental health services compared with children in non-relative foster care, even after taking into account their service needs (Leslie et al. 2000). There is some evidence that placement selections which promote stability may improve the likelihood that children will receive needed services. Nugent and Glisson concluded that as a child's stay in single placement lengthens, the likelihood also increases that the child will receive services (1999).

How Placement Decisions Are Made

The type of placement setting—kinship care, family foster care, treatment foster care, or residential care—should match the child's needs. One of the earliest studies of foster care decision-making found that although a relationship existed between the degree of disturbance and type of recommended placement, the direction of the relationship and the predictions about a child's placement varied substantially among caseworkers (Briar 1963). Published studies do not consistently find that placement decision-making is associated with children's psychosocial functioning or mental health needs, although relationships have been found with children's age, gender, placement history, labels, and service pathways (e.g., enter system as maltreated versus status offenses or criminal behavior) (Knapp et al. 1987; Glisson 1994; Glisson 1996; Martin, Peters, and Glisson 1998).

For example, in a recent study of decision-making by independent Assessment and Care Coordination Teams (ACCT) in Tennessee, Martin found that even with training on the use of decision support tools, case managers based placement and service decisions primarily on the labels applied to children and whether they entered through the child welfare, mental health, or juvenile justice system (Martin, Peters, and Glisson 1998). Recommendations for placement restrictiveness and mental health services were unrelated to the child's psychosocial functioning.

On the other hand, there is evidence that placement decisions are not always arbitrary. Results of the testing of one instrument, the Level of Care Assessment (LCA) in California, showed that children identified for placement in family foster homes or kinship care had significantly fewer perceived problem behaviors than children identified for treatment foster care or group care. Findings demonstrated that meaningful distinctions existed between groups of children in family foster care or kinship care and those in treatment foster care or group care. Differences between treatment foster care and group care were not large enough to reliably discriminate using this particular instrument nor could the instrument discriminate between levels of group care (Courtney, Barth, and Allpin 1992).

In a further analysis of the LCA test data, Courtney found that case manager perceptions of externalizing child behavior and the child's past care history had the greatest influence on

whether a treatment-oriented setting was viewed as necessary (1998). A 1992 Washington State Children's Administration study found that social workers were able to accurately identify children on their caseloads in need of treatment foster care or group care, because these children were found to be similar to those already placed in these types of settings (Bates, English, and Giles 1992).

Children in different levels of placement have been found to exhibit different problems and needs. A survey of children in California treatment foster care and group care found that children in treatment foster care were a less disturbed group than those in group care in terms of acting out behaviors (Berrick, Courtney, and Barth 1993). Hodges, in a study of youths with serious emotional disturbance, found that children in residential placements were significantly more impaired at intake than children living with their parents or children in family foster care (Hodges, Doucette-Gates, and Liao 1999). Children in treatment foster care were not found to be different from children in any other group.

Choosing and Applying Criteria to Placement Decisions

Ideally, practitioners could use criteria that connect children's characteristics and circumstances with decisions about placement settings. If the appropriate level of care were determined at the earliest possible point, placements would more likely be stable, and children would have better outcomes.

Unfortunately, several literature reviews have failed to identify useful criteria. Wells' review concluded that nothing effectively links children's clinical profiles with criteria for specific forms of residential treatment (1991). Another review also concluded that some children are being served in inappropriate settings in the absence of standardized placement criteria (Bates, English, and Giles 1992).

In addition, even with level-of-care criteria, clinicians have difficulty with consistent application. In a study by Bickman, Karver, and Schut (1997), clinicians were unable to reliably use level-of-care criteria regardless of their discipline, position, or experience, although they were able to differentiate between the most and the least severe cases. Their results raise questions about the reliability of clinical judgment; efforts to apply level-of-care criteria and match placement and services to children's needs may not improve outcomes (Bickman, Noser, and Summerfelt 1999).

