Statement of

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Chairman Hatch, Ranking Member Wyden, and Members of the Committee, it is my honor to appear before this Committee on behalf of the Department of Health and Human Services (HHS). The Administration believes that children are best served when raised in safe, loving families, and congregate care use should be limited to children who need intensive residential care due to medical issues, and only for as long as those interventions are needed. That is why the President's Fiscal Year (FY) 2016 Budget includes a proposal to limit the use of congregate care, to increase monitoring of congregate care use, and to support family-based care as an alternative to congregate care. We are grateful to you for having this hearing and bringing more attention to the issue.

My name is Joo Yeun Chang, Associate Commissioner of the Children's Bureau. I have worked as a national advocate on child welfare policies as a senior staff attorney at the Children's Defense Fund, and immediately prior to my appointment to the Bureau, I worked at Casey Family Programs Foundation where I worked closely with state and local child welfare agencies. In my current role, I oversee the Federal foster care and adoption assistance programs as well as a range of prevention and post-permanency initiatives.

At HHS, we work with the state and tribal agencies that run child welfare systems to ensure that vulnerable children in foster care are placed safely in the least restrictive, most family-like settings available and that are in the best interests of each child. Federal law gives states flexibility and discretion to make decisions for a child on a case-by-case basis to ensure that the best placement is made and the individual safety, permanency, and well-being needs of the child are met.

According to the most recent data we have available, in FY 2013, there were 402,378 children in foster care, including both IV-E and state-funded foster care. Over the past 15 years, we have seen a dramatic decline in the total number of children in care, from a high of 567,000 in FY 1999 to a low of 402,378 in FY 2013. In FY 2013, the average age of a child in foster care was nine, but very young children and teens represented the highest subgroups of children in care. Seventy-five percent of children in foster care lived in a foster family home, 14 percent lived in congregate care settings, and five percent have returned home on a trial basis. Most children and youth in foster care are there for less than two years; 20 percent are in care for two to four years; and eight percent are in care for five years or longer. Of all exits from care during the year, the majority (87 percent) exited to a permanent home. However, far too many children spend too much of their childhood in care without the benefit of a safe, permanent family. For children entering care during the year, less than half reached permanency within 12 months, and approximately eight percent of those children later re-entered care within 12 months.

Congregate care includes care in a group home or institution such as a child care institution, residential treatment facility, or maternity home. There is consensus across multiple stakeholders that most children and youth, especially young children, are best served in a family setting rather than in group or institutional care. Congregate care should be used not as a default placement setting due to a lack of appropriate family based care, but as part of a continuum of interventions; the question is not if congregate should ever be used, but when, for whom, and for how long. The Administration believes that stays in congregate care should be based on the specialized

behavioral and mental health needs or clinical disabilities of children. It should be used only for as long as is needed to stabilize the child or youth so they can return to a family-like setting.

In March 2015, the Administration for Children and Families (ACF) issued a data brief providing a national look at the use of congregate care in child welfare. The brief was developed to provide a basic understanding of the use of congregate care, and answer the following questions about congregate care utilization:

1) Who is placed in congregate care?
2) How long do children stay in congregate care?
3) Are there any predictive factors?
4) What are jurisdictional differences in the use of congregate care?

To answer these questions, the Children's Bureau, within ACF, conducted an analysis of state-reported data through the Adoption and Foster Care Analysis and Reporting System (AFCARS). A point-in-time analysis of AFCARS found that as of September 30, 2013, (the most recent data available), an estimated 14 percent of all children in foster care were in congregate care.

In addition to point-in-time data, we created longitudinal cohorts of children who experience congregate care. We followed children who entered care in 2006, 2007, and 2008 over five years. Older youth consistently represented a majority of those who experienced congregate care; they made up 69 percent of children and youth who experienced congregate care in the 2008 cohort. In our analyses, we found that we could effectively group these older children on the basis of diagnosed clinical disabilities and\or removal and placement into foster care due to a "child behavior problem" (CBP). The aforementioned grouping resulted in four subgroups:

1) children without a clinical diagnosis or CBP but had very likely experienced some type of maltreatment, 2) children with at least a mental health diagnosis according to the statistical manual of mental disorders (DSM), 3) children with a CBP excluding all disabilities, but who may have experienced some maltreatment and finally, 4) children with any clinical disabilities excluding a DSM diagnosis.

For the older youth population in congregate care, children whose reasons for removal from their home include having been identified as having a CBP but who do not have a reported DSM diagnosis, nor any other disability represented 44 percent of the children in the cohort who experienced congregate care. Children with a DSM diagnosis represented 21 percent, children with a clinical disability other than a DSM diagnosis represented 6 percent, and children with no clinical indicators, nor a CBP comprised nearly 29 percent of the children in the cohort who experienced congregate care. Among youth with a social/emotional issue, those with a CBP were more likely to initially be placed into congregate care for treatment; youth with a DSM diagnosis were more likely to be subsequently placed in congregate care because they were not able to safely remain in traditional foster family care. Overall, results indicate that youth with a DSM indicator and CBP indicator h may experience a need for higher levels of care. Children with a DSM diagnosis were more likely to have congregate care as a subsequent placement, be previously adopted, and have three or more placement moves compared to the other subgroups. Children with a CBP indicator were more likely to enter congregate care as their first placement, have only one or two placement moves, and exit to permanency. These children also were more likely to reenter care and be transferred to another agency, which may indicate a need for longer term stabilization in an alternate setting.