Compounding the problem of decision-making criteria is the fact that placement criteria are not related to specific treatments provided in residential settings (Wells 1991). It has been observed that residential treatment providers tend to supply identical services to all residents regardless of the child's level of need (Lyons et al. 1998). It is not surprising then, that Berrick's California study of children in treatment foster care and group care found no relationship between the cost of care and the child's level of behavioral disturbance (Berrick, Courtney, and Barth 1993).

The fact that clinicians have difficulty applying standardized criteria and placement services cannot be predicted from the level of placement setting and has hindered improvement of the placement decision-making process. For example, California's 1990 implementation of the

LCA was halted after an evaluation determined that children with similar profiles ended up in a diverse range of placements and in every level of group home. The evaluation concluded there was a low likelihood that the assessment could ever consistently determine appropriate group care for specific children (Health and Welfare 1997).

No studies as yet definitively describe differences in outcomes for children in different levels of care (Berrick et al. 1997; Barth 1997). Bickman, Karver, and Schut (1997) observed that level-of-care standards have not yet been linked to clinical and functional outcomes, and outcomes such as increased level of functioning, enhanced development, and reduced symptomatology should be the ultimate criteria for determining appropriateness of care.

Improving Decision-Making

Three components are repeatedly identified in research as having the greatest potential to improve placement decision-making:

- Systematic and early assessment of all children entering care (Berrick, Courtney, and Barth 1993; Schneiderman et al. 1998; Nugent and Glisson 1999; Newton, Litrownik, and Landsverk 1999);

- Use of standardized decision support instruments (Armsden et al. 2000; Martin, Peters, and Glisson 1998; Lyons et al. 1998; Wells 1991; Newton, Litrownik, and Landsverk 1999; Hodges and Wong 1997; Nissim and Simm 1994; Leslie et al. 2000); and

- Multi-dimensional assessment (Armsden et al. 2000; Perry et al. 1999; Hodges and Wong 1997; Scholte 1997).

Systematic and Early Assessment of All Children Entering Care. Methods to systematically assess children's needs at placement are required to match children with placement settings that can provide the types of services they should receive (Berrick, Courtney, and Barth 1993; Leslie et al. 2000). Comprehensive screening and assessment for children entering out-of-home care, allowing early intervention, can have measurable benefits that include greater placement and relationship stability, reduced risk of multiple placements, and shorter stays in care (Schneiderman et al. 1998; Nugent and Glisson 1999). Newton, Litrownik, and Landsverk maintain that screening should include children entering care who are asymptomatic (1999). The strong relationship between lower ages of children and treatment success argues for early detection and treatment of problems (Berrick et al. 1997). For example, early clinical intervention designed to reduce the anger and oppositional behavior of children with these problems at intake has been found to significantly improve placement outcomes (VanBergeijk, McGowan, and Stutz in press).

Use of Standardized Decision Support Instruments. In order to select the most appropriate options for placement and treatment, children's psychosocial functioning must be accurately assessed (Martin, Peters, and Glisson 1998). The use of standardized instruments provides far more useful and meaningful data than clinician or caseworker judgment because the information is collected systematically, and individual children's scores can be compared.

Measures such as the Child Behavior Checklist (CBCL), Teacher Report Form (TRF), and the Child and Adolescent Functional Assessment Scale (CAFAS) have demonstrated utility in the identification of appropriate placement settings and clinical mental health needs, as well as the evaluation of service outcomes (Armsden et al. 2000; Newton, Litrownik, and Landsverk 1999; Martin, Peters, and Glisson 1998; Hodges and Wong 1997; Hodges, Doucette-Gates, and Liao 1999). These measures have established reliability and validity and are sensitive to changes in child behavior and functioning over time.

The Childhood Severity of Psychiatric Illness (CSPI), developed by John Lyons, is another instrument used to assess psychiatric symptoms, risk behaviors, and child functioning at school, in the home, and with peers. Pilot studies in Illinois indicate that this instrument can accurately measure children's mental health needs and service utilization (Lyons et al. 1998). The Child and Adolescent Needs/Strengths (CANS) instrument (mental health and child welfare versions are available) was developed by Lyons from the CSPI and provides a structured assessment that includes a broader set of dimensions relevant to service decision-making, along with an assessment of strengths.

Decision support instruments have also been developed by specific child welfare jurisdictions, such as the Arizona Level of Functioning Assessment Tool. These instruments have not been tested for validity and reliability but represent an attempt to provide a consistent and objective structure to the assessment of a child's needs and strengths, from which placement decision-making is expected to follow.

Multi-Dimensional Assessment. The diversity and complexity of problems experienced by children in out-of-home care argue for the importance of multi-axial assessment rather than focusing only on a single aspect of functioning (Armsden et al. 2000). Multi-dimensional assessments are those that provide an understanding of the child's cognitive abilities; history of adverse life events; current physical, emotional, and behavioral symptoms; and functioning in key areas. Such assessments can effectively focus treatment planning and provide the basis for a more rational evaluation of appropriate placement settings (Perry et al. 1999; Hodges and Wong 1997).

INNOVATIVE STATE PRACTICES

In response to legislative direction, we examined "best practices" regarding matching needs of children in care with type of placement setting. This review focused on decisions about optimal placement settings, not decisions about add-on rates for basic foster care.[2] Recommendations were initially sought from national experts, including the following:

- Administration for Children, Youth and Families (ACYF);
- Child Welfare League of American (CWLA);
- The Council on Accreditation for Children and Family Services (COA); and
- National Resource Center for Foster Care and Permanency Planning.

The June 2000 *Foster Care Rate Redesign Report*, by Hornby Zeller Associates, was reviewed for information regarding states that employ instruments and procedures for level-of-care decision-making. The *State Child Welfare Exceptional Costs Systems* report and a list of child assessment instruments prepared by the Children's Administration within the Department of Social and Health Services were also reviewed for practices in other states (CA 2000a).

Additional inquiries were made through telephone calls, e-mail queries, and Web research. No states or child welfare jurisdictions were recommended by national experts for their specific placement decision-making practices. States or agencies were mentioned for meeting COA standards or participating in system/value-based reform initiatives such as the Annie E. Casey Foundation's *Family to Family Initiative* (1992).

Categories. This review covers placement assessment and decision-making. These approaches can be classified into four categories:

- *Formal assessment* of children *with level-of-care criteria;*
- *Formal assessment* of children *without level-of-care criteria;*
- *Level-of-care criteria without formal assessment* of children; and
- *No level-of-care criteria with no formal assessment* of children.

The majority of child welfare jurisdictions fall into the fourth category. Like Washington State, they have formal procedures for determining add-on foster care rates and for referral and authorization of behavior rehabilitation services (group care) but lack standards for the comprehensive assessment of needs and employ no level-of-care criteria or guidelines.

[2] Information about practices and instruments used for foster care rate level decision-making were not the focus of this report but can be obtained in the June 2000 Hornby Zeller Associates report, (207) 773-9529.

Formal Assessment With Level-of-Care Criteria

Tennessee. Tennessee's child welfare system employs a formal assessment protocol for every child entering care along with level-of-care criteria linked to the assessment. The assessment protocol is used for every new custody case prior to the permanency planning staffing. The protocol contains seven tools to assist case managers in gathering information about a child and family before determining the need for, and level of, out-of-home care. Decision guidelines incorporate assessment rules into a matrix that recommends in-home or out-of-home placement, and if out-of-home placement, the recommended level of placement. These guidelines are not considered a substitute for clinical judgment and do not have to be rigidly followed by the caseworker. After treatment and placement begin, some tools are completed again for comparison of initial needs with progress or lack of progress. Tennessee has units in each region that conduct assessments on a full-time basis.

California. California is included in this review not because of practices that were implemented, but because of what was attempted. Under a mandate from the legislature, the California Department of Social Services (CDSS) developed a level-of-care assessment (LCA) instrument in 1990 which could be used to match children's needs with their placement resources. The instrument was field tested and evaluated by the University of California at Berkeley. The LCA tool was not implemented in California because "the sophisticated match between child and facility envisioned by [state law] was highly unlikely to occur, and, in fact, it seemed that the level of match possible might be so elemental that it would be of limited use" (Health and Welfare 1997).