Further analysis of those children in care as of September 30th, 2013 (point-in-time data), demonstrated that children currently in congregate care are almost six times more likely to have a "child behavior problem" designation and three times more likely to have a DSM diagnosis compared to children in other foster care settings. Also, on average, these children had spent eight months in their current congregate care setting compared to 11 months for children in non-congregate care settings. However, the overall time in foster care was longer for the children in a congregate care setting compared to those were in settings other than congregate care, with an average of 27 months compared to 21 months respectively.

There has been a significant decrease in the percentage of children placed in congregate care settings in the past decade, and this reduction is at a greater rate than the overall foster care population. Proportionately, children in congregate care comprised 18 percent of the foster care population in 2004 and 14 percent in 2013. While these trends suggest that child welfare practice is moving toward more limited use of congregate care, the depth of improvement is not consistent across states, and in some states the use of congregate care has increased.

In order to understand how states have reduced the use of congregate care at the state and local level, HHS interviewed a number of state and local officials. The data brief highlights practices that states and local jurisdictions have used to shorten lengths of stay in congregate care, develop alternative interventions for children and youth with complex social/emotional needs, and increase the effectiveness of congregate care as an intervention for those who need it for limited periods of time. A number of states shared that increasing placement with relatives has helped

reduce the need for congregate care. For example, Texas has placed an emphasis on family finding and kinship placements in response to the passage of the Fostering Connections to Success and Increasing Adoptions Act of 2008. An indirect result of increased placements with kinship families has been a reduction in the numbers of children placed in congregate care. Utah has developed a method of evaluating its congregate care programs (e.g., outcome measures, qualitative interviews with youth) to ensure that children who need residential services are placed with providers who have demonstrated an ability to meet those particular needs.

Based on the findings from the data brief and the insights we gained from states that have significantly decreased their use of congregate care, the Administration developed a proposal in the FY 2016 President's Budget to reduce the use of congregate care by increasing monitoring of congregate care use and supporting family-based care as an alternative to congregate care. The Administration's proposal for family-based care impacts any child who is in, or at-risk of being placed in, a congregate care setting. The proposal would amend title IV-E of the Social Security Act to provide additional support and funding to promote specialized family-based care as an alternative to congregate care for children with behavioral and mental health needs, and provide oversight when congregate care placements are used. The proposal addresses four specific areas:

- It requires an initial justification of appropriateness:
    - If a child must be placed in a congregate care facility, title IV-E agencies would be required, as a condition of a child's title IV-E eligibility which provides Federal assistance with the cost of caring for a foster child, to justify congregate care as the least restrictive foster care placement setting appropriate to meet the child's needs. Title IV-E agencies would be required to document their

assessment of the child's medical and behavioral health needs that indicate a congregate care setting is necessary. This assessment also would identify the specific goals the child must achieve for discharge to a lower level of care and a more family-like setting, and the time frame in which this transition will occur.

- It would require the continued justification of the appropriateness of the congregate care placement:
    - States would be required to request a judicial determination at six months and every six months thereafter that the placement in the congregate facility is the best option for meeting the child's needs and that the child is progressing towards readiness for a more family-like setting.
- It provides for smaller caseloads and specialized case management:
    - Title IV-E agencies would be reimbursed with 60 percent Federal financial participation (FFP) for specialized casework, and 80 percent FFP for specialized caseworker training. This would provide support for specialized case management where caseworkers would have smaller caseloads and receive specialized training so that the caseworkers can focus on family-based care. Specialized case management will vary at state discretion, but overall worker caseloads would be sufficiently low (approximately 1:10) to allow for workers to provide intensive work with the foster family, child, and the child's family. This would include developing, implementing, and monitoring the child's treatment plan, frequent in-person contact and consultation with the foster family, and permanency planning with the child's family. Workers would receive specialized

training in such things as behavioral management techniques, and treatment for emotional disturbances.

- It provides specific/targeted foster parent training and support:
    - The proposal would provide specialized training and compensation for foster parents who provide a therapeutic environment for a child. A therapeutic foster home is one with specially trained foster families who can provide support and treatment to a child with behavioral and/or mental health challenges.
    - It would provide title IV-E reimbursement for the supervision costs for children who may need specialized services during the day.

This proposal presents a concerted effort to limit the use of congregate care facilities for children in foster care by increasing investments in family-based care for children who have mental, social, or behavioral health needs and monitoring the use of congregate care.

The Administration estimates this proposal to cost $78 million in FY 2016 and reduce costs of title IV-E Foster Care by -$69 million over ten years. As placements in a congregate care facility are significantly more expensive than placements in a foster family home, the main source of savings in the proposal is from the reduced use of congregate care facilities for foster care placements. This proposal also includes supports for foster families and caseworkers; these investments will somewhat increase expenditures on other proposed and existing title IV-E activities especially in the first few years of the proposal. Overall, this proposal will result in a reduction in expenditures on maintenance payments as children are placed in less restrictive settings that best meet their needs.

I very much appreciate the Committee's interest in the issues raised today and the opportunity to speak with you. We look forward to working with you to address this crucial issue and improve services to some of our most vulnerable young people. I would be happy to answer any questions.[i]

[i] All data cited in this testimony is from the:
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau
Adoption and Foster Care Analysis and Reporting System (AFCARS)
Data As Of July 2014