Formal Assessment Without Level-of-Care Criteria

Georgia. Georgia's county child welfare system offers the best example of a statewide effort to assess placement needs of all children entering care without the use of level-of-care criteria in the placement decision-making process. First Placement Best Placement (FPBP) is a statewide initiative to comprehensively assess all children entering out-of-home care in order to make the best placement decision. FPBP, now entering its fourth year, has emerged as the foundation of Georgia's strategy for child welfare reform. Assessments are provided by contracted professionals within 30 to 45 days, based on FPBP standards for family, psychological, educational, and medical assessment components. All assessments must include a multi-disciplinary team meeting as the final stage of the assessment process. Here, a recommendation is made for the best and most appropriate placement for the child. The team's recommendations are not binding on the public agency (county child welfare agency) but are generally followed when resources allow.

An annual allocation of $4.6 million currently funds 330 assessments each year. Approximately 100 professionals, including individuals (e.g., psychologists) and private agencies, are currently approved to provide FPBP assessments at $1,400 per child. Each FPBP contractor has the responsibility to convene a multi-disciplinary team that is individually tailored to each child and family assessment. The team meetings typically last approximately 15 to 30 minutes per case and are generally scheduled back-to-back on designated days. The community professionals on these teams participate as part of their

agency's responsibilities and do not receive separate compensation from FPBP. Family conferencing is also used, although not systematically in every county, as an addendum to the assessment process.

Level-of-care criteria are not used in this process. Demonstration sites are now using the Child and Adolescent Functional Assessment Scale (CAFAS) as one way of measuring progress in care and outcomes. Comprehensive data are also being collected from the demonstration sites that measure the length of time in care and the number of moves. Georgia eventually plans to complete a comprehensive assessment on every child and family already in care. The FPBP strategy of comprehensive assessments is also being used by some demonstration counties on moderate- to high-risk child protective service cases.

Texas. The Children's Crisis Care Center (CCCC) in Texas is an excellent example of a center-based program designed to assess children entering placement. The CCCC is a collaborative partnership in Harris County. Partners in the program include Harris County Children's Protective Services, Texas Department of Protective and Regulatory Services, Baylor College of Medicine: Child Trauma Programs, and Harris County's Mental Health and Mental Retardation Association. The program provides a proactive, up-front, multi-disciplinary assessment of children referred by the child welfare agency. The assessment is performed by a special unit which is completely separate from both the intake/investigation unit and the family maintenance/reunification unit.

Two types of assessments are provided by the CCCC. A family assessment, which consists of a semi-structured clinical interview and the administration of standardized measures of family, child, and parent functioning, is completed within 72 hours of placement. Within the next 10 to 14 days, a multi-dimensional developmental (for children under age 6) or psychological (for children age 6 or above) screening is completed.

The assessment results are reported to the social worker and the court within 20 days of placement. Information from the assessments is used to make recommendations regarding treatment and placement. Program evaluations indicate that assessed children experience fewer placement disruptions, a shorter average time between the initial placement and long-term placement, a higher percentage of relative placements, and higher rates of reunification.

Level-of-Care Criteria Without Formal Assessment

Arizona. Arizona's Level of Functioning Assessment/Service Level Checklist (ALFA) is an example of a non-standardized instrument intended to evaluate the need for intensive treatment services without accompanying requirements for formal assessment. The ALFA is a multi-dimensional, nine-scale instrument developed from the Colorado Client Assessment Record. The ALFA is completed for all children referred for behavioral health services at least every six months during treatment and at case closure. Scores are based on the child's functioning during the previous six months and are used to evaluate the need for clinical review by a psychologist or psychiatrist, screen for serious mental illness, predict the child's service utilization, identify areas needing to be addressed in the child's service

plan, create aggregate profiles of service users and predictions of system needs, and as individual and aggregate measures of symptomatic and functional improvement.

Illinois. Illinois uses a Level of Care (LOC) assessment tool and independent reviewers to determine if a child needs specialized or treatment foster care; placement review teams evaluate the need for residential or group care. If social workers believe that a child needs more than family foster care, they can assemble information for rating by an independent LOC reviewer. The score on the assessment form determines whether a child qualifies for specialized or treatment foster care. Illinois uses Placement Review Teams or Child and Family Teams to hear case presentations of children considered for group care. Illinois is currently attempting to standardize the use of forms and processes, refine its LOC tool, and provide adequate training in its regions.

No Level of Care Criteria and No Formal Assessment

Iowa. Iowa does not employ formal assessment or level-of-care criteria in their placement decision-making process. Like Washington State, there is a formal process for referral and authorization of intensive treatment services. Unlike Washington, Iowa requires a team review for each child referred for rehabilitative treatment services.

Each region in Iowa has one or more Clinical Assessment and Consultation Teams (CACT) to provide clinical assessment and authorization for all rehabilitation treatment services. These services can be provided in a variety of in-home or placement settings. Treatment foster care and group and residential care are included, but special rates for foster care do not require CACT review. Pilot testing of a telephone review and authorization system has begun in two regions. Team members are licensed Practitioners of the Healing Arts. Each CACT assists staff to explore additional resources. Consultation is also provided to enhance staff skills in effective assessment and planning and develop alternatives to out-of-home placement.

Summary

Exhibit 1 summarizes assessment and placement practices in other states.

Exhibit 1

Innovative Practices: Connecting Assessment and Placement Decisions

LOCATION	ASSESSMENT	DECISION-MAKING	BEST PRACTICES	DEMONSTRATED OUTCOMES
ARIZONA (STATE)	✓ Arizona Level of Functioning Assessment/Service Level Checklist		✓ Standardized decision-making tools ✓ Assessments for all children entering care	
GEORGIA (ALL COUNTIES)	✓ First Placement/Best Placement Assessments, including: • Developmental assessments • Psychological assessments • Educational assessments • Medical assessments • Family assessments	✓ Team	✓ Standardized decision-making tools ✓ Assessments for all children entering care ✓ Multi-dimensional assessment	Children not placed per recommendations have a significantly greater chance of placement disruption
ILLINOIS (STATE)	✓ Level of Care Assessment, including: • LOC application • Medical certification • Mental health certification • Caregiver report	✓ Independent reviewer—entry to specialized foster care and group care ✓ Team—Placement Review/Child and Family Team staffing for entry to group care	✓ Standardized decision-making tools ✓ Assessments for all children entering care (specialized foster care and group care only) ✓ Multi-dimensional assessment	
IOWA (STATE)		✓ Team—eligibility for rehabilitative treatment services[3] determined by a Clinical Assessment and Consultation Teams (CACT)	✓ Assessments for all children receiving rehabilitation treatment services	

[3] Iowa rehabilitative treatment services are defined as "services designed to restore a function or skill that a child lost or never gained as a result of interference in the normal maturation learning process due to individual or parental dysfunction. The child must have the capacity to learn the function or skill. Services are designed to address the specific medical-behavioral health needs of the child." These services can be provided in a variety of settings.

LOCATION	ASSESSMENT	DECISION-MAKING	BEST PRACTICES	DEMONSTRATED OUTCOMES
TENNESSEE (STATE)	✓ Assessment Protocol containing seven tools: • Social history • Early and Periodic Screening, Diagnosis and Treatment (EPSDT) • Community Risk Assessment • CPS strength/Risk Assessment • Shortform Assessment on Children • Family Functioning Assessment • Decision Guideline matrices	✓ Individual case manager	✓ Standardized decision-making tools ✓ Assessments for all children entering care	
TEXAS (HARRIS COUNTY)	✓ Children's Crisis Care Center	✓ Individual case manager	✓ Standardized decision-making tools ✓ Assessments for all children entering care ✓ Multi-dimensional assessment	Less time in shelter care, faster return home, less restrictive placements

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